



**Statement
on
Essential Health Benefits**

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Institute of Medicine
Committee on the Determination of Essential Health Benefits**

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I. Introduction

I am Carmella Bocchino, Executive Vice President of Clinical Affairs and Strategic Planning for America's Health Insurance Plans (AHIP), which is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and have demonstrated a strong commitment to participation in public programs. They also have been actively engaged in the health reform debates over the past several years.

We appreciate this opportunity to appear before the Committee today. The Committee's work relates to one of the foundational provisions of the Patient Protection and Affordable Care Act (ACA) – Section 1302, to create an “Essential Health Benefits Package.” The structure of this provision illuminates the challenges of health care reform and the importance of focusing implementation on the goal of making a range of high quality, affordable health care coverage choices available to consumers.

My remarks today focus on the following areas:

- Determining essential health benefits;
- Establishing a framework that reflects balance between comprehensive benefits, affordability and choice;
- The distinction between the process for determining essential health benefits and the process for determining coverage or medical necessity; and
- The potential unintended consequences of including state mandates in the essential health benefits package.

II. Legislative Requirements

Section 1302 of ACA requires the Secretary to define the essential health benefits to be included in a benefits package in the individual and small group markets both inside and outside of the Exchanges. The statute specifies ten general categories of items and services that should be included in the benefits package. Additionally, the Secretary is directed to ensure that the scope of the essential health benefits is equal to the scope of benefits provided under a “typical”

employer plan. The Department of Labor is required to conduct a survey of employer-sponsored coverage to help inform the Secretary's determination.

Finally, the statute allows for different levels of coverage (bronze, silver, gold and platinum) based on different actuarial values of benefits, and places annual limits on both cost-sharing for the individual and small group market and limits on annual deductibles for employer-sponsored plans in the small group market.

Overall, it appears that Congress has adopted a framework that requires the consideration and balance of several factors:

- (1) **Scope:** The statute lays out broad categories of benefits, and requires the Secretary to ensure that the scope of the benefits is equal to the scope of benefits provided under a "typical employer plan".
- (2) **Affordability and Choice:** The statute provides for limitations on: (1) cost-sharing for the individual and small group markets; and (2) annual deductibles for employer-sponsored plans in the small group market (\$2,000 for a plan covering a single person and \$4,000 for other plans). These provisions, together with provisions that eliminate annual and lifetime limits and establish consumer out-of-pocket maximums, indicate that Congress intended to ensure a level of coverage that, at a minimum, would cover most catastrophic health events. Also, by addressing only these cost-sharing requirements, Congress indicated its intention to not have the essential benefit package itself dictate levels of cost-sharing and deductibles and to provide flexibility to allow for consumer choice.
- (3) **Value:** The statute provides that any health benefit plan provide at least a "bronze" level of coverage reflecting an actuarial value of 60% - an important indicator of the percentage of total health benefit expenditures paid. Additionally, the MLR rebate requires 80% of premium dollar expenditures to be devoted to clinical services and quality improvement.

The balance of these three factors is the prism by which the IOM should frame its recommendations to the Secretary on the criteria and methods for determining and updating the essential health benefits package. Our testimony is designed to discuss the critical issues through this framework.

III. Critical Issues that the Committee Should Consider

We believe that the IOM should address the following issues in its recommendations to the Secretary.

A. Determining Essential Health Benefits

The essential health benefits should be based on credible and appropriate scientific evidence. This will best ensure that consumers receive appropriate items or services that improve their health or health status. Ensuring that individuals receive treatments that are safe and effective will become increasingly important as the introduction of new and expensive technologies and treatments accelerates.

In designing a health benefits package in the commercial market, an employer or health plan determines which benefits or the level of benefits will be offered to its members, the degree to which members will be expected to share the costs of such benefits, and how a member can access medical care through the health plan. Through this process, an employer or plan defines categories of services that will be covered and any exclusions or limitations that will apply, sets requirements for deductibles or co-payments, and defines where services may be obtained (i.e., in-network or out-of-network) and the level at which those services will be covered by the plan. Benefit designs evolve as customer and employer needs change.

The ten general categories listed in the legislation are consistent with the categories of items or services that are included in the typical benefit packages designed by employers and health plans in the current marketplace. Thus, we believe that Congress has already specified an appropriate set of “essential” items or services that should be included in the essential health benefits package, and there should be no further defining of specific service elements of the benefit package, such as the number and frequency of services that should be covered. Other programs, such as the Federal Employee Health Benefits Program and the Massachusetts Exchange, generally use a consistent model in which the benefit package only specifies general categories of items or services and does not indicate number and frequency of services that should be covered.

These benefits should be periodically reviewed to evaluate the appropriateness of adding or modifying benefits based on new information/breakthroughs that is supported by evidence and demonstrate increased value, and remove benefits that are no longer supported by evidence. The frequency of reviews should be balanced with the time and resources that will need to be spent on updating codes, modifying payer contracts, and performing other administrative tasks that would be required if benefit packages are modified. Both the process for identifying benefits to be included in the essential benefit package and the process for updating the package should be transparent.

B. Congress has established a framework that reflects a balance between several factors -- comprehensive benefits, affordability, and choice.

As previously stated, ensuring that consumers have access to comprehensive services, that consumers have a range of coverage choices, and that care is affordable are all key goals of ACA. To ensure that each of these goals can be achieved, they need to be “balanced”; in other words, the “richness” of the benefit package needs to be weighed against keeping care affordable and giving consumers a choice of benefit designs that meet their individual needs or desires.

The statute sets out several specific criteria for benefit design. Employers and health plans apply the same practices when offering benefits in existing markets. They include establishing:

- Actuarial value and more specific cost sharing limits for small businesses;
- Consumer out-of-pocket maximums;
- Dollar restrictions on annual and lifetime limits;
- Policies for accessing out-of-network emergency care; and
- Rules to prevent potential discriminatory practices.

The design of the benefits package should not have the effect of forcing individuals and small employers to purchase a richer scope of benefits than is currently available today. The imposition of a richer benefits package will have the effect of raising small group employers’ premiums with less flexibility to manage those costs through higher cost-sharing. This has the effect of requiring the small group employer to “buy up” coverage. Any requirement that small employers “buy-up” to essential benefits packages that are too costly may have the undesired effect of pricing these employers out of the marketplace. Likewise, some individuals

(particularly younger individuals) are likely to see premium increases as a result of the compressed age rating bands, causing them to be even more sensitive to requirements that they purchase coverage that is more costly than currently available coverage.

Broadening the scope of the essential health benefit package could have the unintended consequence of making products unaffordable and thereby limit access and consumer choice. For example, expanding the package further would prevent employers or plans from offering an individual a more limited coverage option which is less expensive. Given the restrictions on cost-sharing and lifetime and annual benefit limits, there is an even greater need for carefully considering how comprehensive the benefit package can be to ensure that the benefits are affordable. As noted, Congress recognized this by stating explicitly that consumers have the right to purchase a benefits package with coverage that exceeds the requirements set forth in Section 1302, and in so doing made clear that it did not intend for the essential health benefits package to include all possible benefits or to limit choices for consumers.

In assessing some of these issues, it is important to keep in mind that there are differences today in premiums and cost-sharing (deductibles and coinsurance) between the typical small employer plan and large employer plan. A typical small group employer may see the same or only slightly lower premiums with higher cost-sharing amounts to the employee as compared to large group. In the most recent AHIP survey of the small group market, it was found that in 2008, premiums were slightly lower than those reported in the 2008 Kaiser Family Foundation (KFF) survey that mostly represents larger employers. Premiums in the KFF survey for all firms with three or more employees averaged \$392 per month (\$4,704 annually) for single coverage, and \$1,057 per month (\$12,684 per year) for family coverage in 2008. However, employee cost-sharing tends to be higher among small group plans than in larger group plans. For example, the average annual deductible for preferred provider organization (PPO) plans reported by the KFF survey of large employers in 2008 was \$413, while the average deductible for single coverage in the small group market (50 or fewer employees) in AHIP's 2008 survey was \$1,059.¹

Defining a “typical employer plan” accurately by market segment is vital for maintaining balance in terms of affordability and choices and ultimately, ensuring the viability for small

¹ <http://www.ahipresearch.org/pdfs/smallgroupsurvey.pdf>

businesses to be able to continue offering coverage, for individuals to continue to purchase coverage, and for states to finance coverage under the Medicaid program.

Other benefit design models support the approach of allowing employers and plans to have the flexibility to innovate and promote consumer choice. In the state of Massachusetts, for example, standards for minimal creditable coverage using broad categories of coverage and actuarial values have been defined. The categories of coverage include items such as ambulatory patient services, diagnostic imaging and screening procedures, emergency services, hospitalization, maternity and newborn care, medical/surgical care including preventive and primary care, mental health and substance abuse services, prescription drugs, radiation therapy and chemotherapy.

The Massachusetts regulations allow for health benefit plans to impose different benefit levels for network versus non-network providers. Plans also may vary levels of co-payments, deductibles and coinsurance within each benefit category. Finally, the state has recognized the importance in utilizing value-based tools to facilitate the delivery of high quality, affordable care. The IOM, in its recommendations, should allow for a similar level of flexibility to provide consumer choice and market competition.

Moreover, there should be sufficient flexibility to allow health plans to continue to use critical tools that improve quality and promote greater value and affordability. Through their efforts to promote innovation and improvements to the delivery system, health plans have developed these tools and created key infrastructures to accelerate, and successfully achieve, meaningful change in the system. The value of these various health plan tools is supported by recent research which suggests that plans can impact quality of care through disease management, provider education efforts, patient education efforts, the development of reminder systems, and the use of financial incentives and other activities.²

Congress, the Administration, and health researchers and experts also have recognized the importance and value of these tools. For example:

- Under the ACA, in order to be certified as a qualified health plan, a plan must implement a quality improvement strategy, which is generally defined under Section 1311(g) as a payment structure that provides increased reimbursement or other incentives for improved outcomes through the implementation of: wellness and health promotion

² Laurence C. Baker and David S.P. Hopkins, International Journal for Quality in Health Care, “The Contribution of health plans and provider organizations to variations in measured plan quality,” (March 18, 2010).

activities; activities to improve patient safety and reduce medical errors through evidence-based medicine; the appropriate use of best clinical practices and health information technology; activities that prevent hospital readmissions; quality reporting; case and disease management; care coordination; and medication and care compliance initiatives.

- The Administration recently issued a Request for Information (RFI) soliciting information on specific examples and best practices of value-based insurance design (VBID) for recommended preventive services, as well as data used to support and inform VBID benefit design, measurement, and evaluation in the context of recommended preventive services. In the RFI, the Administration recognized the important role that VBID can play in promoting the use of appropriate preventive services.
- Several articles recently have been published on the value of VBID to improve health care quality and efficiency by reducing cost sharing for services that have strong evidence of clinical benefit and the potential value of expanding the use of VBID.³

C. The process for determining coverage or medical necessity is not part of the process for defining essential health benefits.

We strongly urge the IOM and the Secretary to not consider processes for determining coverage and medical necessity in the context of designing an essential health benefit package. The process for designing benefits and the process for making coverage decisions are very distinct and should not be conflated.

Coverage determinations are made by a payer as a specific individual accesses care in the system. Under this process, a payer will make a determination that it is appropriate for a particular service or intervention to be covered for a particular individual if it is “medically necessary.”

The medical necessity process is critical for ensuring, among other things, that:

- Individuals receive care that is effective (supported by scientific literature that suggests the treatment will result in a benefit to the patient);

³ A. M. Fendrick, “Applying Value-Based Insurance Design to Low-Value Health Services,” *Health Affairs*, 29, no. 11 (2010): 2017-2021; J. Robinson, “Applying Value-Based Insurance Design to High-Cost Health Services,” *Health Affairs*, 29, no. 11 (2010): 2009-2016.

- Individuals receive care that is provided or ordered by an appropriately licensed health care practitioner;
- Care is appropriate for the individual (likely to be effective for this particular patient, given that patient’s clinical indications); and
- Resources are not expended on care that is unnecessary or even harmful to patients.⁴

If individuals disagree with a coverage determination, they have access to internal and external appeals and grievances procedures. Health plans fully support a fair and timely process for consumers to appeal benefit denials through external review administered by independent third-party review organizations. Our community also believes that patients should be involved in any decision-making process for care received to ensure they fully understand the benefits and risks associated with certain services.

Conflating the process for designing benefits and the process for making coverage decisions will undermine payers’ abilities to ensure both affordability and that patients receive the right care at the right time and reduce the potential for harm. It also will result in a one-size-fits-all approach to care that fails to recognize the unique needs and circumstances of particular individuals.

D. Including State Mandates in the Essential Health Benefits Package May Have the Unintended Consequence of Reducing Consumer Choice and Affordability.

We do not believe that mandates should be considered as part of the essential health benefits package. Currently, there exist more than 2,000 state mandates. It would be impossible to include this large number of existing mandates in a national essential benefit package while at the same time providing affordable access to care for consumers. The Secretary would be faced with the herculean task of trying to make judgments on the relative importance of different conditions.

Even if the number of mandates based on categories of items or services included in essential health benefits could be narrowed, mandates vary widely across states in terms of their scope and application. This variation makes the process for determining which particular mandates are appropriate for inclusion in the benefits package virtually impossible.

⁴ The current process for assessing medical necessity has been operationally tested and generally accepted even in public programs, such as Medicare. According to the Medicare Benefit Policy Manual, “items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are not covered.” Medicare coverage determination policies also state that certain services may only be covered for patients with specific diagnoses as supported by the available medical evidence.

More critical, the inclusion of mandates in the essential health benefits package is likely to have a significant impact on access to affordable coverage and limiting consumer choice. According to a 2008 study, mandates have a direct impact on premium costs and increase the cost of basic health coverage from 20% to 50% depending on the specific state and/or specific mandated benefit.⁵

States have recognized the importance of evaluating benefit mandates based on both quality and cost criteria to promote consumer choice, affordability and improved outcomes. California, for example, established in 2002 the California Health Benefit Review Program. Under this program, the University of California's Office of the President supports a task force that assesses legislation proposing to mandate a benefit or service, and prepares independent analyses of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals. Among other things, each report summarizes sound scientific evidence relevant to the proposed mandate.

Finally, the statutory language suggests that Congress never intended that all benefits deemed necessary by the states should be included in the essential health benefits package. The statute sets out several specific elements and limitations that the Secretary must include or consider when defining the essential health benefits, including specific categories of services, the scope of the benefits, and non-discrimination factors. It does not, however, explicitly require that the Secretary evaluate state mandates for inclusion into the benefit package. Moreover, Section 1311(d)(3)(B) provides that a state may require that a qualified health plan offer benefits beyond the essential health benefits if that state assumes associated costs that individuals may be subject to.

IV. Conclusion

The Secretary's task under the essential health benefits provision is much more complicated than merely setting a list of benefits. The provision also links coverage of essential health benefits to the creation of a benefit package which is subject to specific cost sharing requirements and the creation of different benefit plan tiers defined by "actuarial value." This makes the essential benefits package provision a key component of the overall effort to make affordable high quality,

⁵ *Health Insurance Mandates in the States 2008*, Council for Affordable Health Insurance (CAHI), Victoria Craig Bunce, Director of Research and Policy, and JP Wieske, Director of State Affairs, 2008.

comprehensive, major medical coverage available to all Americans, including individuals and small businesses.