



January 31, 2012

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

Re: Essential Health Benefits Bulletin, Center for Consumer Information and Insurance Oversight (CCIIO)

Dear Secretary Sebelius:

Voices for America's Children submits the comments below in response to the Health and Human Services' (HHS) "Essential Health Benefits Bulletin" ("Bulletin") issued December 16, 2011. We are the nation's largest network of multi-issue child advocacy organizations.

Ensuring a robust and comprehensive EHB package is critically important for children, especially those who are lower-income and/or have special health care needs. Because the private insurance market has not historically provided benefits sufficient to meet children's health needs (as it is geared more towards the needs of employers), HHS must aggressively define the EHB package for children and cannot rely on the sufficiency of the existing benchmark options outlined in the Bulletin. HHS should look to Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program to strengthen the Bulletin and form the foundation for the EHB package for children.¹ While we recognize that the CHIP program has helped children and is referenced in the Bulletin, it should not be the benefit model for lower-income children because it offers inadequate coverage; Medicaid's EPSDT standard for low-income children's benefits is the only one that meets the needs of these vulnerable children.

Because it will serve millions of families living in or near poverty, the EHB standard will be relevant to many low-income children. It is well established that low-income children are more likely to have poorer health than other children.² Low-income children have a higher prevalence of special health care needs and conditions such as obesity, asthma, and attention deficit hyperactivity disorder.³ Low-income children are also at greater risk for extreme prematurity, oral health problems, elevated blood lead levels, and behavioral health problems, all of which can cause long-term disabilities and limitations.⁴ Moreover, children's health care needs are different from adults', making it unlikely that children will be well served by a standard designed primarily to meet the lesser health needs of higher-

¹ See AMERICAN PUBLIC HEALTH ASSOCIATION, MEDICAID, PREVENTION AND PUBLIC HEALTH: INVEST TODAY FOR A HEALTHIER TOMORROW (2005), at <http://www.apha.org/NR/rdonlyres/675F96CD-7701-4049-89BD-D96625A6A3BE/0/MedicaidReport.pdf>. The EPSDT Program provides comprehensive preventive health services, screenings, treatment, and follow-up care for children enrolled in Medicaid under age 21.

² See, e.g., Leighton Ku et al., Center on Budget and Policy Priorities, *Improving Children's Health: A Chartbook About the Roles of Medicaid and SCHIP* (2d ed. 2007).

³ See, e.g., Sara Rosenbaum & Paul H. Wise, *Crossing the Medicaid-Private Insurance Divide: The Case of EPSDT*, 26 HEALTH AFFAIRS, 382-93 (2007); C. Bethel et al, *National, State and Local Disparities in Childhood Obesity*, 29 HEALTH AFFAIRS, 347-56 (2010).

⁴ See, e.g., The George Washington University, *Comparing EPSDT and Commercial Insurance Benefits* (September 2005); Clarisa Ramirez, *Toothaches more likely in minority, poor, special needs children, study finds*, Medill Reports Chicago, Nov. 4, 2010.



income adult populations. The scope and content of the EHB package must therefore be specifically tailored to offer the necessary preventive screenings, developmental services, and treatments that each child requires to be as healthy and functional as possible.

Private insurance plans – like the benchmark plans proposed in the Bulletin – have historically failed to cover services that are critical for children's health. A study in the *New England Journal of Medicine* found that children in private plans are twice as likely to be *underinsured* as their counterparts in public programs.⁵ This is due in large part to the overall lack of emphasis on preventive care. Additionally, private insurers commonly employ a narrow definition of medical necessity, limited to services that diagnose or treat illnesses and are needed to restore normal functioning.⁶ Only limited rehabilitative services are covered, and habilitation services are not typically included at all. Oral and vision care coverage is also unusual. Such narrow definitions too often serve as a blunt tool used to draw sharp lines that deny the type of care that vulnerable children need to stay healthy and thrive.

For the reasons outlined above, HHS should take a prescriptive, rather than flexible, approach in setting the standard for children's health care. Medicaid's pediatric standard of coverage, EPSDT, should serve as the model for the scope and breadth of EHBs for children, including vision/oral care. EPSDT was developed specifically to meet the physical, emotional, and developmental needs of low-income children. EPSDT covers, for all children under the age of 21: medical screens according to a periodicity schedule (including a comprehensive health and developmental history), a physical exam, immunizations, lab tests, and health education; vision, hearing, and dental services; and the necessary treatments and services (consistent with the scope of benefits under the Medicaid Act, 42 U.S.C. 1396(d)(a)) to correct or ameliorate physical and mental illnesses.⁷ Using EPSDT as a model for essential pediatric benefits will ensure that plans are required to provide not only frequent screening and preventive measures, but also comprehensive treatment to correct or ameliorate physical and mental conditions, including chronic diseases and developmental conditions.

Additionally, Voices for America's Children is concerned about the future of state mandates. Because there are many state laws that currently mandate the coverage of services of importance to children, a failure to permanently incorporate those services into the EHB standard is likely to result in a dilution of covered services on which many children currently rely.

In particular, as HHS highlights in the Bulletin, coverage of ABA therapy for autism is currently mandated in 29 states, meaning that privately insured children in a majority of states currently have access to this important clinically proven therapy.⁸ This is a primary example of a mandate that occurs with high frequency and should therefore be included in the EHB standard so as to avoid widespread disruptions in care and untenable positions for states that have made informed policy judgments in response to children's health needs and should not face financial repercussions for doing so.

⁵ Michael D. Kogan et al., *Underinsurance among Children in the United States*, 363 *New Eng. J. Med.* 2010, 841-851, 845 (2010).

⁶ See, e.g., Rosenbaum & Wise, *supra* note 25, at 387-91.

⁷ 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). For further explanation, see, e.g., National Health Law Program, *Towards a Healthy Future: Medicaid Early and Periodic Screening, Diagnostic and Treatment Services for Poor Children and Youth* (2005).

⁸ U.S. DEP'T OF HEALTH & HUMAN SERVICES, *ESSENTIAL HEALTH BENEFITS BULLETIN 7* (2011).



Pediatric Services, Including Oral and Vision Care

Voices for America's Children recognizes the difficulty in determining how comprehensive benefits for children, including oral health services, will be designed and administered in a manner that balances comprehensiveness, affordability, and state flexibility. Particularly as it relates to a comprehensive pediatric-only dental benefit, the process of designing and administering the benefit is complicated by the lack of an appropriate benchmark within the private market.

As such, it is critically important for consumers that the value of the benefit be determined not only by the items and services that are covered but also by the structure and administration of the benefit within the Exchanges. Therefore, we offer three key recommendations to assist in the further refinement of EHB pediatric oral health regulations and the correlated regulations on the requirements of the establishment of the Exchanges:

- 1. Provide detailed regulatory guidance to states on the design of the pediatric dental benefit**
- 2. Assure the Exchange regulations provide consumers equitable affordability of oral health benefits regardless of issuer**
- 3. Allow and encourage states to provide cost-effective risk-based pediatric dental benefits**

Congress designed the pediatric dental benefit in ACA as an essential part of overall child health care by including it in Section 1302(b)(J) [pediatric services, including oral and vision care]. However, traditional commercial dental coverage is appropriately regarded and provided by employers as "dental *benefits*" to help defray the cost of dental care rather than "dental *insurance*" to spread risk across beneficiaries in a group. To ensure affordability for employers while covering a wide range of dental services, they feature limited benefits with high out-of-pocket expenses for individuals generated by copayments, annual and lifetime caps, exclusions, and substitutions. The Medical Expenditures Panel Survey (MEPS) reports that more than one third ($\approx 40\%$) of dental expenditures for commercially insured persons are paid out of pocket – a higher rate than for medical expenditures.

Today, roughly 98 percent of dental coverage in the private market is obtained through a separate policy distinct from medical coverage. Few examples of child-only coverage exist in the market, which adds to the unique challenge of defining the oral health component of the EHB. This challenge is further complicated by the fact that stand-alone dental plans are not explicitly required by ACA to meet the same standards for cost-sharing reductions or annual and lifetime caps as is required of qualified health plans. In addition, as a result of the law's definitions of "excepted benefits" and "minimum essential coverage," there is no tax penalty for families who choose not to obtain supplemental pediatric dental coverage.

Furthermore, families within the identified income category who choose not to buy dental coverage for their children would be allowed to apply all out-of-pocket dental expenses toward the limits to receive cost sharing reductions. Without parity in how the dental benefit is defined and administered in an Exchange, there is tremendous uncertainty about out-of-pocket expenses incurred by families and ironically, the law may create an incentive for some families to forgo supplemental dental coverage for their child in order to apply dental costs to their capped out-of-pocket expenditures.

Voices for America's Children appreciates that the pediatric dental benefit is one portion of the larger set of essential health benefits. However, given the lack of child-only dental plans in the market, without additional clear guidance from HHS, the benefit could become meaningless. Therefore, we recommend that HHS provide detailed guidance to



states on the definition of services that must be provided in the pediatric dental benefit. In addition to service categories, basic information outlining the age of a child that maintains their “pediatric” status for dental benefits is needed.

Both the National Association of Dental Plans and the Delta Dental Plans Association recognize that CHIP is the only market in which child-only policies are regularly offered.⁹ As a result, the benchmark standards outlined in the Bulletin are of little value to states without further guidance. With the lack of child-only plans in the market, states need additional information from HHS on how to proportion existing adult/family benefits that accurately reflect the cost of pediatric-only coverage. CMS has yet to clarify this issue within CHIP, as regulations for the CHIP dental benefit required by CHIPRA are not expected to be released until Spring 2012.

Unlike ACA though, CMS has already stated in a 2009 State Health Official letter that CHIP requires the equivalent to one of the three dental benchmark packages in the CHIPRA statues and is not allowed to provide actuarial equivalence or a modified benefit package.¹⁰ Therefore, further clarification will also be needed from HHS if a state determines to use CHIP as the pediatric dental benchmark for EHB.

The design of the EHB is inextricably linked to the establishment of the Exchange. Therefore, we recommend that HHS address the lack of parity in pediatric dental coverage in the Exchange regulations to ensure the affordability and comprehensiveness of the EHB. Stand-alone dental plans are required to meet the requirements of section 18022(b)(1)(J), which means that they must offer the same children’s oral care benefits as health plans offering essential health benefits package. Unfortunately, stand-alone dental plans are not required to provide the same consumer protections as health plans in the areas of cost-sharing reductions, annual caps, and lifetime limits, among others.

These consumer protections, however, are an inextricable part of the essential health benefits package as the value of a benefit is determined not only by which items and services are covered, but also by how those services are covered and how the benefit is structured. If reduced cost-sharing is available for children’s oral care benefits under a qualified health plan but not under a stand-alone dental plan, those two plans do not actually offer the same children’s oral care benefit, even if the plan otherwise cover the same items or services. We suggest that the only way to create parity among dental benefits (regardless of the carrier through which they are provided) in the Exchange(s) is to require that all plans provide the same relevant consumer protections in order to be certified to offer benefits on the Exchange. Specifically, we recommend that the following “consumer protections” and “cost sharing protections” apply to all pediatric dental benefits.

- coverage of recommended preventive services without cost-sharing
- applicability of cost-sharing reductions
- elimination of annual caps
- elimination of lifetime limits

⁹ National Association of Dental Plans and Delta Dental Plans Association. *Offering Dental Benefits in Health Exchanges: A Roadmap for Federal and State Policymakers*. September 2011, available at: <http://www.nadp.org/Advocacy/HealthCareReform/ExchangeWhitePaper.aspx>.

¹⁰ Centers for Medicare and Medicaid Services (CMS), *Dear State Health Official Letter*, October 7, 2009, SHO#09-012, CHIPRA #7.



Providing regulatory clarity for existing models of dental coverage is essential. However, Voices for America's Children also recommends that HHS allows and encourages states to provide cost-effective risk-based pediatric dental benefits. On September 27, 2011, the Children's Dental Health Project forwarded a letter to Secretary Sebelius signed by 55 organizations and 39 dental benefit companies supporting a pediatric dental benefit that reflects current science, best practices and professional recommendations.¹¹ Additionally, 42 of the nation's dental school deans (more than two thirds) sent a letter to the Secretary similarly calling for a comprehensive and risk-based dental benefit for children that aligns with current teaching. Such a benefit supports early, timely, and ongoing oral health care (preventive and corrective) that is tailored to a child's level of risk and needs.

While Voices for America's Children recognizes that the EHB regulations will not likely provide this level of detail, we have identified companies that are prepared to provide this type of benefit that emphasizes health promotion and disease management instead of dental repair and can be administered at a lower cost than the benchmarks outlined in the Bulletin. We are also fully aware that some dental insurers are eager to provide a dental benefit that provides only an oral health screening by a medical professional and limited fluoride supplements with the opportunity to buy additional coverage through a family plan.¹² We oppose such a "skinny" benefit as failing to meet children's basic needs and, support flexibility for dental benefits companies to offer a cost-effective, evidence-based benefit that is sensitive to children's various levels of risk. Future regulations would need to provide the flexibility and the incentive to those companies to participate without creating a race to the bottom.

States should have additional options for pediatric vision care, as well. Current employer-based plans, including the FEDVIP, 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 needed as they grow.

The ACA places particular emphasis on children's needs by making pediatric services, including oral and vision care, one of the ten required categories of essential health benefits. By including it as a required category of benefits, Congress signaled its intention that children should receive an additional set of benefits beyond that provided in the other nine categories. Those additional benefits include, but are not limited to, oral and vision care. The ACA's legislative history makes it clear that oral and vision care were added to supplement other pediatric services provided under the category, not to limit pediatric services to only those two types.

The Bulletin, however, references only oral and vision care when discussing this category. Children, though, depend on other pediatric services that do not fall into the other nine required categories. As they grow and develop, children's needs differ from those of older health care consumers. For instance, a growing child may require a new wheelchair or other durable medical equipment on a much more frequent schedule than is provided for in an adult benefit package—a new wheelchair every five years would not be adequate for a child.

¹¹ Essential Benefit sign-on letter. September 2011, available at: http://www.cdhp.org/resource/dental_benefit_consensus_letter_secretary_sebelius.

¹² National Association of Dental Plans and Delta Dental Plans Association. *Offering Dental Benefits in Health Exchanges: A Roadmap for Federal and State Policymakers*. September 2011, available at: <http://www.nadp.org/Advocacy/HealthCareReform/ExchangeWhitePaper.aspx>.



In addition, children may require speech therapy to ensure that their development is optimized. As they develop, children also need preventive and supportive services more frequently to ensure they have the tools to maintain or improve their health well into adulthood. These 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 these types of care. Moreover, HHS must explicitly define pediatric services as including these types of care so that states can determine whether benchmark plans cover them and thus whether they must be added when setting essential health benefits.

In conclusion, below are our recommended regulatory approaches for HHS to consider.

❖ ***Recommended Regulatory Approach***

- HHS should take a prescriptive, rather than flexible, approach in setting the standard for children's health care.
- Valuable state mandates securing access to critical services for children should be included in the EHB definition.
- CMS must clarify its regulations on the CHIP dental benefit as required by CHIPRA.
- It is important to provide detailed regulatory guidance to states on the design of the pediatric dental benefit.
- There is the need to assure the Exchange regulations provide consumers equitable affordability of oral health benefits, regardless of issuer.
- HHS should allow and encourage states to provide cost-effective risk-based pediatric dental benefits.
- Medicaid's pediatric standard of coverage, EPSDT, should serve as the model for the scope and breadth of EHBs for children, including vision/oral care. This includes EPSDT's broader medical necessity definition, which is critical to ensuring healthy childhood development.
- The outlined approach regarding potential benchmarks for pediatric oral and vision care should be strengthened, so that states have the option of using the children's Medicaid benefit as a benchmark.

Voices for America's Children appreciates the opportunity to comment on the Essential Health Benefits Bulletin. We hope that HHS will find our comments useful.

Sincerely,

A handwritten signature in black ink, appearing to read "William H. Bentley", written in a cursive style.

William H. Bentley
President and Chief Executive Officer