The National Health Council’s Work on Essential Health Benefits

Marc Boutin
Executive Vice President & COO
National Health Council

ACA: Minimum Essential Benefits

- The ACA creates 10 categories of essential benefits that plans must cover beginning in 2014:
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Mental health and substance abuse services
  - Rehabilitative and habilitative services and devices
  - Prescription drugs
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Maternity and newborn care
  - Pediatric services
ACA: Minimum Essential Benefits

- The essential benefits requirements also place limits on patient costs
  - Limits out-of-pocket costs to Health Savings Account (HSA) levels (in 2011, $5,950 for individuals)
  - Limits deductibles for small group plans to $2,000 for individuals and $4,000 for families

Development of Policy Recommendations

- **EHB White Paper**
  - This report established baseline knowledge and considered the approaches HHS may take in defining the EHB package

- **EHB Cost Analysis**
  - This analysis examined the cost of a comprehensive health benefits package, using the Federal Employees Health Benefits Package as a model

- **EHB Policy Recommendations**
  - This report articulates NHC’s recommendations and proposed solutions and is shared with key policymakers and stakeholders
### Potential Approaches to Developing the Essential Health Benefits Package

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Define benefits narrowly</td>
<td>Define categories of benefits broadly and establish process-oriented requirements as a ‘check’ on plans</td>
<td>Define categories of benefits broadly, granting plans the flexibility to develop coverage policies within each category</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Medicare Part B program</td>
<td>▪ Medicare Part D program</td>
</tr>
<tr>
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### Room in Household Budget for Health Care?

<table>
<thead>
<tr>
<th>Reported Income (% poverty level)</th>
<th>Necessities</th>
<th>Necessities + Premium</th>
<th>Necessities + Premium + Median OOP Cost</th>
<th>Necessities + Premium + 90th Percentile OOP Cost</th>
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<tr>
<td>&lt;Poverty</td>
<td>17.30%</td>
<td>17.30%</td>
<td>17.30%</td>
<td>17.30%</td>
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<tr>
<td>101–150</td>
<td>7.50%</td>
<td>8.40%</td>
<td>8.50%</td>
<td>10.80%</td>
</tr>
<tr>
<td>151–200</td>
<td>3.70%</td>
<td>7.60%</td>
<td>9.00%</td>
<td>17.50%</td>
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<tr>
<td>201–250</td>
<td>3.00%</td>
<td>5.70%</td>
<td>8.80%</td>
<td>26.20%</td>
</tr>
<tr>
<td>251–300</td>
<td>1.10%</td>
<td>5.30%</td>
<td>6.90%</td>
<td>24.20%</td>
</tr>
<tr>
<td>301–350</td>
<td>0.70%</td>
<td>4.20%</td>
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<td>17.50%</td>
</tr>
<tr>
<td>351–400</td>
<td>1.20%</td>
<td>3.50%</td>
<td>3.90%</td>
<td>12.50%</td>
</tr>
<tr>
<td>401–450</td>
<td>0.50%</td>
<td>2.70%</td>
<td>3.70%</td>
<td>15.30%</td>
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<tr>
<td>451–500</td>
<td>0.40%</td>
<td>3.60%</td>
<td>4.70%</td>
<td>12.00%</td>
</tr>
<tr>
<td>&gt;500</td>
<td>0.20%</td>
<td>0.60%</td>
<td>0.60%</td>
<td>2.50%</td>
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</tbody>
</table>

(c) Jonathan Gruber and Ian Perry, The Commonwealth Fund
### At 250% FPL: Family of Four, One Person with Kidney Disease

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Annual Income (Gross)</td>
<td>$55,875</td>
<td>Subtract the cost of taxes, child care, food, housing, transportation, and miscellaneous expenses of 10%</td>
</tr>
<tr>
<td>Median Necessities*</td>
<td>– $39,671</td>
<td>Subtract ACA-defined maximum premium for family at 250% FPL (compared to ~$8,000 for a silver plan with no subsidy)</td>
</tr>
<tr>
<td></td>
<td>$16,204</td>
<td>Subtract reduced out-of-pocket maximum due to 250% FPL (compared to $11,900 with no subsidy)</td>
</tr>
<tr>
<td></td>
<td>– $4,500</td>
<td>Divide by 12 for estimate of remaining funds in monthly budget</td>
</tr>
<tr>
<td></td>
<td>$11,704</td>
<td></td>
</tr>
<tr>
<td></td>
<td>– $5,950</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$5,754</td>
<td></td>
</tr>
<tr>
<td>Per Month</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>~ $480</td>
<td></td>
</tr>
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### At 450% FPL: Individual with Rheumatoid Arthritis

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>Notes</th>
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</thead>
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<td>Annual Income (Gross)</td>
<td>$49,005</td>
<td>Subtract the cost of taxes, child care, food, housing, transportation, and miscellaneous expenses</td>
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<tr>
<td>Median Necessities*</td>
<td>– $30,873</td>
<td>Subtract cost of premium for a platinum plan</td>
</tr>
<tr>
<td></td>
<td>$18,132</td>
<td>Subtract out-of-pocket maximum set by the ACA</td>
</tr>
<tr>
<td></td>
<td>– $5,950</td>
<td>Divide by 12 for estimate of remaining funds in monthly budget</td>
</tr>
<tr>
<td></td>
<td>$6,977</td>
<td></td>
</tr>
<tr>
<td>Per Month</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>~ $580</td>
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</table>
Regulatory Opportunities

Level 1: Balance of Cost and Quality
- Non-Discriminatory Utilization Management
- Continuity of Care Assurance
- Cost-Sharing Protections

Level 2: Patient and Consumer Supports
- State Navigator Programs
- Care Coordination and Management Requirements

Level 3: Mechanisms to Ensure Access
- Medical Necessity and Appeals Processes
- Federal and State Exchange Oversight

Essential Health Benefits: A Pathway Forward

Broad Definition of Covered Services
ACA: Minimum Essential Benefits

- The ACA creates 10 categories of essential benefits that plans must cover beginning in 2014:
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Broad Definition of Covered Services + Statutory Requirements
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Essential Health Benefits: A Pathway Forward

Broad Definition of Covered Services + Statutory Requirements — Specific List of Exclusions
Specific List of Exclusions

Strong evidence that treatments are:

- Unsafe
- Non-effective
- Unlikely to Enhance Outcomes

Essential Health Benefits: A Pathway Forward
Essential Health Benefits: A Pathway Forward

Broad Definition of Covered Services
+ Statutory Requirements
– Specific List of Exclusions

Medical Necessity Processes
Anti-Discrimination Protection

Navigation Services
Essential Health Benefits: A Pathway Forward

Essential Health Benefits Bulletin

- Specific Recommendations
  - Federal review of selected state benchmarks
  - Benefit design flexibility related to permitted substitutions
  - Benefit design flexibility within the formulary structure
Call to Action

- Medical Necessity Processes
- Anti-Discrimination Protection
- Navigation Services
- Federal & State Oversight
- Affordability
Essential Health Benefits (EHB): An Update

February 9, 2012

Reginald Williams
Avalere Health LLC

Agenda

- NHC’s Work to Date on EHB
- Overview of the HHS Informational Bulletin
- Analysis of Drug Coverage in Benchmark Plans
NHC’s Work to Date on EHB

NHC Has Collaborated with Avalere to Bring the Voice of the Patient Community to the EHB Discussion

- **White Paper.** This report established baseline knowledge and considered the approaches HHS may take in defining the EHB package
- **Cost Analysis.** This analysis examined the cost of a comprehensive health benefits package, using the Federal Employees Health Benefits Package as a model
- **Policy Recommendations and Regulatory Language.** This report articulated NHC’s recommendations, proposed solutions, and regulatory language and was shared with key policymakers and stakeholders
- **Alternative to IOM Approach.** This memo described NHC’s recommended alternative to the approach presented by the IOM on developing EHB
- **Comments on EHB Bulletin.** This letter offered comments on CMS’s state flexibility approach to developing EHB
HHS Released a Bulletin Presenting Its Intended Regulatory Approach on the Essential Health Benefits (EHB)

- On December 16, HHS released an informational bulletin presenting its intended regulatory approach on the essential health benefits that plans must cover under the ACA
  - HHS’ proposed approach gives states latitude to select a benchmark plan that reflects services offered by a typical employer plan
- HHS’ bulletin – which serves as a roadmap to inform future rulemaking – only discusses covered services
  - HHS will address issues such as cost-sharing, actuarial value, and implementation of EHB in Medicaid in future guidance

Comments were due by January 31, 2012. No schedule has been announced regarding future rulemaking
To Inform the Definition of Essential Health Benefits (EHB), HHS Gathered Input From Several Sources

DOL
- Report issued in April 2011 detailing the scope of benefits typically covered by employer-sponsored plans

IOM
- Recommendations on the process used to determine and periodically evaluate EHB requirements

ASPE
- Analysis comparing health benefits in small group, and state and federal employee plans, as well as an issue brief on the individual market

Stakeholders
- Input from stakeholders gleaned from a series of public listening sessions

Analysis Indicated General Consistency in Scope of Benefits, But Variation in Cost Sharing

- Based on its review of materials from information gathering, HHS determined that:
  - Plans across all markets studied cover a similar scope of services, including most of the 10 benefit categories outlined in the ACA
  - Across plans studied, variation was greater for cost sharing than for covered services
  - Coverage of some services – such as dental benefits and smoking cessation programs and drugs – varied across markets
  - FEHB plans cover nearly all of the benefits required under state mandates
    - Primary exceptions include in-vitro fertilization and advanced behavior analysis for children with autism

FEHB = Federal Employee Health Benefit
Intended Regulatory Approach Links EHB to Benchmark Plans

- States would define EHB by selecting a benchmark plan from four options:

  - One of the three largest small group plans in the state by enrollment
  - One of the three largest state employee health plans by enrollment
  - One of the three largest federal employee health plan options by enrollment
  - The largest HMO plan offered in the state’s commercial market by enrollment

- States must select a benchmark in the third quarter two years prior to the applicable year (e.g., third quarter of 2012 for the 2014 benefit year)
- If the selected benchmark plan does not include the 10 required service categories, states would need to supplement the plan using the largest plan in the benchmark type by enrollment offering the benefit, or the largest FEHB plan

HHS Intends to Utilize Benchmark Approach for 2014 and 2015, Giving States More Time to Evaluate Benefit Mandates

- **Transitional Approach**: HHS intends that states would use the benchmark approach for 2014 and 2015
  - HHS will conduct an evaluation on the benchmark process for 2016 and beyond
- **State Mandates**: The benchmark approach gives states two years to coordinate benefit mandates
  - If a state selects a benchmark plan that covers state benefit mandates (e.g., a small group plan), then mandates would be included in the EHB package
  - If mandates are not included in the benchmark plan, states would be required to cover the cost of mandates exceeding the EHB package
  - As a result, states with a substantial number of mandates are likely to select one of the state plan benchmarks, which will include all mandated benefits
HHS Is Also Proposing to Allow Plans Significant Flexibility to Design Benefits Based on the State’s Benchmark

- HHS would allow plans to vary from the benchmark plan’s benefit design by:

  **Adjusting benefits and quantity limits**
  - Plans must offer all 10 ACA-required categories

  **Making actuarially equivalent substitutions of benefits within categories, as well as between categories**
  - HHS is considering allowing this flexibility

  **Choosing which prescription drugs to cover**
  - Formularies must include at least one drug per category and class from the benchmark plan (less stringent than Medicare Part D formulary requirements)
  - HHS does **not** intend to adopt Part D’s protected classes policy

- Under the benchmark framework, plans could update their benefits annually

Analysis of Drug Coverage in Benchmark Plans
CMS Releases Additional Data on Benchmark Options

- On January 25, CMS released a list of the largest three small group products in each state
- The release also includes a list of the top three nationally available FEHB plans
- As indicated in their bulletin from December, CMS requires states to select a benchmark in Q3 of 2012 using enrollment information from Q1 of 2012
  - The plans included in this latest CMS release are based on enrollment from Q2 of 2011

The release helps clarify the types of plans CMS references in the bulletin


Avalere Examined Proxy Benchmark Plan Options to Identify the Extent of Variation in Formulary Drugs Covered

- As states begin selecting EHB benchmark plans, it will be important to understand the differences in covered services among the benchmark options
- Avalere sought to examine benchmark plan drug benefit formularies to identify how much variation exists among the options
  - Due to limitations in obtaining state-level plan enrollment for the small group market, we selected plans to serve as proxies for high-enrollment small group plans

<table>
<thead>
<tr>
<th>EHB Benchmark Plan Options</th>
<th>Proxy Plans Examined</th>
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<tbody>
<tr>
<td>Federal Employees Health Benefit Program (FEHBP)</td>
<td>Blue Cross Blue Shield Standard Option PPO, the FEHB plan with the highest nationwide enrollment</td>
</tr>
<tr>
<td>Small Group Plans in Key States*</td>
<td>California: Anthem Lumenos PPO</td>
</tr>
<tr>
<td></td>
<td>Colorado: United Choice Plus POS**</td>
</tr>
<tr>
<td></td>
<td>Maryland: CareFirst Blue Choice HMO HSA</td>
</tr>
<tr>
<td></td>
<td>New York: United EPO Oxford Health Insurance</td>
</tr>
</tbody>
</table>

*Plans were selected based on input from Pfizer and the availability of information on the state's small group markets and formularies. These plans represent small group plans provided by large carriers in the selected states.**This is a 2011 formulary; a 2012 formulary was not yet available.
To Compare Formularies, We Identified the Number of Covered Drugs Within Selected Therapeutic Classes

- The selected formularies were reviewed for the number of brand-name and generic drugs* covered in each of nine classes from the United States Pharmacopeia (USP) Medicare Model Guidelines, Version 5.0

<table>
<thead>
<tr>
<th>USP Category</th>
<th>USP Class</th>
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<tbody>
<tr>
<td>Antineoplastics</td>
<td>- Molecular Target Inhibitors</td>
</tr>
<tr>
<td>Blood Glucose Regulators</td>
<td>- Antidiabetic Agents</td>
</tr>
<tr>
<td>Cardiovascular Agents</td>
<td>- Alpha-Adrenergic Blocking Agents</td>
</tr>
<tr>
<td></td>
<td>- Angiotensin-Converting Enzyme (ACE) Inhibitors</td>
</tr>
<tr>
<td></td>
<td>- Angiotensin II Receptor Antagonists</td>
</tr>
<tr>
<td>Central Nervous System</td>
<td>- Fibromyalgia Agents</td>
</tr>
<tr>
<td>Agents</td>
<td>- Multiple Sclerosis Agents</td>
</tr>
<tr>
<td>Respiratory Tract Agents</td>
<td>- Anti-Inflammatories, Inhaled Corticosteroids</td>
</tr>
<tr>
<td></td>
<td>- Antileukotrienes</td>
</tr>
</tbody>
</table>

*Combination products and extended release formulations were counted as separate products, but varying formulations (e.g., oral vs. injectible) of the same active drug were not differentiated.

Key Findings: Plans Cover Significantly More Than One Drug Per Class

- All of the plans analyzed consistently covered a significant number of drugs in each class, well beyond the HHS’ proposed one-drug-per-class minimum, as well as the Medicare Part D standard of two drugs per class
  - For most of the classes in the study, plans covered at least 50 percent of both brand-name and generic products available in each class; in large classes, such as antidiabetic agents, small group plans cover more than 30 products
- HHS’ proposed minimums would provide health plans significant flexibility in designing formularies that meet EHB standards and could result in significant plan-to-plan and state-to-state differences for consumers
- Additionally, we found that significant variation exists in the number of drugs covered per class among the plans we examined
- The FEHB plan, BCBS Standard PPO, is the most generous of proxy plans, as this plan has an open formulary—covering all commercially available drugs approved by the U.S. Food and Drug Administration
- Level of state-to-state variation within small group plans fluctuated by class
Antineoplastics: Molecular Target Inhibitors*

**Molecular Target Inhibitors* Covered by Each Plan**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Number of Covered Drugs</th>
<th>Brand</th>
<th>Generic</th>
</tr>
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<tbody>
<tr>
<td>FEHBP / Total in Class**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>California</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maryland</td>
<td>7</td>
<td></td>
<td></td>
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<tr>
<td>Small Group EHB Benchmark Plans*</td>
<td>9</td>
<td></td>
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</table>

*There are no FDA-approved generics in this class.

**The FEHBP Standard Option is an open formulary—covering all commercially available drugs approved by the U.S. Food and Drug Administration. FEHBP-covered drugs represent all drugs available in the USP class.

+ Proxy plans in CO and NY do not list antineoplastics on formularies and may address coverage policies for these drugs at a product level; access may vary.

Source: Avalere Health analysis using publicly available commercial formularies.

Blood Glucose Regulators: Antidiabetic Agents

**Generic and Brand Antidiabetic Agents Covered by Each Plan**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Number of Covered Drugs</th>
<th>Brand</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEHBP / Total in Class*</td>
<td></td>
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</tr>
<tr>
<td>California</td>
<td>14</td>
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<td>Colorado</td>
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<tr>
<td>New York</td>
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</table>

*The FEHBP Standard Option is an open formulary—covering all commercially available drugs approved by the U.S. Food and Drug Administration. FEHBP-covered drugs represent all drugs available in the USP class.

Source: Avalere Health analysis using publicly available commercial formularies.
Health Reform Will Continue to Be Implemented at the National Level throughout 2012

- NPRM Employer Reporting Requirements
- NPRM on Individual Mandate/ Penalties
- NPRM on Employer Mandate/ Penalties
- NPRM Employer Reporting Requirements
- NPRM on Employer Tax Credits
- Final Rule on Small Employer Exchanges
- Final Rule on Medicaid and Exchange Eligibility and Enrollment
- Final Rule on Affordability Programs
- NPRM on Cost-Sharing Assistance
- Final Rule on Essential Health Benefits
- NPRM on Annual Limits, Other 2014 Insurance Reforms
- NPRM on Plan Quality Reporting Requirements
- Draft MA/ Part D Regulation for CY 2014 (likely to include MA MLR regs)
- Final Rule on Risk-adjustment, Reinsurance and Risk-corriders
- Final Rule on Essential Health Benefits
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Jan- Mar
- Supreme Court Deliberations

Apr-Jun
- Supreme Court Decision
- Final Rule the Federal-Fall Back Exchange
- Proposed Rule on Basic Health Programs

Jul-Sep
- Final Rule on Small Employer Exchanges
- Final Rule on Medicaid and Exchange Eligibility and Enrollment
- Final Rule on Affordability Programs
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Oct-Dec
- Presidential Election State Elections (11 governors and 5 insurance commissioners)

NPRM = Notice of proposed rule-making