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Institute of Medicine
of the
National Academies
COMMITTEE ON DEFINING AND REVISING AN ESSENTIAL HEALTH BENEFITS PACKAGE FOR QUALIFIED HEALTH PLANS
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I am Linda Fishman, senior vice president of public policy analysis and development at the American Hospital Association (AHA). On behalf of the AHA's more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, I appreciate the opportunity to participate in the Institute of Medicine's deliberations on defining an essential health benefits package for the qualified health plans within the *Patient Protection and Affordable Care Act* (ACA).

A FRAMEWORK FOR DISCUSSION

The Institute of Medicine (IOM) has both the opportunity and the challenge of recommending to the Department of Health and Human Services how essential health benefits should be defined. The AHA is pleased to offer the following framework for those deliberations.

Basic Principle. The essential benefits package should cover treatment that: encompasses a broad range of services, including medical, psychiatric, rehabilitative, dental, vision, preventive and hospice services, as well as pharmaceuticals; is driven by the needs of the individual; is generally available; and adheres to accepted professional guidelines.

From this basic principle, we suggest a three-pronged framework for assessing which benefits to include:

- Are the benefits responsive to individual needs?
- Do the benefits take affordability into account?
- Are the benefits easily understood and transparent?

Benefits that are Responsive to Individual Needs. The essential benefits definition needs to be comprehensive enough to respond to an individual's needs, recognizing that a person's age and medical condition(s) will dictate what services are most important. The criteria should take into account diverse segments of the population and focus on the services that are widely accepted to improve health outcomes for those populations, which may necessitate supplemental or alternative benefits. Consequently, any limits placed on the essential benefits package should be grounded in clinical best practices and could include, for example, the number and frequency of diagnostic tests or procedures. Such limits should focus on services that are marginally effective and could change as underlying scientific evidence or comparative effectiveness research informs the creation of, or revisions to, clinical best practices. Particular types of services should not be eliminated wholesale. The essential benefit criteria also should take into account the rapid pace of change in medical practice, as clinical, technological and pharmaceutical advances are made.

Benefits that Address Affordability. The ACA requires that four levels of qualified health plans – bronze, silver, gold or platinum – be offered through the health insurance exchanges. These plans vary by the level of individual cost sharing. The affordability of the essential health benefits could be governed by the cost sharing amounts among the four levels of qualified health plans. Under this approach, the benefit covered would not vary; rather what would vary is the cost sharing for which the individual would be responsible. This would establish a universal baseline of benefits and prevent insurers from picking and choosing the benefits that are covered, for example, excluding psychiatric or inpatient rehabilitation services.

Benefits that are Easily Understood and Transparent. The essential benefits package, as defined, should be easily understood so that individuals know what their health plan policy does and does not cover. Insurers make coverage and treatment decisions by determining what is "medically necessary," and defining that term is left largely to the insurers. No consistent federal or state definitions exist. This lack of a consistent or recognized standard allows insurers to control not only coverage decisions, but also treatment decisions, sometimes overriding clinical standards and the patient's needs. When an insurer uses its definition of medical necessity to exclude costly care, enrollees are often caught unaware without notice of what will and will not be covered. Similarly, enrollees and providers should be able to rely on a health plan's prior authorization for a procedure or admission, but even under the reforms recently enacted, insurers are allowed to retroactively deny services that they preauthorized. The rules and decision processes that govern essential health benefits, medical necessity and pre-authorization decisions made by qualified health plans should be transparent so that enrollees understand the limitations of their health coverage.

Thank you for the opportunity to present here today. We offer this framework to aid the IOM in its deliberations on essential health benefits and we look forward to working with the committee and staff.