Essential Health Benefits Package: Assuring Affordable Coverage and Care
National Coalition for Cancer Survivorship/
Cancer Policy Roundtable
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America’s Health Insurance Plans

Essential Health Benefits 2014—Exchanges and Market Reforms

Exchanges Established

Individual Income-Based Subsidies

Individual Coverage Requirement

Employers 50+ Play-or-Pay

Actuarial value/cost-sharing

Market Reforms (GI, CK, no pre-ex)

Essential Health Benefits
Essential Health Benefits

Background

- ACA requires insurers to cover the “essential health benefits” package
  - Provide coverage for 10 broad categories of services
  - Limit annual cost-sharing (e.g., OOP caps)
  - Limit annual deductibles in the small-group market
  - Meet minimum standards for actuarial value

- HHS Bulletin on EHB
  - Provides info and solicits comments on the approach that HHS intends to propose to define the EHB package
  - Flexibility for states to select among “benchmark” plans
  - Transitional approach for state mandates
  - Benefit design flexibility

IOM Report—EHB Package Needs to be Affordable

“If cost is not taken into account, the EHB package becomes increasingly expensive and individuals and small businesses will find it increasingly unaffordable. If this occurs, the principal reason for the ACA—enabling people to purchase health insurance and covering more of the population—will not be met.”

Essential Health Benefits
Expensive package will result in fewer covered

Jonathan Gruber at IOM (January 2011)—Estimates from a model similar to CBO:

- 10% rise in cost of essential package = 14.5% rise in government subsidy costs
  - Roughly $67 billion through 2019
- Higher costs = fewer insured
  - Coverage falls by 4.5% or 1.5 million in 2019
- Significant impact on access

Challenges Ahead
Upward pressure on premiums

Premium Taxes
Age Rate Compression
Essential Health Benefits
Underlying Medical Costs
EHB Bulletin—
*AHIP Comments*

- **Focus on affordability**
  - Affordability should be cornerstone of HHS’ consideration
  - HHS should examine impact of benefit “buy-up” in small-group/individual markets
  - Rigorous review of mandates to ensure value
  - Assure that EHB is evidence-based and value promoting over time

- **Support concept of state flexibility—2-year transition**
  - Benefits tailored to the needs of the population
  - Encourage states to choose most affordable plan to ensure the greatest number of people have access to coverage

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IOM Report—Mandates Typically Lack Evidence-Base

“As because state mandates are not typically subject to rigorous evidence-based review or cost analysis, cornerstones of the committee’s criteria, the committee does not believe that state mandates should receive any special treatment in the definition of the EHB and should be subject to the same evaluative method.”

October 7, 2011
State Mandates Add to the Cost of Coverage

<table>
<thead>
<tr>
<th>State</th>
<th>Cost Impact</th>
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<tbody>
<tr>
<td>Connecticut</td>
<td>8.2%-10.4% of claims costs</td>
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<td></td>
<td><em>Mercer</em></td>
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<td>Maryland</td>
<td>$43 million (2009 premium dollars)</td>
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<td><em>Oliver Wyman</em></td>
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<td>North Carolina</td>
<td>$32 million (2014), $38 million (2015), and $45 million (2016)</td>
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<td><em>Milliman</em></td>
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Bulletin Recognizes the Value of Benefit Design Flexibility

- Bulletin’s approach to benefit design flexibility
  - Promotes high quality care at lower costs
  - Assures innovation in benefit design and care delivery models (e.g., disease management, chronic care, etc.)
  - Medical management promotes safe, effective care while helping to keep coverage affordable—as recognized by IOM
  - Assures a level playing field and transparency in any substitution in benefits—within and across categories
EHB—Timing

- Timing is critical—states and plans need final, timely guidance on EHBs and related rules
  - HHS should establish a deadline for states to select an EHB benchmark, no later than June 30, 2012
  - HHS should issue timely guidance to states on the process for selecting the benchmark plan and issue guidance on related standards as soon as practicable

Updating the EHB Package

- IOM’s criteria—benefits must:
  - Be safe—expected benefits should be greater than expected harms;
  - Be medically effective and supported by a sufficient evidence base, or in the absence of evidence on effectiveness, a credible standard of care is used;
  - Demonstrate meaningful improvement in outcomes over current effective services/treatments;
  - Be a medical service, not serving primarily a social or educational function; and
  - Be cost effective, so that the health gain for the individual and population health is sufficient to justify the additional cost to taxpayers and consumers.
Additional Guidance Released on EHBs

- CMS releases additional regulatory guidance (FAQs) on EHBs on February 17th
  - Clarifications related to the benchmark selection process for states
  - Clarifications related to state mandated benefit requirements
  - Benefit design flexibility
  - Large group market

- Guidance also addresses application of EHBs to Medicaid
  - Clarifies that states would not be required to select the same benchmark for Medicaid that applies to individual and small-group market

Guidance Released on Actuarial Value/Cost-Sharing

- HHS Bulletin on *Actuarial Value and Cost-Sharing Reductions* released on February 24th
  - Calculation of AV—uses as standard data set that HHS would develop; AV calculator would be developed by HHS based on national claims data
  - Some variation permitted (e.g. +/- 2 percentage points)
  - Treatment of HSAs/HRAs
  - State flexibility

- Guidance also addresses cost-sharing reductions and OOP limits for certain low-income individuals
  - Modeled after Medicare Part D low-income subsidy program
Health Plans—Driving Quality Improvement

- Centers of Excellence—networks with strong track records of quality care, health outcomes, and patient satisfaction
- Chronic Disease Care Coordination—case managers help patients, coordinate with multiple providers, provide coaching
- Disease Management Programs—comprehensive, integrated approach to care emphasizing patient education and self-management
- Prevention and Wellness Programs
- Medication Management Programs
- Targeting the Right Services to the Right Patient at the Right Time