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Memorandum: An Alternate Process for Developing Essential Health Benefits

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Introduction

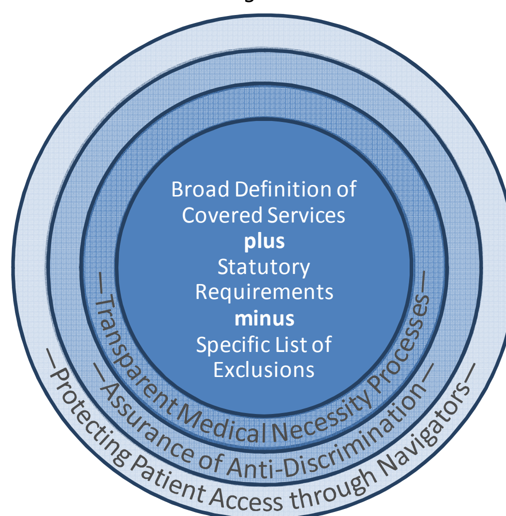
For the past several years, the National Health Council (NHC) has been actively engaged in setting and communicating priorities for patients with chronic conditions to guide policymakers' approach to health reform. A central goal of health care reform is to ensure individuals have access to affordable and adequate insurance. To attain adequacy in insurance coverage, the Affordable Care Act of 2010 (ACA) requires the Secretary of Health and Human Services (HHS) to establish an essential health benefits package—a minimum standard for benefits that all qualified health plans and other non-grandfathered small group and individual insurance plans must cover by 2014. One of NHC's health reform priorities is to ensure that the essential health benefits (EHB) package provides access to affordable and adequate coverage.[1]

The NHC has regularly engaged with the Center for Consumer Information and Insurance Oversight (CCIIO) to share its perspective as a voice for the patient community as the agency drafts guidance on EHB. Upon the release of the Institute of Medicine's (IOM's) recommendations to HHS on a process to develop the EHB package, the NHC determined that these recommendations had several flaws that could negatively impact patients' ability to access affordable and adequate coverage. Specifically, two major concerns of the NHC are the IOM's focus on a national premium target and the strict four-part criteria for items and services to be included in EHB.

An Alternative Process to Develop an EHB Package

Throughout our communications with CCIIO, the NHC has expressed its recognition of the challenge of establishing a standard health benefits package that is adequate across the spectrum of patient needs while remaining affordable for those who will need health insurance coverage. The NHC believes that this objective will best be met not by establishing a rigid definition of the EHB but instead by defining a flexible set of services that meet the ten ACA-defined categories overlaid with patient protections to ensure access, equity, and transparency. Figure 1 illustrates the NHC's recommended approach to developing an EHB package that meets the needs of all enrollees, including patients with multiple chronic conditions.

Figure 1: NHC Approach to Developing an EHB Package
Affordability through a Target Cost of Benefits, Not a Target Premium



The ten categories of services specified in the ACA, with only the minimal details included in the law, are too broad to ensure non-discrimination and

[1] More details about the National Health Council's health reform priorities are available at: http://www.nationalhealthcouncil.org/pages/page-content.php?pageid=78.

comprehensiveness of coverage for patients. Therefore, the NHC recommends for CCIIO to add a more detailed level of specificity to these ten categories to lend clarity and ensure that the EHB package meets the statutory intent of a basic, but comprehensive, standard of coverage. This approach to benefit design — using a broad definition of covered services as the basis for an EHB package — would also require a very specific, itemized list of permissible ***exclusions*** from the EHB package. To this point, the NHC's position on permissible exclusions aligns directly with the IOM:

> Exchanges need to know if it is permissible to exclude certain services when qualifying a health plan. Guidance should provide the most comprehensive description possible that makes such variables clear and permits reasonable judgments (both substantive and actuarial) of what is covered. As noted previously, even if a service is listed as permissible to exclude from the minimum set of benefits that constitute the EHB and the related EHB limits, an insurer could offer the benefit in one of an array of plans they develop for the market.[2]

Further, the IOM's recommendations include a list of four criteria that all items and services under consideration for inclusion in the EHB package must meet. The NHC believes that three of these criteria should be used, instead, to guide the development of the specific list of exclusions. That is, to the extent evidence exists that an item or service is not safe, not effective, or that it does not demonstrate meaningful improvement, the agency could consider placing the item or service on a list of permissible exclusions. The IOM's fourth recommendation — cost effectiveness — is a premise that, for a variety of reasons, has not been accepted by the American health care system; because of this, the NHC believes that it is not a criterion that should be used to determine either inclusion in or exclusion from the EHB package.

The elements of the NHC's recommendations (i.e., a broad definition of covered benefits, the application of statutory requirements and additional specificity from the agency, and an explicit list of items and services that may be excluded from coverage) would be the basis of the essential health benefits package. The broad level of authority granted to HHS in defining an essential health benefits package, in our opinion, gives the agency the flexibility to follow such an approach. Further, this concept would create a coverage principle that, for items or services that meet general terms of coverage and are not specifically excluded, there would be an assumption of coverage by qualified health plans.

For treatments of diseases and conditions where protocols are less established, this methodology would allow coverage of a variety of treatment methods, under the premise that medically necessary, non-excluded items and services are covered. For conditions with a stronger evidence base such as diabetes, heart disease, or HIV/AIDS treatment, the broad definition of covered benefits will be more explicit, but the methodology would result in the same premise that medically necessary, non-excluded items and services are covered, including relevant state mandates.

Layering in Levels of Patient Protections

The success of designing these benefits with this level of flexibility requires substantial patient protections that will result in an EHB package that is a true benefits package — one that will safeguard people as they navigate and enroll in qualified health plans that best meet their medical needs. The NHC recommends three coordinating layers of patient protections: 1) transparent medical necessity processes; 2) assurance of non-discrimination; and 3) access to useful information for selecting an appropriate plan through Navigators.

First, the EHB regulation should outline clear, understandable standards for plan medical necessity determinations. To make these processes transparent, the regulation should require plans to use medical

[2] IOM (Institute of Medicine). 2011. Essential Health Benefits: Balancing Coverage and Cost. Washington, DC: The National Academies Press.

necessity criteria that are objective, clinically valid, and compatible with generally accepted principles of care. A health intervention should be covered if it is an otherwise covered category of service, not specifically excluded, recommended by the treating health care professional recognized under state or federal law, and determined by the health plan's medical director to be medically necessary. Any denials issued by a plan based on lack of medical necessity must explain to the patient in clear language the criteria used to make the determination, and the process of appealing a decision should also be clearly communicated.[3]

Second, the EHB regulation should provide for state and federal oversight of plan benefits design to avoid discrimination caused by unfair utilization management (UM) techniques or other plan design elements. To ensure non-discriminatory utilization management, the regulation should include specific oversight mechanisms for states to use in reviewing plan UM policies to ensure practices are neither unfair nor discriminatory. Further, HHS should have final authority to approve state oversight programs to ensure appropriate measures are in place to guarantee that plans are meeting the requirements of this section. There also should be requirements for plans to disclose to all prospective and current members all utilization management techniques as well as all limits on services. Finally, federal monitoring programs should be established to ensure appropriate checks are in place to guarantee that plans are meeting federal requirements.[4]

Finally, the EHB regulation should contain specific requirements for state Navigator programs to assist patients in identifying appropriate plans for enrollment as well as navigating the enrollment and other key plan process. Even with the EHB service categories clearly defined, plans will still have coverage and cost variations. For this reason, it will be critical for patients, especially those with multiple chronic conditions, to be able to identify the plan that best meets their specific needs. Effective Navigator programs should include assistance with all aspects of plan processes, from selecting a plan to accessing health care benefits during the plan year.[5]

Addressing Cost in the EHB Package

In past work, the NHC commissioned an actuarial analysis to examine the cost of a comprehensive health benefits package, using an often mentioned benchmark standard for adequate coverage — the Blue Cross Blue Shield Standard Option (BCBS-SO) plan offered under the Federal Employees' Health Benefit Program (FEHBP). The NHC strongly believes that a process similar to this analysis should guide the cost of the EHB package.

The NHC analysis used 2011 National Health Accounts projections, standard administrative expenses, and other assumptions to estimate a cost for covered charges (i.e., cost of benefits) for the average person.[6] The NHC encourages CCIIO to focus its cost consciousness on this measure of a plan's benefit, rather than a plan's premium. A plan's premium is based on the cost of benefits, but that cost is adjusted to account for assumptions that differ among plans. Such assumptions include administrative expenses, risk premiums, adjustments for in-network and out-of-network utilization patterns, as well as provider networks. Because of the variations in assumptions used by plans in developing premiums, defining a premium target would result in plans that offer sets of benefits that are not comparable to one another.

[3] See § 301: Medical Necessity Decision Making & Appeals Processes in *A United Patient Voice on Essential Health Benefits*, available at: http://www.nationalhealthcouncil.org/NHC_Files/files/EHB_UnitedPatientVoice.pdf.
[4] See § 101: Barring Discrimination in Utilization Management in *A United Patient Voice on Essential Health Benefits*, available at: http://www.nationalhealthcouncil.org/NHC_Files/files/EHB_UnitedPatientVoice.pdf.
[5] See § 202: Education and Coordination through Navigators in *A United Patient Voice on Essential Health Benefits*, available at: http://www.nationalhealthcouncil.org/NHC_Files/files/EHB_UnitedPatientVoice.pdf.
[6] Actuarial analysis performed by Actuarial Research Corporation and Avalere Health and is available at the National Health Council website at: http://www.nationalhealthcouncil.org/NHC_Files/files/EHB_ActuarialAnalysis.pdf.

In contrast, a cost of benefit measure is a more standard measure of the actual cost of services that are covered under a plan. It is also the basis for the actuarial value calculation. The agency could specify and standardize assumptions needed to calculate the cost of benefit measure to further increase the stability of the measure. Such assumptions include utilization estimates of the covered population as well as standards for reimbursement.

The IOM has used the analogy of a grocery cart to explain their recommended use of a premium target. The NHC believes that this analogy better depicts our proposed approach — a target cost of benefits. A shopper whose budget is like a premium target must use some of that budget for administrative expenses, such as taxes and shopping bags. In contrast, a shopper whose budget is like a cost of benefits target can use that entire budget on groceries. In our approach, plans would be standardized in the value of the actual services covered by each plan.

The NHC analysis of the BCBS-SO plan resulted in a cost of benefit that equaled $4,659 per year for an average person. The BCBS-SO has been cited as a model for the EHB plan design and is considered by many to be a standard for a comprehensive health benefit plan. For these reasons, the NHC believes that the cost of benefit for the EHB package designed by CCIIO should fall within a sensible range of the result of this cost-of-benefit analysis (e.g., $3,500 to $6,000 per person per year). This cost-of-benefit target would be used as the standard for all plans within the exchange — from bronze to platinum. Coverage under the metal levels of plans would vary based on the amount of this cost of benefit that is covered by the plan.

Conclusion

The NHC is committed to ensuring adequate patient protections as the ACA is implemented. As CCIIO finalizes the EHB package, the NHC strongly encourages the agency to follow NHC's alternative framework that would permit flexibility in terms of plan design and that would protect the people who will rely on this benefits package. As the voice for those with chronic diseases and disabilities, NHC believes that broad patient protections are also critical to the success of qualified health plans and Exchanges. As CCIIO finalizes the establishment of the essential health benefits, the NHC strongly encourages the agency to include in its regulations and guidance the approach to developing the EHB package as well as the levels of patient protections supported in this letter.