National
Family Planning
& Reproductive Health Association

December 26, 2012

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
US Department of Health and Human Service
Room 445-G
Washington, DC 20201

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

Dear Administrator Tavenner:

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to respond to the proposed rule issued by the Department of Health and Human Services (HHS) outlining exchange and issuer standards related to coverage of essential health benefits and actuarial value under 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 49 states and the District of Columbia.

The ACA coverage provisions have the potential to drastically improve the insurance options and medical benefits and services currently offered to millions of people, particularly those who have been traditionally denied access to health care. To ensure that insurance coverage and benefits meet the goals of the ACA, HHS should advance policies designed to ensure that patients have coverage of and access to all of the services they need to maintain good health. As HHS finalizes the rule, there are several changes to the proposed rule that NFPRHA thinks are needed to strengthen the EHB coverage for the millions of people who stand to benefit from the insurance options included in the ACA:

1. HHS should identify a comprehensive health plan or a more concrete set of benefits that would define the EHB and serve as a national floor for states.
2. HHS should explicitly state that the women's preventive services benefit applies to 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.
5. HHS rescind the extension of Section 1303(b)(1)(A) to all individual and small market health plans.

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

NFPRHA is pleased to see additional protections for patients in the EHB proposed rule that were not identified in the EHB bulletin issued in early 2012. Specifically, NFPRHA appreciates the prohibition of benefit or network designs that would discriminate on the basis of an individual's medical condition or against specific populations. However, the proposed rule still falls short of clearly outlining in detail which benefits are required in a state's 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. 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. The proposed rule allows states to choose a "base-benchmark plan" from among four types of health plans currently available in the state. The preamble states that HHS chose this course to "reflect the balance between comprehensiveness, affordability, and state flexibility."[2] The excessively broad flexibility granted to the states could result in states choosing coverage that fails to appropriately account for the health or financial needs of all of those who will access the EHB. The ACA granted the Secretary the authority to identify the EHB to guarantee broad access to a nationally-recognized comprehensive set of health benefits for Americans.

HHS should reconsider the broad flexibility it has granted the states in choosing the EHB and identify in the final rule 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 a strong national EHB, the economic, political, and ideological considerations of state policymakers, instead of medical or scientific evidence, could influence the coverage decisions for many crucial women's health services, including comprehensive family planning care. 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. The final rule should establish 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 would ensure all patients

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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] "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation,." *Federal Register* 77:227, (November 26, 2012) p. 70648.
[3] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 through 124 Stat. 1025 (2010).

regardless of economic or demographic factors gains access to comprehensive coverage as was intended by the ACA.

II. HHS should explicitly state that the women's preventive services benefit applies to the EHB.

NFPRHA is pleased that Section 156.115 of the proposed rule clarifies for states that Section 2713 of the ACA requiring coverage of a broad range of preventive health services must be part of any selected EHB. The proposed rule reads, "We propose that a plan does not provide EHB unless it provides all preventive services described in Section 2713 of the PHS Act."[4] HHS acknowledges that it specifically includes the preventive services requirement "because EHB-benchmark plan benefits are based on 2012 plan designs and therefore could be based on a grandfathered plan not subject to PHS Act section 2713." Thus some plans not required to cover the preventive health services benefits at no additional cost-sharing to patients could be selected as the state's EHB, including "grandfathered plans." Grandfathered health plans are specifically exempted from important preventive health policies and other consumer protection policies included in the ACA. The final rule should go further and explicitly identify the women's preventive health services benefit as required in any EHB.

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 Institute of Medicine (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. Some grandfathered plans do not provide the comprehensive 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(a)(4), states could select an EHB that fails to meet the preventive health care needs of women. To ensure access to women's preventive health benefits identified in Section 2713(a)(4) of the ACA, HHS should explicitly identify these services as required in the EHB final rule.

III. HHS should not permit substitutions to occur within the EHB categories specified in the ACA.

NFPRHA is pleased that HHS decided against allowing plan benefit substitutions across coverage categories as was suggested in the EHB bulletin. NFPRHA also thanks the agency for exempting prescription drugs from the benefit substitution policy. NFPRHA's members care for patients who

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[4] "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation,." *Federal Register* 77:227, (November 26, 2012) p. 70651.

[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).

depend on routine access to prescription drugs. Exempting prescription drugs from substitutions will protect their access to important family planning services.

Unfortunately Section 156.115(b) of the proposed rule allows for substitutions within benefit categories. The proposed rule would allow insurance plans to substitute health benefits that are actuarially equivalent.[7] Health plan issuers traditionally make cost-driven benefit design and plan decisions. Permitting plans to make benefit substitutions allows them to calculate coverage based on the financial interest of the health plan instead of the health needs of the plan beneficiaries. To allow plan issuers to make substitutions in 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 ten 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 services, are most effective for the plan enrollees. HHS should prohibit benefit substitutions to ensure that the EHB meets those health needs without unnecessary restrictions imposed by plan issuers. In the alternative, HHS should have strict oversight of benefit substitutions to ensure that the family planning and other health needs of patients are not superseded by the financial interests of the plans.

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. Many underinsured patients seek family planning services not covered by their insurance, which places the cost burden on the publicly supported family planning system, which also sees patients without insurance. 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 of the many poor and low-income people who are likely 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 EHB benchmark plan.

[7] "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation,." *Federal Register* 77:227, (November 26, 2012) p. 70670.

V. HHS should rescind the application of Section 1301(b)(1)(a) to all individual and small group market plans.

The final rule should rescind the application of Section 1303(b)(1)(A) to all individual and small group market plans. Congress did not intend to require health plans operating outside of affordable insurance exchanges to impose new restrictions on women's access to abortion services. The intent of the abortion coverage restriction was to prohibit federal funds from being used to pay for abortion care. The language was carefully drafted to balance the concerns of some legislators. As federal funds cannot currently be used for abortion coverage (except in limited instances as defined by the Hyde Amendment), this policy is related only to qualified health plans ("QHPs") operating in insurance exchanges, where some individuals will receive premium assistance from the federal government.

NFPRHA opposes the singling out of abortion coverage in QHPs, and we strongly urge HHS to set policy that does not burden individuals by requiring them to make separate payments for health coverage that includes abortion. Expanding Section 1303(b)(1)(A) to health plans operating outside of exchanges will result in greater administrative burdens for health plans, which could reduce access to a legal medical service currently available in many health plans.

In addition, Congress explicitly left the decision to prohibit or require insurance coverage of abortion to the states with nothing in the ACA preempting such state laws. With the application of Section 1303(b)(1)(A) to all individual and small group plans, HHS contradicts a compromise on abortion coverage that followed an exhaustive legislative debate. NFPRHA ask that the final rule reflect the plan language in the ACA and rescind the extension of the Section 1303(b)(1)(A) to plans other than qualified health plans.

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We appreciate the opportunity to comment on the Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation proposed rule. If you require additional information about the issues raised in this letter, please contact Dana Thomas at 202-293-3114.

Sincerely,

Clare M. Coleman

Clare Coleman
President & CEO