ACAP
Association for Community Affiliated Plans

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Bob Thompson, Chairman | Margaret A. Murray, Chief Executive Officer

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Center for Consumer Information and Insurance Oversight
Department of Health and Human Services
EssentialHealthBenefits@cms.hhs.gov

To Whom It May Concern,

The Association for Community Affiliated Plans (ACAP) is pleased to have the opportunity to respond to the Essential Health Benefits Bulletin issued by the Center for Consumer Information and Insurance Oversight (CCIIO) on December 16, 2011. ACAP represents 57 nonprofit Safety Net Health Plans in 26 states providing health care coverage to almost ten million people enrolled in public insurance programs, primarily Medicaid, the Children's Health Insurance Program (CHIP), and Medicare. ACAP plans are community-based, partnering with governments to deliver quality health services and provide an essential health care safety net. Among ACAP plans, 21 operate Medicare Advantage Special Needs Plans (SNPs), serving individuals who are dually eligible for Medicaid and Medicare.

Section 1302 of the Patient Protection and Affordable Care Act (the Affordable Care Act) directs the Secretary to define essential health benefits, coverage of which will be required beginning in 2014 of all non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, plans offering Medicaid benchmark and benchmark-equivalent coverage, and standard health plans serving Basic Health Programs (BHP). In advance of issuing formal draft regulations regarding section 1302, CCIIO distributed the bulletin and invited public comment on the intended approach to rulemaking included therein.

ACAP was proud to support the Affordable Care Act, including the provisions that establish standards for essential health benefits. ACAP has previously provided statements related to essential health benefits:

1. ACAP participates in the Exchange Safety Net Coalition, a group of safety net provider and plan associations organized to ensure that low-income and high-needs populations have access to high quality care through state-based health insurance Exchanges. In a July 2011 letter to CCIIO, the Exchange Safety Net Coalition recommended that Exchanges provide meaningful coverage and benefits. We asked that CCIIO require plans serving the Exchanges to offer health benefit packages that include robust essential health care and enabling services that are appropriate and adequate to meet the needs of vulnerable populations including children, individuals with disabilities, the elderly, and others with special needs.

2. In our October 31, 2011 response to CMS' Request for Information regarding the Basic Health Program, ACAP wrote the following:

Robust Essential Health Benefits Package. ACAP's particular concern with regard to the essential health benefits package, which will govern coverage in the Exchange, BHP and Medicaid expansion, is that it may lack robust essential health care and enabling services that are critical for meeting the needs of vulnerable populations including children, individuals with disabilities, the elderly, and others with special needs. In addition to medical and behavioral health care services, a benefits package for a high-needs population should include transportation, translation, and coordination of social services, among others.

Because the BHP will exclusively serve a low-income and potentially high-needs population, and also because the BHP is conceived as including innovative features such as care coordination and care management for enrollees, incentives for the use of preventive services, and the establishment of relationships between providers and patients that maximize patient involvement in health care decision-making, we highly recommend that HHS encourage inclusion of these critical services when outlining guidance related to benefits.

We stand firmly by these positions, and wish for them to be considered recommendations in the context of this letter as well.

We would also like to comment on the following specific areas of the essential health benefits bulletin:

C. Intended Regulatory Approach

Four Benchmark Plan Types

The bulletin states that HHS intends to propose that EHB be defined by a benchmark plan selected by each state. States are to select a single benchmark to serve as QHP standard; potential benchmark plans include:

- The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;
- Any of the largest three state employee health benefit plans by enrollment;
- Any of the largest three national FEHBP plan options by enrollment; or
- The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

If states decline to select a benchmark, the default will be the largest plan by enrollment in the largest product in the state's small group market.

ACAP appreciates that allowing flexibility for states to select benchmark benefits plans could work well, as it did for CHIP. The literature suggests that states often opted to provide benefits to CHIP populations that exceeded federal requirements.[1] However, we question whether states will choose to treat new expansion populations as generously as they chose to treat children in CHIP. We harbor concerns that high-needs and low-income individuals that will be covered by the 2014 Medicaid expansion and qualified health plans in the Exchange will not have access to services that are normally available in Medicaid but not, for example, in small employer health plans. Furthermore, depending on an individual's state of residence, benchmark benefits could be richer or lighter, leading to inequitable coverage across the country.

Recommendation:

> *For these reasons, we respectfully suggest that CCIIO consider implementing a basic benefits "floor" below which no state will be allowed to drop.*

Benchmark Plan Approach and the 10 Benefit Categories

In the bulletin, CCIIO writes that habilitation services currently constitute a poorly-defined area of care. The bulletin mentions that Medicaid and NAIC definitions of habilitative services differ from the types of habilitative services actually provided by commercial coverage today (when covered).

CCIIO is considering two options, the first of which would require plans to offer habilitative services at parity with rehabilitative services, so that plans covering physical therapy, occupational therapy, and speech therapy for rehabilitation must also cover them for habilitation. The second option, a transitional approach, would allow each plan to decide which habilitative services to cover, and then report to HHS, which would evaluate and further define habilitative services in the future.

In both the Exchange and Medicaid, allowing health plans to choose the level of habilitative services may have unintended consequences. Sicker enrollees in need of such care may reasonably be expected to enroll in those health plans that have opted to offer them, leaving this subset of plans with sicker, higher-needs populations. Some plans' competitiveness may be damaged as a result, and plans may be disincentivized from providing adequate habilitative benefits.

[1] Margo Rosenbach and others, *Implementation of the State Children's Health Insurance Program: Synthesis of State Evaluations* (report submitted by Mathematica Policy Research, Inc., to the Centers for Medicare & Medicaid Services, March 2003)

Recommendation:

ACAP supports CCIIO's option one, which would require plans to provide habilitative benefits at parity with rehabilitative services.

Mental Health and Substance Use Disorder Services and Parity

The Mental Health Parity and Additional Equity Act of 2009 (MHPAEA) established that financial requirements and treatment limitations for mental health and substance use disorder services not be more restrictive than for medical services. The Affordable Care Act explicitly included mental health and substance use disorder services among the ten required categories of essential health benefits. HHS stated in the bulletin that it plans to propose that mental health parity applies in the context of essential health benefits.

ACAP believes that applying parity for mental health and substance use disorder services in the context of essential health benefits will expand access to these needed treatments for many people receiving health coverage starting in 2014.

However, we feel as though parity should be defined in terms of the benefit (cost sharing, days, other benefit limits), but should not be defined as requiring the use of the same administrative approach as physical benefits. For example, in some cases, it may make sense to require different administrative procedures for a behavioral health related service where it does not make sense to do so on the physical health side.

Recommendation:

ACAP supports the approach taken by CCIIO to require parity between mental health and substance use disorder services and medical services in the context of essential health benefits.

We encourage the Secretary to define parity in terms of the benefit, rather than in terms of administrative approach.

We appreciate the opportunity to comment. If you have questions, please feel free to contact me at (202) 204-7509 or ACAP's Vice President for Exchange Policy at (202) 204-7518.

Sincerely,

Margaret A. Murray
Chief Executive Officer