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Introduction*

The Patient Protection and Affordable Care Act (herein known as the Affordable Care Act [ACA]) was signed into law on March 23, 2010. Several provisions of the law went into effect in 2010 (including requirements to cover children up to age 26¹ and to prohibit insurance companies from denying coverage based on preexisting conditions for children²). Other provisions will go into effect during 2014, including the requirement for all individuals to purchase health insurance.³ Purchasers are allowed, but not obliged, to buy their coverage through newly established health insurance exchanges (HIEs)—marketplaces designed to make it easier for customers to comparison shop among plans and for low and moderate income individuals to obtain public subsidies to purchase private health insurance.

EXCHANGES AND ESSENTIAL HEALTH BENEFITS

The exchanges will offer a choice of private health plans, and all plans must include a standard core set of covered benefits, called essential health benefits (EHB). The health insurance exchanges will only offer qualified health plans (QHPs), meaning the plans are deemed to cover the EHB and to meet other requirements set by the ACA. In the initial years, the exchanges are open to individual purchasers and employees of small businesses (i.e., with 100 or fewer employees); starting in 2017, a state can decide whether to open its exchanges to larger employers. Additionally, the EHB are required to be included in new private individual and small group health insurance plans offered outside of the exchanges. Publicly supported subsidies, however, will only be available to those purchasing private plans through the exchanges, and these subsidies will be computed on a sliding schedule for individuals whose incomes are between 133 and 400 percent of the federal poverty level.⁴ Certain public insurance programs (i.e., Medicaid

* The report summarizes the views expressed by workshop participants, and while the committee is responsible for the overall quality and accuracy of the report as a record of what transpired at the workshop, the views contained within the report are not necessarily those of the committee. Of note, figures, sources, and citations were provided by presenters in support of their testimony, and are not necessarily endorsed by the committee.

¹ *Patient Protection and Affordable Care Act of 2010*. Public Law 111-148 § 2714, 111th Cong., 2d sess. (March 23, 2010).

² § 1101.

³ Exemptions will be granted for financial hardship, religious objections, to American Indians, to those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8 percent of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was \$9,350 for singles and \$18,700 for couples) (§ 1501 and § 10106).

⁴ Individuals whose incomes are below 133 percent of the federal poverty level will be eligible for Medicaid, and the EHB do not apply to the traditional Medicaid program, although they are applicable to state expansions of insurance for low income individuals, called Medicaid benchmark or benchmark-equivalent plans, and state basic health insurance (§ 2001 and § 1331).

benchmark/benchmark-equivalent plans; state basic insurance) also must include the EHB package.⁵

Section 1302 of the ACA stipulates that the Secretary of the U.S. Department of Health and Human Services (HHS) is to define the EHB (Appendix A). The EHB must include “at least” 10 general categories of care and be “equal in scope to those offered by a typical employer plan.”⁶ These broad categories are outlined in Box 1-1.

STUDY CHARGE AND APPROACH

At the request of the Secretary of HHS, the Assistant Secretary for Planning and Evaluation (ASPE) contracted with the IOM to make recommendations on criteria and methods for determining and updating the EHB package. It is important to note that the IOM Committee on Defining and Revising an Essential Health Benefits Package for Qualified Health Plans was not formed to detail the specific service elements of the benefit package, but rather, the committee was asked to offer advice on criteria and a process for defining and periodically updating the benefits package. The committee was also asked to provide guidance on the policy foundations and criteria the Secretary should take into account when examining the benefits for qualified health plans (QHPs). The specific statement of task for this committee is presented in Box 1-2.

To hear a variety of viewpoints on issues contained within the committee’s charge, the committee held public workshops on January 13-14, 2011, in Washington, DC, and March 2, 2011, in Costa Mesa, CA. Experts from federal and state government, employers, insurers, providers, consumers, and health care researchers were asked to identify current methods for determining medical necessity, express state-specific concerns, and share decision-making approaches to determining which benefits would be covered and other benefit design practices, among other topics. A month prior to the first workshop, the committee posted a set of questions online for public comment (Appendix B); these questions were posted for six months and the comments informed the committee study process.

The following chapters describe and summarize workshop presentations and discussions between the presenters and the committee; the views expressed are those of the workshop participants, not necessarily those of the committee.⁷ While committee members often ask probing questions, those questions should not be interpreted as positions indicative of personal or committee views. At the time of the workshops, the committee had not reached any conclusions; similarly, this workshop report does not present committee conclusions. Rather, this document is a factual summary of the two workshops, focusing in turn on each panel discussion. Every presenter was afforded the opportunity to review their individual portion of the following chapters prior to publication.

The committee acknowledges that this workshop report includes a variety of viewpoints about which different conclusions and therefore ramifications may result; however, these differences will not be reconciled in this report. Instead, the committee will use this information along with other sources when drafting its separate consensus report to provide guidance to the Secre-

⁵ Exchanges may also be a vehicle for determining eligibility for traditional Medicaid and other state programs, even though those do not require inclusion of the EHB, and matching individuals to the appropriate public or private options.

⁶ The Department of Labor the Department was required by law to conduct a survey on the typical employer plan. Survey results can be found at: <http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf>.

⁷ Copies of presentations and audio files of the public sessions will remain on the committee’s website for the duration of the project: <http://iom.edu/Activities/HealthServices/EssentialHealthBenefits.aspx>.

tary on defining and revising the essential health benefits. Furthermore, the content of this workshop report is limited to the views presented and discussed during the workshops and is not intended to be a comprehensive assessment of all issues pertaining to this subject. Readers should be aware that there may not always be countervailing opinions pressed on each issue.

BOX 1-1
Essential Benefits Categories in ACA

Essential Health Benefits

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder 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

SOURCE: §1302(b)(1)(A)–(J).

BOX 1-2
Statement of Task for the IOM Committee

The Patient Protection and Affordable Care Act (Affordable Care Act) established criteria for qualified health plans (QHPs) to participate in exchanges as defined in section 1301 of the statute. An ad hoc IOM committee will make recommendations on the methods for determining and updating essential health benefits for QHPs based on examination of the subject matter below.

In so doing, the committee will identify the criteria and policy foundations for determination of the essential health benefits offered by QHPs taking into account benefits as described in sections 1302(b)(1) and 1302(b)(2)(A), and the committee will assess the methods used by insurers currently to determine medical necessity and will provide guidance on the “required elements for consideration” taking into account those outlined in section 1302(b)(4)(A–G), including ensuring appropriate balance among the categories of care covered by the essential health benefits, accounting for the health care needs of diverse segments of the population, and preventing discrimination against age, disability, or expected length of life. The committee will also take into account language in 1302 on periodic review of essential health benefits, and other sections of the Affordable Care Act: for example, coverage of preventive health services (section 2713), utilization of uniform explanation of coverage documents and standardized definitions (section 2715), and other relevant tasks found in the Affordable Care Act for the Secretary HHS. The committee will provide an opportunity for public comment on the tasks of defining and revising the essential health benefits.

Perspectives on Essential Health Benefits

Workshop Report

Cheryl Ulmer, Bernadette McFadden, and Cassandra Cacace, *Rapporteurs*

Committee on Defining and Revising an Essential Health Benefits Package
for Qualified Health Plans

Board on Health Care Services

INSTITUTE OF MEDICINE
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*“Knowing is not enough; we must apply.
Willing is not enough; we must do.”*
—Goethe



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COMMITTEE ON DEFINING AND REVISING AN ESSENTIAL HEALTH BENEFITS PACKAGE FOR QUALIFIED HEALTH PLANS¹

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¹ The report summarizes the views expressed by workshop participants, and while the committee is responsible for the overall quality and accuracy of the report as a record of what transpired at the workshop, the views contained in the report are not necessarily those of the committee.

REVIEWERS

This report has been reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise, in accordance with procedures approved by the National Research Council's (NRC's) Report Review Committee. The purpose of this independent review is to provide candid and critical comments that will assist the institution in making its published report as sound as possible and to ensure that the report meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the process. We wish to thank the following individuals for their review of this report:

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Although the reviewers listed above have provided constructive comments and suggestions, they were not asked to endorse the final draft of the report before its release. The review of this report was overseen by **CHRISTINE K. CASSEL**, American Board of Internal Medicine. Appointed by the Institute of Medicine, she was responsible for making certain that an independent examination of this report was carried out in accordance with institutional procedures and that all review comments were carefully considered. Responsibility for the final content of this report rests entirely with the authors and the institution.

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Mr. Mark Hayes, Greenberg Taurig, LLP

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Mr. David Schwartz, Senate Finance Committee

Dr. David Bowen, The Bill & Melinda Gates Foundation

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Mr. Michael Turpin, USI Insurance Services

Ms. Helen Darling, National Business Group on Health

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Dr. Jonathan Gruber, Massachusetts Institute of Technology and the National Bureau of Economic Research

Dr. Jon Kingsdale, Wakely Consulting

Dr. Beth Sammis, Maryland Insurance Administration

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Mr. Paul Samuels, Legal Action Center and Coalition for Whole Health
Mr. Peter Thomas, Consortium for Citizens with Disabilities
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Ms. Marty Ford, The Arc and United Cerebral Palsy Disability Policy Coalition

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Ms. Meg Booth, Children's Dental Health Project
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Mr. Troy Zimmerman, National Kidney Foundation
Mr. Richard Smith, Pharmaceutical Research and Manufacturers of America (PhRMA)
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