January 31, 2012

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Via E-Mail to EssentialHealthBenefits@cms.hhs.gov

Re: Request for Information on the Essential Health Benefits Bulletin

Dear Secretary Sebelius:

The Essential Health Benefits Coalition ("EHBC") appreciates the opportunity to provide comments in response to the "Essential Health Benefits Bulletin" as issued by Department of Health and Human Services' (HHS's) Center for Consumer Information and Insurance Oversight (CCIIO) on December 16, 2011.

The Essential Health Benefits Coalition is a broad-based organization representing large and small employers from various sectors of the U.S. economy, pharmacy benefit managers, providers, and health and dental plans operating in every state.

As you finalize the definition of the Essential Health Benefits (EHB) package, we want to emphasize our concerns regarding the affordability of coverage for small employers and individuals under the Affordable Care Act (ACA). HHS seeks to give states flexibility to structure their own EHB package using private market coverage options in use today to serve as benchmarks. Yet these benchmark options are subject to the same state mandates that today keep coverage unaffordable and out of reach for many small employers and individuals. We urge HHS to consider an approach that balances reasonably comprehensive benefits with affordability for employers and individuals. A definition that does otherwise will make health coverage more expensive for employers and individuals to purchase and make jobs more difficult for employers to create.

Attached are the EHBC's detailed comments and recommendations on the Bulletin. We appreciate your consideration of our comments. If you have any questions, please contact me at (202) 626-8170 or at TrautweinN@NRF.com.

Sincerely,

Neil Trautwein
Chairman, Essential Health Benefits Coalition
Vice President, Employee Benefits Policy Counsel
National Retail Federation

Members of the Essential Health Benefits Coalition Steering Committee:

American Osteopathic Association
America's Health Insurance Plans
Blue Cross Blue Shield Association
Express Scripts Inc.
National Association of Health Underwriters
National Association of Manufacturers
National Association of Wholesaler-Distributors
National Federation of Independent Business
National Retail Federation
Pharmaceutical Care Management Association
Prime Therapeutics
Retail Industry Leaders Association
U.S. Chamber of Commerce

The following are the EHBC's detailed comments and recommendations on the Bulletin:

A. Affordability should be considered in the determination of initial essential health benefits package and any updates to it.

Issue: The Bulletin fails to consider the issue of affordability as it spells out a transition scheme for the establishment of the essential health benefits. If cost is not taken into account, and the EHBs are defined too expansively with the inclusion of state mandated benefits not subject to rigorous evidence-based reviews or cost analyses, then it will remain difficult for small employers and individuals to purchase coverage leading to diminished access to health insurance coverage, despite the ACA.

Recommendation: The essential health benefits package should incorporate cost considerations by evaluating benefits, including state benefit mandates, from both a cost and medical effectiveness perspective. We recommend that in order to ensure affordability, HHS encourage states to undertake a review of their most costly benefit mandates, using the method described by the Institute of Medicine (IOM) in its recommendations to HHS on defining essential health benefits[1].

Rationale: The ACA sought in part to help enable low- and moderate-income individuals, and small employers, to obtain affordable health care coverage in and out of the state-based exchanges. To ensure access to essential services, it is critical that the essential health benefits package be affordable so that as many consumers as possible can purchase the coverage. Too broad an EHB package, and one that ignores the importance of a sound evidence base for each service within the general categories of essential benefits, will be unaffordable and wasteful. In light of the particular cost sensitivity of the individual and small group markets, we recommend that states revisit their mandated benefits to help ensure that they are necessary and affordable.

The IOM stressed the importance of affordability and emphasized that only state mandates that are evidence-based should be included in the essential health benefits package.[2] We agree that the essential health benefits package *must* be based on affordability considerations and include an evaluation of benefits from both a cost and medical effectiveness perspective. Specifically, the EHBC supports the IOM's recommendation of using a premium target as a mechanism for bounding decisions about what will be included in the EHB.[3]

B. State mandates included in the essential health benefits package must be medically effective and evidence-based, as recommended by IOM.

Issue: The transitional approach taken by HHS contradicts the ACA statute by, in some cases, incorporating costly state benefit mandates into the EHB package with little basis in medical evidence.

Recommendation: Benefits lacking in a rigorous level of efficacy or evidence-based support should not be included in the essential health benefits package.

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[1] National Research Council. "9 Updating the EHB." *Essential Health Benefits: Balancing Coverage and Costs*. Washington, DC: The National Academies Press, 2011. 1. Print.
[2] National Research Council. "3 Policy Foundations and Criteria for the EHB." *Essential Health Benefits: Balancing Coverage and Costs*. Washington, DC: The National Academies Press, 2011. 1. Print.
[3] National Research Council. "5 Defining the EHB." *Essential Health Benefits: Balancing Coverage and Costs*. Washington, DC: The National Academies Press, 2011. 1. Print.

Rationale: According to the IOM report, many state mandates have been passed into law due to pressure from advocacy groups without sufficient scientific review of the evidence. Additionally, the IOM stated that current state mandated benefit laws should not automatically be included in the EHB package, but should be reviewed in the same manner as other potential health benefits.[4] To provide consumers with access to appropriate care at the right time and in the right setting, the processes, principles, or criteria used to define essential health benefits must be rigorously evidence based, free from political influence.

C. HHS should provide additional guidance on the benchmark plans offered to states in setting a Qualified Health Plan standard.

Issue: HHS identifies four benchmark plan types for 2014 and 2015 and allows states to select a single benchmark plan to serve as the standard for QHPs, both inside and outside of exchanges. If a state does not select a benchmark plan, the default benchmark plan for the state will be the largest plan by enrollment in the largest product in the state's small group market. Additional clarification is needed on this approach in order to ensure it is implemented in states in a way that both fulfills the ACA's intent, and does not further undermine the affordability of coverage.

Recommendations: We recommend that HHS provide further details on the requirements for states to select a benchmark and provide a timeline for how a federally selected benchmark plan would be designated should a state not select one. Specifically, we urge the Department to reiterate that the Bulletin reflects the statutory requirements that:

- **The EHB package does not dictate cost sharing requirements.** In adopting the benchmark approach, the EHB package of the benchmark defines the services that must be covered, not the way in which those services must be covered, e.g., hospital and physician services. The benchmark does not define how specific cost-sharing requirements will be applied by health plans. The EHB package was never intended to define allowed cost-sharing, some of which is mandated in other provisions of the ACA; instead, the actuarial value requirement will shape how issuers design their cost-sharing requirements.
- **Use of benefit limits included within benchmark plans is not barred**. Consistent with existing typical employer plans and the structure of their benefits, any benchmark for essential benefits must not prohibit the use of current limits on state benefit mandates. Under the Bulletin's described benchmark approach, every service covered by a plan selected as a benchmark appears to be "essential," and allowing the provision of these services without the benefit limits already in place at the time of the plan's designation as a benchmark would have significant cost ramifications. EHBC supports flexibility and innovation in benefit design, including flexibility in applying appropriate treatment and benefit limitations to keep coverage affordable for consumers. Any prohibition on the continued use of such limits will increase the price – and thus the actuarial value and affordability – of the subsequent Qualified Health Plan (QHP) products.
- **Future state mandates will not be added to the benchmark plan**. Although we have been advised by HHS that mandates will be frozen at their level in the first quarter of 2012, the Bulletin is not completely clear in this matter. As currently written, it allows for the possibility of a state adding a newly-enacted state benefit mandate to the benchmark plan even long after the benchmark plan was

[4] National Research Council. "4 Resolving ACA Intent." *Essential Health Benefits: Balancing Coverage and Costs*. Washington, DC: The National Academies Press, 2011. 1. Print.

originally selected. Such an approach would mean that the benchmark plan would continuously change over time, which seems contrary to the intent of selecting a benchmark plan. For that reason, EHBC recommends that the benchmark plan definitions be revised to clarify that benefits must be in effect as of March 1, 2012 for the individual market, and for plans years starting March 1, 2012 for the small group market, in order to be included in the benchmark package, and that states cannot add any benefits retroactively. If states want to apply future benefit mandates, then the ACA provision requiring states to finance the coverage of mandates beyond the EHB package would apply, as noted in the Bulletin[5].

- **Use the benchmark plan *only* to define the 10 categories of EHBs required by the ACA, and not any additional benefits that the benchmark may cover**. EHBC believes that the benchmark plan should be used to define benefits only with respect to the 10 categories and should not extend beyond those categories.

Rationale: The EHB package was intended to only define the services that must be covered, and not for defining the way in which those services must be covered. If the rules related to EHB packages are expanded to other aspects of benefit design beyond covered services, it will be particularly disruptive and detrimental to innovation. Additionally, given that HHS has said it will release further guidance shortly in an additional bulletin, without HHS's full intent we may be missing a significant portion of the picture and are therefore unable to take a definitive position yet on the described benchmark approach.

D. HHS should reference commercial market benefits and practices in establishing essential benefits benchmarks for prescription drugs.

Issue: The Bulletin indicates that HHS will provide some flexibility to issuers to adjust benefits, including both specific services covered and quantitative limits, so long as such flexibility is subject to the baseline set by the benchmark plan coverage. HHS would impose a standard requiring health plans to offer benefits that are "substantially equal" to benefits of the benchmark plan selected by the state and modified as necessary to reflect the 10 ACA coverage categories.

The Bulletin states that HHS intends to reflect the flexibility of Medicare Part D with respect to a standard for prescription drug coverage, and notes that it does not intend to require the protected classes the Secretary has identified under Medicare Part D. EHBC opposes deferring to Medicare as the standard for prescription drug benefits for working Americans in commercial health plans. In doing so, the Bulletin ignores commercial sector innovation in designing and delivering broad, cost-effective prescription drug benefits. Private sector innovation is responsible for the development of prescription drug coverage and largely responsible for the decline in the share of drug expenses paid for by consumers out of pocket. The EHBC would also oppose deferring to Medicare as the standard for how commercial plans provide access to other benefits.

Recommendation: To ensure ongoing affordability, flexibility and innovation, EHBC recommends that HHS drop references to Medicare Part D requirements and regulations. It should instead reference commercial market benefits and practices in establishing essential benefits benchmarks for prescription drugs, just as it does for other health benefits. This change is essential to maintain modern benefit designs that respond to beneficiary needs and rapid changes in science and technology.

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[5] Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin,* pg 9. December 16, 2011.

Rationale: The ACA calls for references to typical employer plans in establishing the EHB package. The establishment of all the essential benefits, including prescription drug coverage, thus should be based on existing private sector coverage without reference to Medicare. Medicare is a benefit structure designed for specific populations of elderly and disabled adults and allows very limited comparisons to union, public employer, and private employer plans that promote more rapid modernization in response to consumer demographics and technological changes. Medicare applies to specific populations that are distinct from the commercial small group and individual markets and should not serve as a reference for prescription drugs or any other part of the essential benefits package.

E. The process for updating the EHB package must incorporate cost considerations by evaluating state mandates from both a cost and medical effectiveness perspective.

Issue: To provide access to consumers to appropriate care at the right time and in the right setting, the processes, principles, and criteria used to define essential health benefits must be rigorously evidence-based, free from political influence, and involve considerations of cost-effectiveness, quality and appropriateness.

Recommendation: Updates to the essential health benefits package should balance the need to provide reasonable, appropriate, high quality, evidence-based coverage with the need to assure affordability and access for consumers. In order to prevent market disruption and to facilitate innovation, the EHBC recommends that updates to the essential benefits occur on a 3-5 year cycle.

Rationale: To ensure consumers receive safe and effective care at the right time and in the right setting, the process for updating the EHB package should balance the need to provide reasonable, appropriate, high quality coverage with the need to assure affordability and access for consumers. As previously noted, and as recommended by the IOM, HHS should update the EHB package to make it more fully evidence-based and value-promoting. The importance of using evidence-based guidelines to update the EHB package is critical, and EHBC supports the IOM recommendation that only state mandates that are evidence-based should be included in the future EHB package. Additionally, in updating the scope of the EHB package, it is important to maintain affordability so that if additional services are added to the scope of the EHB package, the incremental cost associated with the added service is offset by the elimination of other services contained within the EHB package, as specifically recommended by the IOM[6]. Finally, it is important to note that the 3-5 year update cycle being recommended by the EHBC refers only to updating the services under the essential health benefits--it should not impact the ability of an issuer to make changes to their medical policy as needed based on evolving clinical evidence or practices.

[6] National Research Council. "9 Updating the EHB." *Essential Health Benefits: Balancing Coverage and Costs*. Washington, DC: The National Academies Press, 2011. 1. Print.