



January 31, 2012

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

Re: Request for Comments Regarding Essential Health Benefits

Dear Madam Secretary:

Thank you for the opportunity to provide comments on the U.S. Department of Health and Human Services' (HHS) December 16, 2011 bulletin on essential health benefits ("Bulletin"). We value the opportunity to provide input and appreciate that HHS will release proposed regulations related to this key issue. Our comments reflect concerns we have with specific language and concepts used in the Bulletin that we hope will inform drafting of the proposed regulations.

We appreciate the need to balance comprehensiveness of coverage with affordability in determining essential health benefits (EHB). We appreciate HHS deferring to States rather than imposing a national standard of mandated benefits. This approach allows each State to maintain consistency with its own insurance market and state-specific standards.

We support the goals of an essential health benefit set to establish a consistent level of coverage for a core set of health care services and public health care programs. In establishing the essential health benefit set, we urge HHS to consider how the essential health benefit set can provide better opportunities for low-income individuals and people with disabilities or chronic conditions to remain employed and to maintain coverage in the private market. We also support the policy that the essential health benefit set must avoid coverage discrimination by disability or medical condition. Our specific comments are noted below and reflect input gathered through a request for public comment.

#### **A Need for Definitional Clarity**

In the Bulletin, HHS officials used substantively different terminology in describing the various options from which states may choose a benchmark plan. Subsequent "question and answer" periods on state calls have further exacerbated confusion about what are the specific benchmark candidates. We believe HHS needs to more clearly define several key terms related to options for benchmark plans and to use those definitions in all communications related to essential health benefits.

- While the Bulletin describes the small group market options as “the largest plan by enrollment in any of the three largest small group insurance products in the State’s small group market,” the fact sheet released by HHS referred to “one of the three largest small group plans.”
- Similarly, the Bulletin describes the Health Maintenance Organization (HMO) option as “the largest insured commercial non-Medicaid HMO operating in the State,” while the fact sheet describes that option as “the largest HMO plan offered in the State’s commercial market.” The HMO option as expressed in the Bulletin language is particularly confusing as it does not refer to a plan with a specific set of benefits and cost-sharing features.
- It will be important that the final regulations clearly define the terms “product,” “plan,” and “enrollment.” The regulations should also clearly articulate the methodology for assigning enrollment to specific products and plans. For example, whether enrollment is to be counted as an average of a quarter or at the end of a quarter. There is not a clear or consistent standard in the industry.
- It would be helpful if the final regulations define the term “benefit mandate” and clarify the distinction from a “provider mandate.” For example, Minnesota requires all private health plan companies to recognize health care homes in their reimbursement methods. This should be recognized as a provider mandate and Minnesota should not be required to defray the cost of requiring health care homes be a component of payment reform and quality improvement efforts.

### **Benchmark Clarity**

We are concerned about the lack of clarity around which specific services will be included in candidate benchmark plans. While we appreciate the need to balance “flexibility” with “clarity” in the definition of services covered under a particular benefit category, the lack of clarity makes it a challenge for policymakers and stakeholders to adequately understand the features of various candidate benchmark plans. Certificates of Coverage and other plan documents may clearly delineate which services are excluded from coverage, but it is not definitively clear what services *are* covered, particularly in the context of appropriate standards such as medical necessity. This lack of clarity is particularly problematic in areas where there is greater variation in services, such as mental health and chemical dependency services.

### **Actuarial Equivalence**

We urge HHS to be more specific about whether and how benefits and services will be assessed within each of the 10 EHB categories. We assume that a measure of actuarial equivalence will be needed in the context of determining whether benefits, services, or limits may be substituted within the 10 EHB categories. We also assume that States will review and approve whether carriers are in fact using an actuarially equivalent set of benefits and services in their role as insurance regulators.

### **Habilitative Services**

The Bulletin discusses the potential for defining habilitative services as “learning new skills or functions as distinguished from relearning existing skills or functions.” The Bulletin uses speech therapy for a child who is not talking at the expected age as an example of habilitative services. This discussion is similar to the Centers for Medicare and Medicaid Services (CMS) discussion with States over the years regarding Medicaid coverage for habilitative and rehabilitative services.

We have two concerns about framing habilitation services as a distinction between “learning new skills” and “relearning lost skills.” The Medicaid definition of habilitative services in section 1915(c)(5) of the Social Security Act is: “...services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings; and ... includes prevocational, educational, and supported employment services...” The Medicaid law does not limit habilitative services to the “learning of new skills.” The Medicaid law also does not limit services provided under the rehabilitation option to re-learning lost skills. This is an important point for children who often require services to bring the child to a level of functioning that they had previously achieved or would have achieved if normal development had not been impaired by a condition or disorder.

The Medicaid program defines habilitative services for the purpose of delineating those services that a State may choose to cover as part of a package of services that are designed to avoid institutionalization, or help people move from institutional settings to the community. For that reason, the Medicaid definition of habilitative services is broad and open-ended, and includes services that are outside the scope of coverage provided through a typical employer plan. The need to distinguish habilitation from rehabilitation in Medicaid occurs primarily due to the particular set of rules and financial limits that Title XIX puts on habilitative services, which is not relevant to the goals of the essential health benefits and may convey a broader array of services is included than what is intended in the context of a typical employer plan.

For all of those reasons, we suggest that the Medicaid distinction between habilitation and rehabilitation as expressed in the Bulletin should not be the basis for the definition of habilitative services in the essential benefit set. To the extent Medicaid definitions are used, the Bulletin is over-simplified and needs to take into account other complex Medicaid factors. For example, physical, speech, and occupational therapies are categories of coverage in Medicaid under 42 C.F.R. §440.110, that is a separate coverage category from rehabilitative services. The most common standard in the medical community for physical, speech, and occupational therapies is bringing a person to normal or maximal level of functioning. This standard does not make a distinction between “learning” and “re-learning” a skill. It is under another category – the rehabilitation option - under 42 C.F.R. §440.130 that CMS makes a distinction between the concepts of “learning” and “re-learning.”

### **Supplementing a Benchmark Plan**

The Bulletin would require a state to supplement its chosen benchmark plan with additional benefits if the benchmark plan does not include all of the ten mandated benefit categories. In the case of habilitative services, the Bulletin contemplates two potential scenarios.

- The first potential approach is that habilitative services would be offered at parity with rehabilitative services. For example, a plan covering physical therapy, occupational therapy, and speech therapy for rehabilitative purposes must also cover physical therapy, occupational therapy, and speech therapy that is habilitative, at a similar scope. This approach, especially for these three types of services, does not align with most of definitions of medical need. In general, therapy is designed to improve functioning, and is therefore somewhat finite, ending when further improvement is no longer likely. Once the therapy has achieved maximum level of functioning, it is not within the standard of practice of most medical professionals to provide skilled interventions in order to maintain functioning. Also, and in general, habilitation services often are not episodic in nature, in that many people require habilitation services throughout their lifetime. For those reasons, the parity approach is difficult to conceptualize.
- The second potential approach would allow carriers to decide which habilitative services to cover, with HHS providing further definition later after evaluating those coverage decisions. We are concerned this approach lacks any common ground for a key set of medical services across plans. This approach is likely to lead to gaps in individuals' care.

We suggest a hybrid approach for supplementing habilitative services when necessary, involving a survey of those therapies that are typically covered under an employer plan and inclusion of the typical amount of coverage in the essential benefit set, without distinguishing between services provided for purposes of habilitation or rehabilitation. This approach should be evaluated and adjusted over time to ensure that individuals' needs are being met and that there is a continuity of services between Medicaid coverage and private-sector coverage as people transition between types of coverage.

### **Devices**

The 10 categories of coverage included by statute include rehabilitative and habilitative services *and devices*. The Bulletin does not discuss whether “devices” includes supplies and equipment. Further clarification is necessary.

### **Relationship to Medicaid (§1937) Benchmark Coverage.**

Although the Bulletin was not focused on benchmark coverage in the Medicaid program, we want to point out some of its interactions with the Bulletin:

- CMS should consider revising the regulations governing section 1937 of the Social Security Act, which define the circumstances in which states can mandate individuals receive Medicaid coverage through benchmark plans. Medicaid has an interest in streamlined and coordinated coverage through the Exchange, where individuals will move back and forth between Medicaid and coverage through qualified health plans. States may use the authority in section 1937 to offer a more market-defined benefit set and provide better continuity between Medicaid and the private market.

Current CMS regulations include a number of exceptions from mandated inclusion in the Medicaid benchmark. Many of those exclusions require functional and medical assessment at the time of eligibility and periodically thereafter. Consequently, the section

1937 Medicaid benchmark option becomes unwieldy for consumers as well as the system itself. CMS should consider defining those exceptions such as “special needs” and “medically frail” more concretely so that states can use available information to have a more streamlined system for administering a Medicaid benchmark and bridging movement across the public and private coverage.

- As HHS considers the issue of actuarial equivalent benefits and the essential health benefit set, we urge HHS to continue to allow a Medicaid-equivalent benefit set as an option for the new Medicaid category (i.e., Category VIII). Section 1937 of the Social Security Act allows States to provide “secretarial approved coverage” as a Medicaid benchmark plan. Maintaining this option in Medicaid is important to States that want to avoid Medicaid enrollees being forced to move back and forth between the “standard” Medicaid benefits and the benchmark benefits as their needs change.

### **Timeline**

Carriers need sufficient lead time to understand what essential health benefits must be incorporated into their individual and small group offerings for the 2014 benefit year. We urge HHS to publish proposed rules on essential health benefits as quickly as possible in order to facilitate carrier planning and product development efforts.

### **EHB in 2016 Following the Transition Period**

As outlined in the Bulletin, a benchmark plan must be selected in the third quarter of 2012 and apply as the EHB for 2014 and 2015. The Bulletin indicates that these two years will serve as a transition period for the benchmark approach, which will be reevaluated for 2016. Once the transition period is over, what does HHS envision for the EHB regulatory framework? Due to the complexities and timelines involved in plan design and insurance oversight, we ask that additional information on the regulatory approach for 2016 and beyond be shared with states as soon as possible.

Thank you for the opportunity to provide input on HHS’s approach to defining essential health benefits. We look forward to the publication of proposed rules on this important issue.

Sincerely,

  
Mike Rothman  
Commissioner  
Department of Commerce

  
Lucinda Jesson, JD  
Commissioner  
Department of Human Services

  
Edward P. Ehlinger, MD, MSPH  
Commissioner  
Department of Health