



January 31, 2012

Mr. Steve Larsen
Director, Center for Consumer Information and Insurance Oversight
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Director Larsen:

AARP is pleased to offer comments on the essential health benefits (EHB) bulletin outlining the intended regulatory approach that the Department of Health and Human Services (HHS) will implement to fulfill the requirements of Section 1302 of the Affordable Care Act (ACA). The regulatory approach selected regarding the EHB package will affect the health and financial security of many of our members and other older Americans. AARP believes an EHB package must strike the proper balance between ensuring access to necessary services and affordability. The definition of EHB should be guided by the principle that all individuals have access to comprehensive, affordable, quality health care coverage that provides adequate financial protection against health care costs.

Four Benchmark Plan Types

AARP appreciates the challenges presented to the Secretary in defining EHB to meet the two major objectives of ensuring that health insurance is affordable and comprehensive. AARP advocates for a standardization of benefits approach that provides access to a minimum benefit package that protects individuals both medically and financially. The regulatory approach outlined in the Bulletin is of great concern because of the potential variability that might result among states.

The Bulletin's proposed regulatory approach may lead to significant variations across states in how EHBs are defined and implemented. Most plans that states may select from will include mandated coverage which could result in drastically unequal coverage across the states. We recognize some state flexibility may be desirable given the variation in state insurance markets, approaches states will take to their exchanges, and insurance rules. However we are concerned the proposed approach could result in individuals getting substantially different benefits across the States – and potentially inadequate benefits. AARP believes the definition of essential benefits should establish a minimum, adequate defined package of benefits to which all individuals are entitled, regardless of where an individual lives. If the decision is made to proceed with the benchmark approach as a starting point in 2013, AARP believes careful monitoring and assessment of variation in benefits must be part of the review and evaluation process used to inform revision of EHBs prior to 2016.

Benchmark Plan Approach and the 10 Benefit Categories

AARP believes the benefit package should cover services across the continuum of care, including prevention and wellness, primary care, care coordination, emergency care, hospitalization, prescription drugs, mental health care, rehabilitation services, end-of-life care, home care, dental and vision, and long term care. We urge the package to include services that will meet the needs of people within the range of health and medical needs. The standards need to reflect the care generally required by people across the age spectrum, including women, children, and those with chronic conditions and disabilities. For example, essential benefits must meet the needs of older adults with multiple chronic conditions as well as those who are healthy. EHB standards should also be crafted to reduce and eliminate disparities in access and outcomes based on race or ethnicity.

A State's EHB determination will set the standard for insurance plans in the individual and small group markets, both inside and outside of the Exchanges (except grandfathered plans), Medicaid benchmark and benchmark-equivalent, and Basic Health Programs. AARP believes it is critical for CMS to utilize a process to review each state's EHB to ensure compliance with ACA and inclusion of all mandatory Medicaid services. A review of state Medicaid plans may also be appropriate where the mandated ACA categories exceed current Medicaid mandates (e.g., prescription medications and chronic disease management).

Benefit Design Flexibility

When defining the EHB package HHS, as required by the ACA, needs to balance the covered categories, determine the types of limits on benefits, establish standards for benefit management mechanisms, as well as define a common standard for medical necessity and how it may be applied. These aspects of benefit design and management have real consequences for access to covered care. AARP urges the proposed plan designs of each insurer be subject to a higher level of scrutiny to mitigate the potential for eliminating important services or benefits in particular categories. In addition, AARP strongly recommends that guidelines for substitution be carefully constructed to ensure issuers do not discriminate against enrollees or applicants with health conditions. The greater the flexibility afforded to insurers, the more difficult it will be to design effective and enforceable guidelines. The Bulletin's proposed approach to allowing insurers to vary benefits from those in the State benchmark could weaken a major objective of the ACA – that insurers compete for enrollment on the basis of price, quality, and service rather than on the basis of risk-selection. Providing insurers within a state the ability to adjust benefits and quantity limits has the potential for benefit designs that discourage enrollment of sicker individuals. If individual insurers are allowed to make substitutions among the 10 categories specified by the ACA, as well as adjust benefits including covered service and quantitative limits, AARP strongly recommends that detailed guidelines be created and that each plan be reviewed by CMS to ensure the flexibility allowed by the Bulletin does not have a discriminatory impact based on age, disability or life expectancy (as specified in the Bulletin), as well as race and ethnicity. Beyond the potential for selection bias, the more flexibility insurers have with respect to benefit design, the more complex plan selection is

for consumers. As noted above, AARP believes the EHB package should be a minimum standardized package, which will also make it easier for consumers to understand and meaningfully compare plans.

AARP recognizes the challenges associated with balancing the consumers need for a comprehensive benefit package with affordability. It is our belief the ACA helps address the affordability issue associated with the EHB package by prohibiting annual dollar limits on benefits for an individual, and placing limits on annual cost sharing and employer plan deductibles. HHS should clearly outline for states and insurers how the limits will be applied within the EHB package. AARP urges HHS to evaluate the affordability of the EHB package from the perspective of individuals and families. The evaluation should consider the cost burdens for the EHB package for those eligible for premium and cost sharing subsidies. Additionally, the evaluation should consider the cost burdens for those ineligible for subsidies, and those with different levels of medical need and cost, including those with conditions that require ongoing treatment. If the package is not adequate, people will be at risk of being underinsured and unable to afford the care they need despite having coverage. If the premium for the package is unaffordable, people may apply for an exemption from their shared responsibility payment or pay the penalty.

Pharmacy Benefits

AARP appreciates CCIO's proposed language regarding standards for pharmacy benefits but we believe several aspects need further clarification. For example, it is unclear whether or how therapeutic categories and classes excluded from a given benchmark plan should be covered. In addition, AARP urges CCIO to clarify whether all of a given benchmark plan's covered categories and classes must be covered by all applicable plans, as well as whether actuarial equivalence will instead be permitted. AARP also believes CCIO should provide issuers with guidance regarding expectations for formulary updates.

AARP is concerned CCIO's proposal to require plans to offer at least one drug in a given category or class does not provide a high enough level of specificity. For example, under Medicare Part D, some drug classes are further subdivided into key drug types: for each of these key drug types, a plan must cover at least one drug. AARP believes, limiting coverage decisions to the therapeutic category and class level will not ensure beneficiaries have access to necessary prescription drugs (e.g., under the proposed language, a plan could be permitted to cover only one reuptake inhibitor even though U.S. Pharmacopeia (USP) has identified three key drug types within the drug class).

AARP believes many of these concerns could be resolved by requiring USP (or a similar entity) to develop a model classification system much like Medicare Part D that must be utilized in all evaluations of applicable plans' formularies. Further, in order to help ensure patient access and adherence, AARP urges CCIO to require all applicable plans to have a simple, standardized exceptions process. Finally, CCIO should ensure applicable plans do not utilize pharmacy benefit design features (e.g., cost-sharing and utilization management practices) to discriminate against enrollees or applicants with health conditions.

Updating Essential Health Benefits

AARP recommends HHS collect information from the Exchanges, state consumer assistance and ombudsman programs funded under title 27 of the Public Health Services Act to determine the nature of the complaints and appeals consumers are filing and their outcomes. HHS should capture information from the review and appeals system to monitor the impact of the state EHB package and to help identify problem areas. This information can inform necessary adjustments in the EHBs package, benefit design parameters, or benefit administration. A system to monitor the EHBs package should be designed prior to the implementation of the package to allow for the collection of a consistent set of information across the states. A critical part of this should be meaningful sampling of population groups with significant health disparities.

AARP suggests that information collection process HHS track the numbers of people who receive exemptions from their individual responsibility payments on the grounds that the plans available to them are unaffordable. As noted above, we urge you to monitor the cost of the EHB package over time, its affordability for different segments of the population, and the distribution of costs across the benefit categories. Surveys could assess whether cost sharing, adequacy of provider networks, or lack of coverage for certain types of care are problems for consumers or result in disparities among the states

The information above along with advances in science, US Preventive Service Task Force (USPSTF) recommendations, and Advisory Committee on Immunization Practice (ACIP), as well as Medicare coverage decisions should inform changes to the EHB package. AARP applauds CCIIO for its proposal to review plans' benefits on an annual basis. We believe an annual review will aid in determining whether updates are needed to address gaps and problems. The update and review process should be a public process to provide consumers and other stakeholders with an opportunity to provide input on potential EHB package improvements.

Other issues related to defining essential health benefits

The Bulletin does not address cost sharing in the EHB package, limits on benefits within the 10 categories, determination of the actuarial value of the benchmark and determination of actuarial equivalence within the EHB package. Additionally, it does not address standards for benefit management mechanisms or define the common standard for medical necessity and how it may be applied. These aspects of benefit design and management have real consequences for people's access to covered care. AARP expects that HHS will provide an opportunity to comment on these key elements.

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As the regulations for the EHB package are developed, AARP believes HHS should keep in mind the role the package might play in reducing health care disparities, as well as the unique needs of minority and other vulnerable populations. The application of Title VI of the Civil Rights Act of 1964 and § 1557 of the ACA to this proposed rule is vital not only to prohibiting discrimination on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation but also to ensuring the provision of competent and comprehensive language services to people with Limited English Proficiency.

Thank you for the opportunity to provide these initial comments. We look forward to providing additional input in response to the Department's proposed rule. If you have any questions, please feel free to contact Leah Cohen Hirsch of our Government Affairs staff at 202-434-3770.

Sincerely,

A handwritten signature in black ink, appearing to read "David Certner", with a long horizontal flourish extending to the right.

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs