NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

MEMORANDUM

TO: Marilyn Tavenner, Acting Administrator
Centers for Medicare and Medicaid Services (CMS)

Steve Larson, Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services

FROM: Joy Johnson Wilson, Health Policy Director

RE: Comments on the *Essential Health Benefits Bulletin*

DATE: January 31, 2012

On behalf of the National Conference of State Legislatures (NCSL), I am submitting the attached comments on the *Essential Health Benefits Bulletin* released by the Center for Consumer Information and Insurance Oversight (CCIIO) on December 16, 2011. First I would like to acknowledge and thank the staff at the U.S. Department of Health and Human Services for responding to our requests to accelerate the process of establishing the Essential Health Benefits Package. The accelerated process affords state legislators an opportunity to provide oversight and input into the development of one of the cornerstones of the Affordable Care Act and to the establishment of American Health Benefit Exchanges. NCSL is also pleased with the "state-based" approach. Benefit options are based on benefit packages already available and popular in each state. The default plan, the plan that becomes effective if a state chooses not to select a benchmark plan, is still based on an existing state plan and protects all state mandated benefits. Finally, the bulletin provides options that will allow states to maintain their existing state mandated benefits without creating a budget liability in 2014 and 2015, providing states an opportunity to review their mandated benefits.

The *Essential Health Benefits Bulletin* was more of a concept paper than an official guidance. While the bulletin establishes a general approach, many questions remain. Time constraints are real and additional information is needed to allow state officials to make informed decisions about the selection of a state's benchmark plan or plans. I hope that additional information on the essential health benefits, as well as guidance on premium assistance and cost-sharing will be available in the coming days.

I appreciate this opportunity to comment on the bulletin and look forward to continuing to work with you on this and other issues regarding the implementation of the American Health Benefit Exchanges. If you have any questions or need additional information, I can be reached by e-mail at joy.wilson@ncsl.org or by phone at 202-624-8689.

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COMMENTS OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES
ESSENTIAL HEALTH BENEFITS BULLETIN (December 16, 2011)

ADMINISTRATIVE ISSUES

Identifying a Verifiable Source for Enrollment Date - Last week the Center for Consumer Information and Insurance Oversight (CCIIO) released a document, *Essential Health Benefits: Illustrative List of the Largest Three Small Group Products by State*. The data was apparently obtained from the Health Information Oversight System (HIOS) maintained by the U.S. Department of Health and Human Services. States seem to have significant concerns about the reliability of the data. Because the selection of benchmark plans is based on the identification of plans/products with the largest enrollment, it is extremely important that the reliability of the HIOS data be established or that acceptable state-based alternatives are identified.

Terms and Definitions –There has been considerable confusion about CCIIOS's use of insurance terms that differ from common uses of the same terms in the states. Future publications should include a glossary to ensure that everyone is using the same language.

Ten Mandated Benefit Categories – The Patient Protection and Affordable Care Act (PPACA) identifies ten benefits that must be components of the Essential Health Benefit package: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. While a number of these services are already included in many plans in the states, some are much less commonly provided and often times the range of services provided under the benefit vary widely. This is particularly true of habilitative services, mental health and substance use disorder services and pediatric care, particularly dental and vision care services. Before states select a benchmark plan, it will be important to know whether or not there is a plan to establish a federal standard for any of these services. If there will be no federal minimum standard, will states be required to establish their own minimum standard?

Actuarial Value – While states have been given the option to select a benchmark plan that would include all of their state mandated benefits, some states may select a benchmark plan that does not. This would require the state to cover the excess costs associated with covering any benefits required outside the benchmark essential benefits package. Who will conduct the review of the excess state mandated benefits? What is the review process? Will there be an appeals process? These are all important questions that were not addressed in the bulletin.

POLICY ISSUES

Benchmark Plans

- Can a state pick a different benchmark plan for the individual exchange and the exchange for small employers? Some state mandated benefits under state law apply only to individual market products or only to small group products. How will that be addressed? Can a state change the benchmark plan they select for 2014 for 2015? If so, under what circumstances would that option be available?
- The bulletin provides significant flexibility to insurers to make changes to the benefit package as long as it remains "substantially equal" to the benchmark plan. Who determines whether the "substantially equal" test has been met? When would a review occur? What role would state lawmakers and regulators play?
- According to the bulletin, the benchmark plans are to be reviewed and revised in 2016. What is the process for the review? How do you envision the role of state lawmakers in the review process?

Medicaid

- Medicaid benchmark plans are supposed to be tied to the essential health benefit package. Unfortunately this issue was not addressed in any detail in the bulletin. It is imperative that states be fully informed on exactly how the Medicaid piece fits into this new approach to the establishment of the benchmark essential health benefit package.