COMMENTS to the Department of Health and Human Services and Centers for Medicare & Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO)

RE: List of Proposed 2017 Essential Health Benefits (EHB) Benchmark Plans
ATTN: FFEcomments@cms.hhs.gov

Submitted by Community Catalyst
September 30, 2015

Community Catalyst respectfully submits the following comments to the Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) in response to the list of proposed 2017 EHB benchmark plans released on August 28, 2015.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone - especially vulnerable members of society.

Community Catalyst thanks HHS for releasing and inviting comment on the full list of proposed EHB benchmark plans for 2017. We applaud HHS for highlighting important areas of concern regarding vital consumer protections alongside the proposed list, including the support of anti-discrimination and parity protections through the recently proposed Section 1557 regulations and the 2008 Mental Health Party and Addiction Equity Act, respectively.

Many states did not hold public hearings during the 2017 EHB benchmark plan selection process. Likewise, many states defaulted to the largest small group plan without any public input on the proposed benchmarks. Unlike 2012 selection, the 2017 selection process can and should be informed by consumer experience with their state's EHB. This experience with state-approved plans that were modeled after the 2012 EHB benchmarks has revealed gaps in compliance with federal regulations and in meeting the needs of consumers in several critical areas. The following letter will identify areas where HHS can strengthen the EHB benchmark and subsequent QHP certification process for consumers and will also summarize our concerns about the EHB selections for 2017.

Actively Review and Enforce the EHB

Community Catalyst has identified three situations where 2017 EHB benchmarks may not conform to recent ACA guidance and rulemaking.[1] First, because the proposed 2017 benchmark plans date to the 2014 policy year, some of the proposed benchmarks may not conform to the Notice of Benefit and Payment Parameters for 2016, the Mental Health Parity and Addiction Equity Act of 2008 or the proposed Section 1557 anti-discrimination regulations. Second, some of these benchmark plans that are not part of the individual or small group market can exclude providing EHB. Finally, grandfathered health plans are not required to comply with the ACA's preventive services requirement along with other federal requirement that apply to EHB, so any proposed 2017 benchmark derived from a grandfathered plan may fail to include these key services.

As a result, we are concerned that a number of proposed 2017 EHB benchmarks may not meet all of the ACA's requirements. Forty-six states and D.C. have a small group plan as their proposed 2017 EHB benchmark, either by state selection or assigned by default. As a result, most benchmarks do not cover certain services, and there is inadequate coverage of EHB statutory categories, including harmful treatment limitations and exclusions impacting access to care.

More specifically, we are concerned that some proposed benchmarks may not sufficiently cover services that are important to vulnerable populations, most notably, children, people with substance use disorders, people with chronic illness, women, and people requiring gender transition related services. We further explain where 2017 EHB benchmarks may fail to comply in the next sections of this letter.

We ask that HHS take the following steps to ensure that benefits covered by Marketplace plans hold full coverage as guaranteed by the ACA:

- **Active review of each proposed benchmark.** HHS must actively review each proposed benchmark, analyzing the benefits and limits table, prescription drug information, and evidence of coverage or other underlying plan documents to identify specific gaps and areas where the plan does not comply with ACA regulations and guidance.
- **Disseminating findings from the review.** After HHS completes its review of the benchmarks, HHS should transmit this information to the states to ensure that state regulators are aware of any needed changes that are required of QHPs. By flagging these problematic plan designs for state regulators, HHS can ensure that state insurance regulators and marketplaces do not perpetuate unallowable coverage by approving QHPs

[1] The Mental Health Parity and Addiction Equity Act of 2008, in addition to 2013 regulation applying the regulation to the individual market in 2014
http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf

HHS Notice of Benefit and Payment Parameters for 2016
https://www.federalregister.gov/articles/2015/02/27/2015-03751/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2016

Section 1557 of the Affordable Care Act 2015 proposed rule
https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-22043.pdf

that include these coverage gaps. HHS must also remind states and issuers that compliance with benchmarks is not the sole standard for plan certification, and issuers offering products in the individual and small group markets must comply with all existing and subsequent regulations and guidance on the EHB, including guidance on preventive services, anti-discrimination and mental health parity. In addition to providing this information to state regulators, HHS must make it publicly available in order to facilitate consumer advocates' engagement in improving plan design.

- **Spot-checking state-approved QHPs for compliance with ACA requirements.** Once HHS identifies gaps in benchmark plan designs, it must also ensure that these gaps are not carried over into state-approved QHPs. CMS should conduct spot-checks of certified QHPs to determine whether these plans violate the ACA by mirroring gaps in EHB benchmarks, or through other coverage design issues.

Hold States Accountable for Mental Health Parity in EHBs

Community Catalyst applauds the 2013 final regulations governing the application of the Mental Health Parity and Addiction Equity Act to private insurance plans. We also appreciate the focus on substance use disorders benefits in EHB highlighted by the Office of the Assistant Secretary for Planning and Evaluation (ASPE). Despite these federal regulations, some 2017 EHB benchmark plans contain parity violations that disadvantage consumers with behavioral health needs.

We are aware that some 2017 benchmark plans selected by states are "grandfathered" plans not required to comply with the federal parity law. It is important that HHS provide robust oversight to ensure that these older plans are adapted so that the federally-mandated substance use disorder (SUD) and mental health benefits are sufficiently met, and that all QHPs meet parity requirements.

More concerning are the states where the 2017 benchmark plan should have already been brought into compliance with the parity law, but parity violations are still present in the plan. The continued existence of marketplace plans that violate parity requirements casts doubt on the ability of state Departments of Insurance to properly regulate and oversee behavioral health benefits. Strong oversight is necessary from HHS to ensure that plans approved as QHPs meet parity requirements. Some examples of these violations include, but are not limited to:

- **Annual dollar and/or aggregate lifetime limits.** Any plan that provides mental health and/or SUD benefits that satisfy a definition of essential health benefits that has been approved by the Secretary of HHS cannot place annual limits on mental health and/or SUD benefits. Some plans continue to place annual caps on the cost of behavioral health treatment. HHS notes that while annual and lifetime dollar limits are not allowable, such limits can be converted to actuarially equivalent treatment or service limits. However, the plan may not impose such limits only on mental health and substance use disorders treatment and services.
- **Quantitative treatment limitations.** Under the federal parity law, quantitative treatment limitations for covered behavioral health services cannot be more restrictive than for other medical/surgical services.

- **Authorization**. Plans often apply some authorization standards for all kinds of services. But if they require providers to obtain authorization for mental health and/or SUD services at earlier stages of treatment or with greater frequency (for example, every 5 outpatient visits), or they apply their authorization standards more restrictively to such services, then they are likely in violation.
- **Court-ordered treatment.** Some plans exclude coverage for court-ordered treatment, treatment related to illegal activity or legal charges, or addiction services that are not "voluntary." Because the kinds of treatment affected are almost exclusively mental health and/or SUD services, plans applying these exclusions are very likely in violation of the federal parity law.

Ensure Habilitative Services and Devices Benefit Meets the Federal Minimum
We applaud HHS' action to provide a uniform definition of habilitative services beginning in 2016. This category is an important benefit for all ages and we appreciate HHS recognizing that separate limits for rehabilitative and habilitative services are essential to ensuring consumer access to appropriate and needed services. HHS should carefully review proposed benchmarks to ensure that limits do not become part of the 2017 EHB standard. For example, Georgia's proposed benchmark plan states that habilitative services apply toward the "Physical medicine and rehabilitative services" maximum number of visits specified in the "Schedule of Benefits." See also IN, NE, ND, and OH for examples of combined limits.

HHS should ensure that states have incorporated, at a minimum, the uniform definition of habilitative services and devices in the proposed benchmarks. Further, HHS should review and closely monitor the inclusion of habilitative services and devices in plan design going forward**.** It is also important to note that without clear guidance from HHS and/or the state Department of Insurance (DOI), the federal definition remains open to interpretation, giving insurers discretion in determining what falls into a habilitative services and devices category.

Further, in reviewing the proposed benchmark for coverage of habilitative services and devices, Community Catalyst has identified how specific limits can arbitrarily limit this critically important benefit for all ages, but in particular for children with special health care needs. For example:

- **Limits to habilitative services and devices can be arbitrary and conflict with medical necessity.** More than two-thirds of the state benchmarks impose arbitrary visit limits on physical therapy (PT), occupational therapy (OT) and/or speech therapy (ST) visits. Additionally, close to 10 state benchmarks impose *combined* visit limits that apply to OT, PT, and ST. The allowed number of visits varies widely, signaling the arbitrary nature of the limits, and the lack of a medical necessity standard. The unique developmental needs of an individual cannot be met when faced with these limits.
- **Some benchmarks impose age limits and other restrictions.** A handful of benchmarks only cover habilitation for children with autism; one state benchmark covers habilitative services only for children up to age 9 with autism, and another only covers habilitation for children ages 2-8 with autism. Some states only cover habilitation for conditions resulting from an injury or illness; conversely, some states only cover services for the treatment of congenital or genetic birth defects.

Carefully Review Pediatric Services, Including Vision and Oral Health Care Services
An important but often overlooked EHB category of care is pediatric services. Many view this as the simple addition of pediatric vision and dental to their base-benchmark plans; however, the language in the ACA clearly states that the category is pediatric services in its entirety: "Pediatric services, *including* oral and vision care."[2]

We want to emphasize our ongoing concern that the current benchmark approach for determining the EHBs does not ensure that children have access to a comprehensive set of benefits that meets their needs. Numerous studies show that the 2012 process for defining EHBs has failed to assure that pediatric services are covered for children enrolled in individual and small group market plans. The small group plans that largely serve as the current EHB benchmarks were not developed with adequate consideration of children's needs, unlike the benefits in state CHIP plans and in Medicaid.

According to recent analysis, potentially 8 million children could be impacted in the event that CHIP is not refunded in 2017.[3] Thus, we recommend that HHS perform a thorough analysis of the 2017 EHB benchmark and its inclusion of pediatric services now—specifically, cross-checking with the state's CHIP plan to document what services are excluded from the benchmark.

We know QHPs are generally effective at providing CHIP-like coverage in "core" categories of services. However, they significantly lag behind CHIP in categories including behavioral health, habilitative services, dental and vision.[4] In these categories, CHIP tends to provide more generous and effective coverage both with respect to the types of services that are covered and with respect to the number of visits allowed.[5] The children most likely to be affected by these types of benefit deficits are children with special health care needs, including those with developmental delays, complex conditions, and mental health diagnoses. There is also mounting evidence that children of color are disproportionately impacted by vision and dental issues, making these benefit categories increasingly important in reducing health disparities.[6] [7]

Most notably, in a review of pediatric services in some 2017 EHB benchmarks for dental and vision raised some concerns:

- **Some benchmark plans may not be supplementing EHB categories when needed.**
    - At least one state benchmark does not appear to cover pediatric dental services at all, with no supplementation noted in the plan documents.
    - In some states, the benchmark plan documents do not indicate which specific dental services are covered and the scope of that coverage.

---

[2] 45 CFR §156.110
[3] http://www.commonwealthfund.org/publications/newsletters/washington-health-policy-in-review/2015/aug/aug-17-2015/childrens-health-advocates-watch-for-overdue-marketplace-analysis
[4] www.wakely.com/wp-content/uploads/2014/07/FINAL-CHIP-vs-QHP-Cost-Sharing-and-Benefits-Comparison-First-Focus-July-2014-.pdf
[5] http://ccf.georgetown.edu/wp-content/uploads/2014/05/Dismantling-CHIP-in-Arizona.pdf
[6] www.healthlaw.org/publications/search-publications/EPSDT-Vision-Services#
[7] www.pewtrusts.org/~/media/Assets/2014/06/27/Expanding_Dental_Case_Studies_Report.pdf

  - A number of states are not supplementing pediatric vision services even though the benchmark offers inadequate coverage of these services for children.
  - At least three states either do not cover eyeglasses or offer only limited coverage. In at least six states, it is unclear how pediatric vision services are covered because the benchmark plan documents do not provide a list of covered vision services
- **Some states are imposing outdated waiting periods.** Some states that supplemented pediatric dental services with FEDVIP appear to be using an outdated version of those benefits, which includes a 12-month waiting period for orthodontia treatment. FEDVIP no longer imposes that restriction, but it is incorporated into the benchmark.

Review Benchmarks for Benefit Designs that Violate Important Nondiscrimination Protections of the ACA

We want to emphasize the potential discriminatory aspect of benchmark designs that impose arbitrary age limits or other limiting factors based on disability or health condition. In particular, arbitrary limits on the scope of benefits that result in inadequate access to or coverage of certain services constricted by age limits, sexual orientation or disability would be in direct violation of the ACA's Section 1557 and proposed implementing regulations.

We also strongly urge CCIIO to clarify that mimicking an EHB benchmark plan does not satisfy a plan's requirement to provide EHB. It should be clear to state insurance regulators and issuers that the benchmark plan itself is not a standard for plan certification and that QHP issuers must comply with all applicable existing and subsequent regulations and guidance, including guidance on preventive services, guidance on coverage for same-sex spouses, and the nondiscrimination requirements of ACA Section 1557.

Thank you in advance for your consideration of our comments on 2017 EHB benchmarks. Moving forward, we hope that the final benchmark plans fully comply with federal regulation by the time 2017 QHPs are reviewed in order to best serve consumers.

We appreciate HHS' continued leadership in ensuring that more Americans have access to health care. We realize that we are at a critical time in implementing the ACA. Decisions that are made now will determine its success. On behalf of consumers, we look forward to regulations that provide access to robust coverage for all.

Respectfully submitted,

Robert Restuccia
Executive Director
Community Catalyst