

**Congress of the United States**  
**House of Representatives**  
**Washington, D.C. 20515**

February 6, 2012

The Honorable Kathleen Sebelius  
Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Secretary Sebelius:

On December 16, 2011, the Center for Consumer Information and Insurance Oversight released the Essential Health Benefits Bulletin (Bulletin) that discusses how to define the essential health benefits package pursuant to section 1302(b) of the Patient Protection and Affordable Care Act (ACA). In providing this early guidance, the Secretary is opening a dialogue with states, consumers, and other stakeholders on the important issue of defining the Essential Health Benefits (EHB). We appreciate the opportunity to provide comments in response to the initial direction proposed in the Bulletin and look forward to a more thorough regulatory notice and comment process to finalize the EHB.

The creation of an EHB package is a vital component of health reform, as it is critical to ensuring Americans have access to high quality health insurance. As authors of the law, we established a defined set of benefits so that families would have access to meaningful coverage and to enable consumers to easily compare coverage options in a transparent and understandable manner -- something totally missing in today's health insurance marketplace. Furthermore, requiring insurers to provide coverage for a defined set of benefits will protect against their ability to design benefit packages to attract certain populations and avoid others.

## **1. DELEGATION TO THE STATES**

When creating the EHB package, we intended this to be a federal decision. We had not anticipated your decision to delegate the definition of the EHB package to states. While we understand the goal of balancing comprehensiveness and affordability, and ensuring an appropriate role for state input, we would reiterate that one of the primary goals of the Affordable Care Act was to create a consistent and comprehensive level of coverage for people across the country. Without very careful protections, we have serious concerns about delegating the decision for the EHB to the States and providing even further discretion to insurers.

We worry that some of the benchmark plans, including the default benchmark plan, the "largest plan by enrollment in the largest product in the State's small group market," could be very lean or contain restrictive amount, duration, and scope limitations. For example, small group plans are not required to meet state benefit mandates in many states and have not had to meet mental health parity or other insurance requirements. A recent GAO report found that 34%

of employers surveyed exclude at least one broad mental health condition or substance use disorder diagnosis from their covered benefits. Furthermore, many state laws require parity only for coverage of treatment for certain mental health conditions (serious or biologically-based conditions). We are concerned that if a state selects one of these small group plans as the EHB benchmark, individuals could have less than adequate coverage for mental illness and substance abuse disorders, or other illnesses that affect them. These results are contrary to the goals of mental health parity.

While we all want to reduce health care spending increases, the EHB should not become a cost control proxy. The ACA has many other provisions that will reduce health care spending trends. The EHB package should be based on meaningful access to medically necessary services.

That said, we are just learning exactly how much variation exists among the potential benchmark plans or how restrictive some of the specific plans may be. Furthermore, states have raised concerns about identifying plans that could serve as potential benchmarks, i.e. the largest small group plan in the state.

For these reasons, in addition to the information that you provided in Essential Health Benefits: Illustrative List of the Largest Three Small Group Products by State, we strongly encourage you to make all plan data collected in the development of this policy and in the development of healthcare.gov publicly available as soon as possible so that potential benchmark plans can be identified, reviewed, and commented upon. Further, it is essential that the policy forms, not just summaries, for each of the potential benchmark plans in every state be made available to the public immediately so that the possible benchmarks can be thoroughly evaluated and understood. Until we know what is included in the proposed benchmark plans, we are unable to determine whether these are reasonable benchmarks.

We support defining EHBs at the state level insofar as this approach will help to protect state benefit requirements. We also appreciate your transition policy that will enable states that choose a plan that includes state required benefits from being financially penalized.

However, we have several serious concerns with delegating the definition of EHBs to the states without, at a minimum, ensuring an open, fair, and transparent process. The ACA intended to expand transparency so consumers can better understand their choices. Defining the EHBs is a critical step. At a minimum, there should be reporting requirements inserted into the process. For example, one idea might be for HHS to require states to submit their EHB process to the Secretary and for the Secretary to make that information available on healthcare.gov in a way where interested parties can easily understand the process and EHB package in each state -- and states can easily compare their process and package to that of their neighbors. All stakeholders should have the opportunity to understand and comment on what an actual EHB package may be in a state.

We also are concerned that the Bulletin is silent on the issue of enforcement. If states are free to define the EHB benchmark, what happens if they either fail to select a package that meets the ACA requirements or fail to enforce the adherence to that package by health insurers? What

will the federal oversight role be with regard to ensuring that states are meeting the requirements of the ACA with regard to EHBs? We recommend that HHS clearly define oversight and enforcement guidelines and procedures to ensure that states' and insurers' EHB packages are compliant with the ACA and that HHS can monitor such compliance.

## **2. BENEFIT DESIGN FLEXIBILITY**

Congress included the ten benefit categories defined in the ACA so that families would be guaranteed access to a defined benefit package that they can understand and which provides meaningful coverage. We have serious concerns with the Department's proposal on benefit design flexibility, in which the Department is considering permitting every health insurance issuer to make substitutions within and across each of the ten benefit categories specified in the Affordable Care Act.

The proposed "benefit design flexibility" would undermine the EHB coverage requirement, the anti-discrimination protections the law intends to provide those with pre-existing health conditions, and the ability of consumers to compare health insurance policies when shopping. The health insurance marketplace can be complex and confusing for consumers. They face difficulty understanding the differences between plans and often find out that a benefit they need is not covered when they need it. This complexity and lack of transparency makes health care more expensive. Recent reports suggest small employers are facing increasing hurdles when looking to purchase health care as insurers in the small group market are offering coverage with fewer benefits at a higher cost.<sup>1</sup>

The ACA will reform the market so that people get more value for their premium dollars and can make informed decisions when purchasing coverage. The high cost associated with a non-uniform health insurance marketplace was evident during recent stories about the closing of the Texas Consumer Assistance Office. Reports suggest that the office spent approximately \$466 on each call to the health office line. The high costs were attributed to a lack of knowledge by the consumers calling the office and "a natural out-growth of a health-care system with little uniformity in benefits and price."<sup>2</sup>

The creation of the EHB package is undermined if health insurance issuers are permitted to substitute benefits within the ten benefit categories. There is extensive consumer behavioral research showing consumers cannot decide between more than five to eight choices. Allowing plans to go even further -- by substituting benefits across categories -- overrides the very notion of an EHB. Allowing such flexibility will return the health insurance marketplace to one in which consumers cannot meaningfully compare plan choices.

Furthermore, it provides insurers with the tools they need to continue avoiding sicker individuals rather than competing on quality and efficiency. From an administrative perspective,

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<sup>1</sup> Elizabeth MacBride, "Need to Buy Health Insurance? Good Luck," *Crain's New York Business* (Jan. 8, 2012).

<sup>2</sup> Sarah Kliff, "The Cost of Shopping for Health Insurance," *New York Times* (Jan. 8, 2012).

it would be difficult for a state or the Department to monitor these variations and discriminatory motives.

However, we understand the argument for allowing some variation from a specific benchmark plan that a state may select. For example, limiting all types of rehabilitation visits to 50 therapy visits annually versus a benchmark plan that prescribes 20 physical therapy visits, 20 occupational therapy visits, and 10 speech therapy visits. A middle ground approach would be to allow states, not individual insurers, flexibility to modify a benchmark plan's covered benefits within a category, thereby maintaining consistency amongst the plan offerings within a state. However, if a state wants to pick one benchmark plan and not permit insurers to deviate, that should be permitted as well. Both of these alternatives maintain greater consistency among the benefits offered by plans and help protect consumers from predatory, discriminatory, and misleading insurer practices. If any insurer flexibility is permitted at all, insurers should be required to file every modification to the benchmark policy with regulators and the public. They should not be allowed to market policies until regulators approve changes and certify they meet tests to ensure that these changes improve consumer welfare, and they do not have a discriminatory result on particular groups of consumers. In addition, insurers should be required to post every modification to the benchmark prominently on their websites and on [healthcare.gov](http://healthcare.gov). Finally, the Department should clarify that riders, endorsements, or other changes are not allowed to change benefits under the benchmark beyond the variations allowed through this "flexibility" approach.

### **3. MEANINGFUL COVERAGE**

The ACA includes insurance market reforms to create a marketplace where everyone can get insurance that meets their needs without being penalized for preexisting conditions. The creation of an EHB along with insurance market rules that prohibit discrimination based on factors such as preexisting conditions, health status, claims history, gender, or genetic predisposition fundamentally overhauls the insurance marketplace, helping expand access to meaningful insurance to everyone.

Prior to passage of the ACA, insurers routinely denied coverage to sick or chronically ill individuals, charged them more for coverage, or provided coverage or benefits but, in fine print, excluded important benefits. Insurers were also permitted to exclude important but sometimes expensive benefits, for example, according to the National Women's Law Center, over 80% of all individual health plans available for review on [ehealthinsurance](http://ehealthinsurance) did not offer comprehensive maternity care in 2009.

The more flexibility provided to states and insurers in developing an EHB, the more critical it is to include up front tests and transparency to ensure EHBs are not designed to avoid sick individuals or discriminate against specific groups of people. For example, a plan should not be permitted to have such minimal coverage of cancer treatments so as to make all those with cancer choose other plans. A plan should not have burdensome barriers on women accessing routine maternity or prenatal care so as to avoid women of childbearing age from signing up for their plans. A plan should not be permitted to set a dollar cap on a specific benefit as an amount,

duration, and scope limit. After all, the individual cannot access the benefit without paying for it. But if non-arbitrary limits are permitted, the remainder of the cost not covered by the plan should be considered cost sharing to ensure it is accounted for in the value of the plan.

Mental health parity is a good example of the importance of clear and comprehensive guidance on how essential health benefits must be offered to consumers. Congress enacted comprehensive mental health parity standards in 2008, and the standards became effective for most covered health plans in January 2010. However, the interim final rules did not make clear that mental health or substance use benefits must be covered where a plan includes coverage of a comparable medical benefit – offering mental health and substance use benefits in parity to medical benefits. As a result, health plans are not fully complying with the law. GAO recently issued a report on mental health parity compliance and found that 41% of employers surveyed are reporting the use of plan exclusions for specific treatments and thus, evading the parity requirements. HHS has conducted its own study and found inconsistent but widespread use of non-quantitative limits on benefits. The Department of Labor has reported a heavy volume of calls and emails by consumers whose plans have not complied with the parity requirements for mental health benefits.

We urge the Secretary to avoid similar problems in the definition of the EHB by including upfront tests and clear and full guidance for the provision of meaningful benefits for all individuals. We further urge the Secretary to shore up these loopholes in coverage of mental health and substance use disorder benefits. Specifically, in addition to the acknowledgement in the Bulletin that EHB benchmarks must meet the mental health parity requirement, the Department must provide clear guidance on what is included as mental health parity and ensure that the full range of mental health services and conditions are covered.

#### **4. DEFINING HABILITATIVE SERVICES**

We understand that habilitative services are a less defined area of care. However we have concerns with the Department's proposed transitional approach to potentially allow "plans [to] decide which habilitative services to cover."

A major goal of the ACA is take health care decisions out of the hands of insurance companies and return those decisions to consumers. Giving health insurance issuers the authority to determine which habilitative services to cover puts the insurance companies back in control. Furthermore, it will create variation among plans, which will make it harder for consumers to easily compare health plans and understand what benefits and services the health insurance actually covers.

We believe a better transitional approach would be to adopt a definition of habilitation using the National Association of Insurance Commissioners' definition of habilitation and Medicaid's habilitation coverage as a guide. The Institute of Medicine also recommends using Medicaid as a guide in defining these benefits and services. We do support the Department's proposal that habilitative services be offered at parity with rehabilitative services. In other words, regardless of the diagnosis that accompanies a functional deficit in an individual, the

coverage and medical necessity determinations for rehabilitative and habilitative services and devices should be based on clinical judgments of the effectiveness of the therapy, service, or device to address the deficit. It is important that habilitative services also include “maintenance of function.” This means patients should receive care to maintain their current level of functionality and prevent deterioration, in addition to services designed to develop functional abilities of a person who has never had them.

## **5. PHARMACY BENEFITS**

The Bulletin is overly restrictive with respect to defining prescription drug coverage in the EHB. We think it is sensible that the Department is looking towards Medicare Part D in beginning the discussion on pharmacy benefits for the essential health benefits package. However, there are significant differences in what the Bulletin recommends and Medicare Part D’s standard. The Bulletin discusses coverage of at least one drug in each class or category covered by the benchmark benefits package. This allows limitations well beyond the coverage provided by the benchmark plan. Even Medicare Part D requires coverage of at least two drugs in each class or category and includes an exceptions and appeals policy for nonformulary drugs. In addition, Medicare Part D requires plans to cover substantially all drugs in six protected classes. These are classes such as antidepressants or chemotherapy drugs where the drugs are less interchangeable and impact individuals differently.

The Department should also be taking into consideration the coverage that currently exists in the employer market. Recent data suggests that even the typical small business plan covers more than one prescription drug in a class. On the other hand, there are also policies offered in the small group market that have very limited prescription drug benefits – for example, they cover generic drugs only. HHS guidance must be expanded to include clearer and more protective guidance on the scope of prescription drug coverage that must be offered in all plans under the EHB standard.

There needs to be consideration of these differences between Medicare Part D or a typical employer plan and defining the EHB. Setting a more restrictive benchmark will affect access to life saving prescription drugs for chronically ill or vulnerable individuals.

## **CONCLUSION**

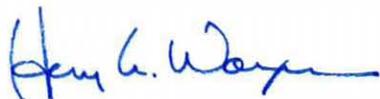
Again, we appreciate the opening of a dialogue and urge you to carefully consider these and other comments. In conclusion, we must emphasize that it is very difficult to provide thorough comments with regard to the EHB package without knowledge of cost sharing and actuarial definitions the Department is considering. Cost sharing impacts people’s ability to access benefits as significantly as the benefit breadth. Thus, our comments are preliminary and based solely on the concepts in this Bulletin. As further information around potential benchmarks is learned, as guidance and regulations come forth, it is very possible that our views on the information put forth in this Bulletin may change.

The Honorable Kathleen Sebelius

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Sincerely,



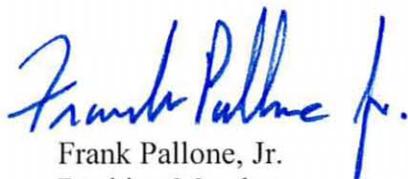
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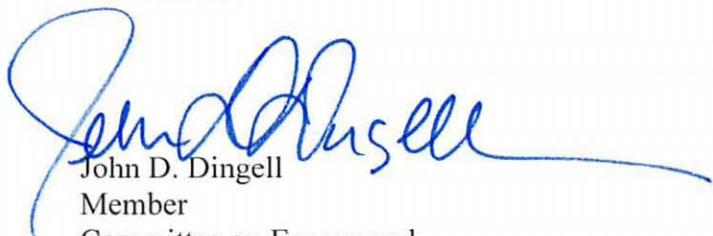
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