Submitted electronically

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Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Washington, DC

To whom it may concern:

The American Cancer Society Cancer Action Network (ACS CAN) is the advocacy affiliate of the American Cancer Society, a nationwide, community-based, voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer through research, education, advocacy, and services.

ACS CAN appreciates the opportunity to provide comments to the U.S. Department of Health and Human Services (HHS) on the Essential Health Benefits Bulletin (the "Bulletin") released on December 16, 2011.

We offer the following specific comments for your consideration in regards to the Bulletin. We have many other concerns about the essential benefit package which will we reserve until the Department publishes a formal proposal.

For further information, please contact me at SFinan@cancer.org.

Sincerely,

Stephen Finan
Senior Director of Policy

Benchmark Plan Types

Under HHS' intended approach, each state would select a single plan, from a list of 10 designated plans, to serve as the state's standard for essential health benefits. To meet the criteria for essential health benefits in the Affordable Care Act, plans eligible to serve as the state's standard for essential health benefits should provide a sufficiently robust level of coverage and should not inappropriately restrict the benefits needed by people with significant, specialized, or high-cost health care needs. Therefore, it is critical to know which specific plans are likely to serve as the potential benchmarks in each state under the HHS approach, as well as the elements of each plan's benefits that would be incorporated if a state selects it as a benchmark.

For example, among the 10 possible plans identified by HHS, a state may choose "the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market." Existing small group plans—even those with substantial enrollment in a state—may provide benefits with problematic benefit limits and may not be appropriate to serve as a state's essential health benefits standard. In the existing small group market, benefit limitations are often used to limit coverage of particular items or services. Such restrictions may be permitted even after full implementation of the Affordable Care Act (ACA).

ACS CAN wants to bring specific attention to the problem of limits on the number of visits covered for a particular service are common because we know of cases where the has been a problem for cancer patients. In some cases, a plan may place a dollar-value limit on how much it will pay out for a particular service, and HHS has not clearly indicated whether the ACA's prohibition on annual and lifetime dollar value limits would apply to service-based dollar limits. Insurers also sometimes limit the frequency at which a service or item will be covered, or will only cover an item or service if the patient meets certain criteria. For example we have seen an example of where a group plan has a limit of 35 doctor visits a year. We learned of this example from a breast cancer patient who had to have chemotherapy once a week for a year, in addition to other doctor visits that were necessary to treat her cancer fully and properly. This particular patient wound up with $135,000 in out-of-pocket expenses for her cancer. Under the ACA, these expenses would not count toward the cap on annual out-of-pocket spending that the law requires of non-grandfathered plans in the individual and small group markets beginning in 2014.

Benefit limits can be used to restrict needed care or steer consumers into or away from certain plans offered on the exchange. HHS should prohibit some limits or exclusions even if they are found in a proposed state benchmark plan. For example, some plans may have condition-based exclusions that target particular vulnerable populations or diagnoses in a way that would not comply with the protections under Section 1302. HHS should consider circumstances in which a benchmark plan chosen by the state contains a condition-based exclusion or other type of restriction that would conflict with the requirement to ensure at least the ten specified categories of services are covered. In general, we are concerned that some of the potential benchmark plans (particularly those without large enrollment) may include benefit details that are problematic for cancer patients and others with serious chronic conditions.

If HHS proceeds with its intended approach, each state will need to decide which benchmark plan to choose or the state will default to the largest plan by enrollment in the largest product in the state's small group market. As this process moves forward, stakeholders—particularly those representing consumers —should have ample opportunity to review the details of benefits covered by each of the 10 potential benchmark plans in each state and to weigh in through a public comment process on the tradeoffs of selecting one plan over another. It is especially important that stakeholders also have information on the potential default plan in the state, and that they have an opportunity to comment on the plan's benefits and recommend any needed modifications should the state fail to select a plan. It is imperative that HHS take necessary steps to make sure the appropriate plan documents or contracts are made available to the public as quickly as possible.

1. Ten Benefit Categories Required as Part of the Essential Health Benefits

The Affordable Care Act specifies ten categories that must be included in the essential health benefit package.[1] Congress explicitly intended these categories be considered essential health benefits in order to ensure consumers have access to comprehensive coverage—especially for conditions that are not covered, or covered inadequately in the individual and small group markets.

HHS should precisely define the scope and services within each of the 10 benefit categories. Because traditional plans do not categorize their services within the same benefit categories or using the same terminology, it is unclear how the essential health benefit package could be compared to potential benchmark plans to ensure that it complies with the ACA. For example, "ambulatory patient services" is not a category that is commonly seen in commercial plans, and it is unclear what specifically would need to be covered to satisfy HHS' standards.

Many of the 10 ACA categories, such as Mental Health and Substance Use Disorders, Rehabilitative and Habilitative care, Maternity and Newborn Care, and Pediatric Oral and Vision Care are examples of conditions or service categories that are specifically included within Section 1302 of the ACA to correct longstanding gaps in coverage that consumers face in the individual and small group markets. It is imperative that HHS provides clear standards for what must be covered under the 10 categories to ensure a standard from which to compare proposed state benchmark plans. A standard definition of the 10 categories would still allow for the state flexibility approach outlined in the Bulletin. Further, HHS should prohibit states or insurers from defining the scope and parameters of the 10 required benefit categories—particularly for categories of services that are not common in commercial insurance such as "habilitative services" or "ambulatory patient services." Allowing a state or insurer to define these categories would erode the intent of Section 1302 of the ACA.

Ultimately, we believe that essential health benefits should be essentially uniform in all states. The benefits available to cancer patients should not fundamentally vary depending on where one lives. (The delivery of benefits may vary to some degree based on geography and other factors,

[1] These categories include: Ambulatory patient services; Emergency services; Hospitalization; Laboratory services; Maternity and newborn care; Mental health and substance use disorder services, including behavioral health treatment; Pediatric services, including oral and vision care; Prescription drugs; Preventive and wellness services and chronic disease management; and Rehabilitative and habilitative services and devices.

but the benefits should not vary.) We understand from the Bulletin that the benchmark approach is transitional and changes may be made in a few years based on experience and more data. However, one area where the Department should act now to develop national uniformity is by developing a standardized definition of medical necessity. It should not be narrowly defined by acute treatment outcomes, but rather, it should be broad enough to include services that improve, maintain, or prevent deterioration of a patient's capacity to function. A clear and uniform definition of medical necessity at the federal level will lead to greater consistency of care, transparency for consumers and providers, and improved procedures for grievances and appeals. The Secretary should require states and insurers to use this federal definition of medical necessity.

The issue of how the benefits provided under a potential benchmark plan match up with the 10 required benefit categories is particularly important when a state's benchmark plan is missing one or more categories and must adopt the required category from another plan, as HHS has proposed. It is not clear from the ACA or from the HHS Bulletin how a benchmark plan would import coverage of a benefit category from another plan when the plan's benefits do not clearly match up with the ACA's ten categories. This is especially true when an ACA category is not well defined in the private market, as is the case with habilitative services. The bulletin acknowledges that "there is uncertainty what is included" in this category. HHS should define the process to adopt a benefit category from another plan (one of 10 benchmark plans outlined in the Bulletin) and create a state benchmark. It is also unclear what is included when a state chooses a benchmark plan. For example, it is unclear whether the benchmark plan includes any associated benefit limits and how those limits would interact with essential health benefit protections required by the ACA.

2. Proposed Approach to Prescription Drug Coverage

The Bulletin states an intention to propose a lower plan requirement for prescription drug coverage than benefits in the other ten categories under the essential health benefits. Rather than requiring plans to provide benefits equal to the benefit provided by the benchmark, the proposal requires plans to provide coverage for only one drug per category or class covered by the benchmark. Although the bulletin notes that the proposed model is based on Medicare Part D, it endorses a significantly lower standard than Medicare's program. Medicare Part D requires plans to offer at least two drugs per category or class and has the protected class policy to protect vulnerable individuals. The Medicare Part D standard was designed to ensure that available plans do not discriminate against enrollees with significant health care needs.

Mandating that plans cover only one drug per drug class or category will not sufficiently protect a patient with cancer. Due to the nature of cancer as a group of diseases, cancers can and do become resistant to a particular antineoplastic or targeted drug within a category or class. Furthermore, patients can develop hypersensitivities or adverse side effects from their first-line drug treatment that can result in a patient no longer being able to receive a certain drug. Therefore patients with cancer often have to take multiple medications in more than one category or class throughout the course of their treatment. If the standard is to cover only one drug per class the prescription drug coverage under the essential health benefits will be inadequate for cancer patients. We would like HHS to provide further clarification on how it plans to ensure

that plan benefit design does not discriminate against individuals with complex health care needs such as cancer.

Finally, we would also like HHS to consider the larger question of long-term access and affordability to high cost medications to treat complex and chronic conditions. Many of the newer medications on the market today to treat cancer are placed on specialty tiers with significant patient cost-sharing. Out-of-pocket costs for some of these medications can easily exceed $400 per month. A recent study conducted by Avalere Health found that 25% of cancer patients with a prescription for an oral cancer drug exceeding $500 per month abandoned their prescription.[2] This is obviously a critical problem. Moreover, there are many very expensive cancer drugs in development that are likely to be on the market in the next few years. ACS CAN is concerned that without some additional guidance for plans on how to ensure access to certain high cost medications that cancer patients may be denied coverage to some of the newer, innovative cancer therapies in the pipeline.

3. Benefit Design Flexibility

Permitting insurance carriers to deviate from the benchmark benefits chosen by the state, as HHS has proposed, would significantly weaken the ACA's Essential health benefits provision. The EHB standard is intended to ensure a consistent, minimum level of benefits across all non-grandfathered, fully-insured plans in the individual and small group insurance markets so that consumers can make an apples-to-apples comparison of plan options and to prevent insurers from adopting benefit designs intended to attract healthier people and deter enrollment by those in poorer health. The proposal for "benefit design flexibility" would undermine these goals, regardless of whether variation is allowed within benefit categories or across benefit categories. Beginning in 2014, there will be considerable confusion among all stakeholders as they learn the new processes and requirements of exchanges and other changes that will be taking effect.

HHS' proposed approach to establishing the essential health benefits already provides significant flexibility by allowing each state to set a different benchmark benefit standard. Giving insurers the additional ability to vary from each state's standard would be highly problematic by further diluting the EHB requirement, as noted above, there is no justifiable reason for benefits to vary significantly among the states. It is unclear what advantage, if any, the proposal for "flexibility" holds for consumers. If insurers can substantially vary the details of the benefits they cover from a state's chosen benchmark benefits standard, consumers will have a difficult time comparing the features of different plan options and making informed decisions about coverage. In addition, some insurers would likely exercise this flexibility to impose problematic benefit restrictions (such as visit limits) that would shift costs to people with significant or rare health care needs. Insurers would thus be able to construct their plans in ways that discourage enrollment by high-cost people or attract enrollment by people who are less costly to cover.

[2] Patient and Plan Characteristics Affecting Abandonment of Oral Oncolytic Prescriptions. The American Journal of Managed Care. May 2011. Vol. 17. SP28-SP44. Accessed at: [http://www.sph.umich.edu/vbidcenter/publications/pdfs/abandonment_of_oral_oncolytic_rx.pdf].

HHS justifies the proposed approach to benefits flexibility for insurers by stating it "would provide greater choice to consumers, promoting plan innovation through coverage and design options…" Upon critical examination, neither justification is compelling.

Consumer behavioral research in general—and with respect to insurance choices specifically—shows that too much choice does *not* benefit consumers. The human mind simply cannot meaningfully evaluate too many options. In fact, having too many options *reduces* consumers' willingness to make a selection.

Health insurance is a particularly difficult product for consumers to assess.[3] Extensive consumer testing in Massachusetts, after the state implemented an insurance exchange called Commonwealth Choice, found that the ideal number of different plan designs in the exchange was six to nine. In Massachusetts, plan design differed mainly in plan cost-sharing charges (with minor exceptions) and even then consumers favored a limited number of choices.[4] Consumers were *not* clamoring for variation in covered services to be added to the list of variables. In Utah's Health Exchange, which is based on an approach that allows all insures who meet minimum standards to participate, offers over 140 plan options.[5] The Utah Health Exchange, as of August 1st 2011, covered a total of 4,200 lives. Early research indicates that when employees enter the exchange, they gravitate toward familiar plans.[6]

Moreover, much of the "innovation" that insurers would want to incorporate into their products are likely to be related to cost-sharing details, incentives to use particular providers, disease management programs, and utilization management techniques. These would be separate from the essential health benefits requirements proposed in the bulletin and would not be hampered by consistent benefit requirements.

Benefit Design Flexibility: Insurer-Controlled Benefit Variation Would Harm Beneficiaries with Significant Health Needs

The HHS proposal to allow insurers to deviate from a state's essential health benefit standard is likely to be used by insurers to limit benefits in ways that would harm or shift costs to enrollees with high-cost or specialized health needs. Beginning in 2014, the ACA requires insurers to take all applicants, prohibits insurers from charging people higher premiums due to health status and other characteristics, and limits the impact that a person's age can have on their premiums. With these requirements in place, insurers who can no longer reject high-cost enrollees or charge more for people with pre-existing conditions are likely to adopt other methods to reduce their exposure to large or certain types of health claims. This could be the case even though the ACA includes provisions, such as a new risk adjustment system, that are intended to reduce the incentive for plans to "cherry pick."

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[3] Lynn Quincy, "What's Behind The Door: Consumers' Difficulties Selecting Health Plans," Consumers Union, January 2012.
[4] *Health Reform Toolkit Series: Resources from the Massachusetts Experience, Determining Health* Benefits Designs to be offered on a State Health Insurance Exchange, Massachusetts Health Connector, November 2011.
[5] States in Action Utah Health Exchange, The Commonwealth Fund March 2011 http://www.commonwealthfund.org/Newsletters/States-in-Action/2011/Mar/February-March-2011/Snapshots/Utah.aspx
[6] The State of the Utah Health Exchange, Utah Health Policy Project September 2011 http://www.healthpolicyproject.org/Publications_files/State/TheStateOfUHEDashboard.pdf

In particular, if this flexibility is allowed, it is likely that insurers will increase their use of "internal plan limits," such as restrictions on the number of visits for a particular service, in order to reduce their costs. Insurers could scale back coverage in one area (perhaps by placing stricter limits than the benchmark on a service more likely to be used by people with greater health care needs) and make up for it by increasing coverage in another benefit. Even if insurers must show each category of their benefits is equal in actuarial terms to each of the 10 benefit categories in the benchmark, there would still be significant room for insurers to design that benefit category in problematic ways. For example the ACA category of "ambulatory patient services" is likely to encompass a number of specific services, although HHS has not spelled out the details of how this would work. This category could, for example include home health services, in addition to physician visits and other outpatient care that does not fit into the ACA's other 10 benefit categories. HHS' proposal for "benefit design flexibility" could allow an insurer to strictly limit home health services (for example, with a low visit limit) and increase care elsewhere in the category in order to match the actuarial value of the "ambulatory patient services" category. (This, of course, assumes that the benefit standard chosen by a state does not already include such onerous limits or restrictions.)

The experience in the Medicare Advantage program offers an illustration of how insurers, when given too much latitude, can use plan design to avoid paying for certain types of care. In Medicare Advantage (MA), private plans offer coverage to seniors and people with disabilities as an alternative to traditional fee-for-service Medicare. Parts A and B of traditional Medicare (which cover inpatient and outpatient services, respectively) serve as a fairly detailed reference package for MA plans' inpatient and outpatient benefits.[7] While MA plans must cover at least the services covered by traditional Medicare in Parts A and B, an MA plan's benefit package can vary from that of the traditional program as long as the plan's overall actuarial value is not less than that of traditional Medicare.[8] Some MA plans, therefore, have utilized the flexibility they have to impose high beneficiary cost-sharing for certain services, such as chemotherapy drugs, skilled nursing facility stays, and kidney dialysis. A variety of analyses documented the problem of MA beneficiaries who need hospital care, home health care, and other specialty services having to pay higher costs under MA plans than they would have paid under traditional Medicare.[9] For example, an AARP study found that, while the average MA beneficiary in 2008 would pay $823 in cost-sharing charges for a 10-day hospital stay (less than the $1,068 average under traditional Medicare), 12 percent of MA beneficiaries would incur cost-sharing of $2,000 or more.[10]

[7] MA plans also cover prescription drugs under Part D of Medicare.
[8] Edwin Park, "Informing the Debate about Curbing Medicare Advantage Overpayments," Center on Budget and Policy Priorities, May 13, 2008. http://www.cbpp.org/files/5-13-08health.pdf
[9] See, for example, Medicare Rights Center, "Too Good to Be True: The Fine Print in Medicare Private Health Plan Benefits," April 2007; Brian Biles, Lauren Hersch Nicholas and Stuart Guterman, "Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal?" The Commonwealth Fund, May 2006; Medicare Payment Advisory Commission, "Report to Congress: Benefit Design and Cost Sharing in Medicare Advantage Plans," December 2004; and Government Accountability Office, "Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Serve May Not Always Reduce Beneficiary Out-of-Pocket Costs," February 2008.
[10] Government Accountability Office, "Medicare Advantage: Relationship between Benefit Package Designs and Plans' Average Beneficiary Health Status," April 2010; Marsha Gold and Maria Cupples Hudson, "Medicare Advantage Benefit Design: What Does It Provide, What Doesn't It Provide, and Should Standards Apply?" report for AARP Public Policy Institute, March 2009.

Over time, the Centers for Medicare & Medicaid Services has adopted stronger cost-sharing rules in Medicare Advantage and increased its upfront scrutiny of plans so that problematic charges are reduced before plans are offered to beneficiaries. A provision in the ACA required that cost-sharing charges for certain services to be no higher in Medicare Advantage than they are for the same benefit in traditional Medicare.[11] For purposes of health care reform, it is significant that the problems in Medicare Advantage Medicare Advantage occurred even with protective mechanisms such as an increasingly sophisticated risk adjustment system and a prohibition against discriminating against people based on health status. HHS can avoid from the outset the types of benefit design and adverse selection problems that arose when insurers were given too much flexibility in Medicare Advantage by prohibiting insurer variation from a state's benchmark benefit standard.

Benefit Design Flexibility: CHIP Benchmark Rules Differ in Many Respects from the HHS Bulletin

In the guidance, HHS proposes using "the same measures defined in CHIP" (42 CFR 457.431) to ensure that any of the proposed benefit flexibility that is exercised by insurers meets actuarial equivalence tests. But the approach suggested by HHS is actually quite different from the framework in CHIP, and HHS should clarify exactly how its proposal for benefit design flexibility would be similar to CHIP. In particular, it is significant that a benchmark or benchmark-equivalent plan selected by a state for CHIP is *uniform across the state* and is provided by all CHIP plans in the state (after being approved by HHS). Individual insurers cannot deviate from this standard. In the case of the EHB, HHS is proposing multiple variations *within* a state, at the insurer's discretion.

Benefit Design Flexibility: HHS Should Add Protections if Insurers Can Vary from the Benchmark Benefits

HHS should protect consumers by allowing only one essential health benefits benchmark per state. Insurers should not be allowed to vary benefits. However, if HHS decides, despite the problems that would occur, to permit insurers to offer benefits that vary from a state's essential health benefits benchmark, a number of additional provisions and protections would need to be adopted.

For example, insurers should not be allowed to merely meet an overall actuarial equivalence test on the value of their benefits compared to the benchmark benefits, as the guidance proposes. This would be far too open-ended to serve as a true standard, as discussed below. In addition, if insurer flexibility from the benchmark is retained at the federal level, states should be able to implement their EHB standards in a manner that is more protective of consumers. States should be allowed to pick one benchmark plan and prohibit any variations from it.

HHS should also establish specific policies and procedures to help ensure that people with rare, high-cost, or significant health care needs are protected if insurers are allowed to modify their benefits compared to the benchmark. For example, insurers could be prohibited from varying

[11] GAO, April 2010, op cit.

from the benchmark for certain services, akin to the recent improvements in Medicare Advantage. HHS could also identify particular types of limits, levels of limits, and levels of variation from the benchmark benefits that would be of particular concern and would trigger a higher level of scrutiny from regulators. HHS should also implement requirements to ensure transparency if insurers are allowed to deviate from a state's benchmark benefits. Such variation should be clearly communicated to consumers and be subject to an approval process by the state (including requiring insurers to justify the benefit design changes). In general, HHS should detail the specific process for oversight and enforcement (both in the approval process and on an ongoing basis) if insurer benefit design flexibility is allowed. We expect that both states and the federal government would need to play a significant role.

Benefit Design Flexibility: Actuarial Equivalence Tests are Unlikely to Provide Sufficient Consumer Protections

As discussed above, HHS proposes to allow a health insurance issuer flexibility to adjust benefits, including both the specific services covered and any quantitative limits provided the issuer continues to offer coverage for all 10 statutory EHB categories. HHS proposes to require any substitutions by an insurer to be "actuarially equivalent" to the state's benchmark benefit, to ensure that the EHB package is not weakened overall. Two types of flexibility are considered: within benefit categories and across benefit categories.

Requiring actuarial equivalence may seem protective of consumers but in actuality is unlikely to be adequate. Actuarial comparisons are traditionally used to gauge the impact of plan cost-sharing provisions across a defined set of medical services. In this case, however, actuarial equivalence would not be measuring differences in cost-sharing but minor differences in the scope of medical services covered. It is not at all clear that actuarial models in use today can accurately measure fine differences in benefits, even though such differences could be significant in their impact on individual plan enrollees.

If HHS retains the proposal to allow insurers to deviate from a state's benchmark benefits, standards other than those based on actuarial equivalence would be better suited to ensuring that available benefits meet the necessary standards. For example, insurers could be allowed to go beyond the state's benchmark benefits to offer additional services or higher visit limits for particular services. (These benefit increases would have to be separate from the calculation of actuarial value for purposes of the "precious metal" coverage levels, which is intended to convey cost-sharing levels based on a fixed set of benefits. They would also have to priced separately and optional for consumers, particularly because federally financed premium tax credits and cost-sharing reductions would not apply to them.)

Another approach to "benefit flexibility" could be to provide a list of explicit, approved substitutions that insurers could make. These substitutions should be subject to several tests to protect consumers:

- The alternate benefit should have a demonstrated improving effect on consumer welfare (note: it is not sufficient to say that more choice is always better).
- Substitutions must be understandable to consumers and a disclosure required so that these differences are easily grasped.

- Substitutions should result in an overall package that is on balance at least as generous as the benchmark.
- Selection effects must be considered. Substitutions that benefit small populations with special needs may be welfare improving but may also result in adverse selection into the plans that offer them. State or HHS must weigh whether the risk adjustment mechanisms are sufficient to address this possibility.

Benefit Design Flexibility: Considerations for Actuarial Equivalence

Actuarial estimates vary greatly depending on the software being used and the assumptions employed to make the estimate.[12] As an example, the claims distribution underlying the model has a profound impact on the estimate, particularly for minor differences such as variations in visit limits. In addition, the assumptions used in the estimation—such as how costs were benchmarked or the strength of the utilization effect—affect the estimates.

If HHS proceeds to use actuarial equivalence as a standard for insurer benefits that vary from the standard benchmark, rigorous rules must be developed to ensure that the actuarial equivalence standard is usable and meaningful. For example, a standard methodology and model must be used to make the estimates or HHS must require that the methodology and model has been certified that is has the capacity to gauge the impact of the fine differences being measured. The claims distribution underlying the model must be sufficiently robust to yield meaningful estimates. Merely requiring the analysis to be conducted "in accordance with the principles and standards of the Actuarial Standards Board" is insufficient. HHS should also promulgate rules for the actuarial equivalence calculations with respect to such elements as the benchmarking of costs, the standard population used for the estimate, utilization assumptions and the specificity of benefit categories to be used. Clearly, some of the categories in the ACA are too broad to use when it comes to modeling the impact of small substitutions. Sensitivity testing by a reputable actuary must be used to test and fine-tune the rules.

4. Updating Benchmark Plans

HHS proposes to require states to use enrollment data from the first quarter two years prior to the coverage year and to select a benchmark in the third quarter two years prior to the coverage year. This seems to suggest, but does not make clear, that states will be required to actively designate an EHB package for each year, selected from among the plans that would qualify as a benchmark based on plan enrollment. In addition, the proposed approach gives significant flexibility to insurers by noting that the provision of a "substantially equal" standard would allow health insurance issuers to update their benefits on an annual basis. To protect against a state's EHB automatically changing throughout the year or changing year-to-year based on carrier-initiated changes in coverage, HHS should make clear states must make an annual choice (or use the default benchmark plan) with benefits locked in for the plan year. HHS should also require states to detail for consumers year-to-year changes in the EHB so consumers can easily identify how coverage will change under the EHB.

[12] Lynn Quincy, "Creating A Usable Measure of Actuarial Value," Consumers Union, January 2012.

In addition, HHS should establish robust data collection requirements for states and carriers to ensure it has the data needed to accurately assess the impact of the benchmark approach on consumers. This data will be necessary for two reasons. First, it will be necessary to meet the Secretary's statutory obligation to periodically review and update the essential health benefits to address any gaps in access to coverage or changes in medical evidence or scientific advancement. It will also be necessary to inform HHS's evaluation of the benchmark approach for the calendar year 2016 and to assess whether an alternative approach, such as a federally defined EHB, would better address access to care, consumer choice, risk selection, and the ACA's goal of establishing a minimum level of benefits.

The Bulletin gives significant flexibility to insurers by noting that the provision of a "substantially equal" standard would allow health insurance issuers to update their benefits on an annual basis. While insurers would be expected on an ongoing basis to reflect improvements in the quality and practice of medicine, the law requires the HHS Secretary to update the essential health benefits.

5. Consumer Protections

The Bulletin does not address what protections will be in place at the state and federal levels in order to assure benchmark plans are subject to strong, enforceable standards to protect consumers. Under Section 1302, the Secretary is prohibited from discriminating against individuals because of their age, disability, or expected length of life in defining essential health benefits. In addition, as outlined in Section 1302, in defining the essential health benefits the Secretary must "take into account the health care needs of diverse segments of the population, including women, children and persons with disabilities, and other groups." HHS has an obligation to ensure that any state benchmark plan should, as the ACA indicates, provide an "appropriate balance" among the 10 categories. In addition to their scope and definition, the proposed benchmark plans must also adhere to nondiscrimination standards in benefit design, including cost sharing.

It is important to note, however, that Section 1557 of the Affordable Care Act additionally prohibits discrimination on the basis of race, color, national origin, sex, age and disability in health programs or activities that receive federal financial assistance, are administered by an Executive agency, or were established by Title I of the ACA.

The Bulletin does not suggest how HHS will evaluate benchmark plans to ensure these requirements are met. HHS should develop a transparent process to evaluate whether states, in choosing the benchmark, are complying with the associated requirements.

In addition, the Bulletin does not address a number of logistical questions that states need to answer in order to move forward and that will directly affect consumers. For example, the approach proposed by HHS does not indicate who has the authority or jurisdiction to decide the benchmark. Presumably states will have to pass legislation so that applicable plans operating in the small group and individual insurance markets (including those outside of an exchange) are required to provide the state's benchmark benefits. A state's Exchange Board or similar entity as well as the Governor or Insurance Commissioner may have a role or related authority. Early reactions to the Bulletin from state consumer advocates suggest a significant amount of

uncertainly on how to proceed at the state level. During the process to determine a state benchmark, HHS should require states to offer a transparent process with ample opportunities for public comment and stakeholder engagement. Consumers should have the ability to review proposed benchmarks and provide comments.

6. State Benefit Mandates

The Bulletin suggests an approach for state mandates indicating that should a state select a benchmark plan for which those state mandates apply, the federal government will assume the costs of those mandates for two years during a transition period. HHS indicates it will evaluate this transition period and propose an additional process for state mandates in 2016. However, the Bulletin does not provide guidance on defraying the cost of mandates for states that do not pick a benchmark plan for which those mandates apply. It also does not indicate how the cost of additional mandates will be determined, in particular mandates for services that in the long-run reduce rather than increase costs.