



NJ For Health Care Campaign
December 25, 2012

COMMENTS to the Department of Health and Human Services and Centers for Medicare & Medicaid Services

RE: Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

New Jersey Appleseed Public Interest Law Center respectfully submits, on behalf of the NJ for Health Care Campaign, the following comments to the Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) in response to the proposed regulations regarding Essential Health Benefits (EHB) released in the Federal Register on November 26, 2012.

The NJ For Health Care Campaign is a broad-based alliance of health care, consumer, senior, student, disability, women's, labor, faith-based, civil rights and social justice organizations working to bring guaranteed, high quality, affordable health care to all New Jersey residents. Such organizations include, but are not limited to, AARP-NJ, New Jersey Policy Perspective, New Jersey Citizen Action, NJ-PIRG, Statewide Parent Advocacy Network and Latino Action Network. See <http://njforhealthcare.org/index.html> (list of all participating organizations). We have been working over the past several years to build strong alliances with patients, providers, small and large businesses and health care and social service agencies across the State in order to ensure that the Affordable Care Act (ACA) is effectively implemented in New Jersey in accordance with our core principles: affordability, transparency, and accountability to all consumers. We were instrumental in assisting our Legislature develop a blueprint for a state-insurance exchange, which unfortunately was vetoed by our Governor, and we are committed to making sure that the ACA works for New Jersey residents.

The NJ For Health Care Campaign expresses our appreciation to HHS for the EHB proposed regulations. These regulations constitute a significant and positive step toward realizing our goal of expanding coverage through the Affordable Care Act (ACA) to New Jerseyans who find themselves currently uninsured. We especially applaud HHS for strengthening consumer protections in the proposed regulations, including the prohibition of substitution across benefit categories, accommodation to previously mandated state benefits, and support of strong anti-discrimination and parity protections.

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Notwithstanding our general approval of these proposed regulations, we believe that there are a number of areas the regulations could be improved to further support consumer access to high quality health care. Accordingly, we are focusing our comments on these areas that raise concern for consumers.

Part 155 Exchange Establishment Standards and other related Standards under the Affordable Care Act

§155.170 (2) – Additional Required Benefits

State mandates are important to consumers, particularly vulnerable consumers. In New Jersey, many of these benefits have been tailored to meet demand in our State. We appreciate HHS clarifying that states, such as New Jersey, will not have to defray the cost of mandates that have been enacted before December 31, 2011.

Part 156 Subpart B

§156.100 - State selection of benchmark

The state benchmark approach to EHB continues to be a concern for many consumers in states outside of New Jersey. While we here in New Jersey are less concerned due to the relative strength of New Jersey's regulatory framework compared to some other states, there are several issues that we, as consumers, would like to see addressed when EHB is reviewed in 2015. First, HHS should document state variability in EHBs; and this variation must be addressed to minimize access variation. HHS should also make the EHB process more transparent to consumers by articulating the process for evaluation over the next two years and determining what the EHB review process will look like in 2016. Consumers need to have a role in shaping EHB in the future, and transparency is key to ensuring that role.

We recommend that HHS assess EHBs across the states and identify areas of variability; this information should be available to consumers. To help consumers understand their state's EHB benchmark in an open and transparent process, HHS should provide this information to the public in an accessible and understandable way or require states, which are establishing their own exchange or have selected a federal-state partnership, to do so. Open forums held throughout a state on the issue would provide consumers with meaningful information about potential EHB plans so that they can choose plans that meet their families' needs, and would serve as a valuable outreach tool. HHS could help states, or outreach partners/navigators in states where the federal government will be operating the exchange, by providing data that bring greater transparency in discerning benefits in the EHB benchmark, including the associated plan documents. Lack of clarity surrounding the EHB plan generally has given our Governor political cover to veto our State Health Insurance Exchange bill; transparency, data and active purchasers will compel him to facilitate implementation of the ACA in New Jersey.

HHS should document the evaluation process for EHBs, including the criteria used to evaluate them, clarification of the data that will be collected, and the process through which consumers can have their voices heard during the evaluation process. These criteria should include plan comprehensiveness, affordability, administrative simplicity, mandate inclusion, and continuity of coverage. The timeframe is short for EHB evaluation. A structured EHB evaluation process for states over the next two years would protect the interests of all consumers and support states in meeting the needs of consumers.

As a part of a structured evaluation process, HHS should use existing networks of consumer advocacy groups as partners in ongoing evaluation. Once people begin enrolling in EHB plans, state consumer assistance programs will become well-versed in how well EHBs meet the needs of consumers. Navigators will play a similarly important role in identifying gaps in coverage for Exchange populations, as well as where EHBs are working well. By working with consumer assistance groups together with nonprofits that serve vulnerable populations, HHS will gain a more expansive understanding of state EHBs. Consumer health advocacy groups such as Statewide Parent Advocacy Network, Latino Action Network, New Jersey Citizen Action and other members of NJ For Health Care Campaign, are well-equipped and eager to play this role and develop relationships with HHS. These are the groups that will be most knowledgeable of consumer experience.

New Jersey has had a spotted history with outreach in our Family Care program and Medicaid programs. Relatively generous eligibility has been countered by relatively low enrollment rates. Only when the State has employed the assistance of community-based consumer groups has it been able to improve its performance. HHS should work with these groups directly and provide incentives for our State bureaucracy to do so as well.

§156.110-State Selection of Benchmark

In the proposed regulation, there is no detailed definition of the 10 categories of care. This makes it difficult for consumers and states to assess whether or not the responsibility to offer the category is fulfilled. Absent sufficient category definitions, it is difficult to assess balance across the categories and parity requirements. Many categories of care may be highly variable, potentially neglecting important services. **We urge HHS to further define the 10 categories of care; and to make clear that States are permitted to adopt more comprehensive definitions if they so choose. That is, federal regulations provide a floor, not a ceiling (for purposes of pre-emption).**

Pediatric services are one area negatively affected by an absence of category definition. The EHB benchmarks are based on the small group market and adult health care needs. Children's health needs are different and the EHB pediatric categories often require supplementation. **We request that HHS further define the pediatric categories to ensure adequate coverage of services of children inclusive of comprehensive vision, hearing and dental services in addition to robust preventive services.**

Habilitative care is another area that requires a more substantial definition of care. This category impacts a diverse set of consumers from children to seniors, many with a range of medical needs. We ask that HHS define habilitative services rather than permitting insurers to determine such criteria. We recommend that the Medicaid program be used as a guide for determining the specific services included under habilitation. Regardless of the diagnosis that leads to a functional deficit in an individual, the coverage and medical necessity determinations for habilitative services and devices should be based on clinical judgments of the effectiveness of the therapy, service, or device to address the deficit. **HHS should adopt a federal standard to serve as a default and/or floor when states do not define habilitative care.**

A clear and uniform definition of medical necessity at the federal level will also lead to greater consistency of care, transparency for consumers and providers, and improved procedures for grievances and appeals. **The Secretary should require states and insurers to use this federal definition of medical necessity, unless the state uses and intends to continue to use a more stringent, rigorous definition.** We understand the demand of national consumer groups to develop a standardized definition of medical necessity that is not narrowly defined by acute treatment outcomes; especially one that is broad enough to include services that improve, maintain, or prevent deterioration of a patient's capacity to function. However, here in New Jersey we have become sensitive to insurance rate review regulations issued under the ACA that have embodied compromises that consumers did not have to make in New Jersey (i.e., methodology to determine medical-loss ratios). Accordingly, we request the Secretary make explicit that these regulations do not pre-empt more rigorous or protective state standards.

§156.115- Provision of EHB

While we are pleased that the proposed regulations clearly state that EHB must be compliant with the federal Mental Health Parity and Addiction Equity Act (MHPAEA), this provision should be strengthened. The proposed rule leaves open the question of states' financial responsibility regarding MHPAEA compliance. **Specifically, states need clarification on what party is financially responsible for bringing plans into compliance.** States should not bear the burden for ensuring compliance with parity.

With respect to parity, HHS should also clarify the specific steps it will take to ensure parity enforcement for the new EHB plans. As states have primary enforcement authority over parity for fully insured plans, how will they be held accountable? HHS should use its status as the back-up agency to enforce parity compliance.

HHS should also clarify that states still have existing authority to enforce the parity law. Many states maintain that they require conforming state legislation to enforce the federal parity law. We urge HHS to clarify that this is incorrect. **HHS should outline a clear process for supplementing the base benchmarks to meet parity requirements.**

We applaud the prohibition of cross-category substitution and the banning of prescription drug substitutions within that category. This provision is important in protecting consumers and

the market from adverse selection. However, consumers continue to be concerned about *within* category substitution; the trading of benefits within a category places consumers at risk.

Accordingly, HHS should limit substitution within the benefit category by subjecting benefit substitutions to a high level of regulatory scrutiny. HHS should ensure that these substitutions are not used to limit important services. HHS could do this by identifying substitution limits, restrictions or prohibitions. These substitutions should be subject to several tests to protect consumers:

- The alternate benefit should have a demonstrated improving effect on consumer welfare.
- Substitutions must be understandable to consumers. There should be required disclosure so that differences are easily grasped.
- Substitutions should result in an overall package that is at least as generous as the benchmark.
- Selection effects must be considered.
- Substitutions that benefit small populations with special needs may be necessary but may also result in adverse selection into the plans that offer them. A state or HHS must weigh whether the risk adjustment mechanisms are sufficient to address this possibility.

§156.120-Prescription of Drug Benefits

We appreciate that HHS has tried to strike a balance that guarantees access to prescription drugs while granting plans flexibility in negotiating with drug companies to develop plans that meet consumers' needs. Inclusion of more than one drug per class is important to consumers with chronic conditions and/or disabilities, and enables patients to better manage their conditions. With the prescription drug benefit, in particular, enforcement of anti-discrimination provisions will play an important role to protecting these vulnerable populations.

§156.125- Prohibition of Discrimination

NJ For Health Care Campaign is pleased that the proposed regulations prohibit discrimination in benefit design as required by the ACA. However, monitoring and enforcement responsibilities are largely delegated to the states without sufficient understanding of the federal government's intended role. **The final rule should better define how the state and the federal government will assess, monitor and enforce the law's non-discrimination provisions.** HHS should develop a clear standard for what is a discriminatory benefit design and provide sub-regulatory guidance on how to evaluate products for discrimination. This sub-regulatory guidance should include concrete examples across the many protected classes of consumers to serve as examples for states. These should be publicly available to consumers. In addition, HHS should require trained evaluators to review insurance contracts for discriminatory benefits.

Because actuarial value calculations and cost-sharing limitations do not account for out-of-network cost sharing, insurers are given an incentive to keep networks small and formularies narrow, and may use these mechanisms to avoid some populations. Evaluation reviews should consider both in- and out-of-network utilization. It is important that HHS ensure that plan benefit

designs and formularies do not result in discouraging enrollment by individuals with significant health needs. **As we have found with respect to federal anti-discrimination laws in other areas such as employment, housing and education, delegation to the states is insufficient. Although here in New Jersey, we have developed over the years strong state anti-discrimination policies, continuing oversight by the federal government is still necessary.**

Plan flexibility such as benefit substitution within a category, as proposed by HHS, could also result in a benefit design that discriminates against one of the protected classes of people in the ACA. Variation in benefits that result in discrimination should not be allowed. The lack of guidance on monitoring and enforcement of the discrimination provision, paired with state and insurer flexibility, leaves consumers unnecessarily at risk. Standards that protect consumers while leaving room for innovation, and localized market solutions are necessary. And as with all consumer protections, transparency is necessary to support an open dialogue and participation by all stakeholders inclusive of a transparency in standards, process, and documents.

§156.130- Cost-sharing requirements

In the proposed regulation, plans may exceed annual deductible limits if the plan “may not reasonably reach the actuarial value of a given level of coverage.” **While we acknowledge that some plans will need flexibility in their AV target, we request that HHS define “reasonably” and detail how HHS will track and monitor these deviations.**

§156.150- Stand Alone Dental Plans

The proposed regulation indicates that there will be a separate cost-sharing limit for stand-alone dental plans in addition to the out-of-pocket maximums that will already apply to a family’s EHB-associated costs. The rule further states that the additional cost-sharing limit be “reasonable,” but fails to propose a specific test for such reasonableness. This proposed change will increase a family’s out-of-pocket maximum and therefore will penalize families when purchasing separate dental coverage. No family should be subject to out-of-pocket expenses in excess of the law’s clearly established affordability provisions. This provision would make pediatric dental coverage less affordable for families purchasing it separately from the rest of their EHBs, effectively creating a disincentive to purchase a critical piece of a child’s benefit package. **The cost-sharing for stand-alone dental plans should not be separate.**

If a state Exchange allows pediatric dental benefits to be priced and offered separately, many families may forgo the purchase of dental coverage for their children for two reasons: they will be forced to consider purchase of a separate insurance product, and their out-of-pocket expenses may be higher.

Families that are enrolled in a stand-alone dental plan should not bear the burden of tracking out-of-pocket expenses for both medical and dental expenses. Insurance companies are well-positioned to coordinate with one another in order to determine when families have reached their out-of-pocket maximums, notify families, and adjust cost sharing accordingly. **We strongly urge HHS to require that out-of-pocket maximums established by the statute be applied to costs related to all EHBs – including those services covered by stand-alone dental plans –**

and to require that costs are tracked and coordinated among all insurance carriers for a family.

§156.140 (c)- Levels of coverage.

The proposed regulations allow variation of actuarial value targets for metal tiers by +/- 2 percentage points. We are concerned that that an actuarial value of 58 percent in bronze level plans is too low. **We urge HHS to create a backstop for bronze level plans, and prohibit flexibility to go below 60 percent actuarial value.** This would protect consumers from inadequate coverage. Finally, the AV calculations should be transparent to consumers so that they can be aware of any deviation from the target within the metal tier.

In sum, while the proposed regulations are a positive step toward implementing the ACA, there are some provisions that should be strengthened in order to sufficiently protect consumers. The regulations do not require sufficient levels of transparency and stakeholder involvement at both state and federal levels. Consumers need an opportunity to fully participate in the process of determining and updating the state-based EHB. NJ For Health Care Campaign request that HHS support principles of consumer involvement, transparency and stakeholder engagement throughout the EHB process to ensure that our Governor, and states generally, implement the ACA in a fair, effective and efficient manner.

On behalf of New Jersey consumers, we look forward to regulations that provide access to robust coverage for all and permit New Jersey to adopt more comprehensive and protective regulations if it so chooses.

Respectfully submitted,

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On Behalf of NJ For Health Care