CPPP CENTER for PUBLIC POLICY PRIORITIES
WORKING FOR A BETTER TEXAS™

January 31, 2012

Secretary Kathleen Sebelius
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Via email: EssentialHealthBenefits@cms.hhs.gov

RE: Essential Health Benefit Bulletin, December 16, 2011

Dear Secretary Sebelius:

The undersigned Texas organizations appreciate the opportunity to comment on the bulletin regarding Essential Health Benefits (EHB) released December 16, 2011.

The **Center for Public Policies** (CPPP) is a nonpartisan, nonprofit 501(c)(3) policy institute established in 1985 and committed to improving public policies to better the economic and social conditions of low- and moderate-income Texans. Improving access to health care for Texans has been at the core of our mission and activities since our founding.

The center is joined in these comments by: Alamo Breast Cancer Foundation, Children's Defense Fund – Texas, Disability Rights Texas, Gateway to Care, La Fe Policy Research and Education Center, Mental Health America of Texas, Texas AFL-CIO, Texas Association of Community Health Centers, and TexPIRG.

The **Alamo Breast Cancer Foundation** is a grassroots 501(c)(3) advocacy, educational, and support organization established for women with breast cancer and for those concerned about breast cancer issues.

The **Children's Defense Fund** provides a strong, effective and independent voice for all the children of America who cannot vote, lobby or speak for themselves. CDF educates the nation about the needs of children and encourages preventive investments before they get sick, drop out of school, get into trouble or suffer family breakdown.

Disability Rights Texas (DRTx) is the federally designated legal protection and advocacy agency for people with disabilities in Texas. DRTx is a non-profit disability rights agency established under federal law in 1977 dedicated to helping people with disabilities understand and exercise their rights under the law, ensuring their full and equal participation in society. Advocating for access to health coverage for individuals with disabilities that provides all appropriate care and services is a priority of DRTx.

Gateway to Care is a Collaborative of 167 member and affiliated organizations that have been working together for more than a decade to connect people to resources that allow them to maintain and improve their health status while reducing costs.

The **La Fe Policy Research and Education Center** works to continually improve the Bienestar (well-being) of Mexican Americans through policy analysis, education, leadership development, and civic involvement. Bienestar affirms our culture, community experience, values, and advocacy to achieve equality of opportunity through responsive social and health policies.

Founded in 1935 as a non-profit 501(c)3 organization, **Mental Health America of Texas** reaches out to communities across Texas to promote mental health, prevent mental disorders, and improve the care and treatment of people with mental illnesses through education and advocacy.

The **Texas AFL-CIO** is a state federation of labor unions representing 220,000 members in Texas. We advocate for working people -- union and non-union alike -- in the political and legislative arenas.

The **Texas Association of Community Health Centers** (TACHC) is a private, non-profit membership association that represents safety-net health care providers in the state of Texas. Our members include Community and Migrant Health Centers, Health Care for the Homeless Grantees, Public Housing Primary Care Grantees, Ryan White HIV/AIDS Grantees, Health Center Networks and other providers who strive to meet the health care needs of the uninsured and underserved. TACHC serves as the federally designated primary care association for the state of Texas.

TeXPIRG is a non-profit consumer advocacy organization that takes on special interests to improve the lives of Texans. TexPIRG advocates work on a wide arrange of consumer issues from health care to transportation, food safety and financial reform.

We believe that EHB are a critical component of health reform. They will benefit millions of Texans who have coverage today in the individual or small group markets where consumers have historically lacked access to comprehensive coverage and millions more who are uninsured today, but will gain coverage through the Affordable Care Act. We respectfully submit these comments to offer ways in which HHS' approach to EHB can be strengthened and improved to support access to health quality health care for all Texans.

Information on Benchmark Plan Options Should be Made Publicly Available

Unfortunately, public interest and consumer organizations do not have all of the information we need at this point to evaluate HHS' benchmark approach to defining EHB. We have been unable to get information on the small group or HMO benchmark options from the Texas Department of Insurance because it does not collect enrollment information at the product level. While HHS released the names of the three largest small group plans by state, we do not have access to information on the specific benefits and limits of those plans or others that will serve as benchmark options.

We strongly encourage HHS to collect and make publicly available detailed information on all ten benchmark options for each state. Information provided should be easy to understand and sufficient to identify the tradeoffs in terms of covered services and limits. This step will help states make informed choices and allow the public to participate in a meaningful way.

Scope of Services within the Ten Categories Should Be Defined by HHS

The EHB should provide access to comprehensive health services. If they do not, many Texans could be left underinsured and at risk of financial hardship when they get sick.

HHS' bulletin does not lay out how a state's benchmark will be determined to satisfy the criteria for including each of the ten benefit categories. For example, if a plan covers physical therapy but not speech therapy, does it satisfy the requirement to cover "rehabilitative and habilitative services and devices?" What if it has a 25-visit limit for physical therapy or excludes coverage for prosthetics or other rehabilitation-related devices? At what point are a plan's benefits robust enough to satisfy the statutory requirements, or alternately, at what point are the benefits so limited that they fail to offer the comprehensive set of services envisioned by the ACA? **HHS should define the scope of services within each of the ten benefit categories necessary for a benchmark to satisfy the statutory EHB criteria.**

HHS should also set strong national standards for the limits, if any, that can be applied to services within the ten categories. If HHS' approach allows a state's EHB package to contain all of the limits found in the chosen benchmark, consumers could be harmed. We are especially concerned about the service limits in the small group benchmark options, which are likely to be the most restrictive.

When consumers hit a benefit limit (for example, a person who needs weekly chemotherapy, but is limited to 25 doctor's office visits per year), they will have to shoulder the full cost of the service beyond the limit and those costs will not apply to the policy's out-of-pocket maximum. This could create financial access issues, especially for people who need ongoing care for chronic or serious conditions.

Insurers Should Not Be Given Flexibility to Adjust Essential Benefits

We strongly oppose allowing insurers the flexibility to substitute or adjust essential health benefits either within or among the ten required categories, as proposed in the bulletin. Such flexibility will harm consumers by: 1) eliminating uniformity and adding complexity in benefit design, and 2) creating a back door-way for insurers to avoid risk and "cherry pick" healthier individuals.

If insurers can substitute or adjust essential health benefits, consumers will be unable to make apples-to-apples comparisons among plans subject to EHB within a state. Providing uniformity in the floor for benefits will help consumers make more informed choices and allow them to focus on the tradeoffs between plans' premiums, cost sharing features, and provider networks. Allowing insurers to offer different essential health benefits packages adds an unnecessary level

of complexity that could undermine the ACA's core aim to make buying and understanding health insurance simpler.

On top of that, insurers could use this flexibility to design their benefits in a way that makes their plans more attractive to healthier individuals and less attractive to individuals in poor health, harming consumers with significant health needs. Benefit design flexibility allows a back-door way for insurers to avoid risk, even though they will not be able to deny coverage based on a person's health status. It is difficult to see how benefit design flexibility can be granted to insurers and at the same time ensure that benefit designs do not discriminates against covered individuals based on their age, disability, or expected length of life. Significant oversight and enforcement would be needed at the state and federal levels to monitor and mitigate the harm to consumers with significant health care needs if insurers could modify essential health benefits.

HHS Should Assure an Open Process for Benchmark Selection

The bulletin does not lay out what office or body within the state has the authority to select the benchmark or what process a state must undertake. **HHS should require an open, transparent state process to select and supplement the EHB benchmark.** The public must be given clear information on all benchmark options and ample opportunity to provide meaningful input in the decision-making process.

HHS Should Define Medical Necessity

HHS should develop a uniform, broad definition of medical necessity as part of establishing EHB. The definition should not be narrowly defined by acute treatment outcomes but rather broad enough to include services that improve, maintain, or prevent deterioration of a patient's capacity to function. Medical necessity as defined by a state or insurer is used frequently to determine which covered benefit an individual will receive. A clear, broad, and uniform definition is needed to ensure that consumers do not have uneven or restricted access to EHB due to varying standards for medical necessity.

Ensure Prescription Drug Benefit Meets Consumers' Needs

In the bulletin, HHS proposes to require coverage for only one prescription drug within each class of drugs covered by the states benchmark, as opposed to either covering all of the drugs within the state's chosen benchmark or requiring at least two covered drugs per class as is done in Medicare Part D. We are concerned that if an insurer chooses to cover only one drug per class, coverage will be inadequate for many people with chronic or serious conditions. Such coverage would not allow individual to try different drugs to determine the one that is most effective, nor would it provide sufficient coverage for individual whose treatment includes more than one drug within a class. **HHS should develop stronger minimum standards for prescription coverage that will ensure it meets the needs of vulnerable enrollees and does not allow plans to discourage enrollment by individual with significant health needs.**

Net Costs of State Mandates Should Be Considered

Determining the marginal cost of a mandated benefit will be challenging. **We recommend that HHS allow state or federal regulators to consider the net, marginal cost of the mandate—the cost of the benefit minus any short or long term savings that result.**

States will need additional information on defraying the cost of state mandated benefits that exceed the EHB before they can make an informed choice on a benchmark. States may not be able to avoid defraying mandate costs just by selecting a small group benchmark. Even if Texas selects a small group benchmark that is subject to state mandates, the state may still have to defray the costs of individual market mandates. Texas has several state mandated benefits that apply to the individual market, but not the small group market, including: hearing screening for children, children's immunizations, reconstructive surgery for craniofacial abnormalities in a child, colorectal cancer testing, diabetes, mental/nervous disorders with demonstrable organic disease, off-label use of prescription drugs, prostate testing, telemedicine/telehealth, transplant donor, and minimum stay with mastectomy or lymph node dissection.

Thank you for consideration of our comments on this initial guidance on the essential health benefits. If you have any questions regarding these comments, please contact Stacey Pogue, senior policy analyst with the Center for Public Policy Priorities at pogue@cppp.org.

Sincerely,

Alamo Breast Cancer Foundation

Center for Public Policy Priorities

Children's Defense Fund - Texas

Disability Rights Texas

Gateway to Care

La Fe Policy Research and Education Center

Mental Health America of Texas

Texas AFL-CIO

Texas Association of Community Health Centers

Texas Public Interest Research Group