Bobby Jindal
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of the Secretary

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

September 27, 2012

Dear Secretary Sebelius,

The State of Louisiana is writing you concerning the selection of an essential health benefit benchmark plan for the State.

On December 16, 2011, the Center for Consumer Information and Insurance Oversight (CCIIO) released a document entitled "Essential Health Benefits Bulletin." This document stated a proposed approach to define the essential health benefits for a State's individual and small group market, as required by Section 1302(b) of the Patient Protection and Affordable Care Act (PPACA). This proposed approach allows for States to select a benchmark plan from products currently on the state and federal insurance markets. The bulletin states:

> *"**[W]e intend** to propose to use enrollment data from the first quarter two years prior to the coverage year and that States select a benchmark in the third quarter two years prior to the coverage year* [note: which ends September 30, 2012 for coverage year 2014]…. *If a State does not exercise the option to select a benchmark health plan, **we intend** to propose that the default benchmark plan for that State would be the largest plan by enrollment in the largest product in the State's small group market."*

Essential Health Benefits Bulletin, p. 9 (emphasis added)

Following the release of this guidance, a frequently asked questions document was released on February 17, 2012 to address questions on essential health benefits. Of significant note is that neither of these documents has the force of law, nor commits federal regulators to any particular course of action.

The State of Louisiana has done its due diligence to review all guidance issued by CCIIO, the Centers for Medicare and Medicaid Services (CMS), and the Department of Health and Human Services (HHS) concerning the essential health benefits and has consistently requested further guidance through formal rulemaking. With the essential health benefits package, regulations have been non-existent. It is apparent that the federal government does not appreciate the urgency of clear rules regarding an issue that will transform the private insurance market in each of the respective states on January 1, 2014.

For over a year, HHS has told States that a proposed rule on essential health benefits would be coming "soon." As the months have passed there still is no sign of formal rulemaking regarding this issue. States have every reason to be concerned that HHS can change this approach through the formal rulemaking process. HHS representatives have already alluded to the potential for changes in the area of pharmaceuticals just as one example.

It is unreasonable for the federal government to ask the States to comply with a deadline on determining a benchmark plan when the federal government had not even formalized the procedure. However, in order to point out the potential problems the state could have implementing this particular piece of the PPACA, the state of Louisiana attempted to do so. Louisiana identified the three largest small group products in the market, collected benefit information on those products, made a comparison of the benefits offered, and participated in all informational sessions on the subject. Working with the limited guidance provided, the State of Louisiana attempted to evaluate the best benchmark plan option for the State's residents. Some of the inadequacies in the guidance provided so far include:

- **Lack of Plan Information**. While HHS identified and provided an illustrative list of the three largest products in each State ranked by enrollment in the small group market along with the largest three nationally available Federal Employee Health Benefit Program (FEHBP) plans on January 25, 2012 this information was based on the "product" rather than "plan" level. Plan information is necessary because it provides more detailed information as to the scope of benefits covered under the respective plan. Only on September 14, 2012, two weeks prior to the end of the third quarter of 2012, HHS released specific plan information to the States to assist in their efforts to select a benchmark plan. Clearly, this did not allow states enough time to analyze the plan information provided when comments were due less than a week after the States received such information.

- **Lack of Clear Definitions of Service Categories**. How will the category "habilitative services" be defined since this term appears to be used differently in the private market and Medicare? The frequently asked questions document released on February 17, 2012 provides two possible approaches, neither of which has been formalized in rulemaking.

- **Supplementation of Services**. How will supplementation take place relative to habilitative care, pediatric oral care and pediatric vision care? Although comments were solicited, no further guidance has been released by HHS leaving it unclear for states as to how to define or supplement these areas.

- **Substitution of Categories**. Will HHS allow health plans to substitute across benefit categories? And if so, will HHS require that such substitution be subject to a higher level of scrutiny in order to mitigate the potential for eliminating important services or benefits in particular categories? Since plans are allowed to perform actuarially equivalent substitutions that may vary from the EHB, are States required to accept such substitutions? That is, can a State modify these substitutions through limitations or restrictions?

- **Payment of State Mandates**. If a State selects a benchmark plan that does not contain all or some of the State mandates, the State would be required to "defray" the costs of those mandates outside the EHB package for qualified health plans. HHS has not indicated how these mandates are to be paid by the State or even how the cost of the mandates will be calculated.

- **Future of the Essential Health Benefits Package**. HHS indicated that it "intends" to evaluate the benchmark approach for the calendar year 2016 and will develop an approach that may exclude some State benefit mandates from inclusion in the State EHB package. HHS has not provided states with any standards that it intends to use to make such evaluation, the approach it will take to exclude certain state mandates in the EHB package, or even if the benchmark approach for essential health benefits will continue past 2015.

After considerable time and effort, it was determined that the State lacks the significant information necessary to evaluate what would be the best possible benchmark plan for Louisiana's essential health benefits.

Furthermore, it is our State's conclusion that while the bulletin states a decision is to be made by the third quarter of this year, this "deadline" has never been formalized through the official rulemaking process. As long as formal rules do not exist, the federal government can change its approach. Since the federal government is not bound by these bulletins, neither are the States. As such, the State of Louisiana is not legally required to submit a benchmark preference by the end of the third quarter of 2012. The State of Louisiana will not permit the federal government to dictate to our residents a default benchmark plan, as the federal government, in its disregard of the requirements of the Administrative Procedure Act regarding essential health benefits and other provisions of the PPACA, has no authority to do so under federal or Louisiana law until regulations are published in the Federal Register, following established notice and comment procedure.

As stated on the CMS website, previous bulletins were "used to communicate with states and other stakeholders interested in Medicaid and CHIP… communications do not establish new policy; they are designed to highlight recently released policy and regulations and also to share important operational and technical information." The process developed for defining the essential health benefit benchmark has been a completely new method of establishing law without proper rulemaking. Implementation of new policies without open and public comment and publication in the Federal Register is in clear violation of the law. The pre-rule bulletin has been out since December, providing more than an adequate amount of time to begin the process of formal rulemaking with an open comment period.

The essential health benefits issue is one of many issues with the implementation of the Patient Protection and Affordable Care Act (PPACA). The administration has charged states to build what the federal government mandates, but the federal government has provided informal guidance and incomplete rules and regulations. No state, even those fully embracing implementation of what we

believe to be an overall bad policy, could possibly determine an essential health benefits package with the guidance currently provided. Accordingly, there will be no essential health benefits package for the State of Louisiana, and we will pursue all avenues to prevent the federal government from selecting one on behalf of the state.

Sincerely,

Bruce D. Greenstein
Secretary
Department of Health and Hospitals

James J. Donelon
Commissioner
Department of Insurance