

ISSUE BRIEF

ESSENTIAL HEALTH BENEFITS



Health care reform mandated that by 2014 adults will need to purchase health insurance or face a tax penalty. To help individuals decide what type of plan to purchase, health insurance exchanges will be set up by states to provide a one point “stop and shop” for the public. The exchange is technically not an actual place but will more likely be a virtual market place where individuals can go online or to a county or state office and browse insurance offerings based on personal criteria they identify such as age, health status, and other personal characteristics. Health plans sold in the exchange (which targets the individual and small group market) must cover federally mandated essential benefits.

Essential benefits refer to what the plans will actually offer in coverage, as a baseline for services, treatments, etc. It is a starting point or base line for health insurance plans. It is important to note that the law exempts large-group health plans, as well as self-insured ERISA plans and ERISA governed multiemployer welfare arrangements from the essential benefit requirements. Be aware of the type of plan you have to determine what parts of the law apply.

These are the general essential health benefit categories required by law: Emergency services; Hospitalization; Maternity and newborn care; Mental health and substance use disorder services; Prescription drugs; Rehabilitative and habilitative services and devices; Laboratory services; Preventive and wellness services; Chronic disease management; Pediatric services, including oral and vision care.

After the health care reform law was passed, the Department of Health and Human Services instructed the Institute of Medicine (IOM) to do a study on how the essential benefits should be designed. The IOM provided recommendations on various items including how benefit packages should be developed, updated over time, coverage decisions and defining medical necessity. Then in December 2011, the Department of Health and Human Services decided to issue “guidance” to states instead of a regulation to give them parameters on establishing essential health benefits. The guidance allows states more flexibility in determining essential health benefits.

HFA interprets the word “essential” as any medical treatment, procedure, service, as well as equipment and supplies indicated and approved by the United States Food and Drug Administration (FDA), for the care of patients with that specific diagnosis or follows generally accepted medical standards. We recommend that states take the following into consideration when evaluating what will be included in essential benefits:

- ✓ STANDARDS OF CARE
- ✓ COMPREHENSIVE CARE
- ✓ MEDICAL NECESSITY DETERMINATIONS, APPEALS, AND GRIEVANCES PROCESSES
- ✓ LIMITS ON BENEFITS
- ✓ STATE MANDATES
- ✓ UPDATING ESSENTIAL HEALTH BENEFITS
- ✓ COST SHARING

ISSUE BRIEF

STANDARDS OF CARE

For patients with rare and chronic conditions such as bleeding disorders, essential health benefits should be based on medical literature and treatment guidelines recommended by medical and patient organizations. An example of such a standard for individuals with bleeding disorders is MASAC #188 from the Medical and Science Advisory Committee at the National Hemophilia Foundation. This standard of service for pharmacy providers could be identified as a minimum expectation for any insurer contracting with a pharmacy to provide Factor concentrates for home use to patients with bleeding disorders.

COMPREHENSIVE CARE

The essential benefit package should allow patients access to needed specialists and allow the physician to formulate the best treatment regime for patients at the appropriate site of care whether in the hospital, outpatient clinic, office of the physician, hemophilia treatment center (HTC) or the home setting. It is important to note that specialized treatment facilities, such as the federally recognized hemophilia treatment centers (HTCs), do not fit neatly into specific categories of services. HTCs provide comprehensive, multi-disciplinary services in a single setting, and have been shown through research at the Centers for Disease Control (CDC) to improve quality and reduce morbidity and mortality of individuals living with bleeding disorders. Allowing access to comprehensive care centers such as these ensures that the most appropriate balance of care is provided to the patient by medical professionals.

MEDICAL NECESSITY DETERMINATIONS, APPEALS, AND GRIEVANCES

Requirements for plans to use medical necessity criteria should be objective, clinically valid, and compatible with generally accepted principles of care. The essential benefits package should always include a process to appeal a claim denial. That process should provide assurance that the insurer has an obligation to consult the patient's physician to discuss a possible denial and the grounds for that decision. States should perform plan oversight to ensure a manageable process and a system to track grievances.

LIMITS ON BENEFITS

HFA opposes additional limits on specific or total benefits in the package. We recommend prohibiting the implementation of treatment caps, prior authorization, utilization management or other restrictions by cost or in limits on treatments (in particular those approved by the FDA).

STATE MANDATES

State mandates have been invaluable to rare, chronic and high-cost disease groups, who might otherwise be excluded from private coverage. Any decision to phase out a state mandate must be informed by possible disruptions in coverage that might ensue.

UPDATING ESSENTIAL HEALTH BENEFITS

As advances in medical evidence or scientific advancement are being uncovered and approved through the FDA, as well as peer reviewed medical journals stating the improved or decreased health outcome, HHS must put in place expeditious pathways for the inclusion of new therapies and treatments in the essential benefits package when these new products or new information become available.

ISSUE BRIEF

COST-SHARING

It is vital for patients with rare diseases to choose a health insurance policy that will meet their unique needs. Individuals with bleeding disorders rely on expensive therapies otherwise known as biologics -where there are no generics available. Therefore, plans should be required to disclose all information about the deductible, co-payment and co-insurance amounts that are applicable to in-network and out-of-network covered services as well as any limitations on services. In addition, specialty tier pricing for prescription drugs should be prohibited and/or plans should offer protections for these high out-of-pocket costs by providing tiering exceptions. States should provide an oversight mechanism to review plan benefit design ensuring that cost-sharing does not discriminate or unfairly target any patients or rare disease groups.

If followed, the above recommendations will result in essential health benefits that **promote quality, affordable care for the bleedings disorders community and for our nation.**

RESOURCES

Healthcare.gov: <http://www.healthcare.gov/glossary/e/essential.html>

Families USA: <http://www.familiesusa.org/health-reform-central/>

Kaiser Family Foundation: <http://healthreform.kff.org/>

Commonwealth Fund: <http://www.commonwealthfund.org/Topics/Health-Policy-Reform.aspx>