

Mim's comments

Essential Health Benefits Bulletin

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National Standards versus State Benchmark Plans

CCIIO proposes that each State develop standards for Essential Health Benefits (EHB) based upon benchmark plans within the State.

Tribes and urban Indian organizations would prefer a national standard for the following reasons:

1. It is easier and less expensive for national Tribal organizations to review one set of standards rather than 52 different sets of standards. Tribes and urban Indian organizations in many states do not have the expertise or resources to review state-specific EHB policies.
2. Many states are not working with Tribes and urban Indian programs in the development and design of Health Insurance Exchanges, despite direction from the Secretary of HHS to do so. A national standard for EHB will likely have more input regarding Indian health care because of federal Tribal consultation policies and practices.
3. The state-by-state approach will lead to different benefits for American Indians and Alaska Natives living in different areas of the country. It is our belief that Congress intended for the Secretary of HHS to approve a single EHB that would apply nationally. The analysis offered by CCIIO suggests that there is actually little variation from state to state, so a national standard is, in fact, feasible. The decision to let state's determine their EHB appears to be a political decision to help reinforce the Administration's message that the Affordable Care Act is a market-based approach and to counter the charges of "socialized medicine" and "federal take over of health care." If this is needed politically, and it results in a high likelihood that the Affordable Care Act is sustained and not repealed by future Congresses, then it may be a small price to pay.

Benchmark Plan Types

The proposed guidance lists four types of benchmarks. All of them are the largest plans in a state in terms of enrollment. An issue that is not discussed in the CCIIO paper is that the largest enrollments will come from urban areas and it is not clear what types of implications this may have for rural areas. One might assume that it will set a higher standard for rural areas than they might otherwise have. On the other hand, people living in rural areas may have different types of needs. For example, if a plan sets a limit on days of stay in a hospital that might affect rural residents who do not have as many supports available to them when they return home. Another example is that emergency care may include ground ambulances but not air ambulances.

Another issue is that the approach suggested gives more power to the largest health care corporations that already dominate the marketplace. This does not encourage competition or innovation. By making it easiest for the largest issuers to offer their plans on the Exchanges, this approach moves the health care system toward oligarchy with a single dominant issuer in each state or region. This makes it more difficult for providers to negotiate with insurance companies. It has been shown that competition does not necessarily drive down the cost of health care, but a lack of competition argues for a stronger federal regulatory presence and that is not being proposed in this paper.

Medicaid Benefits

The paper by CCIIO states on page one:

Non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent, and Basic Health Programs must cover the EHB beginning in 2014.

What is at stake in this decision appears to be not only the EHB for Exchanges, but also for Medicaid and Basic Health Programs. It appears that Tribal Consultation on Medicaid will be subsumed by a decision by Insurance Commissioners to pick a benchmark Exchange plan. In some States where Indian health care is a carve out in the Medicaid program, there are special types of coverage that would not typically be found in the commercial health plans in the urban markets. We would like more clarification about the process of Tribal consultation in the development of Medicaid State Plans, Plan Amendments, and Waivers in the context of this approach to Essential Health Benefits.

Dental Health Benefits

One of the 10 Essential Health Benefits in the Affordable Care Act is pediatric oral and vision care. The analysis by CCIIO states that it is likely that small employer health plans used as the benchmark may not offer these services. As an alternative, it is proposed in footnote 27 on page 10 that people purchase a second plan to cover dental services:

A qualified health plan may choose to not offer coverage for pediatric oral services provided that a standalone dental benefit plan which covered pediatric oral services as defined by EHB is offered through the same Exchange.

This is not a good arrangement for American Indians and Alaska Natives (as well as other Americans) who will likely have difficulty navigating a Health Insurance Exchange to enroll in one health plan and figure out the advanced tax credits, and they may be even more overwhelmed by having to pick two plans – one for medical and one for dental. Furthermore, it will be more difficult and expensive administratively for Tribes to sponsor individuals if it involves enrolling in two health plans instead of one.

Mental Health and Substance Abuse Disorder Services

While mental health and substance abuse disorder services are one of the required Essential Health Benefits in ACA, the CCIIO report notes that the small employer group market often limits these services. Our concern is that there may be limits on the number of visits, the types of inpatient services, the location of services and the costs of prescription drugs to treat mental illnesses. As noted, the Mental Health Parity and Addiction Equity Act (MHPAEA) is supposed to address this, however, there has not been an adequate assessment of the effectiveness of this legislation.

Habilitation

The paper offers two options if a benchmark plan does not include coverage for habilitative services. We prefer the first option on page 11 which creates parity between rehabilitation and habilitation. The second option leaves it up to plans to decide how much habilitation to provide, and we believe that there are incentives for plans to define the level of services at the lowest cost possible.

Preventive and Wellness Services and Chronic Disease Management

By using State benchmarks, it is unlikely that the Affordable Care Act will maximize the opportunity to reorient America's health care system to focus more on prevention and public health. One of the 10 EHBs listed in the ACA is preventive and wellness services and chronic disease management. Tribes have developed some culturally-based approaches to prevention that may not be covered by the urban-oriented benchmark plans, while the benchmark plans may offer coverage for some types of services that are not available in Tribal areas.

[Note: I think ACA requires all health plans inside and outside Exchanges to offer certain preventative services without co-pays. I would like more information about this so that we can see if prevention really is an issue with the State benchmark approach.]

Interface with Indian Health Care Systems

It is not clear whether plans chosen for benchmarks will define their benefits by the types of providers that are covered. The Indian health care systems use a variety of types of providers that may not be covered by plans that are based in urban areas. Some examples are community health aides, midlevel behavioral health practitioners, and dental health therapists. Even though these approaches are cost effective and offer quality care, it is not clear whether the I/T/U would be reimbursed for these types of providers.

Benefit Design Flexibility

On page 12, the paper discusses permitting flexibility in the design of benefits, including substitutions in each of the 10 categories specified by ACA. It is not clear what CCIIO means by the concept of "substitution" and how far states would be allowed to deviate from the benchmark plans. We would support substitutions and flexibility when used to encompass the types of culturally-appropriate services that are offered by the I/T/U. However, in States where there is not a good working relationship with Tribes, the idea of flexibility could be used to eliminate necessary services. The application of substitutions and flexibility to Medicaid benefits is of particular concern to the I/T/U and we strongly urge federal oversight.

Tribal Consultation

We are concerned about adequate Tribal Consultation in the decisions at both the State and Federal levels regarding Essential Health Benefits in the context of Health Insurance Exchanges, Medicaid, and Basic Health Plans. There was a very brief discussion of Essential Health Benefits on a White House teleconference with Tribes that did not even suggest that this decision, which was envisioned in ACA as a federal decision made by the Secretary of HHS, would be delegated to the States. At the teleconference, it was stated that the federal government would hold listening sessions on this topic with Tribes. Tribes were never notified of these listening sessions. However, the paper released by CCIIO on December 16, 2011, states on page 3:

Following the release of the IOM's recommendations, HHS held a series of sessions with stakeholders, including consumers, providers, employers, plans, and State representatives in both Washington, D.C. and around the nation to gather public input.

It appears that Tribes are not being consulted at either the federal or state levels in the planning for Essential Health Benefits for Exchanges, Medicaid and Basic Health Plans.