

Essential Health Benefits: Key Issues for States

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721 South Parker, Suite 200
Orange, CA 92868
800.511.0001
www.choiceadminexchanges.com

Contact:
Kevin Counihan, President
800.511.0001 ext. 7632
kcounihan@choiceadmin.com

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One of the most significant elements of the Patient Protection and Affordable Care Act (PPACA) is the authority given to the Secretary of Health and Human Services (HHS) to define “essential health benefits” (EHB). To assure consistency of coverage, the PPACA requires that health insurance plans offered through state exchanges cover a specific level of preventive, diagnostic, and therapeutic services defined as “essential” by HHS. Health insurance plans that do not cover these services will not be considered adequate health insurance, and owners of such plans will be subject to a penalty as if they did not have coverage.

On December 16, 2011, HHS released a guidance bulletin proposing a regulatory approach to defining EHB. This guidance provides a “transition period” for 2014 and 2015 to allow states to establish a state-specific “benchmark plan” designed to reflect the core services of a “typical employer plan” in their state. The benchmark plan would accommodate existing state mandates, and federal subsidies will be adjusted to reflect the variability of different state benchmark plans.

It is important to note that HHS will assess the benchmark plan process for years 2016 and beyond and will be developing an approach that likely will exclude some state mandates in EHB.

HHS proposes that states that do not select a benchmark plan will default to a benchmark plan representing the plan with the highest enrollment in the largest product in the state’s small group market.

Traditionally, states have overseen the regulation of individual and group insurance coverage and have had the independence to determine covered benefits and oversee mandated benefits for such policies. States on average have roughly 18 benefit mandates, and it is not uncommon for some states to have in excess of 30 benefit mandates.

To assist in the development of EHB, HHS asked the Institute of Medicine (IOM) to recommend a process that would both define the coverage that would comprise EHB and to update EHB coverage in consideration of scientific advancement and its impact on the cost of benefit changes. At the end of October, the IOM issued its recommendations.

The purpose of this paper is fourfold:

- Provide context on EHB
- Summarize HHS guidance bulletin
- Summarize key IOM recommendations
- Outline key issues impacting state policymakers

Background

The PPACA fundamentally changes the existing health insurance market in most states by eliminating pre-existing conditions, coverage rescission, or premium variance other than for such factors as age, family size, geography, and tobacco usage. Further, the PPACA requires that all individual and small group plans must cover health benefits deemed “essential” by the Secretary of HHS. EHB must be “equal to the scope of benefits provided under a typical employer plan as determined by the Secretary.”¹

The PPACA requires that EHB include at least 10 general categories of services. These are:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

The PPACA does not guide the Secretary to determine the basis on which benefits could be deemed *non-essential* with the exception of general limitations to the Secretary’s ability to *exclude* benefits. The Secretary is directed to “...not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways to discriminate against individuals because of their age, disability, or expected length of life” and to “...ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals’ age or expected length of life or of the individuals’ present or predicted disability, degree of medical dependency, or quality of life.”²

Summary of HHS Guidance Bulletin

The following is a summary of the HHS guidance as announced on December 16th:

- HHS proposes that for transition years 2014 and 2015 EHB be defined by a “benchmark benefits plan” selected by each state.
- States are permitted to select a single benchmark as standard for qualified health plans inside state Exchange and plans offered in individual and small group markets.

¹ PPACA § 1302 (b)(2)(A)

² PPACA § 1302 (b)(4)

Summary of HHS Guidance Bulletin (cont'd)

- Four options for benchmark plans for 2014 and 2015:
 - Largest plan by enrollment in any of the three largest small group products in state's small group market.
 - Any of the largest three state employee benefit plans by enrollment.
 - Any of the largest three national Federal Employees Health Benefit Program (FEHBP) plan options by enrollment.
 - Largest insured commercial non-Medicaid HMO operating in state (often a BCBS plan)
- To determine enrollment, HHS proposes to use enrollment data from first quarter two years prior to coverage year (2012), and that states select a benchmark in third quarter two years prior to coverage year (2012).
- If state does not select a benchmark plan, HHS proposes that default benchmark plan be the largest enrolled plan in largest product in state's small group market.
- HHS will assess benchmark process for 2016 and beyond based on feedback and evaluation.
- Benefit Mandates (during transition period in 2014 and 2015): If a state chooses a benchmark plan with mandates, that benchmark would include those mandates in the state EHB package. If a state selects FEHBP as benchmark, which may not include state mandates, the state would be required to cover the cost of mandates outside of the State EHB package.
- If the State EHB doesn't cover any of 10 core EHB benefit categories (such as habilitative care, pediatric oral or pediatric vision services), the state must supplement missing categories using benefits from any other benchmark option.
- HHS is proposing flexibility to health plans to adjust benefits for 10 statutory EHB categories.

HHS encourages public comment on this proposed guidance via email:
EssentialHealthBenefits@cms.hhs.gov. Comments are due by January 31, 2012.

A copy of the guidance is available at:
http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

Institute of Medicine Recommendations

The IOM was asked by HHS to make recommendations on a process for determining and updating EHB, not to develop specific health benefits. The IOM formed a prestigious committee of volunteers and solicited broad input of public opinion both in public forums and online to form their conclusions. The committee's consensus report was subject to external review in accordance to procedures established by the Report Review Committee of the National Research Council. Given the two-year transition period proposed, HHS has an additional two years to study these recommendations in the context of benchmark plans selected by states.

Institute of Medicine Recommendations (cont'd)

The IOM committee considered how four policy domains – economics, ethics, population-based health, and evidence-based practice – could guide the Secretary in formulating the basic EHB package of benefits.³

The committee determined that costs and premium affordability must be considered in both determining the initial package of EHB coverage and its updating. Further, the committee defined a “typical employer plan” as what a typical small employer’s package of benefits would represent. The committee proposed that the initial EHB benefit package be compared to premium target, as defined by the committee, a small employer would have paid, on average, in 2014.⁴ Thus, the IOM committee made a conscious decision to acknowledge the influence of medical trend and the importance of premium affordability in considering EHB.

The committee further proposed that EHB should be modified as appropriate to meet an estimated premium target, and that states operating their own exchanges have the flexibility to design a variation of EHB if certain standards are met. This flexibility is consistent with the flexibility outlined in the Notices of Proposed Rulemaking (NPRMs) issued by The Centers for Medicare & Medicaid Services (CMS) in July and August of 2011.

The IOM committee recommended creating an infrastructure for collecting data and reviewing implementation of the initial set of EHB benefits. The committee believes that EHB should become evidence-based, value-based, and specific over time. Further, the committee recommended that costs must always be considered, so that any service added to EHB must be offset by savings, either through medical management or through the elimination of an outmoded service.⁵

The committee noted that the compounding influence of continued medical trend threatens the affordability and sustainability of EHB and recommends that the Secretary in collaboration with others develop a comprehensive strategy to reduce health care spending. The charge may be made more challenging given the restrictions placed on the Secretary by the PPACA.

³ National Academy of Sciences; IOM Report; Prepublication Copy, 2011

⁴ *ibid*

⁵ National Academy of Sciences; IOM Report; Prepublication Copy, 2011

Institute of Medicine Recommendations (cont'd)

Policy Foundations to Guide HHS⁶

<p style="text-align: center;">Economics</p> <p>Must Protect Against Large Expenses</p> <p>Competition to Promote Quality & Efficiency</p> <p>Should Address Market Failures in Incomplete Excessively Costly Insurance Options</p> <p>Promote High-Value Services</p>	<p style="text-align: center;">Ethics</p> <p>Fair Distribution of Resources</p> <p>Protect Society's Most Vulnerable</p> <p>Maximize Health Benefits Efficiency Or</p> <p>Shared Responsibility for Improving Health among Consumers, Employers, Insurers, Providers & Government</p>
<p style="text-align: center;">Evidence-Based</p> <p>Apply Scientific Evidence to Clinical Decision Making</p> <p>Apply Scientific Evidence to Value-Based Decisions</p> <p>Integrate Clinical Expertise, Patient Values and Best Research Evidence to Patient Care</p>	<p style="text-align: center;">Population Health</p> <p>Insurance Should Facilitate Improved Health</p> <p>Primary, Secondary, Tertiary Prevention Needs Attention</p> <p>Access for Vulnerable Must be Assured; Disparities Should Be Eliminated</p>

Issues for State Consideration

The role of the federal government in defining minimum standards for health insurance coverage raises five key issues for states:

1. Selection of Benchmark Plan or Default
2. EHB Impact on Large Group Plans
3. Absence of Guidance for Benefit Exclusions
4. Impact of Medical Trend
5. Transition Period

⁶ *ibid*

Issues for State Consideration (cont'd)

Selection of Benchmark Plan or Default

The first decision for a state is whether or not to select a benchmark plan or default to the HHS-proposed option. Since the default option is essentially the first benchmark plan type, it may be logical for states to control their benchmark plan selection by selecting one of the four options provided by HHS.

EHB Impact on Large Group Plans

Self-insured (or ASO⁷) and large group policies are exempt from EHB, and they are exempt from regulations overseeing insured group policies. Because large group and ASO contracts comprise a “typical employer plan,” it is possible the IOM recommendations of base line coverage could have reflected the benefits of these plans in addition to those from small employers. By choosing to recommend that a “typical employer plan” be limited to small group plans, the IOM wisely focused on the benefit coverage most typical of the plans EHB will impact directly.

A by-product of this decision by the IOM is that ASO plans may evolve to more closely resemble plans from small businesses and make coverage distinctions between the two market segments more similar.⁸ Instead of raising small group coverage to the level of ASO plans, the idea may be to bring ASO plan designs to the level of small group plans, which are increasingly implementing high deductibles and coinsurance as a means to keep premium costs affordable. This may benefit ASO plans by keeping costs lower due to less rich coverage.

Exemptions from EHB apply to large group insured plans as well. The logic of profiling small group plans as “typical” may impact the benefit design of large insured plans, too.

Absence of Guidance for Benefit Exclusions

As noted earlier, the IOM report outlines steps to pattern EHB after a typical small group employer plan. However, there is direction in the PPACA to determine the basis for which the Secretary of HHS should exclude benefits from EHB.

Since determining EHB is subject to notice and comment, there will be much opportunity for individuals and interest groups to highlight the need for coverage for specific illnesses and specialized treatments. Many mandated state benefits are the result of the influence of similar individuals and groups who persuade state legislators or regulators of the value of including coverage for In vitro fertilization, autism, etc., as covered services. It is often easier for legislators to add coverage than to eliminate covered services.

⁷ ASO is abbreviation for Administrative Services Only group contracts. ASO contracts are self-insured contracts.

⁸ Monahan, A.B.; *Initial Thoughts on Essential Health Benefits*, University of Minnesota Law School Research Paper No. 10-36, 2011. Prof. Monahan actually suggests the opposite thought thinking that “typical employer plan” would be significantly influenced by large group and ASO plan designs.

Absence of Guidance for Benefit Exclusions (cont'd)

Since the PPACA specifically restricts the Secretary from using expected length of life or medical dependency to determine coverage definition, some forms of coverage guidelines used in other countries may not be employed. However, by focusing on small group coverage as the prototype for EHB, the Secretary may be defaulting to a single segment of employer-sponsored insurance in determining coverage inclusions and exclusions without thinking more broadly about ways to improve the health system to enhance quality and affordability.

Impact of Medical Trend

Due to the compounding effect of medical inflation trend on premium costs, as premium increases, the federal government's costs for advanced and refundable tax credits rises. This is because the PPACA essentially limits how much low- to moderate-income individuals pay for coverage. If premium costs exceed this limit, tax credits and subsidies make up the difference. Unless the limits for low- and moderate-income individuals rise with medical inflation, medical trend increases will be essentially born by the federal government and states that would need to subsidize cost mandates that exceed EHB for individuals receiving tax credits.

While this is not impactful during the two-year transition period, it will clearly be relevant in HHS policy making for 2016 and beyond.

Transition Period

The guidance bulletin underscores in several sections how 2014 and 2015 are a "transition period" for states to help defer challenging decisions on benefit mandates and delaying the cost of subsidizing the cost of those mandates beyond a uniform definition of EHB.

Given the expense of federal subsidies for states whose benchmark plans include rich mandates, it is unlikely that in 2016 and beyond federal subsidies for mandate-rich benchmark plans will continue. States will be required to confront the affordability of subsidizing these mandates at this time.

It may be helpful for states to consider their strategic and policy options and to plan for an actuarial assessment of the value of their mandates in comparison to their short-term benchmark plan and to less-rich standard of EHB in 2016.