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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

Good morning.

Thank you for inviting The National Business Group on Health to provide the large employers' perspective at today's open comment session for employers and health plans to provide assistance to the Department of Health and Human Services (HHS) in determining the "essential health benefits" package for the exchange plans required by the Patient Protection and Affordable Care Act (Affordable Care Act).[1]

My name is Michael Baxter, a Senior Public Policy Analyst at the National Business Group on Health. The National Business Group on Health is a member organization representing over 330 mostly large employers—including 68 of the Fortune 100—that provide coverage to more than 55 million U.S. workers, retirees and their families. The National Business Group on Health is the nation's only non-profit organization devoted exclusively to finding innovative and forward-thinking solutions to large employers' most important health care and related benefits issues.

Most of our members, and most employers of any size, self-fund the health care costs for employees, dependents, and retirees in many cases. Therefore, the "essential health benefits" provisions do not directly apply to these plans. However, self-insured employers are affected by the government's definition of "essential health benefits" in a number of ways:

- First, the Affordable Care Act prohibits "unreasonable" annual limits on the "essential health benefits" package beginning in 2014.
- Second, in many cases, people currently covered by our plans may be eligible for tax credits and exchange coverage in 2014 (individuals with coverage the government deems "unaffordable" or not "comprehensive", early retirees, COBRA eligibles, spouses, dependents or contract, part-time or temporary employees).
- Third, large employers may also chose to enter the SHOP exchanges, if permitted by the state exchanges, beginning in 2017.

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[1] The Affordable Care Act defines "essential" health benefits under the general categories of (A) Ambulatory patient services; (B) Emergency services; (C) Hospitalization; (D) Maternity and newborn care; (E) Mental health and substance use disorder services, including behavioral health treatment; (F) Prescription drugs; (G) Rehabilitative and habilitative services and devices; (H) Laboratory services; (I) Preventive and wellness services and chronic disease management; and (J) Pediatric services, including oral and vision care. It also requires the HHS Secretary to ensure the benefits are equal to the scope of benefits provided under a "typical employer plan".

- Fourth, employers' current employees may compare the "essential health benefits" package with their own benefits and ask plans to add any additional benefits not in their plans which could increase costs.
- Finally, special interests may also see the "essential health benefits" package as "the floor" and lobby Congress and states to mandate coverage for additional benefits for plans that already offer comprehensive packages which could make the plans unaffordable without providing any additional benefits to enrollees.

As stated by our President, Helen Darling's recent testimony[2] to the Institute of Medicine (IOM), the National Business Group on Health believes HHS should focus the "essential health benefits" package on the triple financial goals of assuring people affordable coverage, protecting them from catastrophic financial losses when faced with serious illness; and helping them to avoid unnecessary costs. Having spent the last few years beating the drums about the ***urgent*** need to control health care costs and to build affordability into every health care decision, we are very pleased to see the IOM advising HHS to consider "affordability" in the "essential health benefits" package and considering what benefit plan designs and tools for controlling costs and dollar limits health plans can use. The report's clear focus on "affordability" should lower the cost and improve the quality of the exchange plans available to employers' and other exchange eligible populations.

However, we do have ***strong*** concerns regarding the report's recommendation to allow states to implement state-specific "essential health benefit" packages as long as they are actuarially equivalent to the federal package because it could:

- Create problems for multi-state employers attempting to offer uniform benefit packages to their employees in the exchanges;
- Duplicate federal "essential health benefit" efforts;
- Increase bureaucracy, costs and confusion; and
- Potentially allow states to require plans to cover state mandates, often implemented for political reasons rather than based on clinical evidence, which could impact the overall "affordability" of exchange coverage for Americans and their families.

Regarding the specific questions HHS requested for today's comment session, we offer the following responses which reflect the specific suggestions and concerns of our member companies:

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[2] Darling, Helen. Testimony to the Institute of Medicine. Session 2. Recommendation on Criteria and Methods for Defining and Updating Individual Mandates and Packages. Purchaser Perspectives. January 2011. Available at: http://www.businessgrouphealth.org/pdfs/Testimony%20of%20Helen%20Darling%20before%20the%20IOM%20on%20the%20Essential%20Health%20Benefits%20Package%20-%2011311.pdf

In keeping with the title of the Institute of Medicine report "Essential Health Benefits—Balancing Coverage and Cost", how can the Department best meet the dual goals of balancing the comprehensiveness of coverage included in essential health benefits and affordability?

We believe the IOM report's emphasis on cost and clinical evidence is promising and a balance to what has so far been more emphasis on coverage than affordability by a tidal wave of lobbyists and advocacy groups. We also applaud IOM's recommendation to update the "essential health benefits" package to make it more evidence-based, specific, and affordable.

Further, we support the IOM report's recommendation to base the initial "essential health benefits" package on a typical small employer plan adjusted so the national average premium for the silver plan (70% actuarial value) is actuarially equivalent to the average premium for small employers in 2014. The IOM's approach strikes the necessary balance between coverage and affordability by ensuring that the small employer population, who will access the SHOP (small employer) exchanges in 2014, will have access to an evidence-based benefits package that their mid-low wage employees could still afford—particularly since health care costs have continued to increase. What our economy needs is for businesses to grow and hire more workers—a benefits package that is too expensive will hinder business and job growth. The IOM also establishes a collaborative process with relevant stakeholders in the future through the National Benefits Advisory Council (NBAC) to ensure that any changes to the "essential health benefits" package or the premium target do not make this coverage unaffordable to the thousands of employees working for our nation's small employers. .

We also recommend that HHS include efficiency as an important criterion of the "essential health benefits" package. Coverage that promotes efficiency by requiring best management practices will keep benefits affordable and thereby support a more robust package of "essential health benefits".

The following is a list of best management practices that leading edge employer plans implement to promote efficiency in benefits:

- **Focus on Evidence-Based Benefits;**
- **Target Evidence-Based Preventive Care;**
- **Emphasize Primary Care;**
- **Utilize Meaningful Cost-Sharing;**
- **Implement Prescription Drug Management;**
- **Offer Health Improvement Programs;**
- **Provide Targeted Disease Management Programs;**
- **Consider Retail/Convenience Care Clinics;**
- **Offer Consumer Decision Support Tools;**
- **Implement Pay-for-Performance;**
- **Use High-Performance Networks;**
- **Utilize Health Information Technology (HIT); and**

- **Require Transparency (Cost and Quality).**

How might the Department ensure that essential health benefits reflect an appropriate balance among the categories so that they are not unduly weighted toward any category?

Exchange plans should design their benefits to provide appropriate and effective medical care for patients and at that same time ensure that the medical services remain cost effective for both the plan and participants. The ten categories, outlined in the law include care provided in both a medical setting (ambulatory care, hospitalization, etc.) and also care that is provided for certain health conditions (behavioral health, maternity, etc.). "Appropriate balance" must focus on treatment plans with successful outcomes, proper settings, appropriate provider credentials, and also normal utilization patterns.

What policy principles and criteria should be taken into account to prevent discrimination against individuals because of their age, disability status, or expected length of life as the Affordable Care Act requires?

In order to be considered an "essential health benefit", the service or treatment should have demonstrated evidence of effectiveness and be clinically appropriate for the individual. We recommend HHS regularly consult with outside organizations and utilize existing federal agencies like HHS' Office on Disability and the Center for Medicare and Medicaid Innovation (CMMI) with periodic updates from their research on whether the "essential health benefits" package is meeting the diverse needs of the elderly, children and people with disabilities. In addition, after the first year, the HHS Secretary should compile a report on the extent to which the "essential health benefits" in the exchanges have helped to eliminate any health care disparities for these populations.

We also recommend including patient-decision aids in the "essential health benefits" package to help these populations choose treatments aligned with their preferences. Patient decision-aids use the available evidence about relative risks and benefits of treatment choices to help patients arrive at an informed decision about the best course of action based on their risks, preferences, and circumstances such as age, expected length of life, present or predicted disability, degree of medical dependency and quality of life. Most plans design decision aids for use in consultation with a clinician, commonly referred to as shared-decision making.

In addition, a timely appeals process in the exchanges can avoid inappropriate denials that allow patients and their providers to demonstrate a service or treatment is appropriate.

What models should HHS consider in developing essential health benefits?

As I mentioned earlier, we support the IOM report's recommendation to model the initial "essential health benefits" package on a typical small employer plan adjusted so the national average premium for the silver plan (70% actuarial value) is actuarially equivalent to the average premium for small employers in 2014. Plans offered in the

small group market can not afford the benefits in the large employer market and basing the “essential health benefits” packages on “a typical small employer plan” would make exchange coverage unaffordable to one of the main populations designed to have access this coverage before 2017.

We also strongly recommend that HHS recognize account-based Consumer-Directed Health Plans (CDHPs), a model that also plays an important role important role in providing affordable coverage, including for previously uninsured people. CDHPs provide preventive care services outside the deductible and also cover 100% of catastrophic coverage cost for serious illnesses. These plans give individuals more control over their health care while maintaining affordability for those subsidizing health care coverage. More importantly, CDHPs are beginning to show evidence of increased adherence in chronic care, a reduction in unnecessary services and further engagement in health improvement programs. The compelling research, detailed below, illustrates that CDHPs should be permitted as a health option under the “essential health benefits” requirement.

In comparing members in a traditional plan with those in a CDHP, Blue Cross Blue Shield of Minnesota found that CDHP enrollee’s accessed preventive services at a higher rate, had shorter hospital stays and fewer inpatient admissions. CDHPs have been covering preventive care communications at 100% years before the health care law came into fruition. Additionally, research published in the Journal of the American Medical Association observed that avoidable hospitalizations declined by almost a third in the CDHP group. Individuals with CDHPs also use health improvement programs at a higher level with 43% receiving a health screening (with 30% of those with traditional coverage doing so). CDHP enrollees are also 11% more likely to participate in an exercise program.

Lower premiums attract individuals to these types of plans. On average, employees with CDHPs contribute $745 toward plan costs, compared to $1,584 for all other plans. With the lower upfront costs, people can also set aside funds for later years to pay for future health care costs.

In addition, as HHS develops the “essential health benefits” package, we recommend that it factor in the important role that reasonable, evidence-based limits on covered benefits play in health coverage.

Exchange plans should encourage medically effective treatment treatments that are also cost effective for both the plans and participants. HHS should implement limits applied through some type medical management (medical settings, duration of treatments, and approved treatment plans) limits. Limitations should be based on clinical outcome studies to identify the best practice methods, medical settings, treatment durations, provider credentials, and also to identify areas of high utilization of and unnecessary use of medical services by participants that leads to abuse. Additionally, HHS should establish a formal ongoing medical management review process established to incorporate new advances in medical technology and in medical treatment plans to assure that plans cover the appropriate medical services in the appropriate settings. This will prevent ineffective

medical treatment, inappropriate health benefits and avoid a financial burden for both the plan and participants.

Employer plans commonly and routinely place limits on a number of services to keep care affordable, including the following:

- Bariatric coverage for weight loss;
- Chemical dependency;
- Chiropractic benefits;
- Dental coverage:
- Vision coverage;
- Durable Medical Equipment (DME);
- Hearing aids;
- Home health care/hospice;
- Infertility benefits;
- Out-of-network benefits; and
- Physical and speech therapy.

Government programs, including Medicare, the Federal Employee Health Benefits Program (FEBHP), and Medicaid also routinely have limits on benefits. For example:

- The Federal Employee Health Benefit's Blue Cross/Blue Shield's basic option plan places a 75 visit annual limit on physical, speech, and occupational therapy sessions.
- Medicare utilizes a 190-day lifetime limit on inpatient psychiatric care; limits coverage for chiropractic care and a variety of other services; and does not cover acupuncture; dental care and dentures (in most cases); cosmetic surgery; custodial care (help with bathing, dressing, using the bathroom, and eating) at home or in a nursing home; health care while traveling outside of the United States (except in limited cases); hearing aids and hearing exams or orthopedic shoes.
- Medicare Part D (prescription drug benefit) utilizes prior authorization, "step therapy" requirements and quantity limits.

What criteria should be used to update essential health benefits over time and what should the process be for their modification?

In the future, advances in personalized medicine will require a more individualized approach to coverage decisions and the speed at which new, costly medical technologies are coming to market emphasize the need for objective evidence-based assessments to ensure patient safety, quality and affordability. Both of these factors suggest the need for frequent and regular reevaluation of the "essential health benefits" package. Such reevaluations should look not only at benefits to add, but also review existing "essential health benefits" to see if any need culling.

We recommend that HHS conduct an initial evaluation of the "essential health benefits" package after the first 6 months and annually thereafter. The initial evaluation should

include an evidence-based, clinical review of the medical services and medical providers utilized (with an actuarial cost/benefit analysis) and incorporate any new information based on credible, scientific evidence published in peer-reviewed medical literature and remove any benefits that are no longer supported by the evidence.

The annual updates should take into account new evidence garnered from the comparative effectiveness research of the Patient-Centered Outcomes Research Institute (PCORI). With a $2.5 trillion dollar economy, and another 32 million people having comprehensive coverage, some, possibly for the first time ever, the federal government will require speedy action to ensure that there is budgetary room for new effective, evidence-based treatments, technology and medications.

We also support IOM's recommendation to create a National Benefits Advisory Council (NBAC) or a diverse set of stakeholders free from political influences to make recommendations on changes to the "essential health benefits" package, changes to the premium target, and ways to enhance the evidence base and promote the value of the package. However, we strongly recommend HHS add large employers to IOM's list of potential NBAC members, similar to their recent addition in the recent exchange rule, to the list of groups the exchanges should consult with on a regular basis with the relevant expertise in administering effective and efficient health care benefits for plan participants.