

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-11

Subject: Essential Health Care Benefits
(Resolution 106-A-10)

Presented by: William E. Kobler, MD, Chair

Referred to: Reference Committee A
(Joseph W. Zebley, III, MD, Chair)

1 At the 2010 Annual Meeting, the House of Delegates referred Resolution 106, which was introduced
2 by the Illinois Delegation. Resolution 106-A-10 asked that the American Medical Association
3 (AMA) “update its efforts to create and disseminate a list of essential health care benefits that would
4 need to be included in all plans offered by both the private sector and the government, as well as a
5 list of additional benefits that could be added on to a basic benefits package.” The Board of Trustees
6 referred Resolution 106-A-10 to the Council on Medical Service for study.

7
8 This report provides a summary of legislative and regulatory activity pertaining to creating an
9 essential health benefits package, outlines relevant AMA policy and advocacy efforts, discusses
10 concerns raised in Resolution 106-A-10 with respect to broader standards of benefit adequacy, and
11 presents policy recommendations.

12 13 ACA PROVISIONS AND REGULATORY NEXT STEPS

14
15 The Patient Protection and Affordable Care Act (ACA, PL 111-148) included provisions to create an
16 essential benefits package. Effective in 2014, all qualified health benefits plans, including those
17 offered in exchanges and in the individual and small group markets outside of exchanges, with the
18 exception of grandfathered individual and employer-sponsored plans, will be required to offer at
19 least the essential health benefits package.

20
21 The ACA specified that the essential health benefits package must cover the following general
22 categories of services:

- 23
24 • Ambulatory patient services;
25 • Emergency services;
26 • Hospitalization;
27 • Maternity and newborn care;
28 • Mental health and substance use disorder services, including behavioral health treatment;
29 • Prescription drugs;
30 • Rehabilitative and habilitative services and devices;
31 • Laboratory services;
32 • Preventive and wellness services and chronic disease management; and
33 • Pediatric services, including oral and vision care.

34
35 The Secretary of the Department of Health and Human Services (HHS) has the responsibility to
36 determine the scope of the essential health benefits package, which the ACA specified should be

1 equal to the scope of benefits under a typical employer-sponsored plan. A health plan providing the
2 essential health benefits package will be required to cover at least 60% of the actuarial value of the
3 covered benefits. Such health plans will be prohibited from imposing an annual cost-sharing limit
4 that exceeds the thresholds applicable to health savings account (HSA) qualified high-deductible
5 health plans (\$5,950/individual and \$11,900/family in 2011). In addition, small group health plans
6 providing the essential health benefits package will be prohibited from imposing a deductible greater
7 than \$2,000 for self-only coverage, or \$4,000 for any other coverage in 2014 (to be adjusted
8 annually). Plans providing the essential health benefits package will be prohibited from applying a
9 deductible to preventive health services. A qualified health plan has the option to provide benefits in
10 excess of the essential health benefits package.

11 12 AMA POLICY AND ADVOCACY

13
14 AMA policy and advocacy efforts concerning essential health care benefits have been consistently
15 supportive of provisions that would maximize patient choice of health plans and their respective
16 benefit packages. Notably, consistent with AMA policy, such efforts have been strongly supportive
17 of HSAs maintaining their role in the health insurance marketplace as an option for patients (Policy
18 H-165.852, AMA Policy Database). To determine the adequacy of health insurance options, Policy
19 H-165.846[2] supports using existing federal guidelines regarding types of health insurance coverage
20 (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program (FEHBP)
21 regulations) as a reference when considering if a given plan would provide meaningful coverage.
22 Likewise, Policy H-165.865[2] states that in order to qualify for a tax credit for the purchase of
23 individual health insurance, per Policy H-165.920, the health insurance purchased must provide
24 coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses
25 as defined by Title 26 Section 9832 of the US Code. Policy H-165.848 advocates a requirement that
26 those earning greater than 500% of the federal poverty level obtain a minimum level of catastrophic
27 and preventive coverage. Only upon implementation of tax credits or other coverage subsidies
28 would those earning less than 500% of the federal poverty level be subject to the requirement to
29 obtain such coverage. The flexibility afforded in these policies aligns with long-standing AMA
30 policy supporting a system of individually owned and selected health insurance (Policy H-165.920).

31
32 Numerous additional policies support the need to maximize coverage options. Policy H-165.985
33 supports free market competition among all modes of health care delivery and financing, and the
34 freedom of patients to select and to change their medical care plan. Policy H-165.838 supports
35 health system reform alternatives that are consistent with AMA policies concerning pluralism,
36 freedom of choice, freedom of practice, and universal access for patients. Policy H-165.856 states
37 that the regulatory environment should enable rather than impede private market innovation in
38 product development and purchasing arrangements. Concerning health insurance exchanges, Policy
39 H-165.839 states that such exchanges should maximize health plan choice for individuals and
40 families purchasing coverage, and health plans participating therein should provide an array of
41 choices, in terms of benefits covered, cost-sharing levels and other features.

42
43 With respect to Medicare, Policy H-330.912 supports free market choice of plans for beneficiaries.
44 Regarding Medicaid, Policy H-165.855 advocates that the medical care portion of the Medicaid
45 program should be financed with federally issued tax credits that are refundable, advanceable,
46 inversely related to income, and administratively simple for patients, to allow acute care patients to
47 purchase coverage individually and through programs modeled after the state employee purchasing
48 pool or FEHBP. Policies D-290.987 and D-290.985 underscore the importance of the Early and
49 Periodic Screening, Diagnostic, and Treatment (EPSDT) program and encourage that services to
50 children, adolescents, and young adults meet EPSDT standards.

1 Based on these policies, the AMA has been an active participant in discussions pertaining to the
 2 essential health benefits package with HHS as well as the Institute of Medicine (IOM). At the
 3 request of the Secretary of HHS, the IOM has been tasked to make recommendations on the criteria
 4 and methods for determining and updating the essential health benefits package. The AMA
 5 submitted comments and delivered oral testimony to the IOM addressing the methods for
 6 determining and updating essential health benefits for qualified health plans. The AMA also
 7 submitted comments to HHS regarding exchange-related provisions in the ACA that included
 8 feedback on which factors are important in establishing minimum requirements for the actuarial
 9 value/level of coverage. AMA comments have emphasized the importance of providing an array of
 10 choices with respect to benefits covered and cost-sharing.

11
 12 Prior to supporting a system of individually selected and owned health insurance, the AMA had
 13 policy in support of minimum and standard benefits packages, in the context of its previous support
 14 for an employer mandate. The AMA has since rescinded its support for an employer mandate and
 15 the minimum and standard benefits packages. The AMA standard benefits package, adopted as
 16 policy in 1993, included detailed benefits related to preventive services, physician services, inpatient
 17 care, outpatient care, emergency care, home health care, prescription drugs, dental care, skilled
 18 nursing facility and hospice care. The AMA standard benefits package was the result of 18 months
 19 of work by the Council on Medical Service and several external consultants from actuarial firms and
 20 policy research organizations. The AMA minimum benefits package, adopted as policy in 1990,
 21 contained a recommended set of physician services, outpatient services, hospital inpatient services,
 22 and home health services that should be included in a package of minimum health care benefits
 23 under required employer insurance.

24
 25 **ADEQUACY OF BENEFITS**

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 27 Resolution 106-A-10 asks the AMA to update its efforts to create and disseminate a list of essential
 28 health care benefits that would need to be included in all plans offered by both the private sector and
 29 the government, as well as a list of additional benefits that could be added on to a basic benefits
 30 package. The preamble of Resolution 106-A-10 asserts that physicians are uniquely poised to
 31 determine what health care benefits would be considered essential, and would be able to limit the
 32 involvement by special interests in the crafting and development of a basic health care coverage
 33 package. However, the Council's 18 months of work on the previous AMA standard and minimum
 34 benefits packages involved a significant amount of negotiation regarding special interests.

35
 36 Rather than defining a new, specific benefits package to be used in advocacy discussions concerning
 37 the development of the essential health benefits package, the Council notes that AMA policy
 38 supports using existing coverage models, such as FEHBP, as the framework for the essential health
 39 benefits package. In addition, as previously stated, existing policy supports using FEHBP as a
 40 reference when considering if a given plan would provide meaningful coverage (H-165.846[2]). The
 41 FEHBP model aligns well with AMA advocacy and policy in support of individually selected and
 42 owned health insurance, and would support the goal of maximizing patient choice of health plans
 43 and their respective benefit packages. The strength of FEHBP as a model is also evidenced by AMA
 44 policy supporting using FEHBP as a model for restructuring Medicare, Medicaid and how care is
 45 provided to veterans, as well as allowing uninsured individuals to buy-in to the program (Policies
 46 H-330.898, H-165.855, H-510.990 and H-165.995).

47
 48 Significantly, all FEHBP plans cover basic hospital, physician, surgical and emergency care, even
 49 though the program does not require a standard benefit package. FEHBP follows existing evidence-
 50 based guidelines for preventive care for children and adults. FEHBP plans are also required to cover
 51 additional benefits including child immunizations, prescription drugs, mental health services (with

1 parity between mental health and medical care coverage), and a catastrophic limit for out-of-pocket
 2 costs. The FEHBP Web site promotes transparency of the health plans it offers by providing
 3 enrollees with a tool to compare health plans for which they are eligible based on state of residence
 4 (<http://www.opm.gov/insure/health/search/plansearch.aspx>). With this tool, FEHBP enrollees can
 5 compare plans based on plan benefits, including catastrophic limits, deductibles and cost-sharing
 6 levels, as well as the quality of the plans, which includes measures ranging from claims processing to
 7 customer service. Importantly, the Council notes that the FEHBP is able to offer high-deductible
 8 health plans coupled with HSAs, as well as consumer-driven health plans, to its enrollees. The
 9 Council believes that this flexibility is critical, as any criteria outlining an essential health benefits
 10 package needs to maintain and strengthen the vital role in the health insurance marketplace of high-
 11 deductible health insurance plans issued to individuals and families in conjunction with HSAs.

12
 13 AMA Policy D-290.985, which advocates that services to children, adolescents, and young adults
 14 should meet EPSDT standards, recognizes that the scope of recommended services and benefits for
 15 children is different from that for adults. When comparing EPSDT and FEHBP, there are several
 16 differences in coverage, which result from children and adults having different health care needs.
 17 Generally, certain children, including those with special health care needs, face gaps in coverage
 18 under FEHBP that would not otherwise exist if provided the EPSDT benefit. Under EPSDT,
 19 children enrolled in the Medicaid program have access to comprehensive health care, including
 20 preventive health care services. Comprehensive preventive care to be covered under the EPSDT
 21 benefit includes but is not limited to immunizations, physical exams, dental and vision care, and
 22 mental health and hearing screenings. Medically necessary diagnostic services and treatment must
 23 be provided to address any conditions or needs identified during the screening process.

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 25 **DISCUSSION**

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 27 The Council agrees with the sponsor of Resolution 106-A-10 that there is a need for the AMA to
 28 participate in the process to craft the essential health benefits package as outlined in the ACA.
 29 However, the Council continues to believe that creating and advocating for a basic benefits package
 30 would be inconsistent with AMA policy in support of patient choice of health plan, private market
 31 innovation in product development, and the foundation of the AMA proposal for expanding health
 32 insurance coverage and choice through individually owned and selected health insurance. In
 33 addition, the Council recognizes that the requirements of the essential health benefits package will
 34 strongly impact health care premiums and costs. Therefore, the Council believes that the criteria for
 35 the essential health benefits package needs to be flexible to enable patient choice in health plan and
 36 the respective benefits covered while still offering meaningful coverage.

37
 38 Consistent with previously established AMA policy, the Council believes that using the FEHBP as
 39 the model for the essential health benefits package for adults strikes a balance between offering
 40 meaningful coverage, maintaining patient choice in health plans and their respective benefits
 41 packages, and slowing the growth in health plan premiums and health care costs. Supporting
 42 FEHBP as the framework for the essential health benefits package for adults also would allow high-
 43 deductible health plans coupled with HSAs, as well as consumer-driven health plans, to continue to
 44 operate in the health insurance marketplace. The Council recognizes that there is concern that the
 45 role and purpose of HSAs coupled with high-deductible health plans will be weakened and
 46 undermined upon the implementation of an essential health benefits package. Realizing the
 47 importance of this concern, the Council believes it is also necessary to reaffirm AMA policy in
 48 support of HSAs (Policy H-165.852) in addition to supporting FEHBP as the model for the essential
 49 health benefits package for adults.

1 The Council notes that the AMA has been a strong and consistent supporter of EPSDT and the vital
2 role it plays in the promotion of child health and development. The Council realizes that the health
3 care needs of children are unique and differ from those of adults, which is why AMA policy
4 advocates that services to children, adolescents, and young adults should meet EPSDT standards.
5 Therefore, supporting EPSDT as the framework for the essential health benefits package for children
6 will help to ensure that all children receive the right care, at the right place, at the right time.

7
8 Once the essential health benefits package is defined and included in health plans offered both within
9 and outside of exchanges, the Council believes it will be essential for patients to be provided with
10 standardized and easy-to-understand information to be able to compare the health insurance options
11 available to them based on cost, level of coverage and other factors, as supported by AMA policy
12 and similar to what is provided by FEHBP. Accordingly, health plans need to provide necessary
13 information to patients, including clear and accurate explanations of covered services, cost-sharing
14 obligations, out-of-pocket limits, and excluded services. Ultimately, it will be the choice of patients
15 to select health plans that meet their health care needs and budgetary realities, while being offered a
16 base standard of coverage as defined by the essential benefits package.

17
18 **RECOMMENDATIONS**

19
20 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
21 106-A-10, and that the remainder of the report be filed:

- 22
23 1. That our American Medical Association (AMA) reaffirm Policy H-165.852, which supports
24 the role of health savings accounts in the health insurance marketplace. (Reaffirm HOD
25 Policy)
26
27 2. That our AMA reaffirm Policy H-165.846, which states that existing federal guidelines
28 regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal
29 Employees Health Benefits Program [FEHBP] regulations) should be used as a reference
30 when considering if a given plan would provide meaningful coverage. (Reaffirm HOD
31 Policy)
32
33 3. That our AMA advocate that the Early and Periodic Screening, Diagnostic, and Treatment
34 (EPSDT) program be used as the model for any essential health benefits package for
35 children. (New HOD Policy)

Fiscal Note: Staff cost estimated to be less than \$500 to implement.

References are available from the AMA Division of Socioeconomic Policy Development.