December 21, 2012

Marilyn Tavenner, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Via Electronic Submission

Attention: (CMS–9980–P)

RE: Notice of Proposed Rulemaking for the Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

Dear Administrator Tavenner:

On behalf of the Association of Maternal & Child Health Programs (AMCHP), thank you for the Department’s work on the proposed rule on the essential health benefits and the opportunity to comment. Releasing these regulations is a positive step in realizing the goal of expanding coverage to all Americans through the Affordable Care Act (ACA). AMCHP is a national resource, partner and advocate for state public health leaders and others working to improve the health of women, children, youth and families, including those with special health care needs. AMCHP members administer the Title V Maternal and Child Health Services Block Grant program in each state, which provides a foundation for supporting systems for improving health and health care for all women, children and families.

We welcome the opportunity to share our experience leading programs for maternal and child health (MCH) populations and especially the importance of assuring adequate insurance coverage and access to care for all children, particularly children and youth with special health care needs (CYSHCN). CYSHCN are children who typically require a level of services, systems and supports beyond that of children generally.

General Comments

Rehabilitation and habilitation services are important for especially vulnerable children and should be clearly defined. The proposed rule allows states to define habilitation services when they are not present in the base benchmark plan. State flexibility may be appropriate, but insurer flexibility has the potential to limit needed services. A transitional approach that allows insurers to define the habilitation benefit is not acceptable because it would allow insurers to provide a minimal benefit that does not fulfill the ACA’s requirement.

The proposed rule also says that the issuer must only supplement habilitative services when there are no habilitative services offered in the base benchmark plan and the state has not exercised its option to define habilitative services. AMCHP believes that this approach will result in plans that are...
lacking in critical habilitative services. As proposed, a health insurance plan could interpret the
regulation as requiring coverage of only a single habilitative service, as defined by the issuer or by the
state in the case of state-required benefits enacted prior to December 31, 2011. This should not be
considered adequate coverage of habilitative services because it would violate the balance and non-
discrimination standards required by the statute, depending on how HHS defines “category” and
how HHS defines the balance and non-discrimination standards.
The proposed rule gives states the choice to allow issuers to define the benefits in the habilitative
services category if missing from the base-benchmark plan. In this case, the health insurance issuer
must either: (1) provide parity by covering habilitative services benefits that are similar in scope,
amount, and duration to benefits covered for rehabilitative services; or (2) decide which habilitative
services to cover and report on that coverage to HHS. With regard to option (2), HHS intends to
evaluate the habilitative services reported and further define habilitative services in the future.

Therefore, HHS should establish a fallback definition of habilitation services—if states choose not
to define habilitation. The definition should use the definition of medical necessity used by Medicaid
that the extent of coverage of habilitation services and devices should at least be in parity with
rehabilitation coverage. There are existing definitions of habilitative services, which HHS included in
the Notice of Benefits and Plan regulation defining medical and insurance terminology. Namely, the
National Association of Insurance Commissioners (NAIC) has an established definition of
habilitative services: “Health care services that help a person keep, learn or improve skills and
functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the
expected age. These services may include physical and occupational therapy, speech-language
pathology and other services for people with disabilities in a variety of inpatient and/or outpatient
settings” (NAIC Glossary of Terms for the Affordable Care Act).

AMCHP would urge HHS to bar insurance plans from defining their own habilitative benefits, even
by providing coverage on par with rehabilitative services, and instead provide states with a standard
by which to define habilitative benefits. In addition, AMCHP urges that the extent of coverage of
habilitative services and devices should at least be in parity with rehabilitation coverage. In other
words, regardless of the diagnosis that leads to 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. Such judgments should be made on a periodic basis to ensure the individual continues to
benefit from the rehabilitative or habilitative intervention.

It is important that “maintenance of function” be included in the definition of habilitative services.
There are many instances in which a patient requires habilitative services in order to prevent a
decline in function. Failure to cover these services under the essential health benefits will result in
many patients receiving habilitative services only to reach a level of function that they are unable to
maintain because of a lack of access to continued service.

§156.110 EHB-Benchmark Plan Standards

Paragraph (b) Coverage in each benefit category
The proposed rule holds that supplementation must occur when the base benchmark plan does not
offer “any coverage” in one or more of the ACA categories. Some base benchmark plans, however,
offer coverage in a category but cannot be said to cover adequately the category of services named in
the law. Consistent with state flexibility, states should have the authority to determine that a benefit
category in a base benchmark plan is inadequate. HHS has already taken this approach with respect to pediatric oral and vision coverage. Even though some base benchmark plans offer some minimal coverage for eye exams or dental check-ups, HHS determined that this coverage was not sufficient to fulfill the ACA’s requirement for oral and vision care for children. Likewise, states should be required or permitted determine that base benchmark coverage of a certain category is not sufficient. Consistent with the benchmark approach, a state that makes such a determination should have the authority to supplement the inadequate category with the benefits in that category from another allowable benchmark plan. If none of a state’s benchmark plans provide adequate coverage of the category, the state should have authority to define the benefit, as the proposal allows for habilitation services because all benchmark plans offer some pediatric coverage, even if they lack adequate coverage of critical pediatric subspecialty or ancillary services.

Clarification on this issue is particularly important for the EHB categories that include more than one type of service, such as the “habilitative and rehabilitative services” category; the “pediatric services, including oral and vision care” category; and the “mental health and substance use disorder services including behavioral health treatment” category. In the case of the EHB categories most relevant for children – “pediatric services” and “habilitative and rehabilitative services” – plans must be required to supplement categories when items or benefits are missing. The identification of “missing benefits” should be based on a comparison of the covered benefits with HHS-established minimum standards as recommended above. In the case of habilitative services, the definition of habilitative services put forth by NAIC should be the basis for comparison; in the case of pediatric services, the state’s CHIP plan could be the basis for comparison.

§156.110 (b)(2) and (3) Supplementation of Pediatric Oral and Vision Services

As mentioned above, we support HHS’ approach that EHBs will generally require supplementation in these areas and have a few specific comments and questions to ensure that adequate supplementation occurs.

Paragraphs (b)(2)(ii) and (b)(3)(ii) which offer states the option of supplementing oral and vision services by using those provided through a state’s separate CHIP program should be revised to offer states the additional options of supplementing with a benefit that would meet the CHIP standard even if it was not already in existence (as previously suggested in HHS guidance) or the option of supplementing with Medicaid EPSDT dental or vision services at the state’s option. In light of some states moving away from separate state CHIP programs (such as California) as a result of other aspects of the ACA, it is shortsighted to offer only existing separate CHIP plans as an option to states. In fact, we note that Appendix A of the rule lists that California has submitted CHIP benefits as its supplementary plan type, yet at the time that EHB comes into effect California’s separate CHIP program will no longer exist. We seek clarification as to whether this will remain an option for states that do not have a separate CHIP program.

A related recommendation is that HHS should make clear in the final rule how it intends to ensure that supplementation is adequate.

§ 156.110 Age definition
The preamble’s definition of pediatric services is that they are services for individuals under 19 years of age. We support the establishment of a defined age threshold. Some benchmark plans limit pediatric services to a more narrow age range and we believe a federally defined age will help reduce
discrimination based on age. Therefore, the pediatric age limit should be codified in regulation with appropriate flexibility for states to increase the age. We recommend that the age be raised to cover those under 21 to align with the ACA's provision for child-only plans and the child age band proposed in the health insurance market rules (CMS-9972-P).

§156.115 Provision of EHB
The proposed rule allows issuers to make actuarially equivalent substitutions within the EHB categories. While some substitution to allow innovation in benefit design may be appropriate, strict limits on substitution are necessary to fulfill the goals of the ACA. The law establishes essential health benefits to provide a standardized floor for benefits in the individual and small group market. When comparing and purchasing plans, families must be confident that plans are truly comparable and will provide coverage for needed services.

We applaud the prohibition of cross-category substitution and the banning of prescription drug substitutions within that category. We strongly suggest that HHS take additional steps to prevent issuer abuse of benefit substitution. It seems allowable under the proposed rule for an issuer to substitute out a key benefit, such as wheelchairs for children, and substitute in a different benefit that, while actuarially equivalent, provides lesser medical benefit but gives the issuer an advantage in terms of risk selection or marketing appeal. The proposed rule acknowledges this risk by establishing at (b)(1)(ii) that substitutions be made only within benefit categories. However, without a definition of the categories, it cannot be determined whether a proposed substitution falls within the category. To limit this potential for abuse, HHS must define each of the ten benefit categories. When an issuer proposes a benefit substitution, it can then be evaluated as to whether it fits into the category definition. Only substitutions that are actuarially equivalent AND consistent with the category definition should be allowed.

§156.120 Prescription Drug Benefits
It is essential that the final regulation allow access to clinically appropriate drugs that are prescribed, but not included on a health plan drug list. Off-label use of drugs remains an unfortunate, but necessary and routine, practice in the care of children. Though there has been progress in pediatric drug testing laws, including the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act, which resulted in updates to more than 450 drugs with FDA-approved pediatric labeling, more than 50 percent of drugs used in neonates and children lack labeling for a pediatric indication. We know that the absence of labeling for a specific age group or disorder does not necessarily mean that the drug's use is improper for that age or disorder, and that is particularly true in pediatrics. It is critical that children have access to drugs that their pediatricians deem clinically necessary but are not included in the plan's drug list.

§156.130 Cost-Sharing Requirements
Children may have health needs that cannot be served adequately by any in-network provider, even if the network meets applicable network adequacy standards. Children who need complex subspecialty pediatric care are most likely to fall into this category. When medically necessary services are not available in-network, a family should remain protected by the ACA's limits on cost-sharing. Therefore, the final rule should contain an exception that keeps the cost-sharing limit in place for medically necessary out-of-network services that are not reasonably available in-network.
§156.150 Application to Stand-Alone Dental Plans inside the Exchange

Paragraph (a) Annual Limitation on Cost-Sharing.

The cost-sharing limits established in section 156.130 are a critical benefit of the Affordable Care Act for American families. Congress established these limits in the context of the other provisions of the ACA to ensure that families covered in the individual and small group markets have affordable access to essential health benefits. Congress, in turn, identified pediatric dental coverage as an essential health benefit. Therefore, Congressional intent is clear that spending on pediatric dental services should be subject to the same overall limit as other cost-sharing. The cost-sharing limits of the ACA should protect families no matter which of the essential health benefits they need. Paragraph (a) allows for a separate, reasonable cost-sharing limit for benefits under stand-alone pediatric dental plans. This means that families that approach the cost-sharing limit under their QHP may exceed the limit if their children have dental needs. This is problematic for a number of reasons. Firstly, the proposed policy is in direct conflict with HHS March 27, 2012 Final Rule on Establishment of Exchanges and Qualified Health Plans, which states that cost-sharing limits and restrictions on annual and lifetime limits will apply to stand-alone dental plans for pediatric oral care. Secondly, on the dental side, there are no required preventive services with an A or B rating from the U.S. Preventive Services Task Force beyond a weak fluoride supplementation recommendation (oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride). Whereas currently most dental plans provide preventive oral health services such as screenings and cleanings with no cost-sharing, pediatric dental care in EHB benchmark plans are not only subject to cost-sharing under the Proposed Rule, they are also excluded from EHB with respect to statutory cost-sharing limits. Under the Proposed Rule, families will be subject to out-of-pocket expenses in excess of the ACA’s cost-sharing limitations on Essential Health Benefits. This policy is not only in conflict with Section 1302, but it also creates a disincentive for families to obtain pediatric oral coverage for their children. Since the ACA’s minimum essential coverage requirement does not equate with Essential Health Benefits, the result of this policy is that many children may go without pediatric dental coverage.

AMCHP views access to affordable dental coverage as essential to addressing the national epidemic of childhood tooth decay. AMCHP asks that Final Regulations subject families to a single out-of-pocket maximum for all of the EHBs, including pediatric dental care.

Thank you for your consideration of AMCHP’s comments. Should you require additional information please contact Brent Ewig, AMCHP Director of Policy and Government Affairs at 202-266-3041 or bewig@amchp.org.

Sincerely,

Michael Fraser, PhD, CAE
Chief Executive Officer

MRF:BE/cmcc