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

December 24, 2012

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

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

Dear Sir/Madam:

The Asian & Pacific Islander American Health Forum (APIAHF) thanks the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid (CMS) for the opportunity to comment on the proposed rule detailing standards related to Essential Health Benefits, Actuarial Value, and Accreditation. APIAHF is a national health justice organization that influences policy, mobilizes communities, and strengthens programs and organizations to improve the health of Asian Americans, Native Hawaiians, and Pacific Islanders (AAs and NHPIs). For 26 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. We work on the federal, state and local levels to advance sensible policies that decrease health disparities and promote health equity.

The design of the Essential Health Benefits (EHBs) will have a direct impact on the health and well-being of over 70 million Americans. EHB design will also have tremendous impact across our health care system and is a central component of the Patient Protection and Affordable Care Act (ACA). A uniform and comprehensive package of essential health benefits has the potential to improve the health and health care of the 2.4 million uninsured Asian Americans, Native Hawaiians, and Pacific Islanders in the United States.

As advocates for the health and welfare of Asian Americans, Native Hawaiians, and Pacific Islanders who are currently uninsured and underinsured, including business owners, low-income families, and others who stand to benefit from the EHB, we are concerned that the proposed rule's approach fails to guarantee a minimum standard and disappoints the ACA's promise to ensure consistent, universal, and meaningful coverage. We join many other health advocacy organizations including the National Health Law Program (NHeLP), in urging HHS to address the following concerns raised by the proposed rule's approach:

Fundamental Structural Flaw

The proposed rule suffers from a fundamental flaw: **the EHB regulation fails to implement the legal requirement to provide coverage for "the items and services covered within" the ten statutory EHB categories.** While we agree that the ACA sets typical employer coverage as the baseline for the EHB standard, it then layers on the *additional* requirement to ensure coverage of "the items and services covered within" the ten statutory categories. The proposed regulation provides that this coverage requirement is met by "any" coverage within one of the ten benchmark

plans available in the state. This falls far short of the ACA's intent. The ACA does not only require coverage of the category; it also requires that coverage to include "items and services covered within the categories." Thus, HHS must ensure that EHB coverage is 1) based on the typical employer coverage, 2) that the coverage include the ten statutory categories, and 3) that coverage adequately includes items and services within each category to meet the needs of the population to be insured.[1]

HHS' interpretation paradoxically suggests that Congress intended that the EHB include typical employer coverage levels for specific services, such as habilitative services, which typical employers rarely cover. The EHB regulation then attempts to cure this nonsensical outcome by creating special processes to deal with each of the services that typical employers rarely cover.

The fundamental problem in HHS' approach is that the regulation misinterprets the EHB requirement, ultimately leading to a policy that contradicts legislative language and intent, and will lead to insufficient access to health care services for individuals. HHS must correct this flawed framework and, consistent with the ACA, create a baseline typical employer benefit and then require this baseline benefit to be expanded with meaningful coverage in each of the ten statutory categories.

Serious Procedural Concerns

We have grave concerns with the 30-day review process HHS is using to implement these regulations. We are cognizant of the extremely challenging timeline for HHS to develop and implement the EHB standard prior to state preparations for 2014. (We note, however, that this is to some extent a self-inflicted problem, resulting from HHS' decision to ignore the ACA requirement for a national EHB standard and instead pursue a complex state benchmarking system).

Yet, the proposed rule creates an impossible process for stakeholders. The rule requests that advocates analyze and provide comment on the selected benchmark for their state, as well as the non-selected benchmarks since the states may still change their selection up to the last day of the comment period. Furthermore, HHS requests (as it must) that stakeholders review each base-benchmark plan option as it might be supplemented by each of the other benchmark options and provide comment on all possible supplementing options. With ten benchmarks serving as potential base benchmark plans and supplementing plans, this yields a total of ninety (90) different combinations a stakeholder would need to consider for each of the ten EHB categories. This is unreasonable on its face.

We commend HHS for providing information regarding each state's selected base benchmark plan in Appendix A. However, it requires significant additional research to clearly understand the specifics of these plans. Furthermore, for the other nine

[1] We note that while HHS' preamble to the proposed regulation implies, at 77 Fed. Reg. 70646, that this regulation might not apply to Medicaid benchmarks or the Basic Health Plan, we currently have no legal basis to believe it does not apply. If anything, recent HHS guidance on the content of Medicaid benchmarks indicates Medicaid benchmarks will explicitly rely on the EHB standard (except where there is a direct conflict with Medicaid law). As such, we must assume for the purposes of this regulation that Medicaid and BHP populations may in fact be impacted, and are part of the vulnerable population that will depend upon the EHB standard set forth in this regulation. Our comment therefore considers the EHB rule's impact on Medicaid and BHP populations, in addition to "individual and small group markets."

plans in each state that are not listed in Appendix A, advocates may have little information, if any. Yet, advocates are asked to carefully review and provide comments within a 30 day comment period spanning two major national holidays. This is an unreasonable procedural requirement.

To address these procedural deficiencies, we recommend that HHS extend the comment period to 90 days total and make publicly available information for each state's benchmark options, including specific services covered and applicable coverage limits, in an easy-to-use, comparison-friendly format.

Specific Comments

§ 156.100 State selection of benchmark

This section of the proposed rule codifies the benchmark approach announced in the 2011 EHB Bulletin. When Congress passed the ACA and created the EHB it intended to create a uniform minimum benefit standard that would apply to all States, guarantee small group and individual market health plan enrollees a basic level of protection, and ensure that federal subsidy dollars would be spent on quality coverage. APIAHF strongly opposes this benchmark approach, as it contravenes the clear directive in the ACA requiring the Secretary of HHS to define the EHB. While we understand the Department's intent to give States a significant amount of flexibility to design their benefits packages, we believe that a national standard is needed to guarantee strong and specific benefit protections to all covered enrollees, and urge the Department to reconsider its intended approach.

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. 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. § 1302(b) of 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. 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 AA and NHPI communities and others who have historically suffered from health inequities.

The current proposed EHB standard will lead to 51 different EHB definitions and allow further issuer flexibility within those 51 definitions. Monitoring benefit design, access to services, denials, complaints, adherence to non-discrimination provisions, and appropriate coverage among the ten EHB categories will be administratively complex—perhaps impossible—under the proposed scheme. The proposed approach is likely to be fraught with denials of coverage for services that people truly need, complaints regarding lack of adequate coverage in mandatory categories, and general dissatisfaction with the scope of coverage. 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 proposed rule'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.

Although a reconsideration in approach is likely not feasible at this late date, HHS suggests that the current EHB standard will be revisited in subsequent years (2016 and beyond) and otherwise seeks comment on the process to be used in updating the EHB over time. We strongly recommend that HHS use lessons learned in 2014 and 2015 to develop a unified national EHB standard for 2016 and beyond. This would bring the EHB standard into compliance with the text of the ACA.

To this end, HHS must collect appropriate data on EHB problems in 2014 and 2015. This will allow HHS to design a more responsive EHB package for 2016 and beyond. During the 2014 and 2015 benefit years, states should be required to report to HHS on a set of federally identified data points related to the EHB. Responsive to a robust public comment process, these data points should include:

- Reporting on sufficiency of coverage in all 10 EHB categories, including data on denials of coverage and complaints regarding non-coverage of certain services (including the outcomes of all denials and complaints (appeals/overrides);
- Standardized surveys of all EHB recipients with both quantitative and qualitative rating and reporting to assist in determining whether enrollees are facing difficulty accessing coverage due to cost, unlawful practices, or other barriers;
- Field testing all surveys with a variety of audiences, including low-income, limited English proficient, and vulnerable populations to ensure that comprehension and usability are maximized;
- Ensuring that all major stakeholders, including clinicians, administrators, and consumers, have an opportunity to provide feedback via these surveys; and
- Making all information collected and reported publicly available.

Regardless of whether HHS develops a national EHB standard in 2016, and particularly if HHS maintains a state-defined methodology, HHS must develop a process for updating the EHB which includes public input. This requires advance notice of the EHB proposals, sufficient resources to meaningfully evaluate the alternatives, and a robust comment process.

We commend HHS' stated intent to use the enforcement processes and standards established in 45 C.F.R. § 150 to ensure plans adhere to the EHB standards. HHS should be ready to take enforcement actions as provided in §§ 2723 and 2761 of the Public Health Service Act (PHSA) and should use data collected to identify the need for enforcement actions. We believe that HHS will need to be proactive about monitoring and enforcement given the diversity of states and issuers with flexibility to alter the EHB standard.

We recommend against using the largest small group plan as the base benchmark

default. We recommend instead that HHS set the default as any of the largest of the other three base benchmark options (federal employee, state employee, or commercial HMO). This ensures better coverage and promotes uniformity with Medicaid (i.e., § 1937 benchmarks).

<u>RECOMMENDATIONS</u>: If HHS finalizes the proposed state benchmarking framework (which we oppose) for the 2014 and 2015 benefit years, we strongly urge that HHS use this system only as a transition period, taking the lessons learned to implement a uniform national standard. We recommend that HHS clarify that the national standard is the EHB minimum and that states can expand upon them.

In all cases, HHS should develop a process for updating the EHB standard which includes robust consumer stakeholder input.

HHS should also set the default base benchmark plan as any of the largest of the other three base benchmark options (federal employee, state employee, or commercial HMO).

§ 156.110 EHB-benchmark plan standards

§ 156.110(a) EHB Coverage

Proposed § 156.110(a) requires coverage of the ten statutory categories. The basic structural problem with this proposed regulation is evidenced in the failure of the regulation to require coverage of "the items and services covered within the categories" as mandated by the statute. APIAHF joins NHeLP in recommending that statutory language be added and the statute be implemented so as to cover a meaningful set of items and services in each category.

In addition, HHS' interpretation of "pediatric services" to mean services for individuals under the age of 19 years is problematic and could mean that many adolescents are unable to access basic health services meeting their unique needs.[2]

<u>RECOMMENDATIONS</u>: We recommend amending § 156.110(a) as follows:

> (a) *EHB coverage.* Provide coverage of at least the following categories of benefits**, and the items and services covered within the categories**:

We strongly urge HHS to revise this policy such that "pediatric services" include services for individuals up to and including age 21. This is consistent with federal standards defining a child in the Medicaid program. It also helps HHS achieve the goal of defining an age so as to ensure comprehensive and consistent treatment in every state. If HHS fails to improve this standard per our recommendation, we urge HHS to at a minimum retain the proposed state flexibility to improve the standard.

[2] For more on meeting adolescent health needs, see NHeLP Issue Brief, *Addressing Adolescent Health: The Role of Medicaid, CHIP, and the ACA* (Nov. 2012).

§ 156.110(b) Coverage in each benefit category

The ACA defines the EHB package as coverage offered by a typical employer *except* that it also must cover ten categories of coverage. To the extent that a base-benchmark plan is completely missing coverage in one of the required categories, the proposed HHS approach correctly recognizes that it must be supplemented to include coverage of that category. However, the proposed policy fails to comply with the statute for two reasons:

1. The proposed policy only requires supplementation if a base-benchmark plan is not providing *any* coverage in one or more of the categories. A base benchmark that is grossly inadequate however, would not need to be supplemented. For example, if the "maternity and newborn care" benefit under a proposed benchmark included one 5-minute nutrition consultation and no other benefit, it would adequately meet HHS' proposed EHB standard. Similarly unacceptable examples could be proposed for the other nine statutory categories. This flies in the face of the statutory intent, which was precisely to ensure *adequate* coverage in these ten areas regardless of the shortcomings of the insurance market.

2. Even when the base benchmark plan does not in fact include *any* coverage, and therefore supplementation is triggered, the methodology for supplementation proposed by HHS is equally problematic. To begin with, § 156.110(b)(1) does not even require the supplementing plan to have "any" coverage in the category – it merely says that if there is no coverage on the base benchmark then the full benefit of another benchmark (which may also contain nothing) should be imported. Assuming (as we do) that it was HHS' intent that the supplementing plan must in fact have *some* coverage in the category, the proposed policy still fails because the supplementing plan could include coverage that is grossly inadequate (as per our example in #1).

In order to comply with the ACA, HHS must create an objective minimum standard for coverage of each of the ten statutory categories based on adequate coverage of the category. We recognize that HHS does not need to cover "all" services in a category, but HHS should define an "adequate" standard for the categories and require coverage of that minimum. Congress included the ten statutory categories because they are important to health care, and Congress recognized that this coverage was "essential" regardless of the typical employer package. As we have explained in our introduction, it simply makes no sense for the ACA to list these critical services but then require nothing more than bare minimal coverage.

RECOMMENDATION: HHS must require every EHB-benchmark plan to include *adequate* coverage in all ten categories. "Adequate" should be defined by the Secretary by reference to some objective standards for each category and should be based on the services needed to meet the needs of the covered populations.

We recommend amending § 156.110(b) as follows:

> Coverage in each benefit category. A base-benchmark plan not providing **adequate** ~~any~~ coverage in one or more of the categories described in (a) of this

section, must be supplemented as follows:

> (1) General supplementation methodology. A base-benchmark plan that does not include ***adequate coverage of*** items or services within one or more of the categories described in paragraph (a) of this section must be supplemented **until the coverage is determined adequate** ~~by the addition of the entire category of such benefits offered under any other benchmark plan option described in § 156.110(a) of this subpart unless otherwise described in this subsection~~.
>
> > **(i) Adequate coverage shall be defined by the Secretary, based on objective criteria which ensure the coverage meets the needs of the covered population.**

§ 156.110(c) Supplementing the default base-benchmark plan

The proposed policy for supplementing the default base-benchmark plan, to be carried out by HHS, suffers from the same flaws discussed above for supplementation generally; it fails to supplement inadequate coverage, and when supplementing may only supplement with inadequate coverage. HHS should develop a default supplementation methodology requiring adequate coverage of each statutory category, as per our recommendations for § 156.110(b).

RECOMMENDATION: We recommend amending § 156.110(c) as follows:

> *Supplementing the default base-benchmark plan*. A default base-benchmark plan as defined in § 156.100(c) of this subpart that lacks ***adequate coverage in*** any categories of essential health benefits will be supplemented by HHS **until the coverage is determined adequate, as defined in § 156.110(b)(1)(i)** ~~in the following order, to the extent any of the plans offer benefits in the missing EHB category:~~
>
> ***… [delete subsections (1)-(6)].***

§ 156.110(d) Non-discrimination

We commend HHS for reiterating that EHB-benchmark plans must not include discriminatory benefit designs and referencing the standards in § 156.125. Our concerns and comments regarding the non-discrimination standards appear below in § 156.125.

§ 156.110(e) Balance

We commend this requirement for balance, but we do not believe HHS has provided meaningful criteria for evaluating compliance. Given the proposed benchmarking system, exacerbated by state and issuer flexibilities, we believe enforcement of this requirement will be arduous if not impossible. We note that requiring objective minimum standards in the ten statutory categories, per our recommendations, effectively eliminates this concern.

§ 156.115 Provision of EHB.

§ 156.115(a)(1)

In this section, HHS suggests that insurers will be considered in compliance with EHB coverage requirements so long as they provide benefits that are "substantially equal" to the EHB-benchmark plan. The use of "substantially equal" terminology creates an additional loosening of the EHB standard which has no basis in law and threatens to further weaken an EHB standard. This concern is exacerbated by the fact that HHS provides no guidance or framework for analyzing whether covered benefits or limits on coverage meet the "substantially equal" standard. We join NHeLP in recommending that HHS eliminate this language. Failing to do that, HHS must set a strong standard for "substantial" equivalence and will need to monitor this proactively.

RECOMMENDATION: We recommend amending § 156.115(a)(1) as follows:

(a) Provision of EHB means that a health plan provides benefits that—
(1) Are ~~substantially~~ equal to the EHB benchmark plan including:

§ 156.115(a)(2) Mental Health Parity

We join with the National Asian Pacific American Families Against Substance Abuse and the National Asian American and Pacific Islander Mental Health Association in supporting the proposed language requiring that mental health (MH) and substance use disorder services (SUDs), including behavioral health treatment services, comply with the parity standards set forth in 42 C.F.R. § 146.136. However, the proposed rule fails to provide adequate guidance to states on how to supplement the MH and SUD benefits in the base-benchmarks and align treatment limitations and financial requirements to ensure appropriate coverage that complies with the law. It also fails to indicate who is responsible for monitoring and enforcement of parity in the various EHB subject plans, what the ongoing monitoring process includes, how a base-benchmark plan must be brought into parity compliance, and what enforcement mechanisms will be instituted.

The EHB is a critically important opportunity to address the health needs of the 1.25 million AAs and NHPIs with untreated substance use disorders and/or mental illness, promote MH and SUD prevention, and provide necessary services to those seeking care or already in recovery. For example, many Cambodians, Vietnamese, Laotian and Hmong experienced severe trauma during the war in Southeast Asia and it is estimated that 50%-70% of these refugees suffer from post-traumatic stress disorder. It is also estimated that 40% of Southeast Asian refugees suffer from depression while 35% suffer from anxiety. Many people living with substance use disorders also have a mental illness and other chronic conditions. Of these people with substance use disorders or mental illness, many are also limited English proficient and face cultural barriers to accessing services, including stigma and shame.

Providing a comprehensive whole health approach is important to AAs and NHPIs who tend to seek care through the primary care setting but often do not receive

proper mental health services due to the lack of expertise by non-mental health professionals, and the discomfort such professionals have in working with individuals with chronic and serious mental health problems. Mental health, behavioral health and substance abuse conditions ("MH/BH/SA") services have been historically excluded in private market health coverage, and parity is an important step. However, mental health parity itself is not sufficient to ensure coverage and, as a practical matter, has proven difficult to enforce.

RECOMMENDATIONS:

1) We recommend that in addition to parity requirements there should be comprehensive coverage of screening, assessment and treatment of MH/BH/SA conditions to meet the ACA requirement for coverage.
2) HHS should provide a detailed framework for states, insurance commissioners, exchanges, consumers, providers, and other stakeholders detailing the process for supplementing plans with deficient MH/SUD coverage to ensure that the EHB meets parity requirements.
3) We also urge HHS to conduct a comprehensive and transparent MH and SUD parity analysis of all EHB packages and release all of this information and other detailed benefit information for all of the states as soon as possible.
4) We urge the Department to include language in the final EHB guidance that makes clear to states that they have a responsibility to implement and enforce the Mental Health Parity and Addiction Equity Act and the ACA's parity requirement in their State. HHS should further clarify the roles and responsibilities of state and federal governments in the final regulations.

§ 156.115(a)(3)

We commend the Department's explicit application of PHSA § 2713 to the EHB in the proposed rule. With certain exemptions, § 2713 requires group health plans and issuers offering group or individual coverage to offer evidence-based preventive health services without cost-sharing. Recognizing that some EHB-benchmark plan benefits may be based on grandfathered plans not subject to § 2713, we thank HHS for including this regulation in the proposed rule. In addition, we thank HHS for clarifying in § 156.130(f) that nothing in the EHB rule will derogate the cost-sharing protections for plans subject to the § 2713 requirements.

We support the proposed rule's clear inclusion of all § 2713 preventive *services* in § 156.115. We seek the same explicit inclusion of the § 2713 *cost-sharing protections in the EHB.*[3] Without this amendment, any remaining ambiguity could result in some of the neediest enrollees being subjected to cost-sharing for these services when higher income populations in the group and individual markets are not. Cost-sharing is shown to reduce the use of preventive health services and is therefore antithetical to the ACA's commitment to ensuring increased access to and utilization of preventive care.[4] It is critical, therefore, that the robust § 2713 provision requiring coverage of preventive services with no cost-sharing be wholly and explicitly integrated into all health coverage standards.

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[3] To the extent that this rule will form the foundation of the EHB in Medicaid benchmark and Basic Health coverage packages, it is important that the PHSA § 2713 cost-sharing protection be explicitly included within § 156.115(a)(3) of this final rule. *See* note 1.

[4] Inst. Of Med., Clinical Preventive Services For Women: Closing The Gaps 109 (2011).

In addition, the critical reproductive health services required under § 2713(a)(4) for women should extend to men, where appropriate. Men should also be able to gain access to annual counseling and screening for sexually transmitted infections and HIV/AIDS, as well as FDA-approved contraceptive methods (e.g., condoms), sterilization procedures, and family planning education and counseling. We ask that HHS make the application of these services to men explicit in the EHB standard.

> *§ 156.115(b) Benefit substitution is allowed if the issuer of a plan offering EHB meets the following conditions--*

HHS proposes explicit insurer flexibility to substitute benefits *within* a category of services so long as they meet certain actuarial equivalence requirements. Although we disapprove of any such substitution policy, we commend HHS for at least limiting the substitutions *within* categories, as opposed to *across* categories, which would be even more problematic.

Nonetheless, we urge HHS to eliminate any provision for issuer flexibility. This authority completely undercuts the letter and intent of the ACA in a number of areas, including nondiscrimination and meaningful coverage of the ten statutory categories. Allowing insurers this flexibility to substitute services creates dangerous potential for discrimination or insurance rating through benefit design. The EHB standard should serve as a floor, not a ceiling, such that issuers have flexibility to add services but not substitute them.

We support the following protections created by HHS:

- Exclusion of drug coverage from substitution;
- State flexibility to limit or eliminate substitution; and
- General prohibition against plans excluding enrollees from any category of coverage. However, this requirement appears only in the preamble to the regulation (77 Fed. Reg. 70651). We recommend explicitly including it in the regulation at § 156.115(e). Moreover, the preamble's prohibition against excluding dependent children from the category of maternity and newborn coverage is critical and should be included in the regulatory text. *Id.*

RECOMMENDATIONS: We recommend deleting § 156.115(b) and instead requiring that EHB-benchmark standards serve as a minimum for states or insurers to add to, but not reduce, the scope of services. We urge HHS to affirm that insurers should have no role in setting or altering the EHB standard, under any conditions.

We also recommend adding the following language:

> § 156.115(e) A plan may not exclude an enrollee, including a dependent, from coverage in an entire EHB category covered by the plan.

> *§ 156.115(c) A health plan does not fail to provide EHB solely because it does not offer the services described in §156.280(d) of this subchapter.*

We join NHeLP in strongly opposing the proposed § 115.115(c) for several reasons.

First, while the ACA includes some limitations and procedural requirements pertaining to insurance coverage of abortion for QHPs, HHS has impermissibly proposed to extend the provisions in ACA § 1303(a)(1) to health insurance issuers that offer non-grandfathered coverage in the individual or small group market. The ACA restricts the use of federal premium and cost-sharing support funding for abortion services for individuals enrolled in QHPs offered through the Exchanges and in BHP programs. *See* ACA § 1303(a)(1) (Exchange); ACA § 1331(d)(4) (BHP). Nothing in the ACA restricts abortion coverage by health plans outside of this very specific context. *See, e.g.*, ACA § 1303(a)(1). HHS' regulatory proposal to expand the restriction therefore has no statutory basis and must be reversed. Subject to some explicit limits set by the U.S. constitution and federal laws, states have historically legislated and regulated whether, when, and how women may access abortion services. *See also* ACA § 1303(b)(1)(A)(i). HHS' proposed rule, would improperly subvert state authority.

Second, we strongly oppose HHS' proposed exception that would give insurers flexibility to refuse to cover services otherwise required under a state's EHB selection. The ACA sets the EHB package as the minimum floor for services which issuers must cover. States can, however, exceed this federal floor. While the ACA makes clear that there is no federal requirement for states or issuers to provide abortion coverage, the ACA does require issuers to cover state-selected benefits packages and to defer to state law. *See* ACA § 1303(c). HHS' proposed rule would give QHPs unrestricted flexibility to violate the state's benefits package and could adversely impact a state's right to determine its benefits package and set state law. This proposed policy has no valid basis in law and should be deleted.

Finally, we note that there is no legitimate health policy basis for extending restrictions on abortions—an important health care service that women currently have and need. According to the Guttmacher Institute, 87% of typical employer-based insurance policies in 2002 covered medically necessary or appropriate abortions.[5] Abortion coverage is critical for a woman facing an unintended pregnancy, as well as for a woman who has decided to carry a pregnancy to term only to later develop a condition that puts her health at risk. It would be unconscionable for HHS to dictate that women lose abortion coverage that is currently included in their health care policies.

RECOMMENDATION: HHS should delete § 156.115(c) in its entirety.

§ 156.115(d)

This provision excludes certain services--non-pediatric dental or eye exam services, long-term/custodial nursing home care benefits, or cosmetic orthodontia—from being covered as EHB.

To the extent that these services are covered by the base-benchmark plan selected, and under HHS' own proposed approach, these services represent the scope of typical employer coverage. To remove these services from the EHB-benchmark plan

[5] Adam Sonfeld et al., *U.S. Insurance Coverage of Contraceptives and the Impact Of Contraceptive Coverage Mandates, 2002*, 36 Perspectives on Sexual & Reprod. Health 2 (March/April 2004), http://www.guttmacher.org/pubs/psrh/full/3607204.pdf.

or otherwise exclude them as EHB would violate the statutory directive to include services that are typically covered in private market health plans. This approach also fails to recognize the importance of these services to overall health and well-being. For example, adult dental care is essential to quality pre-natal care and improved birth outcomes. Gum disease has been linked to preterm birth and is as large a risk factor for a low birth weight babies as smoking or alcohol. This policy also undermines the ability of states, as discussed above, to include benefits they deem worthy in their EHB packages.

RECOMMENDATION: We recommend deleting § 156.115(d).

§ 156.120 Prescription drug benefits.

§ 156.120(a) A health plan does not provide essential health benefits unless it …

The proposed rule improves on the prescription drug approach outlined in the EHB Bulletin, which indicated that issuers would only be required to cover at least one drug in each category and class in which the EHB-benchmark plan covered at least one drug. We appreciate that HHS sought to improve upon the bulletin's approach in the proposed rule, which proposes to require the greater of: (1) one drug in every category and class, or (2) the same number of drugs in each category and class as the EHB-benchmark plan. While we recognize the improvement over the Bulletin's proposal, we continue to have concerns that the prescription drug approach outlined in the EHB rule is insufficient, especially for those with complex chronic health conditions which include a disproportionate number of AAs and NHPIs. Thus, we urge HHS to reconsider several aspects of this proposal.

First, we recommend that HHS explicitly reiterate that none of the potential limits in this framework (e.g. "one drug per class") supersede the independent and enforceable requirement for every plan to cover all PHSA § 2713 services, including *all* FDA-approved methods of contraception. This is true for *all* plans subject to the EHB because of the applicability of § 156.115(a)(3) and because many of the plans are also directly subject to PHSA § 2713.

Second, the prescription drug category must meet an adequacy and quality standard; a quantity standard by itself is insufficient. In addition, allowing plans to exclude more effective therapies from some classes would violate the non-discrimination protection and other consumer protection requirements of the EHB. At the very least, the rule should set the minimum level of coverage at *two* drugs per class. This ensures doctors will have sufficient clinical options to treat patients who may have medical limits. This also is the best and most congruent policy given that two drugs per class is the norm under Medicare Part D and it would promote uniformity among programs.

Third, HHS should include the Medicare Part D requirement to cover "all or substantially all" of the drugs in six protected classes of drugs which are critical to vulnerable populations. See *Medicare Prescription Drug Benefit Manual § 30.2.5.* We note that these classes were explicitly included in Part D "because it was

necessary to ensure that Medicare beneficiaries reliant upon these drugs would not be substantially discouraged from enrolling in certain Part D plans." *Ibid*. It would violate the nondiscrimination requirement for EHB coverage (*see* ACA § 1302(b)(4)) if this Medicare policy, specifically designed to prevent discrimination against certain populations, were not adopted in the EHB.

Fourth, we strongly commend the use of a standardized classification for the *coverage requirement* ("drugs per class") and *reporting purposes*. However, we urge HHS to clarify that the uniform classification system should also apply to all public *formulary descriptions*. Consistent classes of drugs will facilitate the ability of consumer, providers, and employers to compare plans and evaluate formulary status of medications.

Finally, we urge HHS to re-evaluate its reliance on the USP classification system for drugs. The USP system was created for the Medicare Part D program and its beneficiaries, and therefore may not adequately classify and categorize drugs for individuals who do not meet the Medicare eligibility standards. For example, in terms of *reporting* for contraceptives (*coverage* is independently required by § 156.115(a)(3) and PHSA § 2713), many contraceptives are combination hormone therapies that are not classified by the USP classification system and therefore may not be represented in EHB-benchmark plans' reporting. If only those drugs that can fit within the USP classification system are reported, then HHS will have data deficiencies, making comparison of base-benchmark and supplementation coverage difficult, and other problems will ensue. In addition, defining the prescription drug requirements of the EHB in this manner could potentially exclude life saving drugs like methadone maintenance therapy (which many state benchmark plans do not cover), and limit access to evidence-based care that results in discrimination against a population based on their chronic disease. Similar examples in other areas could create problems for coverage, reporting, or public descriptions of other drugs.

The proposed rule indicates that the affordability of EHB coverage is driving the development of the prescription drug requirements that have been proposed. We do not believe that designing the EHB in a way that denies access to medically necessary services to reduce short-term costs and shift the full costs of certain medications to insured individuals and families is appropriate. In addition, denying needed medications to save money now may result in sicker, more expensive patients in the longer term, increasing future health care costs. We continue to urge HHS to adopt a more comprehensive standard for the prescription drug category.

RECOMMENDATION: We recommend amending § 156.120(a) as follows:

§ 156.120(a) A health plan does not provide essential health benefits unless it:

(1) ~~Subject to the exception in paragraph (b) of this section, c~~**C**overs at least the greater of:

(i) ~~One~~ ***Two*** drugs in every ~~United States Pharmacopeia (USP)~~ **[insert broader classification system]** category and class; or

(ii) The same number of prescription drugs in each category and class as the EHB-benchmark plan; ~~and~~

(2) Covers all or substantially all drugs in the immunosuppressant (for prophylaxis of organ transplant rejection), antidepressant,

antipsychotic, anticonvulsant, antiretroviral, and antineoplastic classes; and
(3) Submits its drug list to the Exchange, the state, or OPM.
…
(d) Nothing in this section is in derogation of the coverage requirements in 156.115(a)(3) of this subpart.

§ 156.120(b) A health plan does not fail to provide EHB prescription drug benefits solely because it does not offer drugs for services described in § 156.280(d) of this subchapter.

Please see our above comments to § 156.115(c) regarding the impermissible flexibility given to insurers related to coverage of abortion services.

RECOMMENDATION: HHS must delete § 156.120(b) in its entirety.

§156.120(c) A health plan providing essential health benefits must have procedures in place that allow an enrollee to request clinically appropriate drugs not covered by the health plan

We commend HHS for requiring an exceptions process that would allow an enrollee to request appropriate drugs that are not covered by the health plan. Many individuals, such as those with complex medical interactions or allergies, will be unable to safely use medications that are on formulary. We ask for clarification from HHS on this exceptions process, including how it will ensure transparency and usability for all enrollees, including limited English proficient (LEP) individuals whose linguistic isolation and difficulties communicating in English impede access to basic health care[6].

We urge HHS to consider making this exceptions process broader than the prescription drug coverage category. With the significant insurer flexibility proposed in this rule, it is especially important that there be a consistent and easily navigated exceptions process for accessing all services recommended by an individual's treating provider but not covered by the health plan. Cost-sharing for such clinically appropriate services and use of the exceptions process should not add any additional burden or barrier to this process.

§ 156.125 Prohibition on discrimination

We commend HHS for the explicit inclusion of a prohibition against discrimination. The proposed nondiscrimination requirements at 45 CFR 156.110 and 45 CFR 156.125 provide much needed protections to ensure benefit and coverage parity for all consumers, including LGBT individuals. We agree with CMS that Section 1302(b)(4) of the Affordable Care Act prohibits discrimination by issuers, and we join the Center for American Progress in strongly supporting the inclusion of health

[6] For example, approximately four percent of Asian Americans have not seen a health professional in more than five years, a rate twice that of non-Hispanic Whites. *Id.* at 46.

condition, sexual orientation, and gender identity among the protected categories in the proposed rule. By prohibiting arbitrary discrimination while permitting insurers to continue using utilization management techniques that help determine the medical necessity, appropriateness, and efficacy of various health care services, we believe the proposed rule fairly balances nondiscrimination protections against existing market practices. These nondiscrimination protections will help consumers access coverage for the care they need while still allowing insurers to encourage effective and economical use of health care services.

In addition, we join the Asian American Justice Center (AAJC) and the Asian Pacific American Legal Center (APALC) in asking HHS to strengthen this provision by specifically referencing § 1557 of the ACA to ensure consistent application of the ACA's non-discrimination protections. We also disagree with HHS' unsubstantiated prediction "that it is unlikely that an EHB-benchmark plan will include discriminatory benefit offerings" (77 Fed. Reg. 70650), as current private market norms perpetuate health disparities among women and minority communities including the AAs and NHPIs.[7]

AA and NHPI communities are extraordinarily diverse with dozens of different cultures and languages. Discrimination related to language, culture, affordability, and restrictions on legal immigrants continues to impose major barriers to accessing quality health care for AAs and NHPIs. Approximately 71% of Asian Americans speak a language other than English at home.[8] Approximately 32% of Asian Americans are limited-English proficient and experience some difficulty communicating in English.[9] Approximately 21% of Asian American households are linguistically isolated, meaning that all members 14 years old and older speak English less than "very well."[10]

Application of §1557

Robust enforcement of non-discrimination procedures including appropriate translation of health materials is crucial for our communities. Unfortunately, HHS' current approach is likely to perpetuate historic inequities in health care and coverage, and the obligation lies with HHS to guard against insurer practices that exacerbate these inequities. This obligation will be all the more important in the context of the current state-based benchmark approach. The Department must require a strong EHB standard that explicitly incorporates § 1557 protections, guarantees safeguards for LEP populations, and robust and comprehensive coverage of preventive and reproductive health benefits. Failure to do so will lead to continued discrimination against minorities and women.

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[7] "Between 2000 and 2010, the Asian American population grew faster than another other racial group, at a rate of 46%." KARTHICK RAMAKRISHNAN, UNIVERSITY OF CALIFORNIA RIVERSIDE & TAEKU LEE, UNIVERSITY OF CALIFORNIA BERKELEY, PUBLIC OPINION OF A GROWING ELECTORATE: ASIAN AMERICANS AND PACIFIC ISLANDERS IN 2012, NATIONAL ASIAN AMERICAN SURVEY 3 (2012), http://naasurvey.com/resources/Home/NAAS12-sep25-election.pdf.

[8] ASIAN PACIFIC AMERICAN LEGAL CENTER (APALC) & ASIAN AMERICAN JUSTICE CENTER (AAJC), MEMBERS OF ASIAN AMERICAN CENTER FOR ADVANCING JUSTICE, A COMMUNITY OF CONTRASTS ASIAN AMERICANS IN THE UNITED STATES: 2011, at 25 (2011), *available at* http://www.advancingjustice.org/pdf/Community_of_Contrast.pdf.

[9] *Id.* at 27.

[10] *Id.* at 29.

We support HHS's inclusion of the ACA's non-discrimination provisions in regulations guiding the implementation of EHB packages. § 156.125 reflects the broad scope of discrimination protection of § 1557 of the ACA. By incorporating the protected categories of Title VI, § 1557, like the proposed rules, prohibits discrimination on the basis of "race, color, or national origin" in "any program or activity receiving Federal financial assistance."[11] The prohibition against discrimination on the basis of national origin requires the federal government to ensure that programs receiving Federal financial assistance, such as American Health Benefit Exchanges, do not discriminate because of a person's language or inability to speak and understand English proficiently.[12] Furthermore, § 1557 includes other protected categories covered by Title IX of the Education Amendments of 1972 (prohibiting discrimination on the basis of sex in any federally funded education program or activity),[13] the Age Discrimination Act of 1976 (prohibiting discrimination on the basis of age in employment),[14] and § 504 of the Rehabilitation Act of 1973 (prohibiting discrimination on the basis of disability).[15] Thus, sex, age, and disability are also covered by § 1557.

Read in conjunction with § 1557, § 156.125 is not separate and distinct from § 1557 but simply echoes its scope. §1557 should be reiterated in a subsection in § 156.125 to ensure that health insurance issuers fully understand their nondiscrimination obligations. Moreover, § 1557's inclusion is necessary to clarify that individuals have the wide range of equitable relief and enforcement mechanisms available under the civil rights statutes, including compelling agency enforcement and a private right of action.

We believe that the history of the insurance market makes plain that discriminatory benefit design is a critically serious concern for any insurance program. Indeed, we believe that this is precisely the reason why Congress made sure to include multiple non-discrimination protections in the ACA – from the sweeping nondiscrimination provisions of § 1557 to the specific statutory EHB nondiscrimination requirements HHS proposes to codify in § 1302(b)(4)(B). Allowing insurers to use benefit design as a proxy for health status will undermine the intent behind not only the non-discrimination provisions of the ACA but also the explicit bans on pre-existing

[11] Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d ("No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1557, 24 Stat. 119, 260 (codified at 42 U.S.C. § 18116) ("[A]n individual shall not, on the group prohibited under title VI of the Civil Rights Act of 1964 . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title.")

[12] *See Federal Protections Against National Origin Discrimination*, U.S. DEP'T OF JUSTICE, http://www.justice.gov/crt/publications/natorigin2.php (last visited Dec. 16, 2012) ("Laws prohibiting national origin discrimination make it illegal to discriminate because of a person's birthplace, ancestry, culture or *language*. This means people cannot be denied equal opportunity because they or their family are from another country, because they have a name or accent associated with a national origin group, because they participate in certain customs associated with a national origin group, or because they are married to or associate with people of a certain national origin.")

[13] *See Title IX of the Education Amendments of 1972*, U.S. DEP'T OF JUSTICE, http://www.justice.gov/crt/about/cor/coord/titleix.php (last visited Dec. 16, 2012).

[14] *See The Age Discrimination in Employment Act of 1967*, U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, http://www.eeoc.gov/laws/statutes/adea.cfm (last visited Dec. 16, 2012).

[15] *See* OFFICE OF CIVIL RIGHTS, U.S. DEP'T OF HEALTH & HUMAN SERVS., FACT SHEET, YOUR RIGHTS UNDER SECTION 504 OF THE REHABILITATION ACT (2006), http://www.hhs.gov/ocr/civilrights/resources/factsheets/504.pdf.

condition exclusions and rating. HHS should develop straightforward non-discrimination standards which include specific criteria for avoiding intentional discrimination and actions that have the effect of discriminating, robust data collection and reporting standards, and monitoring and enforcement protocols.

Need for additional guidance and enforcement

Notably missing from the proposed rules is guidance on what would constitute discrimination by health plans in the design of EHB. The absence of a definition of discrimination in the rule is a fundamental problem that will inevitably lead to uneven enforcement of the non-discrimination provisions.

We disagree with HHS' assumption "that it is unlikely that an EHB -benchmark plan will include discriminatory benefit offerings."[16] Rather, discrimination in benefit design is a persistent practice in the insurance industry, and eradicating such discrimination has historically been a challenging process. For example, breast reconstruction following mastectomy was widely considered cosmetic and routinely excluded from coverage until the passage of the Women's Cancer Recovery Act of 1998. Similarly, carriers continue to argue that exclusions for services or drugs commonly provided for the treatment of conditions such as HIV/AIDS are not discriminatory because they apply to all plan enrollees, regardless of their specific negative effect on people with these conditions. This is an especially troubling access barrier to communities of color which are disproportionately affected by HIV/AIDS. Among AAs and NHPIs, the rate of new AIDS cases increased by 15% from 2002 to 2005.[17] A CDC Morbidity and Mortality Weekly Report noted that AA and NHPI populations were the only groups that showed statistically significant increases in estimated annual percentage changes, and that if left unchecked, HIV rates among AAs and NHPIs would exceed those of Latinos and African Americans. However, the currently regulatory approach allows these discriminatory service exclusions to persist—and an estimated 30% of Americans living with HIV are unable to access coverage—despite the application of current non-discrimination laws.[18]

HHS proposes to defer to states as the frontline authorities to enforce the EHB's non-discrimination protections.[19] Given the outright hostility many states have had to the ACA, this enforcement mechanism is inherently problematic and any approach giving states additional authority to implement key components of the law requires close monitoring by HHS. Absent a federal floor, strong oversight of states' proposals and enforcement actions is critical to ensure that coverage is comprehensive and robust in all states across the country.

Need for comprehensive discrimination analysis

HHS suggests that "discrimination analyses could include evaluations to identify

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[16] EHB, 77 Fed. Reg. at 70,650.
[17] "Asian/Pacific Islanders and HIV/AIDS," The RYAN WHITE HIV/AIDS Program (August 2008) available at ftp://ftp.hrsa.gov/hab/Asian.Pacific.pdf.
[18] AIDS.GOV, *The Affordable Care Act Helps People Living with HIV/AIDS* (Dec. 1, 2012), http://aids.gov/federal-resources/policies/health-care-reform.
[19] EHB, 77 Fed. Reg. at 70,653.

significant deviation from typical plan offerings including unusual cost sharing and limitations for benefits with specific characteristics."[20] In particular, HHS points to the discrimination analysis currently employed by Medicare Advantage Program cost-sharing designs as a model to be emulated.[21]

However, relying on existing Medicare Advantage practices may be problematic in several ways. First, Medicare Advantage plans are compared against original Medicare plans to determine whether there are outlier practices.[22] Because HHS does not have an original EHB package design but will be approving each state's own benchmark plans, HHS should articulate what would constitute a "significant deviation from typical plan offerings." Second, HHS has noted that discriminatory analyses would likely include "unusual cost sharing and limitations for benefits" and follow Medicare Advantage's discrimination analysis for cost-sharing designs. HHS should clarify that the prohibition on discrimination is not limited to cost-sharing designs. § 156.125, which flows from § 1557 of the ACA, covers activities other than just cost-sharing and includes all aspects of all programs receiving federal financial assistance.[23] Third, because Medicare Advantage primarily prohibits discrimination on the basis of health status,[24] its model for discrimination analysis lacks the legal guidance to apply to other categories of discrimination besides health status. Although CMS has issued guidance interpreting Medicare Advantage's codified federal regulations to include additional protected categories besides health status, it does not have the force of law. Under CMS's guidance, Medicare Advantage plans must also

- [c]omply with the provisions of the Civil Rights Act, Age Discrimination Act, Rehabilitation Act of 1973, Americans with Disabilities Act, and the Genetic Information Nondiscrimination Act of 2008; and
- [e]nsure that its [Medicare Advantage] plans have procedures in place to ensure that members are not discriminated against in the delivery of health care services, consistent with the benefits covered in their policy, based on *race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment*.[25]

Moreover, given the wide variation in discrimination and insurance laws among states, HHS should provide states with guidance in enforcing § 156.125. The definition of discriminatory benefit design does not and should not vary across states. The final rule should delineate how and when federal enforcement authority will be used. In the area of language access alone, only "[a] limited number of states have enacted comprehensive laws while most states' provisions focus on a particular

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[20] *Id.*
[21] *Id.*
[22] In providing basic benefits, Medicare Advantage plans must "[p]rovide coverage of . . . all services that are covered by Part A and Part B of Medicare" and must comply with "general coverage guidelines included in original Medicare manuals and instructions." Medicare Advantage Program, 42 C.F.R. § 422.101(a) & (b)(2) (2010).
[23] *See supra* text accompanying n.11.
[24] 42 C.F.R. § 422.110 ("[A]n MA organization may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in an MA plan offered by the organization on the basis of any factor that is related to *health status* . . . ."); *see also* 42 C.F.R. § 422.111(f)(3) (focusing on health status in grievance, appeals, and other procedural rights in the event of a termination of a contracted provider).
[25] CENTERS FOR MEDICARE & MEDICAID SERVS., MEDICARE MANAGED CARE MANUAL, CHAPTER 4—BENEFITS AND BENEFICIARY PROTECTIONS, at 10.6—Federal Requirements Related to Uniform Benefits and Non-Discrimination (June 22, 2012), *available at* http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf.

type of health care provider, service, payer, or patient group. Some of these laws provide detailed guidance; others note the importance of language access but do not specify activities to improve it."[26] The existing variation in language access laws across states is but one example of the variation in the resources, mechanisms, and commitment of state insurance agencies to ensuring equitable access for minority populations.

RECOMMENDATIONS: We urge HHS to closely scrutinize the successes and failures of how discrimination claims filed against Medicare Advantage plans have been addressed. HHS's leadership in articulating clear standards for states is essential to interpreting how civil rights protections should apply to many areas in health care that are unprecedented. Ultimately, the Secretary can and should work with states to ensure adherence to the various non-discrimination provisions related to EHB, but the sole authority to monitor, report, and enforce these provisions must rest with the Secretary. For the reasons set forth above, we join with AAJC and APALC in making the following recommendations:

(1) Require health plans providing EHB services to comply with HHS's existing Title VI guidance against national origin discrimination, and, in doing so, require health plans to pay for translation and interpretation services in connection with accessing EHB services;
(2) Develop clear and specific federal guidelines for states to effectively monitor and identify discriminatory benefit designs and their implementation in all protected categories of § 156.125: an individual's expected length of life, present or predicted disability, degree of medical dependence, quality of life, or other health conditions; and race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

We also join with NHeLP in recommending the addition of the following language:

RECOMMENDATION: 156.125(a) should be amended as follows:

An insurer does not provide EHB if it ***fails to meet the requirements of 45 C.F.R. § [implementing ACA § 1557] or if*** *its benefit design, or the implementation of its benefit design, discriminates* ***or has the effect of discriminating*** *based on an individual's age,* ***gender,*** *expected length of life…..*

Conclusion

We thank you for the opportunity to comment on these proposed rules and look forward to working with HHS to ensure that the benefits and protections of the ACA are fully realized in its 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,

[26] JANE PERKINS & MARA YOUDELMAN, NATIONAL HEALTH LAW PROGRAM, ADDRESSING LANGUAGE HEALTH NEEDS IN HEALTH CARE: SUMMARY OF STATE LAW REQUIREMENTS (Jan. 2008), http://www.healthlaw.org/images/pubs/nhelp_lep-state-law-chart_12-28-07.pdf.

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