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*National Advocates for
Asian American,
Native Hawaiian &
Pacific Islander Health*

Secretary Kathleen Sebelius
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Essential Health Benefits Bulletin, Center for Consumer Information and Insurance Oversight (CCIIO)

Dear Secretary Sebelius:

The Asian & Pacific Islander American Health Forum (APIAHF) thanks the Center for Consumer Information Insurance Oversight (CCIIO) and the Department of Health and Human Services (HHS) for the opportunity to comment on the recent "Essential Health Benefits Bulletin" ("Bulletin") dated December 16, 2011, outlining HHS' regulatory approach to the development of the essential health benefits package pursuant to Section 1302 of the Affordable Care Act (ACA). For 25 years, APIAHF has dedicated itself to improving the health and well-being of Asian American, Native Hawaiian and Pacific Islander communities living in the United States and its jurisdictions. A uniform and comprehensive package of essential health benefits (EHB) has the potential to improve the health and health care of the 2.4 million uninsured Asian Americans, Native Hawaiians, and Pacific Islanders (AA and NHPI) in the United States.

As advocates for the health and welfare Asian Americans, Native Hawaiians, and Pacific Islanders who are currently uninsured, including business owners, low-income families, and others who stand to benefit from the EHB, we are concerned that the Bulletin's approach fails to guarantee a minimum standard and disappoints the ACA's promise to ensure consistent, universal, and meaningful coverage. We urge HHS to address the following specific concerns raised by the Bulletin's approach: first, that the lack of a federal standard will result in EHB plans that discriminate against vulnerable populations; and second, that the lack of formal mechanisms for monitoring and evaluation in the design as well as updating of the EHB does not allow for adequate consumer participation.

A State-Based Approach is Inadequate

By permitting a state-based benchmark approach, the Bulletin's regulatory structure will result in a different set of benefits in each state and jurisdiction without assurance that coverage is meaningful everywhere. Such variation will undermine important provisions of the ACA that are critical to Asian Americans, Native Hawaiians, and Pacific Islanders and that depend upon a consistent and reliable EHB package, including premium tax credits and cost-sharing subsidies and caps on out of pocket costs. We are concerned that the Bulletin's reliance on the States' role in defining EHB will create a system that fails to meet the needs of vulnerable populations and ultimately fail to reduce health disparities. In addition, such an approach could result in discrimination on the basis of personal characteristics of vulnerable consumers.

Under the proposed regulatory approach, each state will have the ability to select from an approved set of benchmark plans, or the state will default to the largest plan by enrollment in the largest product in the state's small group market. First, we are concerned that the approach permitting wide state by state variability contradicts the design of the ACA to create a uniform, simple, and guaranteed set of benefits for all Americans who purchase qualified insurance plans. The ACA explicitly empowers the Secretary to define the EHB, to ensure that the scope of the EHB is equal to the scope of benefits in a typical employer plan, and to periodically review the EHBs and provide a report to Congress and the public. Section 1302(b). We believe that the proposed regulatory approach delegating the Secretary's authority circumvents Congress' intent to create an insurance market that would better meet the needs of consumers, particularly those who have historically suffered from health inequities.

Lack of Federal Minimum Standard Creates Inequality

Variation in the package of essential benefits across states or insurers places administrative barriers and expense to providing a comprehensive set of EHBs across diverse states. Moreover, without a federal EHB package, enforcing the statutory requirements of §§ 1302 and 1557 in more than 50 different jurisdictions will be exceedingly difficult. Given their limited resources, it is unlikely that state insurance regulators would be able to effectively review the numerous permutations in the scope and design of benefits for compliance with the law.

Although HHS has recently released a list of potential benchmark plans, consumer advocates have had no opportunity to review the details of benefits covered by the potential benchmark plans in each state, nor had the opportunity to submit comments on the advantages and disadvantages of selecting one plan over another. Details necessary to compare potential default plans in each state are similarly unavailable. In light of this dearth of information, and strong potential for confusion, additional expense, and discrimination, we strongly urge HHS to adopt a consistent minimum national set of benefits as the EHB standard.

Effective implementation of a number of provisions of the ACA is predicated on a federal uniform EHB package. For example, a Federally-defined EHB package is critical to ensuring that health plans meet the needs of diverse populations, an explicit priority of the ACA. We recognize that the Bulletin also acknowledges this as a major goal. The EHB package will apply predominantly to plans covering low- and moderate-income populations that are more likely to be in worse health than their wealthier counterparts and unable to pay out of pocket for extra services.¹ Communities of color,² women³ and other vulnerable populations tend to be disproportionately represented among low-income populations,

¹ AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL HEALTH DISPARITIES REPORT (2010), <http://www.ahrq.gov/qual/nhdr10/nhdr10.pdf>. Several health indicators demonstrate that low-income people continue to have worse results in several core health measures than those with higher incomes, such as: timeliness in receiving immediate care, hospital admissions for short-term complications of diabetes, and adults with major depressive episodes who received treatment within the last 12 months.

² See RAKESH KOCHHAR, ET AL., PEW RESEARCH CENTER, WEALTH GAPS RISE TO RECORD HIGHS BETWEEN WHITES, BLACKS, AND HISPANICS 1, 5 (2011), http://www.pewsocialtrends.org/files/2011/07/SDT-Wealth-Report_7-26-11_FINAL.pdf. As a result of the declining housing market and the recession, the median net worth of Black households was \$5,677 (assets minus debts) in 2009; the typical Hispanic household had \$6,325 in wealth; and the typical white household had \$113,149. The median Asian household net worth also declined to \$78,066.

³ See ELIZABETH M. PATCHIAS AND JUDY WAXMAN, THE COMMONWEALTH FUND, WOMEN AND HEALTH COVERAGE: THE AFFORDABILITY GAP (2007), http://www.commonwealthfund.org/usr_doc/1020_Patchias_women_hlt_coverage_affordability_gap.pdf.

and the EHB package must be defined deliberately to meet the needs of these populations. Section 1302 of the ACA specifically supports this objective by requiring the Secretary of HHS, in defining the EHB package, to take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups. Unless adequately addressed by EHB rules, state benchmark plans are likely to reproduce existing discriminatory practices, which Congress aimed to eliminate.

We urge HHS to specifically define the ten categories of services as directed by the ACA Section 1302. Providing definitions will actually help to provide important guidance to states. Since many insurance plans do not categorize benefits using the ten categories specified in the statute; it will often be unclear what covered benefits should be considered within each of the ten categories. The Bulletin specifically notes certain services such as habilitative services and children's vision and dental that will need to be supplemented because they are not traditionally covered by the plans that are potential benchmarks. Other categories, such as maternity services and preventive services, will include benefits that will also be part of another category. Providing clear definitions of the categories will provide a minimum scope of coverage that states have the flexibility to build upon.

Adopt Strong Non-discrimination Requirements

If HHS moves forward with a benchmark system as outlined in the Bulletin, the Secretary is obligated to impose strong non-discrimination rules to guarantee fair treatment for diverse populations as well as individuals. Sections 1302 and 1557 of the Affordable Care Act contain specific nondiscrimination requirements that the Secretary must adhere to and enforce. The ACA prohibits discrimination against individuals on the basis of age, expected length of life, quality of life, medical dependency, or predicted disability.⁴ Section 1557 of the ACA prohibits discrimination based on race, ethnicity, national origin, age, disability, functional status, or gender by any ACA provision, including Section 1302, which creates the EHB requirement. Section 1557 provides an independent and additional prohibition on discrimination in the EHB package because the EHB package will be included in plans offered in the Exchanges, which receive federal funds, and because the Exchanges and qualified health plans are regulated by the federal government. Therefore, future guidance should specifically state that the Secretary has a legal obligation to ensure compliance with § 1557 in the essential health benefits, and that benefits deemed essential must not be subject to denial or limitation on the basis of race, color, national origin, primary language, age, disability, gender identity, or sexual orientation. We strongly urge HHS to expressly prohibit such discrimination in rules to fulfill Congress' intent of ensuring that all people covered by an EHB package have equal access to essential care.

Insurer and Plan Variability

APIAHF shares the concern of the National Health Law Program (NHLP), the Leadership Conference on Civil and Human Rights, and other consumer advocates that the EHB design proposed in the Bulletin will discriminate against vulnerable groups because the extreme flexibility allowed to states and insurers will facilitate insurance rating practices whereby sick populations or those who have historically not had insurance and need more initial services will be avoided. Plans may be incentivized to design plans that simply do not cover high cost or stigmatized conditions or populations if insurers are able to use benefit design as a proxy for health status. Many Asian American, Native Hawaiian, and Pacific Islanders have been uninsured for long periods of time and will need a higher level of care to "catch

⁴ Section 1302(b)(4)(B) states that the Secretary "must not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate" based on certain factors. Section 1302(b)(4)(C) provides that essential items and services must not only be nominally covered but must "not be subject to denial to individuals against their wishes" based on certain factors.

up” when they enter the insurance system for the first time or re-enter after a long absence. AAs and NHPs also suffer disproportionately higher rates of certain diseases and chronic conditions, such as Hepatitis B, cervical cancer and diabetes. Therefore, it is critical that practices resulting in discrimination against AA and NHP populations, especially those with health conditions or disabilities, are prohibited.

Allowing insurer or plan flexibility could result in plans designed with the discriminatory intent to discourage enrollment by higher cost enrollees by failing to cover benefits essential to those individuals. In the current marketplace, health insurers utilize practices such as restrictive services limits, condition-based exclusions, medical necessity definitions and utilization management policies, in ways that discriminate unfairly against specific groups of consumers. Reimbursement rates and limited provider definitions for certain benefits can also have the effect of limiting access to care for specific groups of consumers, such as persons suffering from high-cost chronic diseases like HIV and diabetes. These practices are likely to continue even with a more clearly and consistently defined set of covered items and services, absent adequate protections. Unless adequately addressed by EHB rules, state benchmark plans are likely to reproduce these discriminatory practices which Congress aimed to eliminate.

Arbitrary Condition Based Exclusions Should Be Prohibited

Section 1302(b)(4)(D) specifically requires that, in defining the EHB package, the Secretary must ensure that essential benefits “not be subject to denial to individuals against their wishes on the basis ...of the individuals’ present or predicted disability.”⁵ We believe the intent of this provision is to prohibit plans from making arbitrary and discriminatory decisions based on certain characteristics of people rather than on sound, clinical bases. Arbitrary coverage limitations or exclusions targeting a specific medical condition have been used to deny coverage for HIV and cancer treatments, reconstructive surgery following cancer and other illnesses, eating disorders, and care for a variety of other conditions that were considered rare, stigmatized or costly. The clearest precedent for § 1302(b)(4)(D) is the longstanding Medicaid rule providing that state plans may not arbitrarily limit or exclude coverage based solely on a person’s medical condition or diagnosis.⁶

In order to prevent discrimination based on disability, HHS should require that any limitation on an essential item or service that solely targets a particular medical diagnosis, condition or group of conditions must have a clinically relevant basis. Permissible considerations should include clinical efficacy and cost-effectiveness. Determinations about whether an insurer covers care related to a particular condition should not be based on arbitrary factors such as including the rarity of a condition or the goal of limiting claims costs.

Protecting consumers from arbitrary condition-based exclusions is particularly important because without such protections, insurers will have an incentive to expand the use of such exclusions in the future. Core ACA reforms such as the ban on preexisting condition exclusions and limits on lifetime and annual coverage limits remove common methods by which insurers have limited claims costs in the past, and insurers will be incentivized to increase their use of discriminatory limitations to reduce costs.

⁵ To best reflect the provision’s intent, any exclusion that targets a specific medical condition or diagnosis should be subject to scrutiny.

⁶ 42 C.F.R. § 440.230(c).

Include Language Access Services

We urge HHS to ensure that benefits deemed essential are provided in manner that is culturally and linguistically appropriate and accessible to individuals with limited proficiency in English and with limited health literacy. Furthermore, plans covering the EHB package should be required to remove language barriers that impede access to health care, compromise quality of care, and increase the risk of adverse health outcomes among limited English proficiency (LEP) patients.⁷ HHS must set a federal standard that requires the provision of language services- including written translation and oral interpretation- in conjunction with all EHBs to ensure that all people can access health care in a linguistically and culturally appropriate environment. Information about plans and covered benefits should meet existing language requirements, particularly the 5% or 500 person threshold for translating vital documents utilized in both the Department of Justice and HHS LEP Guidance's, CMS Language Access Strategic Plan, as well as recently revised regulations from CMS governing marketing by Medicare Part C & D plans. If individuals are to benefit meaningfully from gaining coverage of an EHB package, the care and services they receive must be available in the language that they understand.

Medical Necessity Should Be Defined

Medical necessity is a management tool which will be one of the core determinants of whether a service should be covered and/or is accessible to an individual. All too often, however, medical necessity is defined by rigid or narrow criteria which prevent individuals from accessing medical treatments which they need. Medical necessity should generally defer to the clinical judgment of the treating physician or treatment team. The major advantage of this view is that it reduces the likelihood that determinations of insurance coverage will be solely cost-based or administratively burdensome.

Accordingly, HHS should ensure that the decisions of the treating provider or team are given great weight and deference. When decisions are reviewed, the purpose of the review by health plans should be to determine:

- Whether the treatment accords with professional standards of practice (these standards should be considered a baseline of professionally agreed-upon practices, generally based on large quantities of evidence from empirical studies (i.e., evidence based), but where such evidence is lacking due to the condition or unique nature of a patient's needs or illness, the standards should be based on a clinician's experience in practice;
- Whether it will be delivered in the safest and least intrusive manner and least restrictive setting, or is necessary to facilitate living in the community;
- Whether there are equally effective treatments, services, and care that are actually available and accessible to the enrollee.

Include Robust Data Collection and Reporting Requirements

The broad state flexibility contemplated by the Bulletin's approach will require vigilance to ensure equitable benefits for those who face the greatest health disparities. Lack of reliable data about the impact of the EHB on all enrollees in each jurisdiction represents a major roadblock to realizing the ACA's protections for vulnerable and minority populations.

⁷ Chandrika Divi, et. al., The Commonwealth Fund, *Language Proficiency and Adverse Effects in U.S. Hospitals: A Pilot Study*, 19 Int'l J. Quality U.S. Health Care 60 (2007).

The collection of high quality demographic data in quantities and granularity sufficient for study is a critical first step in understanding and eliminating disparities in health outcomes and access, including in the selection, monitoring, and evaluation of an equitable EHB as envisioned under the ACA. For example, there are many ethnic subgroups within Asian American, Native Hawaiian, and Pacific Islander communities. Ethnic specific data is critical to monitoring disparities in health status and access to health care for Asian Americans, Native Hawaiians, and Pacific Islanders, as we know that there are wide variations in health status and health care access between subgroups. Additionally, for racial and ethnic groups with a relatively small number of members, such as Asian Americans, Native Hawaiians, and Pacific Islanders, and American Indians/Alaskan Natives, there is often inadequate data to identify important health issues and appropriate interventions and solutions to those issues. Such data is often not collected, collected but not analyzed, or not reported due to inadequate sampling.

Therefore, data used in assessment should be disaggregated by multiple intersecting demographic categories to enable detailed analysis of the impact on subpopulations. We urge HHS to require EHB plans selected by the states to uniformly report enrollees' race, ethnicity, language, sex, and disability status data, as well as data on other demographic categories, including sexual orientation and gender identity, as described in Section 4302 of the ACA. Section 4302 of the ACA (adding new §3101 to the Public Health Service Act), requires HHS to ensure that certain data is collected throughout all HHS programs, activities, and surveys. Since many individuals participating in the Exchanges will be receiving federal subsidies, and the Exchanges themselves have received significant financial assistance in their developmental stages, we believe that the Exchanges meet the requirements of being federally assisted under §4302.

We urge the Secretary to require a uniform set of data from the states and to establish a process for collecting and making demographic data publicly available. If HHS has this data in a standardized format from each state, it will be possible to identify and address health and healthcare disparities when the EHB are periodically reviewed and updated in accordance with Sections 1302(b)(4)(G) and (H) of the ACA. In addition, data will inform HHS and State plans about enrollees who may need language services, and assist states about the need to make policy modifications to ensure that the needs of diverse communities are being met, as well as to prevent and ameliorate discrimination.

Implement Strong Federal and State Accountability Mechanisms

Finally, we urge HHS to provide a regulatory mechanism to ensure that plans offered in all states are in ongoing compliance with the EHB standard. During the process to determine a state benchmark, the Secretary should require states to offer a transparent process with ample opportunities for public comment and stakeholder engagement. Consumers should have the ability to review proposed benchmarks and provide comments.

In addition to federal oversight by HHS, States must provide for oversight of plan features, including cost-sharing, utilization management policies and medical necessity definitions. At a minimum, health plans should be required to disclose this information, as well as information regarding covered services, limits, and exclusions, to the state and the public, including applicants and enrollees. Plans must submit the procedures by which they are ensuring they meet the EHB standard including any changes in benefit design, if allowed under the rule. The states must then establish transparent and public procedures for reviewing plan designs.

We also urge HHS to consider options for more rigorous oversight, such as review and approval or auditing requirements, to ensure these features are not being used in ways that violate the prohibitions on discrimination and other requirements under § 1302. We further recommend that states and HHS outline and provide a clear and accessible

complaint process where consumers can make reports of suspected noncompliance, and make enforcement plans available to the public.

Conclusion

We thank you for the opportunity to comment at this pre-rulemaking stage and look forward to working with HHS to ensure that the benefits and protections of the ACA are fully realized in final regulations governing the EHB package and related provisions. If you have any questions regarding our comments, please contact Priscilla Huang, Policy Director, at phuang@apiahf.org.

Respectfully,

A handwritten signature in black ink, appearing to read 'Kathy Lim Ko', written in a cursive style.

Kathy Lim Ko
President & CEO
Asian & Pacific Islander American Health Forum