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GOVERNOR

State of California
DEPARTMENT OF HEALTH CARE SERVICES
DEPARTMENT OF INSURANCE
DEPARTMENT OF MANAGED HEALTH CARE
HEALTH BENEFIT EXCHANGE
MANAGED RISK MEDICAL INSURANCE BOARD

January 30, 2012

Hon. Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Essential Health Benefits Bulletin (12/16/2011)

Dear Secretary Sebelius:

The State of California has been reviewing and evaluating the *Essential Health Benefits Bulletin* released by the Center for Consumer Information and Insurance Oversight (CCIIO) on December 16, 2011 outlining the intended federal approach for establishment of essential health benefits under the Patient Protection and Affordable Care Act. As part of this initial review process, the California Health Benefit Exchange engaged the Milliman consulting firm to analyze the potential benefit benchmark options for California consistent with the Bulletin. The Milliman analysis is underway.

Based on our preliminary review of the Bulletin, the major entities providing and overseeing health care delivery in California -- the California Department of Health Care Services, the California Health Benefit Exchange, the California Department of Managed Health Care, the California Department of Insurance, and the Managed Risk Medical Insurance Board -- developed these initial comments regarding the intended regulatory approach in the Bulletin to assist the Department of Health and Human Services (DHHS) in refining and developing further federal guidance for states on the essential health benefits issue.

I. General Comments

The intended regulatory approach outlined in the CCIIO *Bulletin* offers a balanced and thoughtful framework for defining essential health benefits as required by the Affordable Care Act. The CCIIO Bulletin affirms the goal of implementing a strong national minimum benefit standard and establishes a process for achieving this goal in stages. The intended approach outlined in the Bulletin recognizes the practical differences among states, and the necessity and benefit to phasing in a national standard by initially basing essential health benefits on existing employer health coverage in each state. Specifically:

- *Moving toward a meaningful and affordable national standard.* The essential health benefit provision in the Affordable Care Act was intended to establish a meaningful and adequate minimum benefit standard to ensure basic coverage for consumers with individual and small employer coverage, and for persons newly eligible for Medicaid or enrolled in a Basic Health Plan if established by the state. The intended approach in the Bulletin proposes to achieve the policy goal of a national benefit standard in phases.

  Affordability is a critical factor in increasing access to health coverage in the individual and small group markets. However, our challenge in addressing this core goal may be compromised if the required essential health benefit level is too high. Our preliminary review of California's ten potential benchmark products suggests that all provide a comprehensive benefit level with relatively little variability in the type of benefits offered. Further analysis will provide more information as to cost implications. The phase-in approach proposed in the Bulletin allows states some flexibility to consider the twin goals of affordability and adequacy in choosing essential health benefits for the first two years of Affordable Care Act implementation, but affordability may be a challenge. Looking beyond the two year transition, additional clarity is needed on the process for assuring that future adjustments can be made to improve affordability, minimize gaps in service and account for changes in medical evidence or scientific advancement.

- *Basing essential health benefits on existing employer coverage in states*. The proposed approach acknowledges that not all states start in the same place when it comes to the health benefits most individuals and employees are used to receiving. Consequently, a "one-size-fits all" approach to benefits early in the implementation of the Affordable Care Act might prove unworkable and potentially costly for states, purchasers and consumers. The CCIIO Bulletin instead initially links the determination of essential health benefits to the public and private-sector mainstream products in each state with the largest number of enrollees and with which consumers are most familiar. If the federal minimum benefit standard was too low, states like California would be forced to either scale back critical health mandates or find the revenues to pay for them. Similarly, if the federal minimum benefit standard was too high, the price shock in some states might be unacceptable. By basing essential health benefits on existing employer coverage in each state, the CCIIO proposal offers a workable, balanced approach.

- *State flexibility and federal support in transitional period*. The proposed two-year transitional period as outlined in the Bulletin will give California the time to review existing state mandates in the context of essential health benefits and also allow policymakers to monitor and consider the early impacts of Affordable Care Act implementation on coverage offerings and markets in the state. The CCIIO proposal affords states the flexibility to fine tune the package of essential health benefits by allowing choices among products that are the most common benefit plans in the state by enrollment. To the extent that there are benefit differences among existing coverage, states may more carefully calibrate the benchmark chosen to reflect preferences and priorities in the state's essential health benefits. The proposed approach also provides states much needed support in defraying the cost of state mandates in excess of essential health benefits during the transitional period.

- *Limit carrier benefit flexibility in complying with essential health benefit requirements.* California has significant concerns about the carrier flexibility proposed in the Bulletin which would allow carriers to provide benefits that are "substantially equal" to the benefits in the state benchmark and to "adjust benefits," both the specific services covered and any quantitative limits. We are concerned that the proposed carrier flexibility could undermine the Affordable Care Act's goals in three ways: (1) consumers would be less able to compare coverage options across products, benefit levels (the five coverage tiers) and carriers; (2) the potential for adverse selection is aggravated if carriers attempt to manipulate benefits in a manner that attracts a healthier population to achieve an underwriting advantage; and (3) the California Health Benefit Exchange – based on an active purchaser model – may be less effective if carriers have flexibility in benefit design not subject to Exchange negotiations. The Bulletin proposes to initially establish minimum essential health benefits based on existing coverage in the state, helping to simplify coverage options so consumers know they are getting basic coverage regardless of the benefit level or tier they choose. We believe that since the Affordable Care Act allows for product tiers with higher and additional coverage above essential health benefits, as well as variations in coverage model, networks and cost sharing, there will be adequate consumer choice without the need for carrier-initiated substitutions in essential health benefits.

  State regulators are concerned that carrier flexibility in this area will seriously undermine and erode their ability to effectively monitor and enforce carrier compliance with essential health benefits. To the extent that substitutions within and across categories are permitted in federal rules and guidance, states must be permitted to apply regulatory scrutiny. Although the Bulletin provides that substitutions must be "actuarially equivalent," similar to CHIP benchmarks, states (rather than carriers) should be responsible for defining and enforcing "actuarial equivalence" of benefits within and across categories. States should not be preempted from limiting or restricting in state law the ability of carriers to adjust or substitute essential health benefits.

- *Need for separate federal guidance related to Medicaid and essential health benefits.* We understand that DHHS intends to provide states with Medicaid-specific guidance on the interaction with Medicaid and essential health benefits. Given the significant impact on Medicaid of the determination of essential health benefits and the potential for complexity, California is fully supportive of the Administration's stated intention to issue future and separate guidance on essential health benefits in the Medicaid program. States will need to evaluate and have the flexibility to develop Medicaid benefits, consistent with the federal flexibility in Section 1937 of the Social Security Act, which may be different than benefits for the general population.

II. Specific Comments and Requests for Clarification

State of California **Comments on Essential Health Benefits Bulletin**	
Proposed Bulletin approach	**Comments**
A. Selection of a Benchmark Plan -- Four Benchmark Plan Types (pp. 8-9) States will be permitted to select a single benchmark to serve as the standard for qualified health plans inside the Exchange and plans offered in the individual and small group markets in their state. The Bulletin identifies four categories of benchmark options, with multiple options in each category, based on the largest plans by enrollment in: (1) small group coverage, (2) state employee plans, (3) coverage for federal employees through the Federal Employees Health Benefit Plan (FEHBP) and (4) the largest commercial non-Medicaid HMO in the state. The Bulletin choices result in 10 different possible Benchmark options for states.	Based on our initial review of the benchmark options, and existing coverage in California, it appears that there could be overlap in the categories. For example, the largest non-Medicaid commercial HMO by enrollment may also be the largest state employee plan by enrollment. Please clarify whether it is anticipated that the benchmark options will be non-overlapping.
B. Establishing Essential Health Benefits (p. 8) The benchmark plan will serve as a "reference plan, " reflecting both the "scope of services and any limits offered" by a typical employer plan in the state [p.8]	1) We would interpret the language in the Bulletin regarding benefit scope and limits to mean that once a state selects a specific benchmark, all of the elements of the "scope of services" and "limits" in the selected policy or contract -- benefit definitions, coverage limitations or service caps, coverage exclusions, key terms affecting coverage (e.g., medical necessity, experimental), service utilization controls (e.g., prior authorization, site or setting) -- would be incorporated into the state definition of essential health benefits. If this interpretation is not accurate, please clarify. 2) Health coverage products, particularly small employer coverage, often feature a set of

	baseline benefits along with optional coverage riders that either add covered services or modify limitations for existing covered services. The Bulletin language implies that, by selecting the plans with the largest enrollment, the most popular optional riders accompanying a specific benchmark product would be included as essential health benefits. If this interpretation is not accurate, please clarify.
C. Defraying the Cost of State Mandates (p.9) The Affordable Care Act requires states to defray the cost of state-mandated benefits in excess of essential health benefits for qualified health plans offered through the Exchange for individuals or small groups. The Bulletin proposes a transition period for 2014 and 2015, through the selection of an existing benchmark. For 2014 and 2015, if a state selects a benchmark subject to state mandates, that benchmark would include those mandates in the state essential health benefit package. If a state selected a benchmark that may not include some or all of the state's benefit mandates, the state would be required to cover any costs associated with state benefit mandates added in the state essential health benefits package.	The intended approach in the Bulletin implies that if none of the benchmark plan options include all of the current state mandates, a state could not add the existing benefit mandates to the benchmark it chooses and still be able to defray the state costs of those mandates until 2016. If this interpretation is not accurate, please clarify. This situation arises in California where benefit mandates may not apply equally to carriers. For example, HMOs and some PPOs must cover medically necessary basic health care services (as defined in state law) while the same requirement does not apply to the remaining PPO and health insurance products. Given this fundamental difference, and two separate controlling bodies of law, over time different mandated benefit requirements have been applied to different product types.
D. Benchmark Plan Approach and the 10 Affordable Care Act Benefit Categories (p.10) The Bulletin acknowledges that all of the proposed benchmarks may not cover all 10 of the benefit categories specified in the Affordable Care Act. If any category is missing in the selected benchmark plan,	Could a state that has a vision benefit in its Children's Health Insurance Program (CHIP) use that benefit as a benchmark option for children's vision coverage to comply with the required 10 essential health benefits?

plans subject to the essential health benefits requirement must nonetheless cover all of the 10 Affordable Care Act categories. If a benchmark is missing a category, the state must supplement the missing categories using coverage from another benchmark, or if none of the benchmark plans cover the benefit, coverage will be determined using the largest FEHBP plan by enrollment.	

III. Medicaid-specific comments and questions

As discussed above, California requests specific separate guidance regarding essential health benefits and Medicaid. It is our understanding that is the intent of DHHS. With this separate track in mind, and based on our initial review, we offer the issues below for consideration by DHHS as it develops guidance related to essential health benefits and Medicaid coverage. Any expectations that can be shared with states in the near future as to the timetable or process for promulgating this additional Medicaid benefit guidance would be greatly appreciated.

Affordable Care Act Medicaid Background. Under the Affordable Care Act, families and individuals with incomes up to 133 percent of the federal poverty level newly eligible for Medicaid must receive "benchmark" or "benchmark-equivalent" coverage, consistent with the requirements of section 1937 of the Social Security Act. Under Section 1937, states can choose from the following benchmark benefit options for application to certain populations: benefits actuarially equivalent to those in the FEHBP; the state's employee health benefits plan; the HMO with the largest non-Medicaid enrollment in the state; the actuarial equivalent of any of these plans; or Secretary-approved coverage. The Affordable Care Act amends Section 1937 to require Medicaid benchmark coverage to provide *at least* the essential benefits required for exchange-offered plans, including prescription drugs and mental health services.

Medicaid Issues. The Bulletin's proposed approach for initially defining essential health benefits adds an element of complexity for Medicaid purposes since state selection of an essential health benefits benchmark for the individual and small employer markets will in turn govern the minimum benefit offerings provided through a *Medicaid*-benchmark package in 2014, per §2001(c) of the Affordable Care Act. Underlying this framework and of particular fiscal importance to state Medicaid programs, the Affordable Care Act precludes federal financial participation for amounts expended towards medical assistance for newly eligible Medicaid beneficiaries beyond the Medicaid-benchmark coverage, per §2001(a)(2)(B).

We highlight the following issues related to Medicaid and essential health benefits and request that they be addressed in future federal guidance:

1. California requests that subsequent federal guidance affirm the state benchmark options for Medicaid as outlined in §1937 and clarify how the Medicaid benchmarks will be impacted by the essential health benefits process outlined in the Bulletin. Please clarify whether the essential health benefits in the state-selected benchmark will be a starting reference point for the Medicaid benchmark for newly eligible persons or a restrictive limit on allowable Medicaid benefits.

2. States will need to know and understand the timing and process for federal review of state decisions on the Medicaid benchmark and the inclusion of state-identified essential health benefits.

3. Given the proposed transition period during which states can choose a benchmark that includes state mandates without incurring state costs for those mandates, please clarify the terms of Medicaid federal financial participation for state benchmark essential health benefits as incorporated into a state's Medicaid benchmark during and after the transition. The approach outlined in the Bulletin, if applied to Medicaid, could expose state Medicaid programs to significant state-only benefit costs once such a relevant transition period expires.

Thank you for considering our comments.

Sincerely,

Toby Douglas,
Director, California Department of Health Care Services

Dave Jones,
Insurance Commissioner

Brent Barnhart,
Director, California Department of Managed Health Care

Peter V. Lee,
Executive Director, California Health Benefit Exchange

Janette Casillas,
Executive Director, Managed Risk Medical Insurance Board