ACAP
Association for Community Affiliated Plans

1015 15th Street, N.W., Suite 950 | Washington, DC 20005

Tel. 202.204.7508 | Fax 202.204.7517 | www.communityplans.net

December 26, 2012

Gary Cohen, Director
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9980-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244–1850

Dear Mr. Cohen:

The Association for Community Affiliated Plans (ACAP) thanks you for providing us with an opportunity to comment on proposed rule *Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation*, published November 26, 2012 in the Federal Register. We appreciate your willingness to consider these comments.

ACAP is an association of 59 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 25 states. Our member plans provide coverage to approximately 9 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dually-eligible people. Nationally, ACAP plans serve roughly one-third of all Medicaid managed care enrollees. Many Safety Net Health Plans currently are developing plans to serve those individuals that will gain new coverage due to insurance expansions enacted by the Affordable Care Act. Many of our members intend to build qualified health plans that will participate in the Exchanges operating in their states.

Our comments are summarized below.

1. **State-Mandated Benefits.** ACAP supports HHS's determination that state benefit mandates enacted prior to December 31, 2011 are not to be considered benefits "in addition" to the EHB package.
2. **Accreditation.** ACAP thanks HHS for articulating a fair policy related to the phase-in of accreditation for qualified health plans.
3. **Habilitative Benefits.** ACAP encourages HHS to provide greater specificity around the habilitative benefit requirement.
4. **Discriminatory Benefit Design.** ACAP applauds HHS for explaining that EHB benchmarks may not include discriminatory benefit designs and must ensure balance among EHB categories.
5. **Drug Benefits.** ACAP asks HHS to strengthen requirements related to the drug benefit.
6. **Aligning Commercial & Medicaid EHB.** ACAP recommends that HHS allow states to select as an EHB benchmark plan a "Secretary-approved coverage" option similar to that in the Medicaid program.

We explain these positions in greater detail below.

1. **State-Mandated Benefits.** Section 155.70(a)(2) states that "A state-required benefit enacted on or before December 31, 2011 is not considered in addition to the essential health benefits." ACAP supports this determination for several reasons. First, state mandates provide to many individuals numerous needed services that might not have been otherwise offered in the small and individual markets. The statutory requirement that states defray the costs of state benefit mandates risked creating an incentive for states to roll back constructive benefit mandates. Furthermore, the requirement that each QHP issuer quantify the cost attributable to each additional required benefit would have added a substantial burden to QHP issuers, in the absence of this policy.

2. **Accreditation.** In section 155.1045, HHS outlines a timeline by which qualified health plans are required to be accredited. In brief, HHS rules that a QHP issuer without existing commercial, Medicaid or Exchange accreditation granted by a recognized accrediting entity must have scheduled or plan to schedule a review of QHP policies and procedures of the applying QHP issuer with a recognized accrediting entity prior to the first year of participation an Exchange. Furthermore, as a minimum, prior to that issuer's second year and third year of QHP certification (2014 for the 2015 coverage year or 2015 for 2016), it must be accredited by a recognized accrediting entity on the policies and procedures applicable to its Exchange products, or must have commercial or Medicaid health plan accreditation on administrative policies and procedures that are the same or similar to the administrative policies and procedures used in connection with the QHP. Lastly, the issuer must be accredited on its Exchange products prior to the QHP issuer's fourth year of QHP certification and in every subsequent year.

   ACAP has previously submitted to HHS our views that because immediate accreditation may be a substantial barrier to participation by Medicaid health plans (including Safety Net Health Plans) in the Exchange, HHS should allow all Exchanges to establish a transitional period until 2017 for all health plans that are not currently accredited to obtain the required accreditation for plan participation. ACAP thanks HHS for articulating a fair policy related to the phase-in of accreditation for qualified health plans in the FFE.

   Furthermore, ACAP has in the past urged HHS to avoid requiring all qualified health plans to be accredited by one particular entity, and instead to allow plans to choose which accrediting entity to use. We thank HHS for recently recognizing both NCQA and URAC as allowable accrediting entities, and for providing additional organizations with an opportunity to be similarly recognized by HHS in the future.

3. **Habilitative Benefits.** Section 156.115(d) of the proposed rule provides that "if the base-benchmark plan does not include coverage for habilitative services, the state may determine which services are included in that category." Because many states do not have experience in developing a habilitative benefit requirement, ACAP encourages HHS to provide more

explicit guidelines regarding what such a benefit must incorporate. Allowing each state to design a habilitative benefit without clear guidelines will likely result in a patchwork of dissimilar and inequitable benefits across the country, and, potentially, within each state, which could create difficulties for consumers as they compare health plans.

Furthermore, we have concerns related to the proposal that habilitative benefits be offered at "parity with rehabilitation" services. The proposed rule explains that "parity" relates to scope, amount and duration of benefits, but because patients' needs for habilitative services differ from needs for rehabilitative services, this approach may result in an inadequate package of habilitative services. For example, habilitative services may be needed for a longer period of time than rehabilitative services.

Lastly, language in the proposed rule stating that the "issuer only has to supplement habilitative services when there are no habilitative services at all offered in the base benchmark plan and the state has not exercised its option to define habilitative services under Section156.110(f)" may leave some enrollees without needed services. As our colleagues at the American Academy of Pediatrics point out, "it would appear that if the base-benchmark plan offers even a single benefit that is considered 'habilitative,' the issuer would not need to supplement the category with any other habilitative services." Based on their reasoning, patients with a significant diagnosis such as cerebral palsy might be able to access speech therapy but be left without the opportunity for physical therapy, which would help the patient learn to walk, as well.

4. **Discriminatory Benefit Design.** ACAP also applauds HHS for section 156.125 of the proposed rule, which explicitly states that any issuer providing a discriminatory benefit design, or implementing its benefit design in a discriminatory manner, does not in effect offer the EHB package. Although Safety Net Health Plans are well-experienced in caring for high-needs individuals, we agree with HHS's concerns about the potential for benefit designs that might discriminate against certain populations or consumers with significant health needs. Therefore, we thank HHS for prohibiting such practices among all issuers.

5. **Drug Benefits.** Section 156.120 of the proposed rule requires issuers to cover "at least the greater of (i) One drug in every USP category or class; or (ii) The same number of prescription drugs in each category and class as the EHB-benchmark plan." ACAP has concerns that covered individuals with significant health care needs, such as HIV/AIDS, mental illness, cancer, as well as other serious chronic illnesses, may be prevented by the proposed policy from accessing drugs they need to preserve and improve their health and productivity.

   Our health plan members are well aware that enhanced coverage of drugs may well diminish the need for more costly health care services. Therefore, ACAP encourages HHS to articulate a stronger policy for comprehensive coverage of necessary drugs for individuals with severe chronic illness as well as to minimize the impact of changes in therapies when individuals move between Medicaid and Exchange coverage programs.

6. **Aligning Commercial & Medicaid EHB.** Section 156.100 of the proposed rule outlines the options states have in selecting base-benchmark plans. In addition to the options described, ACAP recommends that HHS allow states to select as an EHB benchmark plan a "Secretary-approved coverage" option similar to that in the Medicaid program. This option would give states an opportunity to align their chosen commercial EHB package with Medicaid benefits, which is an issue of critical importance, given the number of Medicaid and Exchange enrollees expected to transition between those programs. Allowing this option would also improve coordination between the Exchanges and Medicaid in those states opting to implement the Bridge plan.

Conclusion

Again, ACAP would like to thank you and your colleagues for your willingness to discuss these issues with us. If you have any additional questions or comments, please do not hesitate to contact Jenny Babcock at (202) 204-7518 or jbabcock@communityplans.net.

Sincerely,

Margaret A. Murray
Chief Executive Officer