December 26, 2012

Mr. Gary Cohen
Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Dear Mr. Cohen:

We, the undersigned organizations, write to provide our comments on the Proposed Rule, *Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation.* We agree with HHS that it is critically important to establish standards for states and health insurers regarding the EHB benefit package and associated cost-sharing. However, we are very concerned that federal standards being set are far too low and that the potential consequences for adolescents and others will be long-lasting in terms of underinsurance and medical debt.

In addition, we believe that HHS did not provide the public with sufficient time or information to allow a careful assessment of its proposed benchmark standards and, equally important, states' benchmark selections. The proposed rule actually calls for the public to comment not only on the state benchmark plan summaries provided by HHS but also on *all possible* EHB benchmark plan options within each state. Yet, the public has not being given access to all possible state benchmark plan documents, and even the documents that have been provided are subject to continual changes. Maryland, for example, only recently made a change in its benchmark selection from a state employee option to a small group plan. We urge HHS to make the states' final proposed EHB benchmark plans -- in the form of a certificate of coverage -- available to the public and provide a sufficient time for review and comment.

Having said that, we respectfully express our concerns regarding several aspects of the proposed rule and offer our recommendations to improve the rule so that EHB in all exchanges will furnish adolescents coverage for comprehensive and affordable health care, as promised under the statute.

1. Establish Clear Parity Requirements and Enforcement Policies. We recommend that HHS specify in the final rule what it expects from states to meet the terms of the mental health parity rule, especially since most states have selected small group products that were

previously exempt from the law. Our review of the proposed EHB benchmark plans in the 19 states including the District of Columbia that will be operating state exchanges shows that 4 states (Kentucky, Mississippi, Oregon, and Utah) would impose visit limits on mental health and substance abuse inpatient and outpatient services that are not applied to medical/surgical inpatient and outpatient services. Utah's plan, for example, covers a combined total of 8 outpatient mental health and substance abuse services per year, and a combined total of 30 inpatient mental health and substance abuse services per year. Two additional states would impose visit limits on outpatient mental health services for some (Massachusetts) or all (New York) non-biologically based conditions, while Mississippi would severely limit mental health outpatient coverage to those whose mental health condition is "significantly beyond minor behavior aberrations or whose mental state is such that there is a break with reality."

Clearly, enforcement of mental health parity remains a significant issue that requires federal and state oversight, and these enforcement policies should be described in the final rule. In addition, the final rule should be certain to ensure that nonquantitative treatment limitations -- medical necessity standards, prior authorization requirements, formulary design, and network standards for provider admission or reimbursement -- for mental health and substance abuse treatment services are comparable to the nonquantitative treatment limits in effect for medical and surgical benefits. Finally, the final rule should direct states to define mental health conditions consistent with the latest *Diagnostic and Statistical Manual of Mental Disorders.*

2. Guarantee Nondiscriminatory Drug Coverage. Given that the statute prohibits discrimination, we urge HHS to expand its proposed minimum requirement for one drug in a category or class and set instead a standard for prescription drug coverage that is consistent with Medicare's standard for the Part D drug benefit requirement. Not all adolescents or others with an acute or chronic condition will have the same therapeutic benefit from a particular drug in a given class. Moreover, scientists are only just beginning to understand why patients who appear to have the same condition, illness, or symptom may respond differently to drugs in the same class. The Medicare standard requiring coverage for at least 2 drugs in each category and class *and* for all or virtually all drugs in the protected classes of antidepressants, antipsychotics, anticonvulsants, antiretrovirals, antineoplastics, and immunosuppressants should be adopted as the minimum requirement for all EHB packages.

   Based on our review of the proposed benchmark plans in the 19 states planning to operate state exchanges, there are numerous examples of states in which coverage of drugs

important to adolescents would fail to meet the minimum floor required under Medicare Part D. Looking only at coverage for drugs in certain of the protected classes, we found (as shown in the attached Table), that 9 of the 19 states would not cover all or substantially all of the GABA augmenting agents important in the treatment of bipolar conditions; 5 states would not cover all or substantially all of the SSRIs/SNRIs important in the treatment of depression; 4 states would not cover all or substantially all of the atypical antipsychotics also important in the treatment of bipolar conditions; and one state would not cover all or substantially all of the nucleoside and nucleotide transcriptase inhibitors important in the treatment of HIV.

In addition, among drugs in 18 other classes important to the treatment of adolescents, we found that in one case all 19 states would cover either no drugs in the class or only one in the class. Blood products always failed to meet Medicare's minimum standard for 2 drugs in a class, and vaccines and smoking cessation agents failed to meet them in about half the states.

Further examination of drug coverage in the states' proposed EHB benchmark plans revealed additional problem areas. In both Nevada and New Mexico coverage would only be available for generic drugs; coverage would be excluded for preferred, non-preferred, or specialty drugs. In Oregon coverage would not be available for drugs and biologicals that can be self-administered (including injectibles), except those provided in a hospital, emergency room, or other institutional setting, or as outpatient chemotherapy and dialysis. In both Utah and Washington coverage for non-preferred brand name drugs would not be available.

Without an adequate federal standard for coverage of prescription medicines, such as that established under the Medicare Part D program, it is clear that many states will offer extremely restrictive policies that will adversely affect health outcomes for adolescents and others in need of effective drug treatment.

3. Ensure Adequate Rehabilitative Services Coverage. We are concerned about the adequacy of states' benchmark plan coverage of rehabilitation services -- a benefit that is critical to adolescents who are involved in motor vehicle accidents, sports injuries, and other injuries associated with violent acts. We urge HHS to issue guidance about the adequacy of coverage for this benefit.

   In our analysis of the rehabilitative and habilitative services that would be offered as EHB in the 19 states, it appears that coverage limits would frequently be too restrictive to meet

their intended purpose. Four states -- Idaho, Kentucky, Nevada, and Utah -- would cover only 20 visits total each year for physical, occupational, and speed therapy combined, and they would apply their 20-visit limit to include both rehabilitation and habilitative services.

4. Adopt Realistic Assumptions for Provider Participation and Patient Out-Of-Pocket Costs. We strongly urge HHS to eliminate the proposed cost-sharing requirements for care received from providers outside of a plan's network. That requirement, which restricts individuals/families from counting their out-of-network cost-sharing expenses (except those incurred when using an emergency room) toward the annual limitation on cost sharing, will pose a significant access barrier and financial burden for adolescents. A small but significant proportion of adolescents are certain to require care from mental health professionals -- including psychiatrists, psychologists, or social workers -- many if not most of whom do not accept insurance. Others with chronic physical conditions or developmental disabilities will require care from medical specialists, who also may not be in plans' networks but are essential providers in the care of adolescents with chronic conditions. Further, school-based health clinics and family planning clinics are often out-of-network providers, but they deliver covered services to adolescents who might not otherwise seek or receive them through in-network providers.

5. Give Young Adults Useful Catastrophic Coverage. We believe that HHS should revise the proposed rule as it pertains to young adults under age 30 who will be purchasing a catastrophic plan. Requiring young adults to meet a deductible of $6,250 before they can access the essential health benefits, except for 3 primary care visits, is entirely inadequate to meet even the very basic needs of this population, at least a quarter of whom have a chronic condition. We recommend that HHS allow young adults to also access preventive care, mental health and substance abuse outpatient services, and prescription drugs before the deductible must be met.

6. Establish Consistent Age Policies Under the ACA. We encourage HHS to require that pediatric services, including dental and vision services, extend up to age 21, which is consistent with the upper age limit established in the statute for child-only coverage.

7. Encourage Comprehensive Coverage for Children and Adolescents. We recommend that HHS allow states operating exchanges to select their complete CHIP benefit packages as the EHB package for their child-only plans and not just permit CHIP coverage to be used for pediatric dental and vision services alone. CHIP plans were expressly designed to meet the needs of children and adolescents.

Despite the unusually short time frame under which HHS is accepting and reviewing comments, we respectfully urge that you give consideration to our concerns and recommendations. We recognize that HHS is under tight schedules to approve state exchange plans by April 2013 and enroll eligible individuals by January 2014. However, because of the significance of these ACA coverage and cost-sharing standards as a "reference plan" for insurers in individual and small group markets and Medicaid, we request that HHS issue the final state benchmark documents for public comment.

We would 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) or Peggy McManus (mmcmanus@thenationalalliance.org).

The National Alliance to Advance Adolescent Health
Adolescent Medicine and Young Adult Medical Practice, Children's Hospital, Boston, MA
First Focus
Group Health Physicians, Seattle, WA
Healthy Teen Network
National Assembly on School-Based Health Care
National Association of County and City Health Officials
Society for Adolescent Health and Medicine
The Alliance for Children and Famlies
The SPOT, Adolescent Clinic, Washington University School of Medicine, St. Louis, MO

Table 1: Gaps in Coverage of Selected Drugs Important to Adolescents in Proposed EHB Benchmark Plans in 19 States[i]

Drug Categories and Classes	No. of States Including DC NOT Meeting Medicare Part D Standard[ii] (N=19)
Selected Protected Drug Classes	
Anticonvulsants: GABA Augmenting Agents (10 in this class)	9
Antidepressants: Serotonin/Norepinephrine Reuptake Inhibitors (9)	5
Antipsychotics: 2nd Generation/Atypical (5)	4
Antivirals: Anti-HIV agents, Nucleoside and Nucleotide Transcriptase Inhibitors (8)	1
Other Drug Classes	
Blood Products/Modifiers/Volume Expanders: Coagulants	19
Immunological Agents: Vaccines	9
Anti-Addiction/Substance Abuse Treatment Agents: Smoking Cessation Agents	8
Antibacterials: Beta-Lactam, Other	7
Gastrointestinal Agents: Irritable Bowel Syndrome Agents	7
Respiratory Tract Agents: Antileukotrienes	6
Antiparasitics: Anthelmintics	3
Gastrointestinal Agents: Laxatives	3
Hormonal Agents: Pituitary	2
Antiparasitics: Pediculicides/Scabicides	2
Cardiovascular Agents: Angiotensin II Receptor Antagonists	2
Central Nervous System Agents: Attention Deficit Hyperactivity Disorder Agents, Amphetamines	2
Central Nervous System Agents: Attention Deficit Hyperactivity Disorder Agents, Nonamphetamines	2
Cardiovascular Agents: Diuretics, Potassium-Sparing	1
Gastrointestinal Agents: Proton Pump Inhibitors	1
Hormonal Agents: Androgens	1

[i] Coverage gaps are defined as not meeting Medicare Part D drug coverage requirements of having 2 or more drugs in each class and having all or substantially all drugs in each of 6 "protected" classes: antidepressants, anticonvulsants, antipsychotics, antibehaviorals, antineoplastics, and immunosuppressants.

[ii] We counted as not meeting the standard for protected classes as states that had 7 or fewer SSRI/SNRI, 8 or fewer GABA augmenting agents, 3 or fewer atypical anticonvulsants, 6 or fewer anti-HIV agents, and 0 or 1 in each of the other drug classes.