July 5, 2012

Marilyn Tavenner
Acting Administrator, Center for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8010

Re: Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans

Dear Acting Administrator Tavenner:

AARP appreciates the Department of Health and Human Services (HHS) continued effort to develop the information needed to support its intended approach to defining the Essential Health Benefits (EHB) and to understand the effect on consumers of the selection of different benchmark options on. This data, in addition to information from the Department of Labor benefit surveys and other sources, will also be necessary to meet the Secretary's statutory obligation to periodically review and update the essential health benefits in order to address any gaps in access to coverage or changes in medical evidence or scientific advancement. It will also be necessary to inform HHS's evaluation of the benchmark approach for the calendar year 2016 and to assess whether an alternative approach would better address the ACA's goal of establishing a minimum level of benefits that protects individuals both medically and financially.

Gathering Data on Limits on Potential Benchmark Plans

As noted in earlier comments, AARP has a concern that the intended approach to establishing the essential health benefits package may result in significant variability in benefits among the states. The data collection on the potential benchmark choices is critical to having the information necessary to assess the full scope of the coverage for the 10 categories of required benefits and variability of benefits across states.

We support the proposal to collect information on both quantitative and non-quantitative limits on plan benefits. The lack of readily available information on limits in the potential benchmark plans makes it difficult to get a full picture of the impact limits may have on access to the essential health benefits.

While not mentioned in this proposed rule, it is important to have this information for the other types of potential benchmarks, such as the largest state employee health benefit plans or the largest national FEHBP plans. The same information will be needed for large employer plans to develop a better understanding of what quantitative and non-quantitative limits are in typical employer plans.
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We recommend that the Department use the data collected to understand non-quantitative limits and how they may limit access to EHBs. We specifically encourage the Department to understand whether medical evidence supports non-quantitative limits and issue regulations that reflect these findings for essential health benefits.

Prescription Drug Data Should Help Direct a Robust Definition of Prescription Drug Coverage

AARP believes that it is important to collect detailed information on prescription drug coverage. Specifically, data should include the percentage of available drug products that are on formulary, as well as the percentage of drug products subject to prior authorization, step therapy, or quantity limits. Data should also include the number of tiers utilized, as well as what type (coinsurance or copayment) and amount of cost-sharing is associated with each tier. Out-of-pocket limits on prescription drug cost-sharing (overall or tier-specific) should also be reported. Complete information on the drug benefit design will help ensure that plan features do not discriminate against consumers with health conditions. This data will also help the Department issue regulations to ensure that the essential health benefits include prescription drug coverage comparable to a typical employer plan and ensure consumer access to necessary prescription drugs.

Accreditation

We understand the need to put in place a process to address the statutory requirement for accreditation for the near term; therefore, we agree with the decision initially to allow plans that meet NCQA or URAC standards to participate. However, in our view, even in the short term, it is important to ensure that the processes of each organization are equally rigorous, lest there be an incentive for plans to “venue shop” for the easiest path to accreditation. In addition, the resulting information must be comparable so that consumers have confidence in the accreditation requirement and can make comparisons of plans that have been accredited by different accreditors. To our knowledge, the processes of NCQA and URAC are not comparable.

In the longer term (i.e., phase two), we urge Centers for Medicare and Medicaid (CMS) to establish standards and then compare these with the accrediting bodies by means of a crosswalk to determine whether the accrediting organization's standards should be deemed. The proposed future recognition process that includes an application procedure, criteria-based review of applications, public participation, and public notice of recognition for entities seeking to become recognized accreditors appears to be fair and reasonable.

AARP strongly supports an accreditation process that is performance-based and in which performance is assessed by means of evidence-based performance measures that, preferably, have been endorsed by the National Quality Forum (NQF). While structures to support high quality, efficient care are a necessary precursor to high performance, ultimately, it is the outcome of performance measures that really matters to consumers. Therefore, we agree with the proposal that accreditor's factor performance into their assessments and should play an important role in the final score.

We support the criteria proposed that the quality measure set must: span a breadth of conditions and domains that include mental health and chronic conditions; include measures that are applicable to older adults as well as other age groups; align with the National Strategy for Quality Improvement in Health Care; be endorsed by the NQF; and is evidence-based. Further, we urge CMS to add an additional criterion for auditing it is essential that measure results are audited to instill support among all stakeholders.

Finally, we have concerns about making network adequacy a part of the accreditation process. We believe this is inherently a regulatory function that should be retained by a regulatory body. No plan should be allowed to participate in the Exchange with an inadequate network, regardless of how well it does on other aspects of accreditation review. This element is so vital that we believe it should not be delegated to private accreditors.

Additional Data

Relevant data will help states choose a benchmark plan and will also provide information about coverage available in insurance markets across States. In addition, other parties working on state implementation need to know how limits actually work, including: (1) whether there is an exception process for limits; (2) if there is an exception process, how many enrollees requested one in the last plan year; (3) how many enrollees were granted an exception during the same period; (4) how many people hit the limit in the last plan year; and (5) How many people hit the limit in each of the last two plan years?

Thank you for the opportunity to comment on this important matter. If you have any questions, please feel free to contact Leah Cohen Hirsch on our Government Affairs staff at 202-434-3770.

Sincerely,

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs