Center for American Progress

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The Honorable Kathleen Sebelius
Secretary of Health and Human Services
The Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Sebelius:

The Center for American Progress welcomes the invitation to comment on the Essential Health Benefits Bulletin released by the Center for Consumer Information and Insurance Oversight on December 16, 2011. The Affordable Care Act's requirement that new health insurance plans offered in the individual and small group markets cover "essential health benefits" (the "EHB") is an important consumer protection—and one that makes the exchanges and other health insurance market reforms work more effectively.

The purpose of the EHB is threefold: (1) to ensure that coverage provides access to essential health care; (2) to minimize abuse in which insurers design benefits to attract healthier individuals and deter less healthy individuals; and (3) to provide some degree of standardization to make it easier for consumers and small businesses to make apples-to-apples plan comparisons—thereby enhancing competition based on price and quality.

The department's proposed approach

The department's proposed approach has the potential to meet these objectives in the short term, but would require substantial review and oversight—which could in turn require some modification. Under the proposed approach, states can choose a benchmark plan from among the three largest small employer plans, the three largest state employee plans, the three largest Federal Employees Health Benefits Plans, or the largest HMO plan offered in a state. If a state does not choose a benchmark plan, the default benchmark plan would be the largest small employer plan. Based upon further review and analysis, as recommended below, the department may need to reduce the number of these potential benchmark plans, and/or modify the default benchmark plan.

The law itself requires coverage of benefits within 10 broad categories, including maternity and newborn care, mental health benefits, and prescription drugs. Today many of these benefits are not typically covered by plans offered in the individual market. Other categories—such as wellness services and pediatric oral and vision care—may not

be typically covered by employer plans. The 10 categories, therefore, will go a long way to ensure that coverage provides access to needed care.

Moreover, both within and beyond the 10 categories, the department's preliminary analysis—consistent with other analyses, including that of the Institute of Medicine—indicates that benefits are substantially similar among the Federal Employees Health Benefits Program, small employer plans, and state employee plans. For instance, home health care and routine preventive and basic dental care for adults are benefits that do not clearly fit within the 10 categories—but that appear to be covered by all of these types of plans. If this analysis is correct, then all Americans will have access to benefits that are as comprehensive as the benefits that members of Congress receive.

However, further review and oversight is needed to ensure that all state employee plans cover substantially similar benefits. The department's preliminary analysis was based on an evaluation of 10 state employee plans. If further analysis reveals that a state employee plan covers substantially fewer benefits than other types of plans, that state employee plan should be excluded as a potential benchmark plan in that state.

In addition, while these types of plans may cover substantially similar benefits, insurers might impose a dollar limit, frequency/visit limit, and/or other nonmonetary limits (prior authorization) on a specific benefit. For instance, as the bulletin noted, physical therapy, occupational therapy, and speech therapy are frequently subject to visit limits. Insurers could use such limits as loopholes that undermine the ACA's prohibitions on lifetime and annual limits and the EHB itself.

Under the department's proposed approach, when a state chooses a benchmark plan, that plan's limits on specific benefits would apply. However, it is not clear that the limits on specific benefits are substantially similar among the Federal Employees Health Benefits Program, small employer plans, and state employee plans. Substantial review and oversight is therefore needed to ensure that no benchmark plans—in particular, small employer plans—impose limits that are inconsistent with medical practice or that undermine the ACA's important consumer protections.

Allowing insurers to substitute benefits or limits that are actuarially equivalent could undermine the purposes of the EHB, as stated above. Insurers could use this flexibility to design benefits that attract healthier individuals and deter less healthy individuals—in other words, to "cherry pick" enrollees. Moreover, too much flexibility could exponentially increase the number of plan designs offered through the exchange—making it more difficult for consumers and small businesses to compare and enroll in plans.

Substantial evidence indicates that too many plan designs can overwhelm consumers—resulting in poor choices or no choice at all.[1] In Medicare Part D, consumers frequently choose prescription drug plans that provide less risk protection at higher cost.[2] In Medicare Advantage, the Centers for Medicare and Medicaid Services recently found that "the large number of MA plan options…has made it difficult and confusing for beneficiaries to distinguish between these plans and to choose the best option to meet their needs."[3] Moreover, the nonpartisan Congressional Budget Office concluded that standardization is a key element in enhancing competition and lowering premiums.[4]

Standardization of benefits and limits would not mean that insurers would not be able to innovate. Innovation in benefit design—such as "value-based insurance"—relies on flexibility in cost-sharing, not flexibility in benefits or limits. In addition, the EHB is a minimum benefit standard, allowing innovation through changes in nonessential benefits or through looser limits on certain benefits.

Transition to a national benchmark

CAP recognizes that the department's proposed approach satisfies a significant timing constraint. In order to give insurers enough advance notice to incorporate the EHB into their plan offerings for 2014, states would have to act this year to address their benefit mandates. Many state legislative sessions are already underway, and some sessions will end as early as March. It would be unrealistic to expect states to address these important issues in such short time. Given this reality, a state-based approach is sensible for the short term and will help ensure a smooth implementation in 2014.

Over the long term, however, a state-based approach would not be sustainable. The substantial amount of research, analysis, and oversight required, as discussed above, would likely prove too burdensome. Regardless of what the *current* benefits of small employer plans and state employee plans may be, those benefits could change in the future. In addition, a state-based approach would not satisfy an important principle of equity—that all Americans should be guaranteed access to the same benefits, no matter where they live.

Moreover, a state-based approach would miss an opportunity to reduce the administrative costs of the health care system—which account for 14 percent of excess spending on health care.[5] As a result of the multistate patchwork of benefit standards, large national insurers cannot offer the same plan nationwide. In addition, when states are allowed to open their exchanges to large employers in 2017 and beyond, large employers with operations in multiple states would have to comply with several different benefit standards.

For all of these reasons, CAP recommends that the department adopt a national benchmark as soon as possible. That benchmark should guide both the scope of covered services as well as limits on those services. It should also ensure that the package is equivalent in value to the benefits that members of Congress receive. Such a benchmark would be clear, consistent, and ensure a degree of comprehensiveness that is widely acceptable.

Thank you for the opportunity to comment on this important issue. Regardless of which approach the department takes, the Affordable Care Act will significantly improve health insurance coverage, especially in the individual market—ensuring that millions of Americans will at long last be able to access basic health care such as maternity care, mental health benefits, and prescription drugs.

Respectfully submitted,

Topher Spiro
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Endnotes

[1] Sheena S. Iyengar and Mark R. Lepper, "When Choice is Demotivating: Can One Desire Too Much of a Good Thing?" *Journal of Personality and Social Psychology* 69 (6) (2000): 995-1006.
[2] Jason Abaluck and Jonathan Gruber, "Heterogeneity in Choice Inconsistencies Among the Elderly: Evidence from Prescription Drug Plan Choice," *American Economic Review* 101 (3) (2011).
[3] Centers for Medicare and Medicaid Services, *Announcement of Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, April 4, 2011, p. 122.
[4] Congressional Budget Office, *An Analysis of Premiums Under the Patient Protection and Affordable Care Act*, November 30, 2009.
[5] McKinsey Global Institute, "Accounting for the Cost of US Health Care: A New Look at Why Americans Spend More" (2008), p. 20.