FamiliesUSA
The Voice for Health Care Consumers

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How Can We Establish an Essential Health Benefits Package That Meets Consumers' Needs?

Speak up at a Department of Health and Human Services Regional Listening Session!

The Department of Health and Human Services (HHS) is currently holding 10 regional listening sessions throughout the country on the important question of what benefits health plans should be required to cover as part of an "essential benefits package" under the Patient Protection and Affordable Care Act (Affordable Care Act). It will be important to have input from consumers and consumer advocates at these sessions. You can find information on a hearing near you by going to the following website: http://ccf.georgetown.edu/index/cms-filesystem- action?file=finishline%20private/resources/events/ regional-listening-sessions.pdf. We also encourage consumers and advocates to submit written comments to HHS.

HHS is soliciting comments on the five questions listed below, for which we provide talking points:

1. What models should HHS consider in developing essential health benefits?
2. In keeping with the title of the Institute of Medicine report "Essential Health Benefits—Balancing Coverage and Cost," how can HHS best balance the dual goals of comprehensiveness of coverage and affordability?
3. How might HHS ensure that essential health benefits reflect an appropriate balance among the categories so that they are not unduly weighted toward any single category?
4. What policy principles and criteria should be taken into account to prevent discrimination against individuals because of their age, disability status, or expected length of life—as the Affordable Care Act requires?
5. What criteria should be used to update essential health benefits over time and what should the process be for their modification?

This document provides background information and suggested talking points to use in HHS regional listening sessions.

Background Information

What is the Essential Health Benefits package?

Beginning in 2014, health plans that are newly sold in the individual and small group market and all plans sold through exchanges, as well as Medicaid-benchmark plans and Basic Health Program plans, will be required to cover a package of essential benefits. This essential health benefits package establishes a coverage floor among all of these different plans. The Affordable Care Act states that the essential health benefits package must include at least the 10 categories of benefits specified in Section 1302 and listed below:

- ambulatory patient services
- emergency services
- hospitalization
- maternity and newborn care
- mental health and substance abusive disorder services
- prescription drugs
- rehabilitative and habiliative services and devices
- laboratory services
- preventive and wellness services and chronic disease management
- pediatric services, including oral and vision care[1]

Section 1302 also states, "The Secretary shall ensure that the scope of essential health benefits . . . is equal to the scope of benefits under a typical employer plan as determined by the Secretary."[2]

Summary of the Institute of Medicine's committee report on Essential Health Benefits

Last month, a report by the Institute of Medicine (IOM) made recommendations on how HHS should establish and update the essential health benefits package. The report was initiated at the request of HHS and conducted by the IOM Committee on Defining and Revising an Essential Health Benefits Package for Qualified Health Plans. While many of the recommendations provide valuable insight, they fall short of establishing a comprehensive package of benefits and do not address important issues like medical necessity. The report strongly emphasized a cost-driven approach to establishing and updating the essential health benefits package and recommended allowing state flexibility in the implementation of an essential health benefits package—policies that could limit the ability of the essential health benefits package to meet consumers' medical needs. The Secretary may depart from IOM's recommendations, so the listening sessions, as well as written comments, are important opportunities for advocates to weigh in.

Below is a summary of the IOM recommendations:

- Peg the initial cost of the essential health benefits package to a "premium target." The IOM specifically recommends a target based on the average cost of coverage for small employers in 2014.
- Have the Secretary establish a strategy to reduce health care spending growth across all sectors.
- Have the Secretary establish a framework for obtaining and analyzing the data necessary to monitor and update the essential health benefits.
- Allow for state-based innovation and flexibility. The report reads, "For states administering their own exchanges that wish to adopt a variant of the federal essential health benefits package, the Secretary should use statutory authority to grant such requests . . ."[3]

- Require benefit updates to the essential health benefits package to be evidence-based and not cost more than the target premium for the next year and be offset with tradeoffs of new and existing services.
- Have the Secretary, working in collaboration with others, develop a strategy for controlling rates of growth in health care spending across all sectors in line with the rate of growth in the economy.
- Establish a National Benefits Advisory Council (NBAC) that makes recommendations to the Secretary about changes to the essential health benefits package.

Talking Points

Many interested parties have pushed, and will continue to push, for a cost-driven approach to establishing the essential health benefits package, which can arbitrarily limit benefits. This would lead to an essential health benefits package that keeps consumers under-insured—making care unaffordable and out of reach for patients when they need it. Therefore, the process for determining and updating the essential health benefits package must also be driven by the need to make coverage comprehensive and benefits accessible.

I. The Affordable Care Act recognizes the need for a comprehensive benefit package without arbitrary limits that leave consumers under-insured

- **The essential health benefits package should be comprehensive:** Low- and middle-income households that either receive Medicaid benchmark benefits or receive premium and cost-sharing assistance for the exchange will gain new access to coverage under the Affordable Care Act—but they will not be able to afford benefits that are not covered by their plans. Therefore, the essential health benefits package must be comprehensive, so that consumers have access to the care they need.
- **The Secretary must define the benefit package based on established medical guidelines:** The Secretary must use established medical guidelines to determine the appropriate benefits to include in the essential health benefits under each category of care, ensuring that the scope of coverage in each category is medically appropriate. The Affordable Care Act requires that benefits not be unduly weighted towards any of the 10 required categories of benefits.[4] However, deciding if coverage for all categories is similar in scope will be difficult because benefits for different categories are often not comparable, as medical needs for each category vastly differ. Therefore, medical guidelines should form the basis for determining the scope of coverage in each required essential health benefits category.
- **The Secretary should prohibit arbitrary limits on the amount and duration of covered benefits:** Arbitrary limits on the amount and duration of covered benefits erect a significant barrier to consumers in need of medical care. If plans are allowed to place any limits on their coverage of essential benefits, the Secretary must set forth standards for determining benefit limits that are based on the latest medical evidence. The Affordable Care Act prohibits plans from placing annual and lifetime dollar limits on covered services. However, if plans may still limit, for example, the number of visits that they will cover for a particular service under the essential health benefits package, limits should not be arbitrary, but based on medical evidence and determined through a transparent, public process. If limits are established, a consumer-friendly and expedient appeal process must be available to allow these limits to be lifted if additional care is determined to be medically necessary.

- **The Secretary must define "medical necessity" and establish standards for medical necessity determinations that are based on the latest medical evidence:** The definition of medically necessary care should include care needed to regain, maintain, and maximize functioning. This principle is in keeping with the statutory requirement to provide habilitative services. Further, the Secretary should ensure that there is continued funding for consumer assistance services to help consumers file appeals if they believe that plans have not properly determined the medical necessity of their health care services.
- **The Secretary should provide funding for consumer assistance programs and provide support for navigators:** Consumers will need help understanding what plan best meets their medical needs. They will also need assistance understanding their coverage and filing grievances if they are denied care that they need. Ensuring comprehensive coverage and access to that coverage requires investments in consumer assistance and navigator programs to help consumers to address grievances when they arise.

2. The Affordable Care Act requires an appropriate relationship of the essential health benefits package to employer-based coverage

- **The essential health benefits package should initially be based on typical large employer coverage and include adequate benefits in all 10 categories:** HHS should model the essential health benefits package after typical large group coverage—not small employer coverage, as the IOM report on essential benefits recommends. While the lack of standardized language across plan documents makes it hard to establish what "typical" small and large employer coverage is, between the two it has been documented that large employer coverage typically has a wider scope of benefits and uses cost-sharing provisions that are less financially taxing on consumers.[5,6] Additionally, the majority of workers who receive employer-sponsored coverage work for firms with 50 or more people.[7] Therefore, large employer coverage is statistically the "typical" employer plan and therefore is what the Secretary should consider to comply with Section 1302 of the statute. Further, because the Medicaid benchmark plans will be affected by the essential health benefits package, HHS should also consider typical states' Medicaid benefit packages as a possible model for essential health benefits.
- **The Secretary should not employ a premium target to restrict benefits:** The IOM report recommends pegging the scope of the essential health benefits package to a "premium target" based on the estimated national average premium that would have been paidfor plan with the same actuarial value as a silver level plan by small employers in 2014 if the Affordable Care Act had not been enacted. However, premiums are only one cost that health insurance users face in obtaining care, so considering premiums alone does not accurately capture health care affordability for consumers. Considerations of affordability should not just examine premium costs, but also out-of-pocket cost-sharing and the costs of uncovered benefits that enrollees may incur. Further, a premium target approach to determining benefits does not take into account the cost drivers of premiums. As the IOM committee acknowledged in its report, premiums are driven by other factors. We believe that the Secretary, in determining the essential health benefits package, should take into account these other factors, such as insurer profits and administrative expenses, provider payment rates, and the degree of medical management. Using a premium target to address affordability does nothing to contain the actual costs of care or drive value in coverage. Instead, using a premium target to determine the essential health benefits package would detrimentally limit the scope of benefits, leaving consumers under-insured.

- **Address current gaps in employer coverage:** Section 1302 states that the essential health benefits package must include at least the 10 categories of coverage (listed on page 1) and be equal to the scope of benefits under a typical employer plan as determined by the Secretary. However, the IOM report found that current, standard commercial plans, on the whole, lacked habilitation, mental health and substance use disorder services, wellness services and chronic disease management, and pediatric oral and vision care.[8] Therefore, the essential health benefits package will have to address the current gaps in employer coverage by establishing comprehensive benefits for categories of care listed in Section 1302 that employer coverage currently lacks.

3. The Affordable Care Act is clear that the essential health benefits package should not allow for discrimination or "cherry-picking" based on health status

- **Benefit designs must not be discriminatory:** Section 1302 clearly states that, in defining the essential health benefits package, the Secretary shall "not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits that discriminate against individuals because of their age, disability, or expected length of life." Section 1557 additionally disallows the discrimination on the basis of race, national origin, sex, age, and disability for any health program or activity that receives "Federal financial assistance, including credits, subsidies, or contracts of insurance. . . ."[9]
- **Plans must not be allowed to design benefits packages that allow them to "cherry-pick" healthy consumers:** The Secretary and states must establish oversight mechanisms to monitor benefit designs to ensure that they are not discriminatory. Plans should be monitored to ensure that they are not implementing benefit structures to attract only healthy enrollees or to deter specific populations from enrollment. They should also be required to disclose information about cost-sharing provisions to policyholders and plans should be monitored to determine if they are using cost-sharing structures to cherry-pick healthy consumers. Plans should also be monitored to ensure that they provide sufficient access to services that are not typically covered comprehensively in private insurance currently, such as mental health and substance use disorder services and habilitative care.
- **Plans should be required to establish effective and patient-focused care coordination:** Better care coordination, especially for patients like those with chronic illnesses, can help patients obtain the care they need and, at the same time, reduce unnecessary and redundant tests or services. Utilization management and care coordination need to focus on prevention and on getting patients the care they need and must not reduce access.

4. Appropriate state flexibility and the essential health benefits package

- **States should not have flexibility to further limit the scope of essential benefits:** Allowing states flexibility with the essential health benefits package would erode the coverage floor that the essential health benefits package is intended to create. Flexibility would result in disparate coverage for residents of different states. Beyond the essential health benefits package, states and health insurance plans have the option to be innovative and flexible with how they administer and design benefits, allowing for cost and utilization control strategies that do not undermine the comprehensiveness of coverage for consumers.
- **The Secretary should study each existing state mandate and determine if it should be incorporated into the essential benefits package:** If a state mandate does not clearly fall under the scope of coverage outlined in the established essential health benefits package, the Secretary should study the mandate and determine if it should be included. Eliminating benefits

that have been mandated in a state without careful consideration of how people will receive those services in the future could have negative outcomes on health and access to care.

5. Considerations when updating the essential health benefits package

- **The essential health benefits package should be regularly reviewed and updated to reflect advances in medical care and evidence:** The Secretary should have to power the add new services, medications, and devices that are comparatively more effective and that will provide substantial savings in the future, but may not be fully cost-neutral when first covered. Adding such new services would reduce health care costs in the long run.
- **A National Benefits Advisory Council to make recommendations to the Secretary about changes to the essential health benefits package should be established, as recommended in the IOM report:** This council should contain work groups with expert researchers and medical professionals, as well as consumer advocates who can speak on the various coverage categories. It should consider advances in medical science and the experiences of consumers garnered through the benefit appeals system.

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[1] *Patient Protection and Affordable Care Act,* Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010,* Public Law 111-152 (March 30, 2010), Title 1, Subtitle D, Section 1302 (b)(1).

[2] *Patient Protection and Affordable Care Act,* Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010,* Public Law 111-152 (March 30, 2010), Title 1, Subtitle D, Section 1302 (b)(2)(A).

[3] Institute of Medicine of the National Academies, *Essential Health Benefits: Balancing Coverage and Costs* (Washington: Institute of Medicine of the National Academies, October 2011) available online at http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx

[4] *Patient Protection and Affordable Care Act,* Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010,* Public Law 111-152 (March 30, 2010), Title 1, Subtitle D, Section 1302 (b)(4)(A).

[5] Bianca DiJuilio, *Employer Sponsored Health Insurance- A Comparison of the Availability and Cost of Coverage for Workers in Small Firms and Large Firms* (Washington: Kaiser Family Foundation, November 2008), available online at http://www.kff.org/insurance/snapshot/chcm0111898oth.cfm.

[6] Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits 2011 Annual Survey* (Washington: Kaiser Family Foundation, 2011) available online at http://ehbs.kff.org/pdf/2011/8225.pdf.

[7] Ibid.

[8] Institute of Medicine of the National Academies, op. cit.

[9] *Patient Protection and Affordable Care Act,* Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010,* Public Law 111-152 (March 30, 2010), Title 1, Subtitle G, Section 1557(a).

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