

ISSUE BRIEF: Essential Health Benefits and Patient Centricity

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BACKGROUND

The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA),¹ creates exchanges, which are virtual marketplaces where individuals and businesses can compare health insurance product coverage as well as purchase health insurance.

The products offered through exchanges are referred to as qualified health plans (QHPs), that may vary in coverage levels yet meet certain standards in categories of care and limits on patient cost sharing. The PPACA requires QHPs to cover the following general categories: 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; and pediatric services including oral and vision care.

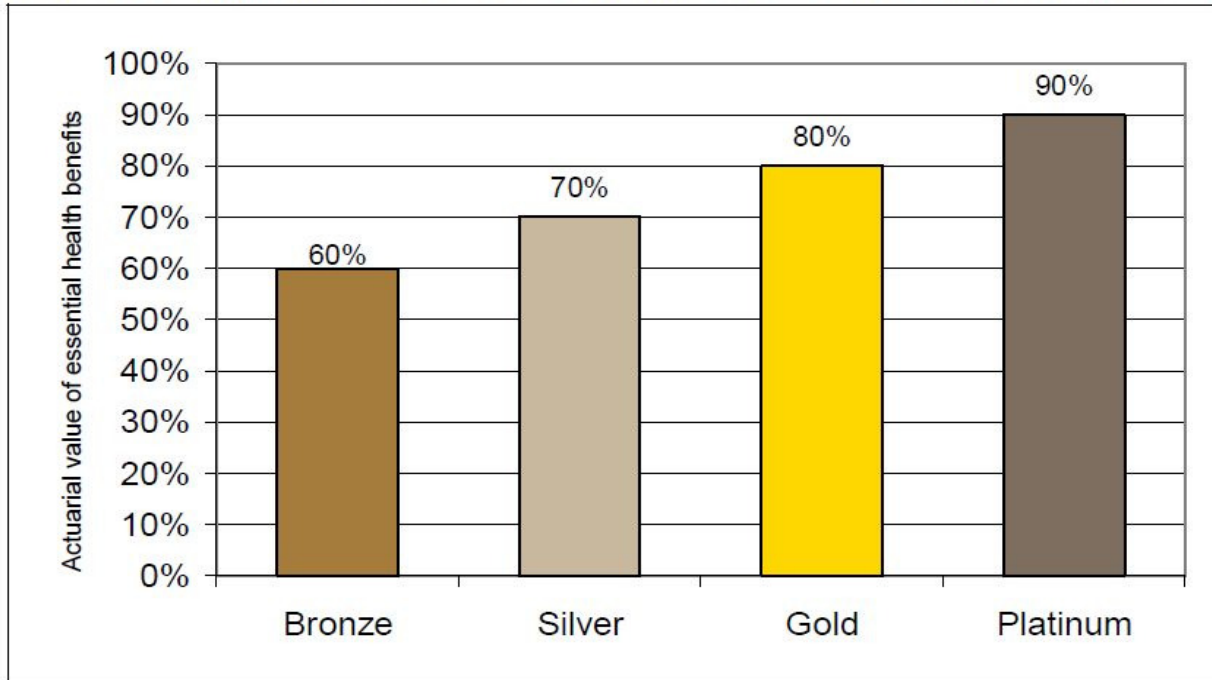
¹ Patient Protection and Affordable Care Act, §1302, p 45. http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf. Accessed June 18, 2011.

HHS is directed to specify the “essential health benefits” included in the “essential health benefits package” that QHPs will be required to cover (effective beginning in 2014) based on the

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scope of benefits offered by a typical employer plan. The agency must not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life, and must take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups. The PPACA also directs HHS to periodically review the essential health benefits and address any gaps in access to coverage.

Figure 1. Actuarial Values for Levels of Coverage Provided by Qualified Health Plans



Source: CRS analysis of the Patient Protection and Affordable Care Act.

THE FIRST STEP: THE DEFINITION

HHS' success in appropriately defining essential health benefit packages will determine the success or failure of the program, and may serve as a litmus test for the overall value of health reform efforts in general. HHS' website (www.healthcare.gov) promotes exchanges as private health insurance markets that will provide access to health insurance options to small businesses and to individuals. Exchanges are the vehicle by which health insurance consumers will be educated on how to choose a health insurance product and as well as the entity by which consumers will purchase these products. The ultimate goal is to have a greater number of Americans covered.

Health insurance products differ by coverage level. The PPACA stratifies levels of health insurance coverage that QHPs must provide into four color categories- bronze, silver, gold, or platinum.² Coverage levels will be based on

a specified share of the full actuarial value of the essential health benefits (see Figure 1). Each specific service added to the essential health benefits package increases the total actuarial value of the plan as well as the actual dollar value of the enrollees' cost sharing. According to an analysis completed on behalf of the Kaiser Family Foundation by three actuarial and benefits consulting firms, a consumer purchasing a bronze-level plan could be responsible for a deductible ranging from \$2,750 to \$6,350 and a coinsurance rate for bills between the deductible amount and the out-of-pocket cost limit ranging from 0% to 30%.³ The bronze level plan has the lowest actuarial value for level of coverage and therefore would cover only 60% of expenses before the out-of-pocket cost limit kicked in. (See Figure II from the Kaiser Family Foundation on next page.)

² §1302(d)

³ Henry J. Kaiser Family Foundation, "What the Actuarial Values in the Affordable Care Act Mean," April 2011.

Figure II. Estimates of Plan Designs Meeting Selected PPACA Actuarial Value Thresholds, 2014

	Actuarial Value	Out-of-Pocket Maximum	Actuarial Research Corporation		Aon Hewitt		Towers Watson	
			Deductible	Coinsurance	Deductible	Coinsurance	Deductible	Coinsurance
A	60%	\$6,350	\$6,350*	0%	\$4,350	20%	\$2,750	30%
B	70%	\$6,350	\$4,200	20%	\$2,050	20%	\$1,850	20%
C	70%	\$4,200	\$4,200*	0%	\$2,650	20%	\$1,550	30%
D	70%	\$3,200	\$3,200*	0%	\$3,200*	0%	\$2,050	30%
E	73%	\$3,200	\$3,200*	0%	\$3,200	0%	\$1,750	25%
G	87%	\$2,100	\$1,050	20%	\$250	20%	\$150	20%
I	94%	\$2,100	\$60	10%	\$200	5%	\$0	8%

Note: Amounts shown for the out-of-pocket maximum and deductibles are per person; figures for families would be double these amounts. Where an asterisk appears, the firm was unable to construct a plan design within the constraints of the actuarial value and out-of-pocket maximum. The deductible shown in these cases is equal to the out-of-pocket maximum, which is the highest it can be. The out-of-pocket maximum amounts are based on those for high-deductible plans that qualify to be paired with a Health Savings Account, inflated forward to 2014.

PATIENT DATA ANALYSIS REPORT

As documented in the preceding pages, it is imperative for HHS to carefully consider the pros and cons of each service inclusion to the essential health benefits package. The deliberative process must be a thoughtful one informed by a wide myriad of healthcare stakeholders. One important stakeholder is the patient advocacy community. These nonprofit groups serve as a trusted voice upon which health policymakers can rely to design programs that truly benefit patients. Their voice is also the voice that patients have relied on to receive information that they understand to be in their best interest.

The level of sophistication in advocating on behalf of patients that patient advocacy groups have attained renders their perspective pivotal if HHS is to realize the potential it claims PPACA offers. That potential can only be realized if PPACA programs are designed in a patient-centric manner. This means policies must be designed in a manner that considers their ultimate impact on access to quality health care services for patients. National data on patient

access challenges is likely best exemplified by the Patient Advocate Foundation’s Patient Data Analysis Report (PDAR). The Patient Advocate Foundation has a 15 year track record of serving as the trusted patient voice and compiles its efforts in resolving patient access issues into a PDAR. In 2010, PAF resolved 82,963 cases nationally and provided information to almost 4 million online contacts. The PDAR reflects the extensive documentation recorded by PAF case managers as they resolve cases and input data on 260 unique data fields.

Information from the PDAR and any other similar quality documents should guide HHS’s efforts when considering essential health benefit inclusion or exclusion. People with existing health conditions will be at the forefront of health consumers interested in health insurance coverage. HHS’ efforts to define essential health benefits must not only consider the tension between health benefit inclusion and health insurance product cost, but what purchasing the insurance product will mean when the health consumer becomes a patient. The health benefit inclusion

deliberation must consider the health consumer as future patient.

One important, yet often under-appreciated challenge that faces people when they become patients is that of debt crisis/cost of living. The PDAR data reveal the uninsured population seeking its services had debt crisis/cost of living issues that increased to 19.77%, up from 10.27% in 2009, representing an increase of 92.50%. As noted in the PDAR, regardless of the presence or lack of health insurance, patients are struggling more and more with debt-crisis/cost of living issues that result from an onset of illness. These data reveal health insurance product costs will significantly impact health consumer decisions in general, and patient decisions in particular when purchasing health insurance products. While HHS is carefully considering health insurance product pricing in essential health benefit evaluations, it should also include patient debt crisis issues faced by patients who have coverage that is inadequate.

The adequacy of coverage will become increasingly more important as the American population ages and their illnesses become more serious. Patient severity of illness should be considered when estimating health costs of exchange consumers. The PDAR identified “no access to care” as the greatest sub-issue for the uninsured, representing 36.01% of uninsured issues. The second most frequently cited issue demonstrates the frequency of patient illness severity as a healthcare access issue. “No access/no coverage for prescription needs” grew to 19.76%, up from 15.48% in 2009.

Patient severity of illness will play an important role in defining essential health benefits not only because of the cost to adequately treat an

aging population with severe illnesses yet not eligible for Medicare, but because of the nation’s escalating incidence of disease chronicity and co-morbidities. Any health reform effort, including efforts to define essential health benefits must recognize that before we can bend the cost curve, we must first bend the chronicity of disease curve. The Robert Wood Johnson Foundation predicts that by 2020, 164 million people (almost 50% of the population) will have a chronic condition and 81 million (24%) of them will have two or more conditions.⁴

An essential health benefit definition must address the adequacy of health insurance coverage, particularly for a nation experiencing

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an exponential growth in chronic disease prevalence. Health policymakers should be guided by an Institute of Medicine quote on patient care- “Getting the right care at the right time to the right patient for the right price.” Escalating chronic disease incidence must be factored into any essential health benefit definition otherwise this trend will frustrate attempts to realize true health care savings. The costs savings that might be achieved by health consumer purchases of attractively-priced yet benefit-poor health insurance products might

⁴ Wu S, Green A. Projection of chronic illness prevalence and cost inflation. Prepared for Partnership for Solutions by RAND Corporation. Baltimore: The Johns Hopkins University; 2000.

be consumed by the cost of a shrinking healthy workforce resulting from people unable to receive the care necessary to remain in the workforce.

The PDAR data make a strong case for the assertion that essential health benefits must include any and all health benefits that help patients suffering from chronic, debilitating and life-threatening diseases. Although the inclusion of such comprehensive benefits will certainly raise the price of insurance products, government must weigh the price of subsidizing those costs with the cost of having a growing population burdened by chronic disease who without adequate access to healthcare will simply become unable to contribute to growing the economy as their disease state worsens and becomes financially more difficult to address.

The PDAR data on commercially insured patients reveals issues involving debt

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crisis/cost-of-living, medical co-payment, and pharmaceutical co-payment represented 61.17% of all issues reported by commercially insured patients, which increased from 56.06% in 2009. These data evidence the fact that mere health insurance coverage does not prevent access to care challenges. Health benefits must be robust enough to make health insurance coverage the gateway to healthcare access.

RECOMMENDATIONS

Based upon the PDAR, NPAF makes the following recommendations:

A. The definition of essential health benefits must not be merely appealing to health consumers, but must include benefits that consumers will be able to avail themselves of when they become patients. Health benefits become essential health benefits when the consumer steps into the role of patient.

NPAF believes any state health exchange implementation process shouldn't frustrate the ability for patients to avail themselves of the most essential of benefits, provider choice and specialty care.

B. HHS must consider the fact that provider choice may be implicitly impacted by essential health benefit definitions as practice patterns vary. For example, to accommodate practice patterns, any essential benefits package must include oral chemotherapy parity through major medical coverage, and define "experimental" to include patient benefit for the purposes of determining acceptable treatments.

C. To be truly considered patient-centric, essential health benefit definition must consider the economic and social issues that patients endure. Hidden costs not only affect patient ability to afford medical treatment, but can have devastating effects on their economic status and the economic future of our country.

Essential health benefit identification is only the first step in assuring health consumers, particularly patients get the care they need. Exchanges must be operated in a manner that educates consumers of this important benefit.

D. Regarding the operations of exchanges -

i) HHS should assign appropriately trained officials to provide consumers with information about specific insurance-related questions regarding the exchange.

ii) HHS should utilize a standard format when presenting plan options and costs, thus allowing consumers to efficiently compare options and choose their plans accordingly. Any printed or online material should be written at a 6th grade reading level in order to communicate information that consumers can fully understand in culturally sensitive language.

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iii) HHS should provide a toll-free information hotline operating on Saturday and after business hours, as well as an automated frequently asked questions and answers option for those consumers who may not be able to call during normal Monday-Friday business hours. The exchange should make online support available that includes responses to online inquiries.

iv) HHS needs to make sure that whatever exchange design is selected, legislative language is clear enough not to cause any ambiguity.

v) The exchange governance process needs to be transparent, and provide adequate opportunities for patient advocates to be involved in the implementation process. Patient

advocates should include those who have years of advocacy experience and a good reputation in the patient community.

E. Regarding the enrollment and eligibility of consumers accessing exchanges -

i) HHS should provide two options for consumers to enroll in the exchange, via phone and online. NPAF recommends that the preferred enrollment method should be online, as online enrollment can benefit both consumers and insurers.

ii) Real-time personal assistance must be made available during hours which potential enrollees are most likely to view the site, such as 8:00 AM to 8:00 PM.

iii) HHS should develop a brief, easy-to-understand paper handbook that describes the essential health benefits as well as the online enrollment procedure in a step-by-step format. Enrollees may find this a useful tool when attempting to enroll online.

iv) In the event that consumers may not be able to utilize the online application tool, NPAF recommends establishing service centers with staff who can walk applicants through the process. NPAF also recommends contracting through a public/private partnership with existing non-profit patient service groups to assist with this initiative.

F. Regarding outreach for consumer enrollment -

i) Because the exchange program with its array of products will be difficult to explain to consumers who haven't previously had to make selection decisions relative to insurance, the methods that are used to convey the information must be simple and easy to use. In

this capacity, HHS should conduct town hall meetings in public venues such as libraries, community centers and free clinics, and distribute impartial information about essential health benefits and plan choices through national non-profit patient organizations. An enrollee survey system to evaluate consumer satisfaction with participating plans should also be developed.

ii) HHS may want to consider the important role that social media plays in informing “young invincibles” when designing outreach material.

G. Regarding consumer experience and their perception of ease-of-use -

i) NPAF believes that a clear, detailed explanation of each plan and any optional services should be provided. In order to disseminate plan information and assist in best choice selection by consumers, web presentations in a variety of languages and partnering with large retailers and employers, including the U.S. Chamber of Commerce and the National Federation of Independent Business, should be considered.

ii) NPAF also recommends reaching out to culturally appropriate organizations, inclusive of churches, sororities, fraternities, community health centers, free clinics and Indian Health Services, as they are trusted sources within certain cultural communities.

Conclusion

While the federal government has yet to define the essential benefits required for plans operating in the exchanges, its consideration should not be limited to pricing health insurance products so that they are attractive to consumers but rather assuring health plan benefit adequacy so that they improve the health of consumers when they become patients, which will benefit the health of our economy.