THE NATIONAL ALLIANCE
TO ADVANCE ADOLESCENT HEALTH

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Steve Larsen
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
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Washington, DC 20201

Dear Mr. Larsen:

We write to provide comments on the Health and Human Services Essential Health Benefits Bulletin issued on December 16, 2011. The National Alliance to Advance Adolescent Health is a non-profit organization devoted to education, research, policy analysis, and technical assistance in support of improved health outcomes for adolescents.

We urge HHS *not* to follow its proposed approach of deferring its responsibility for defining essential benefits to the states and allowing them to select one of the optional benchmark plans modified to the meet the requirements of the ACA. The charge from Congress to the Secretary to define each of the 10 essential benefits herself is evident in the language throughout the statute. In prohibiting discrimination on the basis of age and disability, for example, Congress assumes that as part of her duties the Secretary will be making coverage decisions, determining reimbursement rates, establishing incentive programs, and designing benefits. The Secretary, in fact, is required to periodically review and update the essential health benefits and provide a report to Congress and the public.

We are especially concerned that the proposed approach would not ensure that the health care needs of children and adolescents are sufficiently addressed in health insurance policies developed by states and by plans. We believe that HHS must define the category of "pediatric services, including oral and vision care," taking into account, as statutorily required, the unique health care needs of children. Oral and vision services are expressly mentioned in this pediatric category. The language, however, does not imply that these are the only two services meant to be defined in the category. In addition, although the statute requires the Secretary "to ensure that the scope of the essential health benefits is equal to a typical employer plan," it would seem that this language is meant only to establish a minimum requirement, given that several required services – wellness services, substance abuse treatment services beyond detoxification, and habilitative services – as well as pediatric services are generally *not* part of a typical employer plan. The broad intent of Congress was clearly to address the health care needs of all Americans and to provide a package of insured benefits that can ultimately reduce health care costs for families and for the nation.

We urge HHS to define the pediatric services category so that benefits are available to promote optimal physical and mental health and development for children and adolescents. This category should include essential pediatric services – such as audiology services and hearing aids – that are not expressly included in the other nine categories and should also include coverage for medically necessary services that may be additional to the coverage otherwise provided under the other nine categories. Two categories of services are particularly important to the adolescent population: one is *mental health and substance abuse treatment services*, and the other is *rehabilitative services*.

> According to new national estimates, mental health conditions causing severe impairment have affected 22% of adolescents during their lifetime.[1] Although benefit limits for behavioral health services have largely been eliminated as a result of the Mental Health Parity and Addiction Equity Act of 2008, plan policies exempting coverage for certain adolescent conditions such as eating disorders, impulse control disorders, sexual and gender identity disorders, or for critical interventions such as family therapy, still present a barrier to appropriate care for many adolescents.[2]
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> Accidents and injuries are the leading cause of morbidity and incapacitation for adolescents,[3] and a small but significant proportion of these adolescents can be expected to need intensive or extended therapeutic interventions in order to recover and to achieve and maintain their optimal level of functioning. Yet, coverage arbitrarily limited to 20 or 30 visits for rehabilitative therapies is common in commercial policies. In addition, coverage for psychiatric rehabilitation services is frequently unavailable. [4]

Moreover, as noted in the Bulletin, the category least likely to be included in the proposed allowable benchmark plans is "pediatric services, including oral and vision services." HHS proposed that if a state selects a benchmark plan that does not include benefits in each of the 10 categories, coverage for the omitted services should be taken from another benchmark, such as the FEHBP Blue Cross/Blue Shield Standard Option Plan. This approach would not fulfill the intent of the ACA, even with respect to oral and vision care, since the BC/BS standard plan, which is designed primarily for adults, provides only minimal coverage under this category. For vision services, coverage is limited to one pair of eyeglasses, replacement lenses, or contact lenses for each of the following incidents: "to correct an impairment directly caused by a single instance of accidental ocular injury or intraocular surgery; if the condition can be corrected by surgery, but surgery is not an appropriate option due to age or medical condition; and for the nonsurgical treatment for amblyopia and strabismus, for children from birth

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[1] Merikangas, Kathleen R. et al. "Lifetime Prevalence of Mental Disorders in U.S. Adolescents: Results from the National Comorbidity Survey Replication – Adolescent Supplement (NCS-A)," *Journal of the American Academy of Child & Adolescent Psychiatry*, 49, no. 10 (October 2010): 980, http://www.jaacap.com/article/S0890-8567%2810%2900476-4/abstract (accessed January 19, 2012).

[2] United States Government Accountability Office. "Mental Health and Substance Use: Employer's Insurance Coverage Maintained or Enhanced Since Parity Act, but Effect of Coverage on Enrollees Varied," (report to Congressional Committees, November 2011).

[3] Sleet, David A. et al. "A Review of Unintentional Injuries in Adolescents," *Annual Review of Public Health*, no. 31 (April 2010): 195-212, http://www.annualreviews.org/doi/abs/10.1146/annurev.publhealth.012809.103616?journalCode=publhealth (accessed January 23, 2012).

[4] United States Department of Labor, "Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services," (April 15, 2011).

through age 18."[5] For dental services, coverage is limited to an $8 benefit for preventive dental care and a $9 benefit for detailed and extensive oral evaluation.[6]

Another service category that must be adequately defined by the Secretary is the category of "preventive and wellness services and chronic disease management." Section 1001 of the ACA amends section 2713 of the Public Health Services Act and specifically requires non-grandfathered plans to cover, without cost sharing, a comprehensive package of preventive services. These are to include items and services with an A or B rating by the USPSTF; immunizations recommended by the CDC's ACIP; preventive services for women developed by the IOM and recommended by HRSA; and screening and other services for children and adolescents recommended in comprehensive guidelines supported by HRSA, specifically the Bright Futures Guidelines. We believe the Secretary must ensure that these services are available through the Exchange and in the individual market. Yet, no mention of this requirement was made in the Bulletin, and states were not prohibited from selecting as their benchmark a plan that would be considered grandfathered and not subject to these requirements.

Finally, we urge HHS to set a national standard for medical necessity for children under the ACA. The standard should ensure adequate access to coverage by defining as medically necessary services: to promote age-appropriate development as well as health; to address signs, symptoms and conditions as well as accidents and illnesses; to prevent as well as treat such health conditions; and to provide services to prevent deterioration as well as to improve functioning. In addition, since scientific research on the effectiveness of health interventions for children and adolescents is very limited, services should also be considered medically necessary if they meet professional standards of care or, in the absence of such standards, are considered appropriate by pediatric and adolescent medicine experts. This is consistent with the medical necessity language endorsed by the American Academy of Pediatrics.[7] In the absence of a uniform medical necessity standard for children, transparency protections and the right to appeal will mean little. Plans will be free to restrict or deny benefits without a clinical basis for doing so.

We welcome the opportunity to discuss our comments with you or your staff. If you require any additional information, or have any questions, please contact Harriette Fox at The National Alliance to Advance Adolescent Health (hfox@thenationalalliance.org).

Sincerely,

Harriette B. Fox

Margaret A. McManus

Harriette B. Fox, CEO
The National Alliance to Advance Adolescent Health

Margaret A. McManus, President

[5] Blue Cross and Blue Shield, "2012 Blue Cross and Blue Shield Service Benefit Plan, Standard and Basic Option Section 5(a)," page 44.
[6] Blue Cross and Blue Shield, "2012 Blue Cross and Blue Shield Service Benefit Plan, Standard and Basic Option Section 5(g)," page 101.
[7] Committee on Child Health Financing, "Model Contractual Language for Medical Necessity for Children," American Academy of Pediatrics, http://aappolicy.aappublications.org/cgi/content/full/pediatrics;116/1/261 (accessed January 26, 2012).