DRAFT

Essential Health Benefits and Access to Providers

The Affordable Care Act (ACA) lists ten broad categories of "essential health benefits" for which coverage will be mandatory both in the Medicaid expansion and in private plans offered through state exchanges. The 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; and pediatric services, including oral and vision care.[i] The Secretary is directed to ensure that the scope of benefits is equal to that of benefits provided in a "typical employer plan."[ii]

The federal essential benefits package is a "floor"; states may require plans in Exchanges to offer additional benefits. States may also choose to cover additional benefits in their Medicaid expansion programs.

The Secretary asked the Institute of Medicine to conduct a study that would make recommendations about the criteria and methodology for defining the essential benefits package. The IOM Committee is expected to release its recommendations to the Secretary in the fall of 2011.[iii] In late fall, HHS is expected to issue proposed regulations defining the scope of services to be covered within each of the essential health benefits categories.

Overall, the level of specificity that HHS will apply to the essential health benefits package is unknown. As discussed below, a certain amount of flexibility will likely be left to the states to define minimum benefit requirements for plans in their respective exchanges and Medicaid expansion plans.

Essential Health Benefits in Exchange Plans

Under the ACA, as of January 1, 2011, all new private insurance plans are required to cover a range of preventive services with no cost-sharing: any services given an A or B recommendation by the US Preventive Services Task Force (USPSTF); any vaccination recommended by CDC's Advisory Committee on Immunization Practices; and certain preventive services for children, adolescents, and women.[iv] This requirement does not apply to health plans that are "grandfathered"—meaning that existing health plans are exempt as long as they do not make changes to specific features detailed in regulation such as cost-sharing. However, as existing health plans make changes over the next several years, it is expected that eventually most plans will fall under the requirement.

Plans offered through exchanges will be covered by this requirement. Therefore, with respect to these plans, the Secretary's implementation of the "preventive and wellness services" category within the essential health benefits package will build on this

existing set of required preventive services. For example, the Secretary could require inclusion of CDC-recommended preventive services, such as routine screening for HIV, that are not currently in USPSTF recommendations. In making decisions about the essential health benefits package, the Secretary is directed to weigh the overall cost of the essential health benefits package, which will likely impact the scope of preventive services she is likely to mandate.

Essential Health Benefits in Medicaid Expansion Plans

As of January 1, 2014, Medicaid eligibility will be expanded to reach all children and adults under age 65 with incomes at or below 133% of the federal poverty level.[v] The Congressional Budget Office estimated that the expansion will result in coverage for an additional 16 million low-income people.[vi] Many of the newly-covered will be low-income childless males, who prior to ACA were ineligible for Medicaid in most states.

Most adults newly eligible for Medicaid due to health reform will be entitled to "benchmark" or "benchmark-equivalent" coverage based on typical employer coverage. Benchmark coverage will be defined by the HHS Secretary, but this coverage must include, among other things, the essential health benefits package.[vii] States may also choose to offer Medicaid coverage beyond the federal requirements.

Essential Community Providers

Under the Affordable Care Act, health plans that participate in exchanges will be required to include in their networks "essential community providers, where available, that serve predominately low-income, medically-underserved individuals."[viii] The law refers to providers participating in the 340(b) drug pricing program and those eligible for Section 1927 "nominal drug pricing" as examples of essential community providers (ECPs), but gives HHS discretion to include other types of entities, as well as to clarify what level of inclusion will be considered adequate for network coverage.

In July of this year, HHS released proposed rules on issues relating to state exchanges, including the ECP requirement. The proposed rule defines ECP as including *only* 340(b) and 1927 entities described above; HHS requested comment on whether this scope was broad enough. HHS noted that in an earlier request for comments, multiple commentors had urged a broader scope; however, the proposed rule does not reflect this concern. In addition, the proposed rule requires that qualifying health plans include "a sufficient number" of ECPs in their networks; HHS requested comment on whether this language is adequate. The proposed rule notes that plans would not be required to contract with essential providers for specific medical procedures.

Access to ECPs, and other providers, will depend in part on how the Department and states define overall "network adequacy." In its July proposed rule, the Department proposes a requirement that "An Exchange must ensure that the provider network of each [qualified health plan] offers a sufficient choice of providers for enrollees." The

Department also requested comment on a potential additional requirement that Exchanges develop standards for qualifying health plans to have:

(1) sufficient numbers and types of providers to assure that services are accessible without unreasonable delay;
(2) arrangements to ensure a reasonable proximity of participating providers to the residence or workplace of enrollees, including a reasonable proximity and accessibility of providers accepting new patients;
(3) an ongoing monitoring process to ensure sufficiency of the network for enrollees; and
(4) a process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible for that benefit in a timely manner.

Comment is also sought on a potential requirement that Exchanges ensure that plans' provider networks "provide sufficient access to care for all enrollees, including those in medically underserved areas."

Actions in the National Prevention Strategy that Relate to Essential Health Benefits and Provider Categories

A number of actions called for in the National Prevention Strategy relate to the scope of benefits coverage or to accessibility of providers:

scope.***

Action	**Section of Natl. Prev. Strategy**
The federal government will support delivery of clinical preventive services in various health care and out-of-home care settings, including Federally Qualified Health Centers; Bureau of Prisons, Department of Defense, and Veterans Affairs facilities; and among Medicare providers.	Clinical and Community Preventive Services (p. 20)
The federal government will identify, pilot, and support strategies to reduce cardiovascular disease, including improving screening and treatment for high blood pressure and cholesterol.	Clinical and Community Preventive Services (p. 20)
The federal government will develop new and improved vaccines, enhance understanding of the safety of vaccines and vaccination practices, support informed vaccine decision-making, and improve access to and better use of recommended vaccines.	Clinical and Community Preventive Services (p. 20)
State, tribal, local and territorial governments can increase delivery of clinical preventive services, including ABCS, by Medicaid and Children's Health Insurance Program (CHIP) providers.	Clinical and Community Preventive Services (p. 20)
The federal government will make [smoking] cessation services more accessible and available by implementing	Tobacco-Free Living (p.29)

applicable provisions of the Affordable Care Act, including in government health care delivery sites.	
The federal government will provide education, outreach, and training to address parity in employment-based group health plans and health insurance coverage for substance use disorders.	Preventing Drug Abuse and Excessive Alcohol Use (pp. 32-33)
The federal government will increase access to comprehensive preconception and prenatal care, especially for low-income and at-risk women.	Reproductive and Sexual Health (p. 45)
The federal government will promote and disseminate national screening recommendations for HIV and other STIs.	Reproductive and Sexual Health (p. 45)
The federal government will improve access to high-quality mental health services and facilitate integration of mental health services into a range of clinical and community settings (e.g., Federally Qualified Health Centers, Bureau of Prisons, Department of Defense, and Veterans Affairs facilities).	Mental and Emotional Well-Being (p. 49)
The federal government will improve use of patient-centered medical homes and community health teams, which are supported by the Affordable Care Act.	Clinical and Community Preventive Services (p. 20)
The federal government will encourage HIV testing and treatment, align programs to better identify people living with HIV, and link those who test positive to care.	Reproductive and Sexual Health (p.46)

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[i] Section 1302(b)(1).
[ii] Section 1302(b)(2)(A)
[iii] Institute of Medicine Consensus Study, "Determination of Essential Health Benefits" (online at http://www.iom.edu/Activities/HealthServices/EssentialHealthBenefits.aspx).
[iv] Section 1001.
[v] Patient Protection and Affordable Care Act, Sec. 2001. Because of a 5% disregard, the effect income cutoff will be 138% of the federal poverty level. Some children between 100% and 133% of the poverty level are currently covered under CHIP and will be moved to Medicaid under the expansion.
[vi] Congressional Budget Office, Letter to the Honorable Nancy Pelosi, Estimate of direct spending and revenue effects for the amendment in the nature of a substitute released on March 18, 2010 (March 18, 2010) (online at http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf).
[vii] Certain populations, whether already on Medicaid or newly eligible, are exempt from mandatory enrollment in benchmark plans and must be permitted to enroll in traditional Medicaid. These include people who qualify for Medicaid because they are blind or disabled, "dual-eligibles" who are in both Medicaid and Medicare, the "medically frail," certain low-income parents, pregnant women, the "medically needy," women who qualify because of breast or cervical cancer, children in foster care or receiving adoption assistance, and people receiving emergency Medicaid only. Kaiser Family Foundation, "Explaining Health Reform:Benefits and Cost-Sharing for Adult Medicaid Beneficiaries" (Aug. 2010) (online at http://www.kff.org/healthreform/upload/8092.pdf).
[viii] Section 1311(c)(1)(C).