

Committee on Determination of Essential Health Benefits

Statement

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January 13, 2011

Introduction

Good afternoon. Let me begin by thanking the Committee for this opportunity to appear before you today.

This Committee's work concerns one of the foundational aspects of the Affordable Care Act. My remarks focus on the legislative framework of the essential health benefits statute, because of the extent to which this framework must guide the Committee's deliberations. This Statement reflects my research into the legislative, administrative, and judicial aspects of the regulation of the content of health insurance in both the public and private markets.

The essential health benefits statute is unique. Because its legislative history is quite limited, the text itself takes on particular importance. The provisions of the statute differ significantly from the highly detailed coverage terms of Medicare Parts A and B. Similarly, its provisions differ from the coverage provisions of the Employee Retirement Income Security Act, which governs virtually all private employer-sponsored health benefit plans and which (with the important exception of the insured small group market)² remains unaffected by the essential health benefits provision. In referencing broad benefit categories, the essential health benefits statute bears some resemblance to the structure of the Medicaid benchmark coverage statute³ and the Children's Health Insurance Program (CHIP).⁴ At the same time, however, the statute is substantially more robust and in certain respects carries echoes of Medicaid's heretofore unique non-discrimination rule.

I begin with an overview of the legal structure of health insurance coverage and then turn to the provisions of the statute, concluding with recommendations for the Committee's deliberations.

¹ Support for this statement comes from the Commonwealth Fund, and the analysis presented here is based in part on a forthcoming policy brief prepared for the Fund.

² PHSA §2707, added by PPACA §1201

³ 42 USC §1396u-7

⁴ 42 U.S.C. §1397cc(a)

The Legal Structure of Health Insurance Coverage

Health insurance coverage entails legal and financial risk. For this reason the health benefit services companies that sell licensed insurance and third party administered products logically seek to structure their products to provide as much risk exposure protection against the covered population. These risk avoidance techniques go well beyond simply strategies for assuring that insurance pays only for medically necessary care and allow insurers to exclude and deny health care and treatment that are justified by the clinical and scientific evidence but considered to fall outside the scope of coverage.⁵

A review of the extensive case law generated by health benefit and coverage disputes over the decades -- and that through the discovery process offers incomparable insight into the coverage practices of both public and private insurers -- underscores the various structural and drafting strategies used by insurers to limit coverage risk:

Definitions and terms related to specific benefit categories or specific treatment items and services within categories: By defining a coverage term narrowly, an insurer or plan administrator can shield itself from risk. For example, defining speech therapy as therapy needed to restore previous speech function, an insurer can prevent its exposure to the costs associated with developmentally disabled children who demonstrate a clinical need for speech therapy to attain speech. An insurer also can eliminate its exposure to an individual with muscular dystrophy who needs therapy from a clinical perspective to maintain a level of speaking function or avert the loss of speech.

Definitions of “medical necessity” and “experimental.” In defining broad terms such as medical necessity, insurers and plan administrators similarly can place limits on coverage. Perhaps the two most important definitions in this regard are “medical necessity” and “experimental,” both of which can be used to narrow the scope of otherwise available coverage. A medical necessity definition that ties coverage to restoration or recovery would have such a limiting impact on coverage, because its impact would be to place certain types of treatments (i.e., treatments to aid in development or avert loss of function or maintain function) beyond the scope of coverage, regardless of the facts of the case. Similarly, a definition of experimental that excludes any treatment not proven effective through scientifically structured clinical trials would in turn result in the exclusion of most accepted forms of medical treatment from the terms of the plan.

Coverage exclusions. Plan documents may contain coverage exclusions whose impact is to place otherwise covered benefits outside the scope of a plan, even when the documented clinical and scientific evidence for coverage may be evident. These exclusions can be based on the patient’s condition or characteristics or linked to the treatment setting (e.g., otherwise-covered speech therapy when furnished in a school

⁵ One of the clearest examples of such an exclusion is the “intoxication” exclusion, by which on “moral” grounds, insurers and health plans routinely exclude coverage for the type of clinically effective treatments identified by Elizabeth McGlynn and colleagues in “The Quality of Health Care Delivered to Adults in the United States,” *New Eng. Jour. Medicine* 348:2635-2645 (June 26, 2003) Table 5.

setting). For example, clinically appropriate physical therapy for a child with developmental disabilities might be excluded on the basis that it is “behavioral” or “educational,” either because one purpose of the intervention is to aid in proper development or because the need for therapy is identified in an individualized educational plan. (Not surprisingly, perhaps, many coverage denial cases involve children with physical, mental, behavioral, and developmental disabilities).

Embedding treatment guidelines into plan documents. Treatment guidelines can be used as informal aids that guide coverage determinations. Insurers and plan administrators also can embed treatment guidelines into plan documents, in which case the limits operate as fixed coverage limits that automatically narrow the scope of coverage to whatever might be contained in the guideline, regardless of whether a patient’s particular condition or clinical and other evidence might suggest a different or more intensive approach.⁶

Numerical limits on certain treatments. A plan can contain fixed limits on services such as 10 outpatient therapy sessions or 30 days of hospitalization per spell of illness or exclusion of certain types of treatments such as complications in connection with an underlying condition whose treatment is excluded.⁷ Such limitations on coverage would, in the absence of other language, apply across the board regardless of patient condition.

Reserving discretion to interpret and apply plan terms and limiting the opportunity to challenge denials resulting from individual utilization review. In the absence of federal or state law to the contrary, a plan administrator or insurer can reserve to itself the discretion to define the terms of its plan.⁸ This reservation in turn creates a deferential standard in the courts (unless a conflict of interest is found to exist).⁹ (The Affordable Care Act establishes independent external review as a right of all ERISA health plan participants and beneficiaries,¹⁰ although how this right ultimately affects the ERISA deference standard is yet to be decided by the courts.)

The Provisions of the Affordable Care Act and the Essential Health Benefits Statute

Elsewhere, the Affordable Care Act addresses issues of transparency and access to independent reviews. These provisions ultimately have the potential to temper the level

⁶ See, e.g., *Jones v The Kodak Medical Assistance Plan*, 169 F.3d 1287 (10th Cir. 1999); *Mondry v American Family Mutual Insurance Co.* 557 F. 3d 781 (7th Cir., 2009).

⁷ See, e.g., *Kenseth v Dean Health Plan*, 610 F. 3d 452 (7th Cir., 2010)

⁸ The authority to reserve discretion to interpret plan documents in the case of ERISA-governed plans was set forth by the United States Supreme Court in *Firestone Tire and Rubber v Bruch*, 489 U.S. 101 (1989). In the context of insured health plans, several states have enacted laws barring the use of discretionary clauses, which have been upheld under ERISA as “saved” on the ground that they are laws that regulate insurance. *Standard Ins. Co. v Morrison*, 584 F. 3d 837 (9th Cir., 2009), *cert. den. sub nom, Standard Ins. Co. v Lindeen*, 130 S. Ct. 3275 (2010)

⁹ *Metropolitan Life Insurance Company v Glenn*, 554 U.S. 105 (2008)

¹⁰ PHSA §2719, added by PPACA §1001 and applied to ERISA through PPACA §1563

of deference accorded insurers and plan administrators in cases in which plan documents related to coverage must be interpreted and applied.

The essential health benefits statute itself principally focuses on the actual content of coverage. Under the terms of the Act, the provisions apply to the individual and small group markets both inside and outside state health insurance Exchanges.¹¹ As a result, the statute has the potential to transform coverage in these markets on a national scale. Furthermore, because a relatively handful of companies are so influential in the design of insurance and health plan products, coverage changes flowing from the essential benefit statute eventually may reverberate through the larger group markets as well, whether insured or self-insured.

The following provisions of the statute set forth the core parameters of the Secretary's decision-making powers where essential health benefits are concerned:

First, the statute sets forth the HHS Secretary's definitional duties. Specifically the statute directs the Secretary to "define the essential health benefits *except that such benefits shall include at least the following general categories and the items and services covered within the categories*: A. ambulatory patient services; B. emergency services; C. hospitalization; D. maternity and newborn care; E. mental health and substance use disorder services, including behavioral health treatment; F. prescription drugs; G. rehabilitative and habilitative services and devices; H. laboratory services; I. preventive and wellness services and chronic disease management; and J. pediatric services, including oral and vision care [italics added].¹² The statute thus not only enumerates 10 general categories of covered services and benefits but also specifies that the categories include the items and services covered within the categories.

Second, the statute imposes certain requirements related to the Secretary's interpretation of coverage. Specifically, the statute provides that the "Secretary shall ensure that the *scope of the essential health benefits . . . is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary*" [italics added].¹³ The concept of benefit scope would commonly be understood as relating to the items and services falling within each general category. Under the statute, the question of scope is an empirical one that is to be informed by an employer plan survey to be conducted by the Department of Labor. The question of scope, furthermore, is not merely legal but under the terms of the statute is also actuarial, since equality in coverage must be actuarially certified.¹⁴

Complicating the question of equal scope is the fact that common exclusions used by insurers and plan administrators mean certain general categories of services (e.g., behavioral services, habilitative services) are seldom found in an employer plan; if

¹¹ PHSA §2707, added by PPACA §1201. A small group that self insures would not be subject to the essential health benefit requirements, since self insured plans are not governed on matters of benefit content by laws that regulate insurance.

¹² PPACA §1302(a) and (b)

¹³ PPACA §1302(b)(2)(A)

¹⁴ PPAA §1302(b)(2)(B)

present at all, they may contain limits far below the standard of treatment. Indeed, were the scope of behavioral or habilitation services to be equal to that found in the typical employer plan, the essential health benefit package conceivably might contain zero coverage for certain general benefit categories.

Third, the statute sets forth certain “required elements for consideration.” The core elements are as follows: In “defining” essential health benefits, the Secretary “shall” (A) “ensure” that the essential health benefits “reflect an *appropriate balance among the categories*. . . so that benefits are not *unduly weighted* toward any category;” (B) 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*;” (C) “*take into account* the health care needs of diverse segments of the populations, including women, children, persons with disabilities, and other groups;” and (D) “ensure that health benefits established as essential not be subject to denial to individuals against their wishes *on the basis of* the individuals’ age or expected length of life or of the individuals’ present or predicted disability, degree of medical dependency, or quality of life”.¹⁵ [italics added]

Key Considerations That Can Guide the Committee’s Deliberations

1. Who decides the scope of coverage?

Under the terms of the statute, it is the HHS Secretary who, aided by a survey conducted by the Department of Labor, decides the scope of coverage including the coverage categories, the items and services that fall within coverage categories, and therefore, the definitional terms that apply to categories, items, and services. These decisions are expressly left to the discretion of the Secretary, not insurers or plan administrators, although the Secretary conceivably could instruct insurers and plan administrators to utilize the terms and definitions in their most popular group health products as long as such terms and definitions are not discriminatory within the meaning of the statute.

2. How to define coverage categories, as well as items and services within coverage categories, that are not contained in plan documents?

As noted, through total exclusion or the use of exclusionary definitional terms, plan documents may exclude entire classes of coverage categories or items and services within coverage categories. In such circumstances the duty clearly lies with the Secretary to develop the definitions that convey scope, since to limit her interpretation only to items and services found in plan documents risks reading entire coverage categories out of the statute. Terms such as “behavioral” services and “habilitative” services therefore may necessitate a review of the literature as well as consultation with experts in the field in order to ensure that effective treatments are properly brought within the terms of coverage.

3. What is an “appropriate balance” among coverage categories?

¹⁵ PPACA §1302(b)(4)(A)-(D)

In the context of the statute, the concept of “appropriate balance” appears to relate to the actuarial value of the benefit categories in relation to the total premium so that to at least some degree, all items and services are represented. Furthermore, this determination is to be made by the Secretary in consultation with the CMS chief actuary and does not appear to signal an actuarial equivalency test that can be independently applied by insurers and plan administrators. Indeed, in cases in which Congress has permitted an actuarial equivalency test, it has been explicit in permitting such an approach.¹⁶

4. *What does it mean to not discriminate against individuals because of their age, disability, or expected length of life and how far does the non-discrimination prohibition extend?*

With the exception of discrimination based on sex, civil rights laws addressing discrimination against individuals based on status (being an individual with a disability, on the basis of race or national origin, or on the basis of age) have not been understood as reaching the content of health insurance.¹⁷ The clearest precedent for the prohibition found in the essential benefit statute can be found in the Medicaid statute, whose “reasonableness” provision¹⁸ has, since the law’s original enactment,¹⁹ been understood by both the agency²⁰ and the courts²¹ as barring arbitrary limits in required services based solely an individual’s condition, diagnosis, or type of illness. Furthermore, at least two recent court decisions suggest that at least some courts also will reject coverage denials under Medicare where the basis of the denial is the arbitrary exclusion of otherwise covered services based on absence of “recovery” potential.²²

Of particular importance to the Committee would be the following considerations:

- *The circumstances in which age reasonably can be a coverage factor that rests on clinical and scientific evidence.* The statute bars discrimination, not the use of patient characteristics when such characteristics rest on a reasonable clinical and scientific evidentiary base. A decision cannot be made “on the basis of age,” but a decision based on clinical factors of which age is a recognized factor (such as

¹⁶ See, e.g., Children’s Health Insurance Program and the Medicaid benchmark coverage statute, *supra*.

¹⁷ See, e.g., *See Doe v. Mutual of Omaha Insurance Co.*, 179 F.3d 557 (7th Cir. 1999), cert. denied, 528 U.S. 1106 (2000) (The public accommodations provisions of the ADA do not reach the content of private health insurance); *Alexander v. Choate*, 469 U.S. 287 (1985) (Section 504 of the Rehabilitation Act does not reach the content of public health insurance); see also Sara Rosenbaum, *Insurance Discrimination Based on Health Status* (Georgetown University, O’Neill Institute) <http://www.law.georgetown.edu/oneillinstitute/national-health-law/legal-solutions-in-health-reform/Discrimination.html> (Accessed January 5, 2011); Mary Crossley, “Discrimination Against the Unhealthy in Health Insurance,” *Kansas Law Review*, 54 (2005): 73-153, at 85-87.

¹⁸ 42 U.S.C. §1396a(a)(17)

¹⁹ The precursor to the federal non-discrimination rule can be found in the *Handbook of Public Administration, Supplement D*, issued in 1966 by HEW.

²⁰ 42 C.F.R. §440.230(c0)

²¹ See, e.g., *Pinnecke v Preiser* 623 F. 2d 546 (8th Cir. 1980)

²² See, e.g., *Papciak v Sibelius* ___ F. Supp. 2d ___, 2010 WL 3885605 (W.D.Pa.); *Anderson v Sibelius*, ___ F. Supp. 2d ___, 2010 WL 4273238 (D.Vt.) ;

when best to immunize a child against certain diseases), would not be a decision whose basis is age.

- *The types of situations in which coverage decisions would impermissibly discriminate on the basis of disability.* Presumably the Committee will be guided by the Americans with Disabilities Act in defining the concept of disability, since the ADA addresses the issue of employee health benefits and individual insurance coverage outside of the content of coverage context.²³ As noted, a common discrimination scenario that arises under private health insurance is one in which a “restore” or “recover” test is part of the item specific or broad terms of coverage or practice guidelines embedded into plan documents that define the scope of coverage and what is excluded from coverage. Tests that require recovery or restoration inherently discriminate against individuals for whom the appropriate clinical basis of an intervention is its impact on the attainment or maintenance of function or the aversion of functional loss. When these conditions are present, the fact that a covered treatment also may be reflected in an employment plan, an individualized education plan, or some other document addressing the work-related, social, developmental, or educational needs of a patient should not be a permissible basis of exclusion.
- *The circumstances under which an individual’s expected length of life is appropriate.* In the case of hospice treatment, for example, length of life would appear to be a proper consideration. On the other hand, the statute withdraws expected length of life as a criterion where reasonable clinical and other relevant evidence shows an individual’s ability to benefit from a treatment, with the concept of “to benefit” defined to encompass attainment and maintenance of health as well as avoidance of deterioration).

In sum, what the statute bars is discrimination in coverage design and plan administration. Limits are not prohibited; what are prohibited are limits that discriminate. Thus, hospitalization of 30 days per spell of illness or 60 physical therapy treatments may limit medically necessary care, but they do so without regard to the underlying condition. To be sure, such limits fall with particular severity on the sickest members of the coverage groups and are undesirable for many reasons (the most desirable result is of course to have enough scientific and clinical evidence to be able to make coverage design and administration decisions solely on the basis of the evidence). But courts have ruled that across-the-board limits on scope are not discriminatory against persons with disabilities under federal civil rights laws, nor, presumably, would across-the-board limits “discriminate” against individuals because of age or expected length of life. What makes the conduct of insurers “discriminatory” is the use of coverage terms, limits and exclusions that fall solely on protected groups that cannot meet the qualification standards for whatever coverage is available.

It is also important to note that the scope of the statute’s non-discrimination provision sweeps broadly, reaching questions of both coverage design and plan administration

²³ ADA Titles I and III and §505 (related to the insurance “safe harbor”)

activities related to the implementation of coverage, including “coverage decisions,” “reimbursement rates” and “incentive programs.” In this context there thus are two types of coverage decisions: decisions related to plan design (what benefits, items and services will be covered for any member) and the application of plan design to individual patients (that is, whether a particular covered item or service be allowed for a particular patient given her clinical condition and other relevant and reliable evidence). Coverage decisions related to plan design, as well as permissible approaches to reimbursement rates and incentive programs, plainly are within the province of the Secretary under the law. Individual coverage decisions would most likely be made by a plan administrator during the course of utilization review and claims appeal provisions of the Affordable Care Act.

In the context of the non-discrimination provision, an important precedent to consider is regulations implementing the 2008 mental health parity amendments. These amendments have been interpreted by the Departments of Health and Human Services, Labor, and Treasury as addressing issues of both coverage design and plan administration as well as discrimination in both quantitative (i.e., day limits, treatment frequency limits) and non-quantitative matters (discriminatory terms and definitions, discriminatory medical necessity standards, discriminatory use of embedded treatment guidelines).²⁴

5. How might the health needs of diverse population segments be taken into account?

The question of coverage that takes the needs of diverse populations into account is one that appears to address the decision-making process rather than a particular result. Thus, through the rulemaking process, including requests for information and comments, as well as by referencing evidence-based treatment guidelines where available (such as guidelines for the treatment of conditions affecting women, children, persons with disabilities, and other groups), the Secretary would appear to fulfill the requirements of the statute.

6. How might the Committee approach the bar against coverage denials against an individual's wishes on the basis of age, expected length of life, or present or predicted disability, degree of medical dependency, or quality of life?

As with the question of discrimination, the bar against denials on the basis of age, expected length of life, or present or predicted disability, degree of medical dependency, or quality of life can be read as barring the use of any of the prohibited factors as the sole basis for denial, or the use of coverage terms that exclude otherwise covered treatments *a priori* on prohibited grounds. Thus, coverage terms that exclude treatments because they are not restorative would constitute a denial based on present or predicted disability, medical dependency or quality of life. By contrast, however, unwise in relation to access to necessary medical care, an across-the-board limit on treatment for all persons, while disproportionately affecting persons with serious illnesses, medical dependency, or disability, would not be a limitation that turns on a prohibited factor. Similarly, an individual coverage decision that denies an otherwise medically necessary and

²⁴ See 75 Fed. Reg. 5410-5451 (Feb. 2, 2010). See 45 C.F.R. §146.136(a) defining the scope of parity in relation to both qualitative and quantitative treatment limits.

appropriate treatment on the basis of the individual's status as a person with a disability or medical dependency, obviously would be prohibited.

In sum, the key concept that runs throughout the statute is "on the basis of." In health insurance, questions of coverage, whether arising as part of a plan design that applies to all members, or as a result of the application of design to a particular case, would optimally always be grounded in clinical and scientific evidence regarding appropriateness of treatment. The use of arbitrary limits unrelated to the need for care is always unwise because of the impact of such limits on persons who need care. At the same time, certain arbitrary limits are inherently discriminatory because they fall exclusively on persons with disabilities or serious illness, the prime example being the use of a recovery test. Viewed in this light, the Committee might consider a recommendation that permissible coverage limitations and exclusions be restricted to those that apply across the board rather than falling exclusively on sub-populations with health conditions that either prohibit "recovery" or that, because they are present at birth, make recovery irrelevant.