

45 CFR Part 156

Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans

Part 156, Subpart B, Section 156.120. Collection of data from certain issuers to define essential health benefits.

New York appreciates the opportunity to comment on the provisions set forth in Part 156. It is important that riders be included in as part of the benefit packages eligible for state selection as benchmark options.

Definitions of “health insurance product” and “health plan” are set forth in subpart B, section 156.120. These definitions also incorporate definitions previously set forth in Part 159 which were developed to provide a summary of benefits and coverage (SBC) “that accurately describes the benefits and coverage under the applicable plan or coverage.” New York supports the uniformity and simplification that results from consistent application of the SBC definitions. New York also strongly supports the applicability of these broad definitions to the standards for Essential Health Benefits (EHB) because they appropriately define the scope of benefit packages eligible for selection as benchmark plans.

Specifically, subpart B of section 156.120 defines “health insurance product” as “a package of benefits that an issuer offers that is reported to state regulators in an insurance filing.” This definition allows for the inclusion of riders applicable to the regulatory filing, as regulatory filings include contracts, amendments, riders, endorsements and applications. Inclusion of riders when defining the scope of the benchmark benefit package is important. If riders were not included, important benefits or mandates would be omitted and, when such benefits are state-mandated, states would bear the associated costs.

Additionally, subpart B of section 156.120 defines “health plan” to have the meaning of “portal plan” set forth in section 159.110. The definition of “portal plan” is the discrete pairing of a package of benefits with a particular cost sharing option. This definition is similarly broad, since a “package of benefits” includes riders. As with the definition of “health insurance product,” the definitions of “health plan” and “portal plan” do not exclude riders from consideration.

By law, riders have the same force and effect as the underlying contract. Riders are used to modify insurance policies to include additional benefits, change benefits and remove benefits. Riders are used in conjunction with both mandatory benefits that all consumers must purchase (due to state mandates or health plan requirements) and optional benefits that consumers can either purchase or reject.

For practical reasons, riders are very frequently used to add new state mandates to a policy. State mandates are typically enacted with a tight timeframe for implementation. Therefore, issuers need to modify all contracts impacted by the mandate to comply with the new state law.

Adding a state mandate by rider allows issuers to quickly develop and obtain state regulatory approval of language modifying all or a significant subset of their existing contracts. This eliminates the need to independently revise and obtain regulatory approval of modified contractual language for each contract.

If state mandates are omitted from benchmark plans merely due to the contractual vehicle used (e.g., riders), state law would still require issuers to extend the state mandates to the consumers and the Affordable Care Act (ACA) would require the state to pay the cost of the state mandates. This creates either a fiscal obligation for the state or limits the state's benchmark options.

States must be provided with access to the full range of benchmark options identified by HHS so that states can effectively balance coverage and affordability when selecting the essential health benefits. A state's choice of a benchmark plan will have a tremendous impact on its individual and small group markets, as essential health benefits will need to be incorporated into all non-grandfathered products offered both inside and outside of the Exchange.

The broad regulatory definitions set forth in subpart B, section 156, include riders in the definitions of "health insurance product" and "health plan" and provide states with sufficient flexibility to strike a necessary balance in choosing a benchmark plan.

HHS issued a Frequently Asked Questions (FAQ) document on February 17, 2012, which "intended to provide additional guidance on HHS's intended approach to defining EHB." This document indicated that benchmark plans should be analyzed without applicable riders. Based upon this early direction, New York engaged in preliminary analysis of our benchmark options. This analysis determined that the exclusion of riders would, in some cases, eliminate state mandates from the benchmark benefit option. In other cases, this approach would eliminate ACA-required essential health benefits from the benchmark option (which would then need to be substituted from another benchmark option that included the benefit in its base contract). With the exception of one benchmark plan option, all of New York's benchmark plans offer prescription drugs by rider, leaving New York with a single benchmark option that includes prescription drugs. Further, important updates to coverage accomplished by rider would also be omitted.

Selection of the broad regulatory definitions set forth in subpart B, section 156.120, appears to replace the early guidance set forth in the FAQ document issued February 17, 2012, providing states with the ability to effectively implement the December 16, 2011 bulletin regarding the selection of an EHB benchmark.

Subpart B, Section 156.275. Accreditation of QHP issuers.

Section 1311(c)(1)(D)(i) of the ACA requires Qualified Health Plans (QHPs) to be accredited by an entity recognized by the Secretary of Health and Human Services. HHS will be recognizing accrediting entities through an interim process to meet the time frames established for the QHP certification. Accordingly, HHS has selected the National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) as recognized accrediting

organizations and solicits comments on setting standards for seeking and obtaining recognition as an accrediting entity.

New York urges HHS to give due consideration to existing state licensing and oversight processes, standards and procedures. For example, the process and criteria used to license and oversee Medicaid HMOs in New York are arguably more rigorous than the standards used by NCQA and URAC.