

January 31, 2012

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Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, DC 20201

RE: Comments on "Essential Health Benefits Bulletin"

Dear Mr. Larsen:

The Children's Defense Fund (CDF) appreciates the opportunity to submit comments in response to the regulatory approach to defining essential health benefits that the U.S. Department of Health and Human Services (HHS) set forth in the "Essential Health Benefits Bulletin" (the "Bulletin") issued December 16, 2011. CDF's Leave No Child Behind® mission is to ensure every child a *Healthy Start*, a *Head Start*, a *Fair Start*, a *Safe Start* and a *Moral Start* in life and successful passage to adulthood with the help of caring families and communities. CDF provides a strong, effective and independent voice for *all* the children of America who cannot vote, lobby or speak for themselves. We pay particular attention to the needs of poor and minority children and those with disabilities. CDF educates the nation about the needs of children and encourages preventive investments before they get sick, drop out of school, get into trouble or suffer family breakdown.

CDF has worked for many years, in collaboration with others, to expand health coverage that is comprehensive, accessible and affordable for children and youth. We believe the landmark Affordable Care Act (ACA) moves us closer to that goal, particularly with the development of a strong single essential health benefits (EHB) package. We are concerned, however, that the approach to determining the EHB outlined in the Bulletin will fail to result in the creation of the appropriate health benefits package children need to survive, thrive and drive the economy of tomorrow.

Allowing states to create their own variations of the EHB package undermines the intent of the ACA to create a comprehensive and national standard for health insurance coverage. Such a clear national standard is needed to help level the playing field for children. The ACA makes clear that the Secretary of Health and Human Services (the Secretary) is to define essential health benefits to help ensure that children will be better off – and in no case worse off – as a result of passage of the ACA. Allowing fifty states and countless health plans to define essential health benefits differently for children would be a huge step backwards for millions of children. Allowing plans to offer "substantially equal" benefits with "actuarially equivalent" substitutions will only perpetuate the lottery of geography that currently exists. Every child, no matter where he or she lives, should have the same opportunity to grow up healthy.

As you develop regulations regarding the EHB package, the Children's Defense Fund offers the following recommendations:

1. To be consistent with the Affordable Care Act, the Secretary should clearly define the essential health benefits *for children.* The creation of a strong federal floor for all, but particularly for children, would help ensure that all children, regardless of where they live, get the comprehensive health and mental health services they need to survive and thrive.

2. The essential health benefits must take the unique health care needs of children into account, as required by the Affordable Care Act, and guarantee every child access to all medically necessary services.

3. Any essential health benefits package must limit the ability of insurers to circumvent the requirement to cover the full range of pediatric services.

4. There should be a transparent process in place during the states' selection of a benchmark plan, the Secretary's approval process, and the updating of benchmark benefits as ACA implementation moves forward.

We elaborate below on each of our recommendations to ensure children have access to an acceptable national standard of pediatric services.

1. To be consistent with the Affordable Care Act, the Secretary should clearly define the essential health benefits *for children.* The creation of a strong federal floor for all, but particularly for children, would help ensure that all children, regardless of where they live, get the comprehensive health and mental health services they need to survive and thrive.

The Secretary should define the essential health benefits for the nation and particularly for children.

In passing the ACA, Congress clearly intended and required in the ACA that the Secretary must design a standard essential health benefits package to be applied across the nation, and required a number of considerations be taken into account in that development. (ACA, Secs. 1302(a); (b)(1); (b)(2)(A), (B); (b)(3); and (b)(4)). The move toward one national essential health benefits package to be established by the Secretary was a hallmark of the ACA. The ACA's definition of the essential health benefits at Sec.1302(b) states that "…the Secretary ***shall*** define the essential health benefits…." (emphasis added). There is no authority in the ACA for the Secretary to delegate the development of the EHB to states or to insurers, nor does the ACA authorize states or health plans to define the EHB standards. This helps to demonstrate that Congress clearly intended the Secretary, not states or health plans, to develop EHB standards. Additionally, numerous provisions of the ACA presume that the Secretary will establish a single national EHB standard for the nation.

The proposed benchmark options do not provide adequate benefits for children or pregnant women. Generally developed for working age adult employees, some of these plans may not even address dependent coverage, much less the full range of medically necessary screenings, diagnosis and treatment that effectively meet their developmental needs. Section 1302(b)(4) of the ACA specifies that children's specific needs should be taken into account in the EHB package. An EHB package that will meet the needs of all children, especially children who are lower income and /or have specific health care needs, can only be met if the Secretary clearly defines the EHB for children. The Secretary should define the essential health benefits for pediatric services, even if she does not do so for adults. In the case of children, there is strong evidence that a prescriptive approach, not a flexible approach, is needed to establish a comprehensive standard for coverage.

2. The essential health benefits must take the unique health care needs of children into account, as required by the Affordable Care Act, and guarantee every child access to all medically necessary services.

The EHB should be modeled off the benefit package designed specifically for children in Medicaid.

Children are not small adults. They have unique health needs that can help define the path they take for the rest of their lives, from cradle to career, or from cradle to prison if children get stuck in the cradle to prison pipeline because they lack access to critical health services that will get them to school ready to learn and address their special health and mental health needs. A child's health impacts educational attainment, future productivity and earning potential.

CDF believes *all* children should be guaranteed access to the comprehensive health and mental health services they need to survive and thrive, and to become contributing members of society. The best way to ensure such benefits is to incorporate in the EHB Medicaid's Early Periodic Screening, Diagnostic and Treatment (EPSDT) Program, which was specifically designed to meet the unique developmental needs of *children.* EPSDT recognizes the importance for children of all ages to get regular and periodic screenings and assessments at various intervals through their lives and all the medically necessary health and mental health care they need. It includes preventive, diagnostic and treatment services and all medically necessary care to address chronic conditions, functional impairments and significant or multiple health needs without arbitrary limits on scope and duration. When functioning as intended, EPSDT is widely considered to be the best standard for quality age-appropriate child health coverage.

EPSDT is the best approach for meeting the needs of the millions of lower income and underserved children to be served, some for the first time, under the exchanges. Research clearly shows that these children often have different and more complex needs than those of historically privately insured children. They experience special health care needs and conditions such as asthma and obesity at higher rates than their counterparts from higher-income families. Low-income children are also at greater risk to be born prematurely, and to suffer from oral health and behavioral health problems, all of which can lead to long-term disabilities and functional limitations. While the majority of states already provide coverage through Medicaid and the Children's Health Insurance Program (CHIP) to children up to at least 200 percent of poverty, a significant number of lower-income children living in families up to 400 percent of the poverty line are expected to enroll in the health insurance exchanges. Their needs will be similar to those of children served by Medicaid and CHIP.

To ensure that the promise of the ACA is realized for children, the EHB must improve health benefits for children to make children better – not worse – off than they were prior to its passage.

In 2010, 7.7 million children were enrolled in CHIP. CHIP allowed states to benchmark coverage to EPSDT and many states took up this option; currently twelve states and the District of Columbia operate Medicaid expansion programs and 11 additional states use "Medicaid-lookalike" benefit packages for CHIP through the "Secretary approved coverage" option. The remaining states are required to provide children in CHIP with well-baby and well-child care, doctor visits, shots and immunizations, x-rays, laboratory services, hospitalization, surgical services, and preventive dental care and treatment for emergency dental conditions. Research conducted in 2009 by Watson Wyatt Worldwide for First Focus compared children's coverage in CHIP to what they would receive in exchange plans if CHIP were to be eliminated. Their study found that on indicators including covered

benefits, as well as out-of-pocket costs, premiums, access to pediatric providers and the guarantee to care, CHIP coverage was far better than the plans proposed in the exchanges. This is important to recognize, as most of the children enrolled in CHIP today will be income eligible for the exchanges if or when CHIP is terminated.

The ACA requires that children not be moved from CHIP to the exchanges until the Secretary can certify that the benefits and cost sharing in the exchanges for children are at least comparable to, if not better than, those in CHIP (ACA, Sec.10203(c)(2)(C)). The Secretary is required to complete a comparability study by April 1, 2015, to evaluate whether the EHB standards set forth by the exchanges will meet such a requirement. Establishing EPSDT as the EHB for children will help ensure that comparability is achieved. It will also help ensure that the exchanges can meet the needs of children in 2019, as required by the ACA, and that children will be better – not worse – off under the ACA than they were before its passage.

Pediatric services should be explicitly defined and reflect the full range of children's needs, not be limited solely to oral and vision care.

While it is CDF's position that the Secretary should adopt EPSDT as the essential health benefit for children, if that is not possible, we recommend that at a minimum, all states must be required to adopt a clear, comprehensive core benefit specifically for children that includes not only pediatric vision and dental care, but also the full range of preventive, diagnostic and treatment services, including mental and behavioral health services, and both rehabilitative and habilitative services. A prescriptive, uniform EHB "floor" would ensure that the millions of children across the country who will enroll in coverage through the exchanges would receive a minimum level of coverage regardless of their state of residence. States could always add additional coverage options to the standard core benefits, but, at the very least, a floor - a benefit package specifically designed to meet the varied needs of children - must be required of all insurers.

Given the clear need for and benefit from this full range of services, CDF is concerned the Bulletin references only oral and vision care, when the ACA intended for pediatric care to be much broader. Basic rules of statutory construction suggest that pediatric coverage, including *but not limited to,* oral and vision care was intended to be the tenth category, distinct from the other adult categories of services (ACA, Sec. 1302(b)(J)).

It is also important to recognize that nine of the ten benchmarking options proposed in the Bulletin were designed for working-age adults, not for children. Even though a small business plan may provide family coverage, by definition these plans were not designed for children. A strong EHB designed for children should not, for example, have the same limits imposed on adults for certain services (e.g., durable medical equipment), and would cover child-specific services that adults do not need, such as anticipatory guidance for parents, developmental screenings and certain counseling services. By including pediatric services as a required category of benefits, Congress signaled its intent that children should receive an additional set of benefits beyond that provided in the nine other categories.

Children depend on pediatric services that do not fall into the other nine required categories. As they grow and develop, children's health care needs differ from those of older health care consumers, making it unlikely that children will be well served by a standard designed to meet the lesser health needs of higher-income adult populations. For instance, a growing child may require a new wheelchair or other durable medical equipment on a much more frequent schedule than is provided in an adult

benefit package—a new wheelchair every five years might be adequate for an adult, but not for a growing child. As children develop, they also need preventive and supportive services more frequently to ensure they have the tools to maintain or improve their health well into adulthood. For example, they may require speech therapy to optimize development. Supportive services include, for example, developmental assessments and screenings, education, counseling, and services such as anticipatory guidance, nutritional counseling and treatment of pediatric obesity. Pediatric services must be interpreted to include this full continuum of care, as EPSDT does.

The benchmarks for oral and vision services must be strengthened to provide sufficient care for children.

While potential benchmarks for pediatric oral and vision care are provided in the Bulletin, the outlined approach must be strengthened. We urge the Secretary to define a strong federal floor, preferably EPSDT, for pediatric oral and vision care instead of leaving it up to the states. Allowing states to select a model based on Medicaid's EPSDT program as their benchmark option for pediatric oral and vision services would also help to ensure a smooth transition when individuals and families are moving between the Medicaid program and coverage under health exchange plans. CDF supports the specific recommendations to improve pediatric oral and vision care outlined in the comments submitted by the Children's Dental Health Project and the American Academy of Ophthalmology, respectively. We urge you to take their comments into consideration as you work to strengthen the guidance on these critical benefits for children.

States should have additional options for pediatric vision care as well. Like the other benchmarks proposed, current employer-based plans, including the Federal Employees Dental and Vision Insurance Program, are intended for working age adults, not children. They are not the most effective way to screen for and treat eye disease and refractive problems in children. Again, states should have the option of using the children's Medicaid benefit as a benchmark for pediatric vision care. This will ensure that children receive the vision screenings, diagnosis and treatment that they need as they grow.

The EHB should include a standardized definition of medical necessity for children. The commercial standard of medical necessity is not sufficient for children.

Medical necessity is a key component for deciding which benefits individuals will receive. A standard definition of medical necessity for children should be incorporated in the EHB to ensure that plans do not restrict benefits by using different ways of determining medical necessity or use a standard that is not appropriate for children. We recommend that you adopt a clinically appropriate pediatric medical necessity definition for children, as Medicaid uses in its EPSDT program.

Commercial insurance plans tend to limit what is considered medically necessary to treatments or services that diagnose or treat illness or injuries and are needed to restore "normal" functioning. These rules can exclude the types of treatments needed by children with long-term developmental disabilities that may be linked to prematurity and other conditions such as cerebral palsy. EPSDT, on the other hand, ties medical necessity to children's individual conditions and requires coverage consistent with the goal of ensuring healthy child development, reducing significant health risks, and preventing, detecting, diagnosing, and treating physical, mental, or behavioral conditions, injuries, or disabilities. The EPSDT standard focuses on whether the care and/or treatment are necessary to correct or ameliorate physical and mental illnesses. The definition of medical necessity used for children should be broad enough to include services that improve, maintain and promote health and function or that prevent deterioration of a patient's capacity to function.

Special accommodation is needed for child-only plans in state exchanges.

The ACA requires that child-only plans be available in state exchanges (ACA, Sec. 2707(c)). CDF was a strong proponent of the inclusion of child-only plans in the health insurance exchanges during the health reform debate and also submitted comments urging the inclusion of child-only plans in the Pre-Existing Condition Insurance Plans (PCIPs). Child-only plans are essential to ensure coverage for all children that is comprehensive and affordable, and we are concerned that the Bulletin is silent on guidance surrounding the benchmark benefits for child-only plans in the exchanges. The Bulletin does not mention child-only plans or discuss how the predominantly employee-focused potential benchmark plans can serve as a benchmark for the child-only benefit package. A strong pediatric benchmark must be defined to ensure children's needs are adequately met by the child-only plans that insurers will be required to offer if they plan to participate in the exchanges.

3. Any essential health benefits package must limit the ability of insurers to circumvent the requirement to cover the full range of pediatric services.

As written, the Bulletin proposes to grant states and health plans a significant degree of flexibility in determining and defining the EHB. CDF is deeply concerned that the flexible approach outlined will continue to perpetuate a "lottery of geography" for children. For almost four decades, CDF has urged Congress and the Administration to create an equal playing field for children, so that all children have the opportunity to grow up healthy and ready to learn regardless of where they live. Instead, the Bulletin envisions an EHB that will differ from state to state and additionally within a state by insurer, with the result that the health of millions of children will continue to depend on where they live. The proposed flexibility within and between the ten required categories of care runs counter to the intent of the ACA. Once pediatric coverage is established within an essential health benefit package, families must be able to count on it being fully available for their children in all of the plans.

Allowing insurers to differ the benefits in their plans will make it difficult for families to make "apples to apples" comparisons between health insurance products when faced with the decision and will increase the likelihood that a plan will not meet the needs of their children. Risks are great when insurers are allowed to make substitutions in benefits even though they are required to be "substantially equal" to the benefits of the benchmarked plans. When choosing plans, consumers will already face differences among the plans' provider networks, premiums, and cost-sharing charges and have to make tradeoffs. Allowing insurers to offer different sets of essential health benefits will introduce another level of complexity, leaving many consumers uncertain as to what benefits they are entitled to when they purchase a plan.

It is impossible to predict exactly what health care needs a child will have as he or she grows and develops. No child should be denied necessary services because their parent or guardian did not anticipate the services he or she would need, or chose the "wrong" health insurance plan.

4. There should be a transparent process in place during the states' selection of a benchmark plan, the Secretary's approval process, and the updating of benchmark benefits as ACA implementation moves forward.

The Bulletin is silent on the process states should undertake in selecting their EHB that includes the ten categories of services, or how they must fulfill other requirements of the ACA. As discussed

previously, CDF believes that the approach outlined in the Bulletin ignores the obligation in the ACA for the Secretary to define the EHB and to ensure that it takes into account the needs of special populations including children. CDF is deeply concerned that the EHB, as proposed in the Bulletin, will not reflect the unique needs of children in many states and benchmark plans. However, if the Secretary were to delegate decision-making to the states and state flexibility is allowed, HHS must take steps to ensure that the process for establishing the EHB is an open and transparent one that allows for input from consumers, advocates and other stakeholders. We recommend that the Secretary require states to include a consumer advocate or advocates with expertise in pediatric health needs as part of the process for establishing the standard for pediatric coverage. The public should also have adequate time and opportunity to examine the potential benchmark plans, including complete benefit information, and to provide testimony and comments.

The Department must also outline the process for the Secretary to approve a states' EHB selection and ensure that it includes a process for regularly reviewing over time and updating the essential health benefits consistent with the ACA's requirement to address gaps in coverage and changes in the evidence base.

Thank you for the opportunity to comment on the intended regulatory approach outlined in the "Essential Health Benefits Bulletin." Ensuring comprehensive health and mental health coverage for all children is critical to their future lives and health and the future prosperity of our nation. We ask that you revisit the approach proposed in the EHB Bulletin to guarantee all children the EPSDT benefit package widely viewed as the most appropriate to meet their unique health care needs. At the very least, we urge you to define a strong federal floor of benefits for children to ensure that children are better – and certainly no worse – off than before passage of the ACA. We look forward to working with you to ensure that all children realize the promise of the ACA with a guarantee of a strong benefit package. We appreciate your consideration of our comments and would be pleased to discuss them with you further.

Sincerely yours,



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