Comments Submitting to the Institute of Medicine's Consensus Study: Determination of Essential Health Benefits – December 6, 2010

Question #1: What is your interpretation of the word "essential" in the context of an essential benefit package?

The National Small Business Association (NSBA) is the nation's oldest small-business advocacy group representing employers in every state. As an organization, we represent all sectors and industries of the U.S. economy from retail to trade to technology—our members are as diverse as the economy which they fuel. More than one in two people in the U.S. private workforce—70 million—work for or run a small business, according to data from the U.S. Small Business Administration Office of Advocacy and U.S. Census Bureau. Thank you for the opportunity to provide comments to the Institute of Medicine's (IOM) study on the determination of essential health benefits.

Sec. 1302, Essential Health Benefits Requirements, of the *Patient Protection and Affordable Care Act* (P.L. 111-148, PPACA, as amended by the Health Care and Education Act, P.L. 111-152) suggest a broad definition of "essential" in characterizing a minimum set of health coverage used to comply with other requirements in the law (e.g., individual mandate, free-rider requirements). Sec. 1302 also requires that essential benefits be equal to the scope of benefits provided under a typical employer plan, as informed through a survey conducting by the Secretary of the Department of Labor and determined by the Secretary of the Department of Health and Human Services (HHS).

PPACA includes 10 broad benefit categories that NSBA believes should be interpreted as basic requirements to meet the individual and employer requirements for health coverage. Conceivably, each category could mandate treatments, providers, and populations for a plethora of services, some of which are not essential or needed by the individuals searching to comply with the basic coverage requirements. Furthermore, tremendous inefficiencies and overutilization can surface in the health care system when insurance policies are crafted with excessive benefits.

"Essential" for small business owners who provide benefits for themselves and to their employees, as well as the self-employed who purchase coverage for themselves, denotes benefits that are absolutely necessary or indispensible. In order to allow small businesses and the self-employed to afford coverage, "essential" benefits should translate into coverage that is meaningful, but more importantly affordable.

Small businesses in PPACA are generally defined as those with less than 50 employees. Businesses of this size have felt the brunt of rising health care costs over the past decade. According to a new Commonwealth Fund study, premiums for employer-sponsored family plans increased an average of 41 percent across states from 2003 to 2009—more than three times faster than median incomes. In response, employers have been forced to absorb more costs, pass along cost to employees, change benefit design, or simply drop coverage.

Under PPACA, remedies for unsustainable health costs used in the past will be limited for small businesses and their employees post-2014. To be sure, small businesses ability to continue to

absorb costs will be less-and-less viable, particularly after maximizing their ability to do so in recent years. There are no assurances from the Congressional Budget Office or the Centers for Medicare and Medicaid's Chief Actuary that health care costs and premiums will decrease under PPACA in the coming years (i.e., for those not receiving government subsidies). In fact, most economists suggest costs will continue to rise. Additionally, passing future costs on to employees through changes in plan design will diminish post-2014 under the new insurance market reforms (e.g., annual/lifetime limits, deducible limits, cost-sharing limits, tiered coverage requirements). Finally, while dropping coverage is still an option, albeit extremely undesirable, business owners and employees will still be faced with purchasing essential coverage to meet the individual mandate.

Premium and cost-sharing subsidies will help low-income individuals making less than 400 percent of the federal poverty line. Small business tax credits will aid targeted businesses with less than 25 employees meeting strict salary criteria for two years after the essential benefits package is implemented. NSBA supports the need for these reforms in relation to the greater context of the law. However, small businesses and employees not receiving federal government subsidies stand with no alternatives to future rising costs.

IOM deliberations to determine the criteria and method for determining and updating the essential health benefits package presents are great opportunity to put downward pressure on health care costs while allowing individuals the opportunity to select the insurance coverage that meets their needs. Essential health benefits must truly be essential; that is, basic. DOL surveys of employer-sponsored plans should focus on what is representative within specific markets (i.e., large-group, small-group, and non-group markets) and account for other factors, such as geography. Revising the essential benefits should also use this same model. Furthermore, similar to Sec. 1311(d)(6)(C) in PPACA that requires consultation of small businesses in the establishment of the Small Business Health Option Program in the American Health Benefits Exchanges, processes for determining essential health benefits should also include consultation from the small businesses that will be purchasing essential health benefits for themselves and their employees.

Question #9: By what criteria and method(s) should the Secretary evaluate state mandates for inclusion in a national essential benefit package? What are the cost and coverage implications of including current state mandates in requirements for a national essential benefit package?

While attention should be given to current federal benefit mandates, the overwhelming majority and continued proliferation of mandated benefits resides at the state level. As a result, states have wide discrepancies in state mandated benefits. For instance, the state of Idaho has 13 mandated benefits and the state of Rhode Island has 70. By the late 1960s, state legislatures had passed only a handful of mandated benefits; today, the Council for Affordable Health Insurance has identified 2,133 mandated benefits and providers.

While the explicit link between mandates and premiums remains controversial, the implicit reality of mandated benefits is that it suggests or encourages consumer utilization. In other words, the more benefits mandated and covered by an insurance policy the more likely a

consumer is to utilize the service. Overutilization of health services, a result of consumers shielded or unaware of the cost of the care they pursue, is a leading driver of health care costs and should be addressed through the IOM's deliberations and recommendations to HHS.

The IOM study presents a great opportunity to undermine the state practice of mandating excessive benefits by setting a national floor of benefits that is truly basic, yet meaningful. States could still mandate additional benefits, albeit they would have to be offset, and individuals would still be able to purchase coverage with greater benefits at a higher price. A balanced approach using actuarial-based cost effectiveness analysis combined with an evidence-based medicine framework to determine what mandated benefits achieve the goal of basic coverage in relation to the lowest costs should be paramount for the IOM and HHS.

In addition, determining what benefits should be mandated can quickly become a highly politicized exercise. Elected officials and other policymakers can easily be motivated by interest groups to proliferate additional mandated benefits through policy decisions that reflect political choices as much as efficiency. The criteria and methods for determining and updating the essential health benefits package should include safeguards that ensure benefit mandate choices are kept outside the purview of elected officials and rely solely on cost-effective and evidence-based analyses.