New York appreciates the opportunity to comment on the proposed regulations for 45CFR 147, 155, and 156; Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Proposed Rule [CMS-9980-P].

New York has previously submitted a comment on Appendix A (Proposed Essential Health Benefits (EHB) Benchmarks for each state) of the proposed regulations and, at this time, would like to offer the following additional comments:

Part 156. Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

- Preamble – 2. Subpart B, Section c - EHB Benchmark Plan Standards (§156.110)
  Page 70649 of the preamble in the Federal Register indicates that HHS will "interpret 'pediatric services' to mean services for individuals under the age of 19 years." Further, the preamble indicates that states have the flexibility to extend pediatric coverage beyond the age of 19. However, the regulation itself does not contain language with regard to either, which may create difficulties for implementation and enforcement efforts.

- §156.110(f) Determining habilitative services
  For habilitative services, New York appreciates the deference given to the states to determine the extent of the benefit to be included as EHB. The regulation does not appear to specify what process must be followed to achieve state definition of habilitative services (i.e., will it require a HIOS entry, letter from the state, or something else).

- §156.115 Provision of EHB
  Section §156.115(b) indicates that plans may substitute benefits as spelled out in the proposed regulations. New York would like to confirm its interpretation of the regulations: that states may allow plans to substitute benefits as indicated in §156.115(b), but states are not required to allow plans to substitute benefits. States can standardize benefits consistent with the traditional role as regulators of policy forms. Standardization of benefits is consistent with the intent of the ACA to improve markets by improving the ability of consumers to comparison shop and ensuring that insurers will compete based on price and quality, not risk selection.

- §156.120 Prescription drug benefits
  With respect to prescription drug coverage, it is unclear what the intended process will be for issuers to update formularies. Currently, formularies are updated throughout the plan year as drugs are reviewed and approved, evaluated for efficacy, and costs of covering them change. It appears that formulary updates could be made without falling below the minimum standards of drug coverage provided in the regulation. However, the process for doing so may involve review and approval that was not previously required. We encourage HHS to continue to permit issuers to modify formularies in a way that ensures it accommodates best practices and medical developments.

- §156.135(c) Employer contributions to health savings accounts and amounts made available under health reimbursement arrangements

New York is concerned that this proposed requirement would be difficult to implement in the first several years of Exchange operations. Calculating the actuarial value of a HRA/HSA plan requires knowing the employer contribution. There is a high level of administrative difficulty for the Exchange and for carriers to implement this proposed regulation because HRA/HSA amounts are not standardized. As such, an AV value would have to be developed for each different HRA/HSA amount. This would be administratively feasible if these benefits are standardized. We request that HHS remove this factor from the AV calculator until states have sufficient experience and data regarding typical employer contributions with which to develop standardized benefits.

- §156.150 Application to stand-alone dental plans inside the Exchange
  With regard to stand-alone dental coverage, the regulation appears to address only coverage issued as QHPs within the exchange. In order for the same health plans to be sold outside the exchange, the same consideration for stand-alone dental plans (i.e., that a health plan may still meet EHB even though it does not contain coverage for pediatric dental, so long as it is otherwise available) would be desirable. We encourage HHS to give this matter further evaluation so that issuers are not unintentionally disadvantaged, and markets are not unnecessarily adversely impacted.

Appendix

- Appendix A: List of Proposed Essential Health Benefits Benchmarks
  New York seeks to clarify the benefits we propose to supplement our base benchmark plan because there were some inconsistencies with the HIOS EHB submission template. New York intends to supplement the base benchmark benefit as follows:
  - Habilitation: New York will set habilitative services at modified parity with rehabilitative services. The intent is to set the habilitative benefit at parity with the rehabilitative benefit. However, in New York's Base Benchmark Plan, the rehabilitative services benefit is covered only if the services are provided on a post-hospitalization or post-surgical basis. By setting habilitative services at parity with rehabilitative services, New York will require the same types of services and the same number of covered days for both benefits, but New York does not consider the post-hospitalization and post-surgical requirements for rehabilitative services to be requirements for habilitative services.
  - Pediatric dental: New York State Child Health Plus benefit
  - Pediatric vision: New York State Child Health Plus benefit
  - Mental Health/Substance Abuse Parity: Any existing limits on these benefits must be removed as mental health parity is included as part of the EHB definition

New York appreciates HHS' consideration of these comments and looks forward to continuing to work with our federal partners to refine the proposed regulations.