January 31, 2012

Steve Larsen
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, DC 20201

Dear Mr. Larsen:

On behalf of the Association of Maternal & Child Health Programs (AMCHP), thank you for the Department’s work to begin the process to define Essential Health Benefits and for this opportunity to comment. 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 especially appreciate the efforts noted in the Bulletin to strike an appropriate balance between comprehensiveness of coverage, cost, and flexibility. To this end, we welcome the opportunity to share our experience leading programs for 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.

The Title V MCH Block Grant assures a special focus on supporting children and youth with special health care needs (CYSHCN) by requiring each state devote at least 30% of its Block Grant allocation to services for this population. Accordingly these programs play a significant role in states in promoting outreach and enrollment in both public and private insurance and demonstrating progress for a number of statutory requirements, including “increasing the number of low income children receiving health assessments and follow-up diagnostic and treatment services…. providing preventive and primary care services for low income children….provide[ing] rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under title XVI, to the extent medical assistance for such services is not provided under title XIX; and provide and promote family-centered, community-based, coordinated care, including care coordination services…for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families.”

1 United States Code, §§701-710, Subchapter V, Chapter 7, Title 42. Available at

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In essence, many state Title V CYSHCN programs play a traditional role in providing gap-filling services to under and uninsured children, as well as promoting innovations in better care coordination through promotion of medical home and better integrated health systems. Determination of EHB may have significant impact on these and other traditional state Title V MCH program activities.

While we appreciate the many competing demands the Department is trying to balance in defining essential health benefits, our essential concern is that utilizing typical employer sponsored insurance as the benchmark for coverage may perpetuate well-documented gaps in the adequacy of insurance coverage particularly for CYSHCN. In 2010, 14.16 million (19.2%) of the estimated 74 million children in the United States had one or more ongoing health conditions that resulted in greater need for or use of health services of a type or amount than is required by children generally. Among children with current health insurance, 15.7 million (23.5%) had parents who reported their coverage was never or only sometimes adequate in terms of coverage, access to, and costs of needed health care for their child, and publicly insured children had a lower reported frequency of inadequate insurance compared with privately insured children (18.6% vs. 25.8%). Additionally, 34% of currently insured CSHCN report that their insurance coverage is not adequate.^{2}

These data and findings underscore a concern that some private insurance plans – like the benchmark plans proposed in the Bulletin – have historically failed to cover some services and out of pocket costs that are critical for children’s health. This is due in large part to the overall lack of emphasis on preventive care as well as adequate coverage of developmental, habilitative and rehabilitative services.

Under Section 2713 of the Affordable Care Act, all non-grandfathered plans must cover a range of preventive health services for women, infants, children and adolescents without cost-sharing. The statute states that insurers must provide coverage for all services contained in Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, immunizations recommended by the Advisory Committee on Immunization Practices, and services receiving a recommendation of “A” or “B” from the US Preventive Services Task Force. Section 2713 also requires the preventive health care services to include a package of services for women developed by the Institute of Medicine and promulgated by the U.S. Health Resources and Services Administration. This package is intended to ensure that all women covered by Exchange plans will have coverage for preventive health services such as preconception care, well woman visits, all Food and Drug Administration (FDA) approved contraceptive methods and contraceptive counseling and breastfeeding support supplies and counseling. We request that future guidance include clarification on how these standards will apply to state selected benchmark plans.

Another critical issue, which is not directly mentioned in the Bulletin, is the differing definition of medical necessity in the context of children. In our experience, private insurers commonly employ a narrow definition of medical necessity, limited to services that diagnose or treat illnesses and are needed to restore normal functioning. Only limited rehabilitative services are covered, and habilitation services are not typically included at all. Such narrow definitions too often serve as a blunt tool used to draw sharp lines that deny the type of care that vulnerable children need to stay healthy and thrive.

In contrast, Medicaid uses a clinically-appropriate pediatric medical necessity definition, which takes into account children’s developmental needs, while commercial insurance plans tend to limit what is considered necessary to treatments or services that diagnose or treat illnesses or injuries and are needed to restore “normal” functioning. Commercial insurance standards may disadvantage children and youth with special health care needs covered by private plans. Private plan rules routinely exclude or often limit the types and frequency of treatments, services and supports needed by children such as those with long-term developmental disabilities linked to prematurity or other conditions such as autism and cerebral palsy. We request that future guidance provide additional clarity on this issue.

Finally, the Bulletin makes reference to plans for HHS to periodically review and update the EHB. Because of the expertise of state Title V MCH programs in serving vulnerable populations and the statutory requirements that will likely be impacted by EHB definition, we urge you to seek regular consultation with state MCH leaders and other key stakeholders as the monitoring and updating process is further designed and implemented.

If you have additional questions or suggestions on how we can be of further assistance 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