



# Improving the Health Insurance Marketplace

## *Essential health benefits*

Longstanding AMA policy aims to maximize patient choice of health plans and their respective benefits package, including by strongly supporting the role of health savings accounts. As such, the AMA realizes that patients define essential benefits differently, based on their health needs and budgetary restrictions. At the same time, the AMA recognizes that children’s health care needs are different from those of adults, and believes that ensuring a comprehensive and robust essential health benefits (EHB) package is critically important for children, especially those who have special health care needs.

The AMA supports: maximizing the choice of health plans and benefits packages for adults; using the Medicaid program’s Early and Periodic Screening, Diagnostic, and Treatment benefits as the model for any EHB package for children; and minimizing state benefit mandates that are included in the EHB package to ensure the affordability of health insurance coverage.

The American Medical Association (AMA) believes that the definition of essential health benefits (EHB) should strive to maximize patient choice of health plans and their respective benefits packages. The AMA recognizes that the requirements of the EHB package will strongly impact health care premiums and costs. Therefore, the criteria for the EHB package for adults need to be flexible to enable patient choice of health plan and the respective benefits covered while still offering meaningful coverage. Such flexibility would also allow high-deductible health plans coupled with health savings accounts (HSAs), as well as consumer-driven health plans, to continue to operate in the health insurance marketplace. The health care needs of children are unique and differ from those of adults, which is why AMA policy advocates that services to children, adolescents and young adults should meet Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standards.

### **Patient Protection and Affordable Care Act provisions**

- The Patient Protection and Affordable Care Act (ACA), Public Law 111-148, included provisions to create an EHB package. All qualified health benefits plans, with the exception of grandfathered individual and employer-sponsored plans, are

required to offer at least the EHB package, including those offered in health insurance exchanges and in the individual and small group markets outside of exchanges (see “Health insurance exchanges” in this series).

- The ACA specified that the EHB package must cover the following general categories of services:
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care
- The Secretary of the U.S. Department of Health and Human Services (HHS) has the responsibility to determine the scope of the EHB package, which the ACA specified should be equal to the scope of benefits under a typical employer-sponsored plan.

## HHS final rule on essential health benefits

Regulations addressing EHB stated that EHB shall be defined by state-specific benchmark plans through at least the 2017 benefit year. HHS also stated that “the EHB-benchmark plan would serve as a reference plan, reflecting both the scope of services and limits offered by a typical employer plan in that state.”

HHS outlined four benchmark plan options for states:

- The largest plan by enrollment in any of the three largest small group insurance products in the state’s small group market
- Any of the largest three state employee health benefit plans by enrollment
- Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment
- The largest insured commercial non-Medicaid health maintenance organization operating in the state

## Strategies to foster healthy markets

### Maximize choice of health plans and benefit packages for adults

The AMA believes that the definition of EHB should maximize patient choice of health plans and their respective benefits packages, including strongly supporting the role of HSAs. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the U.S. Tax Code and Federal Employees Health Benefits Program regulations) should be used as a reference for EHB for adults. These existing regulations have reflected the reality that patients define essential benefits differently, based on their health care needs and budgetary restrictions. At the same time, they make clear that health insurance should provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses, as defined by Title 26, Section 9832 of the U.S. Code.

Health insurance issuers offering options that provide coverage of at least the EHB package should still have the ability to respond to patient demand for ample health plan choices, in terms of benefits covered and

out-of-pocket costs. Similarly, the AMA firmly believes that the determination of an essential health benefits package should not undercut the vital role in the health insurance marketplace of high-deductible health insurance plans issued to individuals and families in conjunction with HSAs.

### Use the EPSDT benefit as the model for children

The health care needs of children are unique and differ from those of adults. Ensuring a comprehensive and robust EHB package is critically important for children, especially those who have special health care needs. Failure to ensure an adequate scope and design of benefits for children can result in life-long health consequences with extensive and, in many cases, avoidable costs.

Using the EPSDT benefit as a model for any EHB package for children ensures that all preventive, diagnostic and treatment services that are medically necessary for children are covered. When comparing EPSDT and private health plan coverage, there are several differences in coverage, which result from children and adults having different health care needs. Generally, certain children, especially those with special health care needs, face gaps in coverage under private health plans that would not otherwise exist if provided the EPSDT benefit. Under EPSDT, children enrolled in the Medicaid program have access to comprehensive health care, including preventive health care services that include but are not limited to immunizations, physical exams, dental and vision care, and mental health and hearing screenings. And, most importantly, medically necessary diagnostic services and treatment must be provided to address any conditions or needs identified during the screening process.

### Minimize state benefit mandates

Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options. Increasing the number of state mandates included in the EHB package will result in an increase in the cost and reduce the affordability of health insurance coverage, affecting the ability of individuals and small businesses to purchase health insurance coverage due to higher premiums.

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