January 31, 2012

The Honorable Kathleen Sebelius
Secretary
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Essential Health Benefits Bulletin

Dear Madam Secretary:

Thank you for the opportunity to comment on the Department’s bulletin concerning the determination of Essential Health Benefits (EHBs).

First, we wish to express our support for the practical approach taken by the Department. Allowing states the latitude to select from several options presents a pragmatic approach that recognizes the importance of the local marketplace in shaping what is right for each state, provides a practical solution for handling state mandates, and facilitates a solution consistent with the recommendations of the Institutes of Medicine for beginning with plan designs conscious of cost structure.

The comments made in this letter are intended to further those aims by offering practical solutions to some of the potential adverse effects of the interplay between the approach described in the bulletin and the statutory requirements of the Affordable Care Act (ACA). We believe the ultimate goal must be attaining and maintaining health for all citizens covered under the plans by aligning incentives for patients and providers to seek and deliver high quality, cost-effective care at the right time. Uniformity is desirable when it provides a baseline against which consumers can meaningfully decide among options in their marketplace. Uniformity becomes an obstacle to progress when it forecloses choice and innovation within a market simply for its own sake, preventing states from being the laboratories in which evidence-based approaches to cost-effective care delivery are tested. States, rather than the federal government, should set Essential Health Benefits beyond 2016.

Re-balancing the Benchmarks

One result of the approach proposed in the bulletin is to expand the categories of EHBs
beyond the ten identified in the statute to include all services that happen to be covered in the selected benchmark plan. Since EHBs cannot have an annual or lifetime maximum, any such maxima in the benchmark plan must be disregarded even if the service is not included in the ten categories identified in the statute. Ancillary services when provided under a plan are frequently subject to cost-limitations such as annual maxima.

Another result of the proposed approach, as described in the bulletin, is to require that the benchmark plan be expanded to include all ten categories where not already addressed. Taken together, this creates at the outset a plan that is more expensive than the current benchmark plan in two ways, all other things being equal.

In New Jersey, for example, the legislature established a mandate requiring insured health benefits plans to provide coverage toward the purchase of hearing aids for children less than 16 years old. The law states that benefits provided are $1,000 per hearing aid for each hearing-impaired ear every 24 months. The legislature therefore struck a balance between the desirability of financial support for hearing aids and the need to control health insurance costs. The benchmark plans based on New Jersey HMO, small employer and State Health Benefits Plans accordingly include such a benefit.

Removal of such maxima and the addition of services included in the ten categories identified in statute should not be required to be mechanically additive to the benchmark plan, but should come with tools for maintaining the cost-benefit balance anticipated by the original design. Plans based on such a benchmark should have alternatives to annual limits that are no longer permissible. For example, such a plan could be permitted to have cost-sharing that steps up to 100% for services not included in the ten categories that are delivered within a time period. Alternatively, the plan should be able to constrain the reimbursable amount to some benchmark such as Medicare’s level of reimbursement. Plans should have latitude to retain the original cost structure by trading changes in dollar caps, visit limits, or plan allowances not included in the benchmark, without regard to whether such design elements are ultimately deemed cost-sharing, as discussed further below.

 Covered Services versus Cost-Sharing Features

The bulletin makes a distinction between ‘covered services’, which are ascertained by the selected benchmark plan, and ‘cost-sharing features’, to be the subject of future guidance. These terms, however, are not self-defining or exhaustive of all aspects of plan design affecting coverage and reimbursement. For example, ‘covered services’ could reasonably be defined as the catalog of health care services and supplies to which the plan provides access or reimbursement, and ‘cost-sharing’ as deductible, copayment or coinsurance. Other aspects of plan design also affect reimbursement. Plans will provide different reimbursement levels based on network status, for example using negotiated rates in network and some benchmark such as Medicare for out-of-network reimbursement, no out-of-network reimbursement for network-only plans, or plans with out-of-network services subject to dollar limits. Plans may also include other limitations such as frequency limits or number of visit limits. Plans may cover services differently when performed in a hospital, doctor’s office or ambulatory surgery center, or when provided on an outpatient versus inpatient basis. Pharmaceuticals may be covered differently depending upon whether they are dispensed at a pharmacy, in a provider’s office, or in a
facility. These are elements of plan design intended to incent the most cost-effective
and/or highest quality access to care.

At the same time, innovations in the marketplace are re-engineering the financing and
delivery systems to better align incentives for quality outcomes through things like
patent-centered medical homes and accountable care organizations. We believe that for
purposes of using a benchmark plan for defining the EHB, only the covered health care
services and supplies in the benchmark are relevant, and plans should continue to have
the ability to vary coverage levels and alter reimbursement and delivery models. This
would include different reimbursement methodologies for out-of-network utilization or
based on place of service, different methodologies for determining the plan's payment
allowance, different frequency and visit limitations, pre-authorization requirements, and
different dollar maxima, as long as the member has a venue for receiving EHBs that are
not subject to an annual or lifetime dollar limit. Limitations leaving unreimbursed
amounts would of course figure into the actuarial value calculation as appropriate.

Habilitation

As the bulletin notes, the concept of covering habilitative services including maintenance
of function is virtually unknown in commercial insurance. A well-crafted plan would
provide vital services and devices to people with developmental delays or disabilities or
debilitating injuries or illnesses. An ill-defined plan could redirect scarce premium
dollars to many services and supplies that do not add value commensurate with the cost.

While parity could provide some ability to control costs, it artificially constrains coverage
within parameters really designed for recovering lost function. Habilitative devices, in
particular, are not analogous to rehabilitative devices. We would prefer the transitional
approach, under which habilitative services and devices would be decided at the plan
level. In New Jersey, individual and small employer standard plans are promulgated by
Program Boards for the market, and we would anticipate the definition here similarly
being defined New Jersey-market wide. Since this is a largely new area for coverage, we
believe it requires some level of study and experimentation first at the local level.

Pediatric Oral and Vision Care

The bulletin seeks comments on whether pediatric oral and vision services should be
permitted to be set at the plan level. We believe this would be problematic. Families
may elect to be covered under an EHB issued by a medical carrier that includes some
level of pediatric dental coverage, and by a separate dental carrier that includes
comprehensive coverage for the entire family. The required level of pediatric dental
coverage should be standardized so that the two plans are seamless in their coverage,
with no gaps or redundancies. This would require a level of standardization. The same is
true of vision coverage. Unlike habilitative services, coverage of dental and vision care is
relatively mature, so the clear demarcation of benefits provides under the medical versus
dental or vision plan becomes the more important consideration.

We would also recommend that the rules make it clear that the medical plan need not
cover pediatric dental or vision services if the child is covered under a separate dental or
vision plan.
The Department proposes in the bulletin that the EHB definition would not include non-medically necessary orthodontic benefits. We would like to confirm that that would apply without regard to whether the benchmark plan includes orthodontia.

The concept of medical necessity with respect to a procedure such as orthodontia is problematic. Most considerations of medical necessity look to the current medical literature and clinical practice guidelines to determine whether a procedure is generally accepted as safe and efficacious for the treatment of the illness or injury complained of. To the extent malocclusion is accepted as an illness or injury, almost all orthodontia would be deemed medically necessary. We would suggest strictly defining the coverage parameters, such as orthodontia medically necessary due to accidental injury to natural teeth or malocclusion resulting in other physical dysfunctions such as temporomandibular joint disorder.

Moving Forward

We believe it would be disruptive to the market to reset the benchmark entirely each year based on past year plan popularity. This also has the effect of requiring the number of covered services to continually increase, as all covered services in one year’s plan become the minimum EHBs in next year’s.

A state with a governing body responsible for establishing minimum standards should have the authority to review the EHBs each year and make changes based on the evolution of the health care delivery and financing marketplaces in that state.

Respectfully submitted,

[Signature]

Thomas B. Considine
Commissioner