



Published on *The Connecticut Mirror* (<http://www.ctmirror.org>)

---

## Health experts struggle with the question, 'What's an essential benefit?'

Deirdre Shesgreen

March 9, 2011

WASHINGTON--When it comes to health insurance, deciding what is an essential benefit--and what isn't--is a political and medical minefield, with far-reaching consequences.

Should health insurance plans be required to cover chiropractic visits? Should there be a limit on the number of physical therapy sessions a patient gets? What about cancer treatments?

Health care policymakers and medical experts are struggling with these questions right now. As part of federal health reform, the Department of Health and Human Services is required to design an "essential benefits" package.

MIT's Jonathan Gruber: 'There's no easy answer'

That definition will have direct implications on the kind of health insurance coverage available through the state-based insurance exchanges, to be set up in 2014. Any insurer that wants to participate in the exchange will have to offer at least the basics, as set out in HHS's definition. And all Medicaid programs, the state-federal insurance plan for the poor, must cover these services by 2014.

The health reform law lists ten categories that HHS must include as essential, such as prescription drug coverage and emergency hospitalizations. But HHS has broad

discretion within those categories to require generous coverage or allow limits. And HHS also has a free hand to add in other health care services, from treatments for autism to infertility.

"It's a Herculean task," Mark Fendrick, a doctor and health policy expert at the University of Michigan, said of crafting the essential benefits package. It's like answering "Talmudic questions," full of ethical and moral quandaries for which there are not firm or easy solutions, he said.

It's also a debate being closely watched in states capitals, where governors are trying to determine whether they will set up their own health insurance exchanges or let the federal government run the program.

Kathleen Nolan, the top health care advisor at the National Governors' Association, said she's had several governors tell her that the definition of essential benefits will be the "the linchpin" in their decision on whether to do a state exchange or not.

"If they can't make it fit their needs and their environment and their programs, then they're just signing up for something they're not going to be able to sustain," she said. "A lot of governors are very interested in running this exchange, but they have to be able to do it in their way. This is one of the most critical issues" in determining that.

At a conference Tuesday sponsored by the health insurance industry, Nolan and others said HHS should aim for a careful balance between an inclusive package and an affordable, flexible one.

There's a constituency for every disease, and lobby groups pressing for a range of mandates--from rich maternity care coverage to expansive mental health services to expensive kidney transplants.

But since the health reform law requires people to buy insurance, Fendrick said, regulators have to be mindful of the price tag their essential benefits package will carry.

"It's important to make sure the essential benefits package is one we can all afford... even if there's some very difficult and controversial exclusions," he said.

Jonathan Gruber, a health economist at Massachusetts Institute of Technology, said an overly expansive definition of essential benefits could undercut the main goal of health reform: getting more of the uninsured covered.

He noted that although there is a mandate to buy insurance, individuals are eligible for an exemption if the cost of a plan exceeds 8 percent of their income.

"There's both a moral and political obligation to make insurance affordable," Gruber said at the conference, sponsored by America's Health Insurance Plans. "This directly conflicts with our desire to make insurance generous. There's no easy answer here."

But while the answers may not be easy, he said, the math involved in these decisions is pretty straightforward.

"If you want to add a chiropractor benefit to the essential benefits package... an actuary can tell you what that's going to cost. Is that going to add \$1 a month, \$2 a month, \$5 a month?"

Then regulators will have to ask themselves whether it's worth making everyone pay \$5 or so more a month in premiums so make sure they have that benefit. He noted that the essential benefits package will not only impact the cost of private insurance, but also of government programs.

"The easiest way to avoid that [debate over cost vs. benefit] is to not put numbers on it. The easiest way is to say, 'Gee, we just have to cover this. It's a good thing to do'," he said. "But we have to avoid that kind of sloppy thinking, put numbers on all these decisions, and then make politicians face up to these trade-offs."

He knows something about trade-offs. In addition to his research at MIT, Gruber served on the board of Massachusetts Health Connector, the state's health insurance exchange, a precursor to federal reform. Gruber was involved in requiring, for example, that insurers in Massachusetts cover prescription drugs, among other decisions.

He said defining that state's benefits taught him another lesson: Once government provides a benefit, it's very hard, if not impossible, to take it away.

"It's hard to reverse if you overreach," Gruber said. Another reason to start small.

Ron Pollack, executive director of Families USA, a consumer advocacy group, agreed that federal regulators should be careful, aiming to keep costs low and flexibility high.

"But that doesn't mean that it should be a poor benefit package," he said.

Pollack said he's "deeply concerned" that regulators will set "arbitrary limits" on things like the number of days a patient can receive in-patient hospital care or the number of prescriptions they can get. "Those are poorly advised ways to go," he said. And they would undercut another key element of health care reform--curbing industry abuses that have led to unjust denials of needed patient care.

No matter what definition HHS comes up with, he and others said, it needs to be updated regularly to reflect changing medical research and emerging health care needs.

HHS has tapped the Institute of Medicine to come up with some preliminary guidelines on essential benefits. The IOM is expected to release its report this fall, with HHS likely to follow up with a proposed outline of benefits before the end of the year.

---

**Source URL:** <http://www.ctmirror.org/story/11790/essentialbenefits>

# The New York Times

---

February 28, 2011

## Obama Backs Easing State Health Law Mandates

By [SHERYL GAY STOLBERG](#) and [KEVIN SACK](#)

WASHINGTON — [President Obama](#), who has stood by his landmark health care law through court attacks and legislative efforts to repeal it, told the nation's governors on Monday that he was willing to amend the measure to give states the ability to opt out of its most controversial requirements right from the start, including the mandate that most people buy insurance.

In remarks to the [National Governors Association](#), Mr. Obama said he supported legislation that would allow states to obtain waivers from the mandate as soon as it took effect in 2014, as long as they could find another way to expand coverage without driving up health care costs. Under the current law, states must wait until 2017 to obtain waivers.

The announcement is the first time Mr. Obama has called for altering a central component of his signature health care law, although he has backed removing a specific tax provision that both parties regard as onerous on business.

But the prospects for the proposal appear dim. Congress would have to approve the change through legislation, and House Republican leaders said Monday that they were committed to repealing the law, not amending it. Even if the change were approved, it could be difficult for states to meet the federal requirements for the waivers.

The White House described the proposal, based on a bipartisan bill recently introduced in the Senate, as a common-sense date change that would give states the freedom to innovate and act as laboratories. Mr. Obama called it "a reasonable proposal," telling the governors, "It will give you flexibility more quickly while still guaranteeing the American people reform."

Political calculations, as much as policy ones, were at work in the president's announcement. The shift comes as the health care law — and the mandate in particular — is under fierce attack in the courts, where federal judges have issued conflicting opinions on its constitutionality. The mandate is also a rallying cry for conservatives and [Tea Party](#) supporters, who regard it as a prime example of overreaching by the federal government.

Mr. Obama has been trying to reposition himself in the political center on some issues in the wake of the drubbing his party took in the November midterm elections; dropping his insistence on the mandate is one way to do that. And with governors pressing the administration to allow them to cut Medicaid rolls to ease their fiscal distress — a step Mr. Obama does not want to take — the president is trying to look flexible in other ways.

But Mr. Obama's flexibility goes only so far. "I am not open to refighting the battles of the last two years," he said, "or undoing the progress that we've made."

Mr. Obama's announcement did not appear to appease his Republican critics. The House majority leader, Representative Eric Cantor of Virginia, told reporters that the health law was "an impediment to job growth" and that Republicans remained committed to its repeal.

And while some Republican governors praised Mr. Obama for reaching out, they said the move did not address their underlying discomfort with the law or the major structural flaws facing state budgets. In meeting with the governors, Mr. Obama also asked them to come up with a bipartisan group to find ways to reduce Medicaid costs.

"I was disappointed," said Gov. Rick Perry of Texas, chairman of the Republican Governors Association. "Pretty much all he did was to reset the clock on what many of us consider a ticking time bomb that is absolutely going to crush our state budgets. The states need more than that."

Some Democrats also reacted warily. Many are convinced that it is not possible to expand health care coverage and achieve deficit reductions without the federal mandate, and they worry that amending the law would be tantamount to weakening it.

Senator Max Baucus, a Montana Democrat who as chairman of the Senate Finance Committee wrote a bill that included an idea similar to the one Mr. Obama proposed, issued a tepid statement saying he would consider it.

"We want to give states as much flexibility as possible," Mr. Baucus said, "but that flexibility shouldn't fail to ensure that Americans in every state have access to quality, affordable health care."

The White House said the proposal was unrelated to the challenges to the constitutionality of the mandate. But encouraging states to pursue alternative ways of expanding coverage could prove useful should the Supreme Court ultimately rule that the mandate is unconstitutional.

At the same time, the mandate, and the health care law more generally, is sure to be an issue in the president's 2012 re-election campaign, which may be a reason he is offering the proposal now.

“It’s to his advantage to show that he wants to be more moderate on this,” said Dan Mendelson, a health policy expert who worked in the Clinton administration, “because the mandate is terribly unpopular politically and he doesn’t want to be saddled with that going into the next election.”

The bipartisan legislation that Mr. Obama is now embracing was first proposed in November, eight months after the enactment of the Affordable Care Act, by Senators Ron Wyden, Democrat of Oregon, and Scott Brown, Republican of Massachusetts. Senator Mary L. Landrieu of Louisiana, a Democrat, is now a co-sponsor.

The legislation would allow states to opt out earlier from a range of requirements, including the mandate, if they could demonstrate that other methods would allow them to cover as many people, with insurance that is as comprehensive and affordable, as provided by the new law. The changes must also not increase the federal deficit.

If states can meet those standards, they can ask to circumvent minimum benefit levels, structural requirements for insurance exchanges and the mandates that most individuals obtain coverage and that employers provide it. Washington would then help finance a state’s individualized health care system with federal money that would otherwise be spent there on insurance subsidies and tax credits.

Representative Peter Welch, Democrat of Vermont, has proposed similar legislation in the House, but he said in an interview Monday that his bill had no Republican co-sponsors, making its prospects for passage uncertain at best. Still, Mr. Welch called Mr. Obama’s announcement “extremely significant,” adding that the waivers were “an act of empowerment for the states.”

In Vermont, Gov. Peter Shumlin, a Democrat, is exploring the idea of using a waiver to create a so-called single-payer system, a government-run health care plan.

Such a plan, dubbed the public option in last year’s health care debate, would never have passed Congress. But Mr. Welch said he saw no reason Vermont should not get a waiver to establish one.

“My Republican friends argue that you should drive power and responsibility for implementation to the local level, and they’re right,” Mr. Welch said.

Health economists have mixed views on how difficult it would be to expand coverage and hold down costs in the absence of a mandate.

Jon Gruber of M.I.T. published a recent analysis arguing that eliminating the mandate would “significantly erode the gains in public health and insurance affordability” made possible by the health care law. But David Cutler of Harvard said that “given the uncertainty generated by the mandate, it was reasonable” to let states

experiment with other ways to achieve the law's broad goals "and let the evidence decide" if the mandate is necessary.

When the health measure was moving through Congress last year, its authors set 2017 as the date that such experimentation could begin, based on an analysis by the Congressional Budget Office, which said it would take three years of experience to determine how much a state should receive in unrestricted block grants if it opted out of aspects of the law.

Otherwise, the budget analysts advised last year, the legislation's 10-year cost estimate would be about \$4 billion higher because Washington would probably have to make higher than needed payments to states. Senior administration officials said they had not discussed where to find the additional \$4 billion, but described it as "not a lot of money" compared with the estimated \$1 trillion, 10-year cost of the law.

*Sheryl Gay Stolberg reported from Washington, and Kevin Sack from Atlanta. Jeff Zeleny contributed reporting from Washington.*