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BENEFIT NEWS BRIEFS

IOM Recommends Criteria and Methods to Develop Essential Health Benefits Package

The Institute of Medicine (IOM) released a *Report* providing the Department of Health and Human Services (HHS) with a set of criteria and methods to develop a package of essential health benefits that will cover many health care needs, promote medically effective services, and be affordable to purchasers. The *Report* recommends that HHS decisions about which benefits warrant designation as "essential" should be made in a transparent manner that is informed by input from structured public discussions. The *Report* committee stated the government should announce the initial package of essential health benefits by May 1, 2012.

In addition to the *Report*, IOM also made available a set of criteria for HHS to use (available by "*clicking here*") and a summary report (available by "*clicking here*"). A free pdf of the prepublication version of the 297-page *Report* is available at: *http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx* or by *"clicking here."*

One of the reasons defining "essential health benefits" (EHBs) is important is that certain insurance plans, including those participating in the state-based health insurance exchanges to be established under the *Patient Protection and Affordable Care Act (ACA)*, must cover a package of preventive, diagnostic, and therapeutic services and products in areas that have been defined as "essential" by HHS.

Another reason it is important to define EHBs is that the lifetime/annual limits portion of the *ACA* define acceptable dollar limits in terms of EHBs. For now, health plans have been taking a "good-faith" approach as to what might be an EHB when determining if the *ACA* would allow dollar limits on certain benefits – that is on "non-essential" health benefits.

In addition to EHBs, insurers may offer additional benefits in their plans. The report neither recommends a list of essential benefits nor comments on whether any particular service should be included or excluded, as doing so would have been beyond the committee's charge.

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Establishing the "Essential Health Benefits" Package

The *ACA* stipulates that EHBs should reflect the scope of benefits covered by a typical employer plan and include 10 specific categories. The *Report* suggests that HHS staff should determine EHBs based upon what is typical of small employer plans because they will be among the main customers for policies in the state-based exchanges. HHS officials should gauge potential services and products against a set of criteria, including medical effectiveness, safety, and relative value compared with alternative options, and evaluate whether the package as a whole protects the most vulnerable individuals, promotes services that have proved effective, and addresses the medical concerns of greatest importance to the public, the report says. Benefits that have been mandated for insurance coverage by individual states should be subject to the same review and criteria. Products and services that do not meet the criteria should not be included.

The ten EHB categories are:

- 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

Because the EHB package must be affordable to the small firms and individuals who will be the principal customers for the exchanges, its comprehensiveness should be balanced with its potential cost, the *Report* concluded. In particular, the *Report* recommends that HHS determine what the national average premium of typical small employer plans would be in 2014 and ensure that the package's scope of benefits does not exceed this amount. This premium target would be used only as a criterion in developing the package; the premium that a particular employer or individual purchaser ultimately pays for a plan with the package could be different because of a variety of other factors.

The *Report* indicated that HHS officials would benefit from gathering input on the health priorities of the public from a series of structured deliberative sessions held nationwide. These sessions should engage small-business owners, uninsured people, and others in weighing benefits and costs and considering trade-offs, and the process would promote transparency, the *Report* says.

The *Report* also urged HHS officials to be as specific as possible about what benefits are included and which can be excluded when they issue the resulting package. However, the *Report* recognizes that HHS will not be able to spell out every service and product that would be included initially.

Updating the Package

The *Report* notes that HHS will need to amend the package over time to keep pace with advances in clinical technologies, changes in patient populations, and other trends. Further, as research yields more knowledge, the list of EHBs can become more detailed and promote greater value over time, the *Report* notes, and the *Report's* criteria should continue to be used to evaluate the list in light of such. The *Report* also posts that the premium target should be updated to reflect medical inflation, and changes in the benefits package should be cost-neutral against this revised target.

Flexibility

The *Report* urges HHS to grant states' requests to adopt alternatives to the federal EHB package only if the alternatives are consistent with *ACA* requirements and the criteria specified in this report and if they do not vary significantly from the federal package.

Appendices

The *Report* also has 7 helpful appendices:

A. Patient Protection and Affordable Care Act Section 1302 and Web Questions for Public Input on Determination of Essential Health Benefits

B. Stakeholder Decisions on Health Insurance

C. Examples of Degrees of Specificity on Inclusions

D. Models of Benefit Package Statutory Guidance and Resulting Designs

E. Description of Small Group Market Benefits, provided by WellPoint

F. General Exclusions

G. Medical Necessity - Comparison of Existing Advisory Groups

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