

The Children's Health Fund
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October 4, 2010

BY ELECTRONIC TRANSMISSION

Secretary Kathleen Sebelius
Department of Health and Human Services

Re: Request for Comments Regarding Exchange-Related Provisions in Title I of PPACA (August 3, 2010)

Attention: OCHIO-9989-NC

The Children's Health Fund (CHF) is submitting the following comments in regards to the Request for Comments issued on August 3rd, pertaining to Exchange related provisions in Title I of the Patient Protection and Affordable Care Act (PPACA).

CHF is a non-profit organization and designated as a 501(c)(3) by the Internal Revenue Service. Since its inception in 1987, CHF has supported the delivery of comprehensive health care to medically underserved children and families in rural and urban areas. Our programs seek to provide care under the medical home model, which means care is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective, serving the overall needs of the child.

As title I of the PPACA expands access to health insurance through the establishment of American Health Benefits Exchanges ("Exchanges"), it also puts forth an outline regarding required benefits that health plans must cover in order to take part in these new health insurance marketplaces. The following comments are in reference to the provisions in the PPACA regarding new essential benefit requirements as part of the qualification process for health insurance plans to take part in the Exchanges. We hope our input about this important provision is taken into consideration as HHS moves forward with the rulemaking process.

Establishment of Essential Health Benefit Requirements

Under Section 1302 of the PPACA, the Secretary of the Department of Health and Human Services (HHS) is directed to further define essential health benefits that all health plans will be required to cover in order to participate in the new Exchanges. Ensuring that children's needs are considered in the establishment of these benefit requirements is critical. It is also important to ensure that the numerous healthcare components that make up a "medical home" are part of this required benefit package.

Pediatric Benefits

Children are not little adults. Pediatric healthcare needs often differ from those of adults as kids require healthcare that meets their unique developmental needs. These include, for infants and young children, multiple check-ups each year; immunizations; hearing, vision

and developmental screening; and oral health screening. Comprehensive pediatric primary care should also include assessment of psychosocial needs, including mental health screening and referral and help for family problems that affect the child's health and development. There is an abundance of evidence to support the need for early identification of perceptual, developmental and psychosocial problems, and to establish the potential life-long negative impact of failing to do so.

CHF is pleased that Section 1302(b)(J) of the PPACA specifically references "Pediatric services, including oral and vision care" as benefits that should be included in a required package of coverage. This inclusion conveys Congress's intent to ensure appropriate child-specific benefits are part of the required coverage package. For children, there is a critical shortage of dentists, especially those who will accept Medicaid. Pediatric primary care providers often must deliver preventive oral health services in addition to screening. Vision screening for young children is more complex and time-consuming than for older children and adults, but it is essential to identify problems like strabismus that, if not treated early, may result in permanent visual impairment.

We applaud the promulgation of the Interim Final Regulation at 75 Fed Reg 41726-41760, which establishes that non-grandfathered plans are required to provide coverage for all *Bright Futures* services. CHF supports the use of the American Academy of Pediatrics' best-practice guidelines, *Bright Futures*, as well as Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program criteria in defining essential benefits for children.

Access to the right care at the right time for children is essential, and therefore we urge HHS to ensure that pediatric healthcare benefits are considered separately from those of adults. We recommend that both primary care pediatricians as well as pediatric subspecialists are part of any advisory committee that is formed to help establish essential health benefit requirements.

Medical Home

The medical home model, defined as care that is accessible, continuous, comprehensive, coordinated, family-centered, compassionate and culturally effective, was first developed by the American Academy of Pediatrics for children with special health care needs. The Children's Health Fund advocates for an enhanced medical home model of care, taking the standard of care a step further. For medically underserved children, the enhanced medical home is particularly effective in meeting their complex health care needs. In the enhanced medical home, pediatric primary care providers have an expanded scope of practice to include evidence-based protocols for chronic disease management (e.g., for asthma); on-site access to services that are necessary and often difficult to access, like oral health and mental health services; and assistance receiving care from other pediatric subspecialists when needed. This often must include transportation services, because in medically underserved areas, especially rural communities, families do not have the means to get to health providers when care is needed. In addition, electronic health records to facilitate the use of best practice guidelines to treat chronic diseases. Regular evidence-based screening in the medical home ensures healthy growth and optimal development of a child.

Although Section 1302 does not grant the Secretary the ability to establish new incentive programs as part of the essential benefit package, it is possible to encourage coverage of the enhanced medical home. CHF urges that HHS consider the needs of medically underserved children and ensure access to the various components of the enhanced medical home, such as mental and oral health and facilitated access to pediatric subspecialists, when defining essential health benefits.

Conclusion

Thank you for this opportunity to comment. We trust that HHS will take into consideration all of the comments from the health care community and will continue to do so moving forward. We look forward to commenting on proposed rules and regulations regarding these issues throughout the implementation process.

For further information please contact:

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PPACA Excerpt:

SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS.

(a) ESSENTIAL HEALTH BENEFITS PACKAGE.—In this title, the term “essential health benefits package” means, with respect to any health plan, coverage that—

- (1) provides for the essential health benefits defined by the Secretary under subsection (b);
- (2) limits cost-sharing for such coverage in accordance with subsection (c); and
- (3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) ESSENTIAL HEALTH BENEFITS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

- (A) Ambulatory patient services.
- (B) Emergency services.
- (C) Hospitalization.
- (D) Maternity and newborn care.
- (E) Mental health and substance use disorder services, including behavioral health treatment.
- (F) Prescription drugs.
- (G) Rehabilitative and habilitative services and devices.
- (H) Laboratory services.
- (I) Preventive and wellness services and chronic disease management.
- (J) Pediatric services, including oral and vision care.

(2) LIMITATION.—

(A) IN GENERAL.—The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.

(B) CERTIFICATION.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

(3) NOTICE AND HEARING.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.

(4) REQUIRED ELEMENTS FOR CONSIDERATION.—In defining the essential health benefits under paragraph (1), the Secretary shall—

- (A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category;
- (B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;
- (C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;
- (D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length

of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that—

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(F) provide that if a plan described in section 1311(b)(2)(B)(ii) (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the standalone plan that are otherwise required under paragraph (1)(J); and

(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains—

(i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

(ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;

(iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;

(iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and

(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).

(5) **RULE OF CONSTRUCTION.**—Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.

(c) REQUIREMENTS RELATING TO COST-SHARING.—

(1) ANNUAL LIMITATION ON COST-SHARING.—

(A) 2014.—The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for

self-only and family coverage, respectively, for taxable years beginning in 2014.

(B) 2015 AND LATER.—In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall—

- (i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and
- (ii) in the case of other coverage, twice the amount in effect under clause (i).

If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

(2) ANNUAL LIMITATION ON DEDUCTIBLES FOR EMPLOYER-SPONSORED PLANS.—

(A) IN GENERAL.—In the case of a health plan offered in the small group market, the deductible under the plan shall not exceed—

- (i) \$2,000 in the case of a plan covering a single individual; and
- (ii) \$4,000 in the case of any other plan.

The amounts under clauses (i) and (ii) may be increased by the maximum amount of reimbursement which is reasonably available to a participant under a flexible spending arrangement described in section 106(c)(2) of the Internal Revenue Code of 1986 (determined without regard to any salary reduction arrangement).

(B) INDEXING OF LIMITS.—In the case of any plan year beginning in a calendar year after 2014—

- (i) the dollar amount under subparagraph (A)(i) shall be increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and
- (ii) the dollar amount under subparagraph (A)(ii) shall be increased to an amount equal to twice the amount in effect under subparagraph (A)(i) for plan years beginning in the calendar year, determined after application of clause (i).

If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

(C) ACTUARIAL VALUE.—The limitation under this paragraph shall be applied in such a manner so as to not affect the actuarial value of any health plan, including a plan in the bronze level.

(D) COORDINATION WITH PREVENTIVE LIMITS.—Nothing in this paragraph shall be construed to allow a plan to have a deductible under the plan apply to benefits described in section 2713 of the Public Health Service Act.

(3) COST-SHARING.—In this title—

(A) IN GENERAL.—The term “cost-sharing” includes—

- (i) deductibles, coinsurance, copayments, or similar charges; and
- (ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue

Code of 1986) with respect to essential health benefits covered under the plan.

(B) EXCEPTIONS.—Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

(4) PREMIUM ADJUSTMENT PERCENTAGE.—For purposes of paragraphs (1)(B)(i) and (2)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

(d) LEVELS OF COVERAGE.—

(1) LEVELS OF COVERAGE DEFINED.—The levels of coverage described in this subsection are as follows:

(A) BRONZE LEVEL.—A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

(B) SILVER LEVEL.—A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

(C) GOLD LEVEL.—A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

(D) PLATINUM LEVEL.—A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(2) ACTUARIAL VALUE.—

(A) IN GENERAL.—Under regulations issued by the Secretary, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (b) shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to).

(B) EMPLOYER CONTRIBUTIONS.—The Secretary may issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of the Internal Revenue Code of 1986) may be taken into account in determining the level of coverage for a plan of the employer.

(C) APPLICATION.—In determining under this title, the Public Health Service Act, or the Internal Revenue Code of 1986 the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage that are provided by such plan or coverage, the rules contained in the regulations under this paragraph shall apply.

(3) ALLOWABLE VARIANCE.—The Secretary shall develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

(4) PLAN REFERENCE.—In this title, any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.

(e) CATASTROPHIC PLAN.—

(1) IN GENERAL.—A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if—

(A) the only individuals who are eligible to enroll in the plan are individuals described in paragraph (2); and

(B) the plan provides—

(i) except as provided in clause (ii), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713); and

(ii) coverage for at least three primary care visits.

(2) INDIVIDUALS ELIGIBLE FOR ENROLLMENT.—An individual is described in this paragraph for any plan year if the individual—

(A) has not attained the age of 30 before the beginning of the plan year; or

(B) has a certification in effect for any plan year under this title that the individual is exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 by reason of—

(i) section 5000A(e)(1) of such Code (relating to individuals without affordable coverage); or

(ii) section 5000A(e)(5) of such Code (relating to individuals with hardships).

(3) RESTRICTION TO INDIVIDUAL MARKET.—If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

(f) CHILD-ONLY PLANS.—If a qualified health plan is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and such plan shall be treated as a qualified health plan.