MEMORANDUM

To: Center for Consumer Information & Insurance Oversight,
U.S. Department of Health & Human Services
via email to EssentialHealthBenefits@cms.hhs.gov

From: Colorado Division of Insurance & Colorado Health Benefit Exchange

Re: Comment Responding To Essential Health Benefits Bulletin (December 16, 2011)

Date: January 30, 2012

The following comments are submitted in response to the December 16, 2011 Essential Health Benefits ("EHB") Bulletin ("Bulletin") issued by the U.S. Department of Health and Human Services. They are a joint submission on behalf of the Colorado Division of Insurance ("DOI") and the Colorado Health Benefit Exchange ("COHBE"), with support from the Office of Governor John Hickenlooper. In compiling the following comments and questions, DOI and COHBE engaged stakeholders statewide, including representatives of health plans, providers and health facilities, employers, patient advocates, and consumers. Collectively, our aim is to develop a process for Colorado that provides our citizens with the best options for health insurance, both inside and outside of our state-based Exchange.

The Bulletin and subsequent HHS guidance indicates that each state shall select a benchmark plan from among several HHS-mandated options, including:

(1) The largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;
(2) Any of the largest three State employee health benefit plans by enrollment;
(3) Any of the largest three national FEHBP plan options by enrollment; or
(4) The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

The plan selected will serve as the foundation for creating a statewide EHBP that will be applicable both inside and outside of the Exchange. As Colorado goes through the process of defining an EHBP for our state, we urge HHS to act with expediency in their guidance and clarification related to EHB questions raised in reaction to the bulletin so that we, along with other states, can move forward as we are ready.

I. IN AN EFFORT TO DETERMINE AN APPROPRIATE BENCHMARK PLAN FOR THE STATE'S ESSENTIAL HEALTH BENEFITS PACKAGE ("EHBP"), COLORADO REQUESTS THE FOLLOWING:

A. THE ABILITY FOR STATES TO RETAIN FLEXIBILITYAND ENCOURAGE INNOVATION AS BENCHMARKS ARE SELECTED AND IMPLEMENTED

The Bulletin instructs states to select a benchmark plan by the third quarter ("Q3") of 2012, and the benchmark selected should be based on plans in existence in the first quarter ("Q1") of 2012. Colorado is concerned that innovation in benefit design, payment structures, and healthcare delivery will be limited through the use of this "snapshot" model.

We are also concerned with our ability to ensure that benefits comprising the EHBP meet up-to-date evidence-based standards and our continued flexibility to modify the EHBP as those standards evolve. HHS should provide additional information addressing the amount of leeway states will have to make adjustments to the selected benchmark and EHBP, once established. Additionally, Colorado asks for more clarity as to whether or not states that are committed to innovation and updated evidence-based standards will have to bear the burden of additional costs once the EHBP is established.

B. GRANT STATES THE FLEXIBILITY TO DETERMINE THE PROPER ASSESSMENT OF CURRENT ENROLLMENT IN BENCHMARK OPTION PRODUCTS AND PLANS

It is our understanding that the federal Health Information Oversight System (HIOS) will be releasing data in February 2012 related to insurance product enrollment, and that this data may be used by states that do not currently track enrollment independently with information to facilitate their benchmark selection. The Bulletin is unclear as to whether states will be *required* to use the HIOS data, or if using the HIOS data is optional. Colorado requests flexibility to supplement HIOS information, if necessary, with existing data collected at the state level. This will enable decision makers in Colorado choose the best benchmark option for our market.

There are a number of methods that may be used to determine product and plan enrollment. As just one example, should the "three largest products" be interpreted to mean the largest product from each of the three largest carriers, or simply the three largest products in the state, even if all three are offered by the same carrier? Has HHS considered developing guidelines to standardize the method states should use? Has HHS engaged outside organizations, such as NAIC, or state-level officials to develop consistency across state lines?

C. CLARIFY DEFINITIONS OF KEY TERMS

The Bulletin did not provide precise definitions of several key terms, nor did it fully describe some of the benchmark options available to states. It is imperative that state-based stakeholders have a consistent understanding of these terms and options, as well as their respective applicability and scope.

The Bulletin's use and reference to the terms "product" and "plan" seem to differ from common use of those terms in the commercial insurance industry. Although the Bulletin

describes "products" as "the services covered as a package by an issuer, which may have several cost-sharing options and riders as options" and a "plan" as that which "refers to the specific benefits and cost-sharing provisions available to an enrolled consumer," it was our interpretation that cost-sharing would be part of the assessments regarding actuarial value, rather than part of the EHBP decision making process. With these definitions in mind, each benchmark option would appear to require an analysis of enrollment at both the product and plan levels. If this is accurate, has HHS collected enrollment data at both of these levels?

D. GRANT STATES THE FLEXIBILITY TO SELECT AN ALTERNATIVE BENCHMARK OPTION

The Bulletin does not provide enough information on options and the flexibility available to states.

First, the Bulletin does not address whether separate benchmarks may be selected for the individual market and the small group market. Many interpretations of the Bulletin have thus far assumed that a state must select only one. HHS should clarify requirements in this regard. Currently, it seems a state could select two separate benchmarks to address the inherent differences between the individual and small group markets. However, having two separate benchmarks is likely to complicate administration and further bifurcate these two market segments.

Second, one of the benchmark options is "the largest commercial non-Medicaid" HMO in the state. The benchmark option does not appear to restrict the market segment from which the largest HMO must be selected. Thus, could a state select the largest HMO in any of the individual, small, or large group market segments?

Third, Colorado is concerned with needlessly duplicating existing survey methodologies. May states look to the "most sold" products and plans rather than "lives covered" enrollment data? We have developed our small group basic and standard benefit plans through a process under state statute in C.R.S. 10-16-105 (7.2) and the required basic and standard benefit plans are set forth in Insurance Regulation 4-6-5 (and revised biennially). May the state have the flexibility to accommodate its current market needs by selecting one of these plans?

II. COLORADO REQUESTS MORE INFORMATION FROM HHS TO ENSURE SUFFICIENT COVERAGE LEVELS WITHIN AND ACROSS THE TEN MANDATE CATEGORIES

Without a comprehensive understanding of federal minimum standards and their concomitant cost obligations for states, it will be impossible for states to assess the scope of benefits contained in potential benchmarks. Therefore, Colorado strongly urges HHS to simultaneously provide minimum standards for the ten mandate categories specified in Section 1302(b) of the Affordable Care Act ("ACA mandates"). It would be very helpful to states for HHS to issue a calendar of anticipated regulatory decisions that outlines both content and deadlines HHS will be issuing regarding EHBs.

The Bulletin reiterates the ACA mandates; however, the Bulletin provides no additional guidance regarding the scope of each mandate category. Colorado seeks to balance three issues as it develops an EHBP: 1) providing adequate coverage for consumers; 2) maintaining affordability for consumers, 3) avoiding fiscal burdens on the state budget. It is very important for Colorado – and for all states – that the EHBP reflect an adequate balance between coverage and cost. HHS should remain mindful of this guiding principle in all decisions regarding EHB regulations that will apply to states.

Of particular concern, the Bulletin does not contain any information defining the extent to which a state's EHBP must cover each ACA mandate. However, the language and intent of the ACA clearly indicate that some type of federal minimum standard ("FMS") further defining the ACA mandates is necessary. Without information regarding the FMS, states face the challenging task of assessing and comparing existing state mandates and potential benchmark plans with the FMS. We need to be able to identify the minimum and any maximum boundaries of the ACA mandates.

Fiscal impacts on the state are also of concern; as such, additional information regarding the FMS is essential and time-sensitive. Colorado hopes that HHS will, at a minimum, provide additional information regarding the scope of the ACA mandates and FMS, so that the state may engage in a reasonable comparative assessment.

III. IN AN EFFORT TO RECONCILE EXISTING STATE LAW WITH FEDERAL REQUIREMENTS, COLORADO REQUESTS GUIDANCE AND FURTHER CLARIFICATION FROM HHS RELATED TO:

A. THE INTEGRATION OF EXISTING MANDATES INTO THE STATE EHBP

In Colorado, not all mandates apply across all segments of the insurance market; many mandates apply only to the small group market, for example. Will states be allowed to supplement a mandate-exempt benchmark with existing state mandates, and if so, will states be required to pay additional costs? On the other hand, if a state selects a benchmark plan that includes existing state mandates, will these be "grandfathered" into the EHBP and applied to market segments that do not currently include them?

What if a state can demonstrate that the net cost of a particular mandate is budget-neutral? If a state mandate is added after the EHBP is determined, when will the state begin to incur these costs and what will the cost structure be? Will these costs apply equally to subsidy-eligible and subsidy-ineligible individuals in the Exchange as well as private purchasers outside of the Exchange?

Colorado would also like clarification of what type – if any – limits may be placed on benefits. For example, although the ACA prohibits maximum benefit levels, is there any way for a state to retain existing benefits that include a set number of annual visits or treatments in order to control costs? Will states – or health plans – have the ability to modify state-mandated benefits with actuarially equivalent alternatives to comply with the ACA? Colorado requests that HHS clearly outline areas in which states will retain flexibility to set limits related to benefits.

B. ALIGNMENT OF STATE AND FEDERAL LAW TO ENSURE STATE EXCHANGE CERTIFICATION

It is important for Colorado to evaluate existing state law in comparison with ACA requirements. In that analysis, it is possible that elements of existing Colorado law will be determined to be inconsistent with portions of the ACA and associated federal regulations. As we work to develop an EHBP that best suits the needs of Colorado residents, we are concerned that these potential inconsistencies will impact our Exchange's ability to be federally certified. Colorado would encourage HHS to collaborate with states on a plan to reconcile inconsistencies that may impact the Exchange certification process.

IV. COLORADO REQUESTS TIMELY INFORMATION THAT WILL ENABLE COLORADO TO DEVELOP A TIMELINE FOR 2012-2015 AND CREATE A STRATEGY FOR 2016 AND BEYOND

As outlined in the Bulletin and discussed in Section I-A above, a benchmark plan must be selected in Q3 2012, and the subsequent EHBP that results from the benchmark selection will be in effect in 2014 and 2015. The Bulletin indicates that these two years will serve as a "transitional period" for the benchmark approach, which will be reevaluated in 2016. Colorado is concerned that if the selection of an EHBP is not completed early in Q3 2012, the state will not have sufficient lead time to reconcile plan benefits and meet certification deadlines to be sold on the Exchange. Colorado would like more specific information on when the state-selected EHBP is to go into effect and urges HHS to act with expediency so that states are able to move forward as soon as they are ready.

Specifically, when will benefits in the EHBP need to be finalized by the state? What will the process be for ensuring that a state's defined EHBP meets the FMS? Will the EHBP become effective for subsequent plan years following the state's finalization of the EHBP, or will it go into effect across-the-board on January 1, 2014?

Additionally, once the transitional period is over, what does HHS envision for a regulatory framework beyond 2015? When will HHS' plans for 2016 and subsequent years be articulated? Due to the resource requirements, complexities, and timelines involved in plan design and insurance oversight, Colorado requests additional information on HHS' plan beginning in 2016 as soon as possible.