National
Family Planning
& Reproductive Health Association

January 25, 2012

Secretary Kathleen Sebelius
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Comments on Essential Health Benefit Bulletin, Center for Consumer Information and Insurance Oversight

Dear Secretary Sebelius:

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to respond to the bulletin issued by the Department of Health and Human Services (HHS) to provide information and solicit comments on the regulatory approach HHS might take to define the essential health benefits (EHB) under section 1302 of the Affordable Care Act (ACA).

NFPRHA is a national membership organization representing the nation's family planning providers – nurse practitioners, nurses, administrators and other key health care professionals. NFPRHA's members operate or fund a network of more than 3,700 health centers and service sites that provide comprehensive family planning services to millions of low-income, uninsured or underinsured individuals in 48 states and the District of Columbia.

The ACA coverage provisions have the potential to drastically improve the health of many people, particularly those who have been traditionally denied access to health care. It is imperative that HHS advance policies that would achieve the goals outlined in the ACA to ensure that patients have coverage of and access to all of the health services they need to maintain good health. As HHS continues its process to define and clarify the EHB, NFPRHA believes that HHS should consider the policies outlined when developing the EHB guidance to improve health care access for the millions of people who stand to benefit from the insurance coverage options included in the ACA:

1. HHS should identify a comprehensive health plan or a set of benefits that would define the EHB and serve as a national floor for states.
2. HHS should not permit grandfathered health plans to serve as the benchmark plan which will define the EHB.
3. HHS should not permit substitutions to occur within the 10 categories of health services specified in the ACA or across benefit categories.

4. HHS should require that stakeholders, particularly safety-net providers with familiarity serving medically underserved populations, are involved in selecting the plan that will define the EHB.

I. HHS should identify a comprehensive health plan or set of benefits to define the EHB.

Section 1302 of the ACA reads, the Secretary of HHS "shall define the essential health benefits," and "ensure that the scope of the essential health benefits . . . is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary."[1] As written, the statute explicitly directs the Secretary to define the EHB. The EHB bulletin currently allows each state to choose a benchmark plan that would define the EHB for the specific state. The policy outlined in the EHB bulletin would require states to choose a plan that would "serve as a reference plan, reflecting both the scope of services and any limits offered be a 'typical employer plan.'"[2] To allow each state to select a plan that defines the EHB will result in states selecting widely varying health plans without any guarantee that the plan selected can be shown to meet the health needs of the consumers in the state. Although the bulletin suggests four benchmark plan types for the years of 2014 and 2015, , the current bulletin offers little guidance to states on what benefits and services must be included in those plans. The excessively broad flexibility granted to the states by this process falls far short of meeting the goals of the ACA, which is to guarantee access to a nationally-recognized comprehensive set of health benefits for Americans.

HHS should identify a comprehensive health plan or uniform set of benefits that meet the health care needs of women and other populations that have traditionally encountered barriers to health care access. Section 1302(b)(4) of the ACA directs the Secretary to consider several elements in determining the EHB including "[to] take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups."[3] Without further guidance from HHS to the states, coverage decisions for many crucial women's health services, including comprehensive family planning care, could be influenced by economic, political, and ideological considerations not based in scientific or medical evidence. As the Institute of Medicine's consensus recommendations for the EHB report identified, family planning is a covered benefit in most of the health plans made available in

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[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 through 124 Stat. 1025 (2010).

[2] US Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, "Essential Health Benefits Bulletin," December 16, 2012.

[3] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 through 124 Stat. 1025 (2010).

both the small and large group market.[4] Despite the evidence identified by the IOM, pressure from stakeholders with economic or ideological motivations coupled with the broad flexibility granted to states in the bulletin could result in states selecting a plan that does not include a comprehensive family planning benefit. Access to family planning and many other critical health services should not be determined by stakeholders with limited interest in promoting public health and expanding health care access for patients. HHS should set a national standard either by selecting a health plan or a set of health benefits that serves as a floor for the EHB decisions. By having the Secretary set a standard or a national floor on which states can build, , HHS could best ensure that the EHB meets public health goals ant patient needs. .

II. HHS should not permit grandfathered health plans to serve as the benchmark plan which will define the EHB.

HHS should prohibit states from selecting a grandfathered plan as the EHB. Grandfathered health plans are specifically exempted from important preventive health policies and other consumer protection policies included in the ACA. If a state selects a grandfathered health to serve as the EHB standard, many patients could be denied important preventive health services.

Section 2713(a)(4) of the ACA requires all health plans to cover a set of preventive health services designed to meet the unique health care needs of women.[5] In a historic victory for women's health, the IOM recommended and HHS adopted a set of benefits that will increase access to important health services at no cost-sharing to the consumer.[6] The women's health preventive benefit requires that health plans cover all FDA-approved contraceptive methods, contraceptive counseling, and the family planning visit, as well as a number of other important women's health services. It is imperative that every woman who accesses health care coverage through the ACA obtains coverage of these important benefits. Many grandfathered plans do not provide the set of services outlined in the IOM report. Without an explicit requirement that the selected benchmark plan defining the EHB includes the benefits identified in Section 2713, states could select a grandfathered plan without the preventive health benefits identified by Congress as important for public health. To ensure access to women's preventive health

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[4] Cheryl Ulmer, John Ball, Elizabeth McGlynn, Shadia Bel Hamdounia, *Essential Health Benefits: Balancing Coverage and Cost,* October 2011.

[5] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 through 124 Stat. 1025 (2010).

[6] IOM (Institute of Medicine). 2011. *Clinical Preventive Services for Women: Closing the Gaps.* Washington, DC: The National Academies Press (July 2011).

benefits and the others identified in Section 2713, HHS should prohibit states from choosing a grandfathered plan to define their EHB standards.

III. HHS should not permit substitutions to occur within the 10 categories of health services specified in the ACA or across benefit categories.

HHS should not allow insurers to make plan substitutions within the 10 ACA-specific health services categories or across benefit categories. Health plan issuers traditionally make cost-driven benefit design and plan decisions. For example, health plans have routinely denied women maternity-related coverage, which placed an additional financial burden on plan enrollees. The ACA specifically mandates maternity coverage to address plans discriminating against women in need of maternity-related care. To allow plan issuers to make substitutions across benefit categories would directly undermine the goal of the ACA coverage requirements.

Moreover, to allow plans to make substitutions within a benefit category could adversely impact women's access to important family planning services. Preventive and wellness services and prescription drugs are two of the 10 benefit categories outlined in statute as required for coverage in the EHB. As previously discussed, women need access to a range of preventive health benefits including different family planning services. A plan issuer should not be given the latitude to decide which preventive health benefits including specific family planning benefits are most effective for the plan enrollees, especially without any federal oversight. Health plans impose many different medical management techniques to control costs. This is particularly true for prescription drug benefits. Women have varying birth control needs throughout their lifetime and should have access to health services that are clinically appropriate. HHS should prohibit benefit substitutions to ensure that the EHB meets those health needs without unnecessary restrictions imposed by plan issuers.

IV. HHS should require that stakeholders, particularly safety-net providers with familiarity serving medically underserved populations, are involved in selecting the plan that will define the EHB.

HHS should require that any decisions that are made about the EHB at federal and state level are made with input from safety-net providers. Many of the patients seen in the safety net will be the beneficiaries of the insurance coverage expansions in the ACA. Moreover, publicly-funded providers have a unique perspective on how access to health insurance translates into health care access. NFPRHA's members provide largely uncompensated care to a growing number of patients. Many underinsured patients seek family planning services not covered by their insurance, which places the cost burden on the publicly supported family planning system. As the federal government and states move forward with determining the plan that will define

the EHB, the services included in the benefit and the scope of the benefit should address the health care needs the many poor and low-income people who seek to gain coverage through the ACA. To ensure that the coverage is effective ad comprehensive, HHS should require that safety-net providers are at both federal and state"tables" when selecting the plan that will define the EHB.

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We appreciate the opportunity to comment on the bulletin issued by the Department of Health and Human Services (HHS) implementing the essential health benefits of the Patient Protection and Affordable Care Act. If you require additional information about the issues raised in this letter, please contact Dana Thomas at 202.293.3114.

Sincerely,

Clare Coleman
President & CEO