

New York State Comments on December 16, 2011 Essential Health Benefits Bulletin

New York appreciates the opportunity to provide comments on the Essential Health Benefits Bulletin released by the Department of Health and Human Services (HHS) on December 16, 2011. Establishing an appropriate benchmark for Essential Health Benefits (EHB) is a decision of critical importance to successful implementation of Health Benefit Exchanges. We appreciate the balance that HHS seeks to achieve in this Bulletin between the provision of baseline services and state flexibility to develop benchmark packages that reflect states' decisions regarding mandated insurance benefits and current markets. We urge HHS to consider the following as it drafts proposed EHB regulations.

1) Timing for Selection of Benchmark Plan

Selecting benchmark benefits in 2012 is well in advance of the January 1, 2014 operational date of the Exchange. In the months that ensue between state selection of the benchmark and the start date of the Exchange, the benefits included in the selected benchmark could be modified by any one of a number of factors including state legislation, decisions made by issuers, the federal government with respect to the FEHBP or, in the case of the state employee plan, collective bargaining.

The selection of the benchmark benefit is one of the most important decisions a state will make in designing its Exchange. Therefore, we urge HHS to clarify that the benefits included in the benchmark plan, including any state legislation enacted prior to issuance of HHS's December 16th Essential Health Benefits Bulletin, will be "locked in" for 2014.

For example, if a state benefit mandate was enacted in the fourth quarter of 2011 and will be implemented in the fourth quarter of 2012, would this benefit be included in the benchmark plan? In this scenario, the mandate was enacted prior to the issuance of the federal EHB bulletin. HHS should clarify whether the EHB benefit package for a state includes all mandates set forth in law prior to the issuance of the guidance. This will eliminate any state or consumer uncertainty as to what is included in the benchmark plan in 2014 and 2015.

2) Meaningful consumer choice

We are concerned that the degree of issuer flexibility outlined in the Bulletin may create circumstances in which it is extraordinarily difficult for consumers to compare products. We are especially concerned with the ability to substitute services within and across categories without state review, as proposed in the Bulletin. States should have the option to offer standardized benefits within the Exchange to simplify the products for consumers and to minimize confusion in comparison of products. The Bulletin seems to preclude this.

Plans offered through the Exchange will be required to meet state insurance and health laws and any additional Exchange requirements to be certified. The discretion to vary either the benefits or the limits of a state's benchmark plan should belong to the state. Language in a

federal rule giving issuers flexibility in benefits and limits may be interpreted as constraint on a state's ability to regulate products within its exchange.

3) Updating Essential Benefits

While we appreciate state flexibility in 2014 and 2015, from a fiscal and legislative prospective, 2016 is just around the corner. Recognizing that HHS's intention to evaluate the benchmark benefits for calendar year 2016 may have significant implications for consumers and states alike, we urge HHS to provide guidance as early in the process as feasible in order to plan for 2016.

4) Benefit Limits

Because HHS is giving states the option to choose a benchmark plan, it follows that states should be permitted to create their own standards (e.g., setting quantitative limits on benefits). HHS should allow states to modify any current quantitative limits associated with a benefit in the benchmark plan (e.g., if further analysis determines that modification is needed to reflect a balance among the categories and/or to balance affordability with comprehensiveness). It seems the Bulletin may only allow issuers, and not states, to vary the scope of services and limits of the State benchmark.

The Bulletin is clear that if one of the 10 categories of essential benefits is not included in the benchmark plan, it is possible for the state to look to another one of the benchmark options to define that benefit. However, we urge HHS to also allow states the same flexibility with respect to benefits in one of the 10 categories that is included in the state's chosen benchmark, if the state feels the benefit is inadequate. For example, physical therapy is not standardized in NY, but is included in the rehabilitative category under the ACA. If New York determines that the physical therapy benefit in the chosen benchmark is not sufficient, the state should be allowed to substitute the physical therapy benefit from another benchmark plan. The state needs the flexibility to ensure that the benefits provided meet the needs of its consumers and ACA's goal of providing meaningful coverage (particularly in the 10 designated benefit categories).

5) Cost-sharing

It has been noted that Cost-Sharing Reductions (CSR) only apply to the essential health benefits, any additional benefits not part of EHB will not receive CSR. If a state should choose a benchmark that contains benefits outside the 10 mandated EHB categories, will consumers be afforded CSR for these additional benefits? When can states expect to see guidance on cost sharing?

6) Technical Comments

In the sections below, we take this opportunity to pose specific questions, organized by topic, related to state decision making in determining essential health benefits.

Definitions

Please clarify how the following terms/benefits will be defined:

- Ambulatory patient services;

- Chronic disease management;
- Prescription drugs. Specifically, which classes and categories of drugs will be required;
- Health plan and health product; and
- Habilitative and rehabilitative services.

Annual Limits & Lifetime Limits

We seek clarification on annual limits/lifetime limits. Are these limits prohibited for all benefits in a state's benchmark for EHB or does the prohibition apply only to the 10 required benefit categories? A prohibition on annual or lifetime limits on services not included in the 10 required benefit categories may result in an adverse impact on premium rates and affordability of these products and thus we urge HHS to allow state flexibility on these additional categories.

Pediatric Oral & Vision Services

We note that child-only plans are for children up to age 21, and dependent coverage is up to age 26. Please clarify the age requirement for pediatric services.

We seek HHS clarification on the scope of services to be included in the pediatric oral and vision services benefit. For example, it's common for a routine eye exam to be covered as part of a well child visit. Refractive services for prescribing eyeglasses, however, are most often not covered by a medical benefit and are sometimes carved out to a separate vision care program.

Coverage of Prescription Drugs

We urge HHS to issue additional guidance on the drug categories and classes that must be covered under the required prescription drug category. HHS should also provide information about restrictions, if any, on the use of formularies and other clinical drug review programs.

Habilitation

HHS should further define habilitative and rehabilitative services to specify which services are to be covered, or alternatively, confirm that this definition will be left to the states.

Per HHS' request for comment on the inclusion of maintenance of function as part of the definition of habilitative services, consistent with our comment on the "Summary of Benefits and Coverage and Uniform Glossary," maintenance of function should be included across all benefit categories as medically necessary services.

Catastrophic Plans Sold in the Exchange

Carriers may provide catastrophic plans on the Exchange. HHS should provide clarification on whether catastrophic plans will also be subject to the benchmark plan.