



Statement

of the

American Medical Association

to the

Institute of Medicine's
Committee on Determination of
Essential Health Benefits

January 14, 2011

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The American Medical Association (AMA) appreciates the opportunity to testify on behalf of our physician and medical student members before the Institute of Medicine's (IOM) Committee on Determination of Essential Health Benefits (Committee) at today's public workshop. As the Committee studies methods for determining and updating essential health benefits for qualified health plans and prepares its recommendations to Secretary of Health and Human Services (HHS) Sebelius pursuant to the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148), we hope you find our comments useful.

The ACA includes provisions to create an essential health benefits package. Effective in 2014, all qualified health benefits plans, including those offered in exchanges and in the individual and small group markets outside of exchanges, with the exception of grandfathered individual and employer-sponsored plans, will be required to offer at least the essential health benefits package. The ACA specifies that the essential health benefits 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; and
- Pediatric services, including oral and vision care.

The Secretary of HHS has the responsibility to determine the scope of the essential health benefits package, which should be equal to the scope of benefits under a typical employer-sponsored plan. The IOM Committee, which will make recommendations to the Secretary on methods for determining and updating essential health benefits, has reached out to stakeholders, such as the AMA, with a number of questions related to defining and delineating essential health benefits. Our testimony focuses on some of these key questions.

Interpretation of “Essential”

AMA policy addressing essential health benefits aims to maximize patient choice of health plans and their respective benefit packages, including strongly supporting the role of health savings accounts (HSAs). The AMA believes that the interpretation of “essential” in the context of an essential benefit package should align with 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 [FEHBP] regulations). 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. Section 9832 incorporates by reference Section 213 of Title 26 (Medical, dental, etc., expenses), under which “medical care” means amounts paid for the “diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body,” and for transportation primarily for and essential to medical care.

AMA policy supports using the existing FEHBP as a reference when considering if a given plan would provide meaningful coverage. All FEHBP plans cover basic hospital, physician, surgical and emergency care, even though the Program does not require a standard benefit package. FEHBP follows existing evidence-based guidelines for preventive care for children and adults. FEHBP plans are also required to cover additional benefits including child immunizations, prescription drugs, mental health services (with parity of coverage with medical care coverage), and a catastrophic limit for out-of-pocket costs. It is important to note that even with these requirements, FEHBP is able to offer high-deductible health plans coupled with HSAs, as well as consumer-driven health plans, to its enrollees.

It is imperative that the definition of “essential” in the context of an essential benefit package, which will include the general categories of services outlined in the ACA, does not preclude patients from being offered a range of health plan options from which to choose, or further impede private market innovation in product development, benefit packages, and purchasing arrangements. The AMA believes that exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features. Along these lines, the AMA firmly

believes that the development of an essential 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. Offering a range of health plan choices in exchanges that includes high-deductible health insurance plans coupled with HSAs enables patients to select health plans that meet their health care needs and budgetary realities.

Medical Necessity

The Committee has asked a number of questions related to the definition of medical necessity and how this definition is applied by insurers in coverage determinations. The AMA defines medical necessity as: “Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.” The “prudent physician” standard of medical necessity ensures that physicians are able to use their expertise and exercise discretion, consistent with good medical care, in determining the medical necessity for care to be provided each individual patient.

In advising physicians and in its efforts with health plans, the AMA has historically opposed definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness. Such definitions of medical necessity interfere with the patient-physician relationship and prevent patients from getting the medical care they need. Health plans should develop formal protocols as to their methodology for determining "medical necessity," including distinctions between those instances where in-house medical expertise is considered sufficient and those where outside consultation is considered necessary. In "medical necessity" decisions where the determination may be modified by additional medical evidence, there should be an opportunity for the treating physician to provide such evidence before a final decision not to pay is made. When health plans deny coverage for reasons of medical necessity, they need to facilitate the expeditious handling of physician requests for reconsiderations and appeals of such denials.

Appropriate Balance Among Essential Care Categories

Rather than striving for an “appropriate balance” among the ten categories, the AMA believes that the goal instead should be to ensure parity in terms of access and coverage among the ten categories listed. In ensuring parity among these categories, such factors as out-of-pocket costs and benefit limits must be considered. A “prudent physician” standard could even be applied in this arena, as physicians, with their training and expertise, have the unique ability to help ensure that patients get the right care at the right time, and in the right place.

The “prudent physician” standard could only be strengthened by results of comparative effectiveness research (CER), which has the potential to have a profoundly positive impact on the quality of the information available to physicians and patients. CER can help foster the delivery of patient-centered care, by enhancing—not dictating—physician clinical decision-making.

Non-Discrimination and Other Critical Factors

It is critical for patients to become active partners in their health care, and through a strong physician-patient relationship, physicians and patients should jointly participate in making value-based health care decisions. The coverage of essential benefits should be consistent with the goals of patient-centered care, which is ultimately based on evidence and factors relevant to each individual patient. Physicians should have easy access to and consider the best available evidence at the point of decision-making, to ensure that the chosen intervention is maximally effective in reducing morbidity and mortality. Clinical information about health conditions, treatment options, and potential outcomes could then be discussed with the patient.

Age and disability have to be taken into consideration by the "prudent physician" in deciding what is medically necessary. Essential benefits, like any other health insurance benefit, need to be age-appropriate. Individuals within each age group should have a wide variety of coverage options from which to choose, which could include coverage options more comprehensive than the essential benefits package. Individuals with congenital or acquired disabilities should have access to appropriate and affordable medical care throughout their lives, and benefits deemed to be essential for them may go beyond those of patients without disabilities. To address those with additional health care needs, there may be a role for high-risk pools.

The AMA supports the coverage by health plans of care, services, treatments, and interventions uniquely for women. The AMA is also cognizant that individuals with disabilities have unique health needs and supports their access to adequate and affordable medical care.

The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program can be used as a model for moving forward in taking into account the health care needs of diverse segments of the population. Under EPSDT, if a medical treatment or service will help the child even when the state Medicaid program doesn't specifically cover the treatment, it can be authorized (by the Medicaid medical director) on an individual basis.

The AMA believes that it is absolutely vital for an appeals process to be established in every state through the state department of insurance or other state agency regarding the coverage of essential benefits to ensure fair and non-discriminatory practices.

Updating the Essential Benefit Package

In order to assess whether and how enrollees are facing difficulty in accessing needed services for reasons of cost or coverage, HHS should establish a hotline as well as a Web site to collect data on problems from patients, physicians, hospitals, and other stakeholders. Also, surveys of patients, physicians, hospitals and other stakeholders would be a useful tool. It will also be important for HHS to enlist the assistance of patient groups such as AARP and Families USA, as well as physician organizations and other stakeholder groups that provide services covered as essential benefits to patients, to assess the experiences of enrollees regarding the essential benefits package. For updating the essential benefits package, HHS should consider convening an advisory committee to be comprised of physicians, patients, and other stakeholders. Physician (especially those in clinical practice) and patient representation on this committee should be central and significant.

Conclusion

The AMA appreciates this opportunity to provide input to the IOM Committee and we offer our assistance to the Committee as it develops its recommendations to the Secretary.