AMA
AMERICAN MEDICAL ASSOCIATION

James L. Madara, MD
Executive Vice President, CEO

American Medical Association
515 N. State Street
Chicago, Illinois 60654

ama-assn.org

(p) 312.464.5000
(f) 312.464.4184

January 30, 2012

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius:

On behalf of our physician and medical student members, the American Medical Association (AMA) appreciates the opportunity to comment on the Department of Health and Human Services' (HHS) Informational Bulletin on Essential Health Benefits (Bulletin) issued on December 16, 2011. The Bulletin sets out the approach that HHS intends to pursue in rulemaking to define the essential health benefits (EHB) package that is required to be covered under the Affordable Care Act (ACA) by qualified health plans participating in the state-based health insurance exchanges and by non-grandfathered plans sold in the individual and small group markets outside the exchanges.

AMA policy addressing essential health benefits aims to maximize patient choice of health plans and their respective benefit packages, including strong support for 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[1].

[1] 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.

By proposing that essential health benefits be defined by a benchmark plan selected by each state, the Bulletin recognizes that individual states may also have different definitions of "essential" benefits, based on the demographics and health needs of their populations. In *Essential Health Benefits: Balancing Coverage and Cost* (Institute of Medicine [IOM]), the IOM Committee on Defining and Revising an Essential Health Benefits Package for Qualified Health Plans stressed that the "initial design of the EHB continue to support innovation in the design of insurance products offered." The AMA agrees that the essential health benefits package, and therefore the benchmark plan selected by each state, should not preclude patients from being offered a range of health plan options from which to choose, or impede private market innovation in product development, benefit packages, and purchasing arrangements. Health insurance issuers offering options that provide coverage of at least the essential health benefits 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. Along these lines, the AMA firmly believes that the determination of an essential health benefits package by each state 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.

However, allowing states to define essential health benefits by selecting a benchmark plan may inadvertently undercut the intent of Section 1311(d)(3)(B) of the ACA, which requires states to pay for the costs of any state-mandated benefits not included in the essential health benefits package. As the Bulletin would allow states to choose a benchmark plan that covers all state benefit mandates, states therefore would no longer be responsible for covering the costs of any of their benefit mandates, transferring such costs instead to the federal government. Including additional state mandates in the essential health benefits package would impact the overall affordability of health insurance coverage, affecting the ability of individuals and small businesses to purchase health insurance coverage due to higher premiums.

While the AMA generally supports the flexibility granted to states to select their own state essential benefits package for adults using the benchmark approach outlined in the Bulletin, we do not support such an approach for children. For the reasons described further below, we urge HHS to use Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program as the model for defining any essential health benefits package for children.

In addition, we have concerns about the Bulletin's proposed approach for prescription drugs, as well as operational questions about how the flexible benchmark approach would work in implementing additional ACA provisions that also use the essential health benefits package, such as state-established basic health programs, Medicaid, and multi-state plans. This letter discusses in further detail these concerns and questions.

Pediatric Services

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. The ACA specified that the EHB package must cover pediatric services, including oral and vision care, as one of the 10 general categories of services. The EHB package for pediatric services should ensure affordable access to care for the vast majority of relatively healthy children, and, at the same time, protect families from excessive costs when children have special health 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.

The pediatric EHB package should include all preventive, diagnostic, and treatment services that are medically necessary for children. We do not believe that the benchmark options outlined in the Bulletin will meet this standard, and therefore, we recommend that Medicaid's EPSDT program be used as the model for any EHB package for children. The AMA has been a strong and consistent supporter of EPSDT and the vital role it plays in the promotion of child health and development, and has longstanding policy advocating that services to children, adolescents, and young adults should meet EPSDT standards.

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. Comprehensive preventive care covered under EPSDT includes but is 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. Under EPSDT, if a medical treatment or service will help the child, even when the state Medicaid program does not specifically cover the treatment, it can be authorized by the state Medicaid medical director on an individual basis. We believe that using EPSDT as the model for the EHB package for children will help to ensure that all children receive the right care, at the right place, at the right time.

Prescription Drugs

The Bulletin states that in order to ensure competition within pharmacy benefits, HHS intends to propose a standard modeled on the flexibility permitted in Medicare Part D (Part D) in which plans must cover the categories and classes set forth in the benchmark but may choose the specific drugs that are covered within categories and classes. The Bulletin recommends requiring coverage of only one drug per class. However, Medicare requires coverage of two chemically-distinct drugs at minimum for most classes. In addition, the

Centers for Medicare and Medicaid Services (CMS) may require more than two drugs for particular categories or classes if additional drugs present unique and important therapeutic advantages in terms of safety and efficacy, and their absence from the plan formulary would substantially discourage enrollment in the plan by beneficiaries with certain diseases. Part D plan formularies must include all or substantially all drugs within the immunosuppressant, antidepressant, antipsychotic, anticonvulsant, antiretroviral, and antineoplastic classes. If HHS intends to use the formulary structure of Part D, then we recommend they follow the Part D requirements discussed above.

Updating Essential Health Benefits

The ACA requires the Secretary of HHS to periodically review and update EHB. The Bulletin indicates that HHS will assess whether enrollees have difficulties with access, changes in medical evidence or scientific advancement, market changes not reflected in the benchmarks, and the affordability of coverage. This is a critical part of implementing the ACA, and we recommend that HHS establish a hotline as well as a website to collect data on problems from patients, physicians, hospitals, and other stakeholders. Surveys of patients, physicians, hospitals, and other stakeholders also would be a useful assessment 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 EHB package. For updating the package, HHS should consider convening an advisory committee to be comprised of physicians, patients, and other stakeholders. Significant representation by physicians (especially those in clinical practice) and patients on this committee should be central.

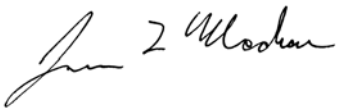
Operational Issues

While we generally support, as previously noted, allowing states the flexibility to define their own EHB package for adults using the benchmark approach outlined in the Bulletin, there are a number of operational issues that will need to be clarified. If each state is going to choose from among the four benchmarks suggested by HHS, what is the process that each state will use in choosing the standard and what will the criteria be? How will HHS review and provide the necessary oversight of potentially hundreds of state- and plan-defined benchmark standards? In order to ensure transparency and appropriate input, consumers, physicians and other providers, and other stakeholders will need to have access to all of the plans under consideration. This will be quite a daunting challenge and require substantial oversight resources by HHS and the states, which may be difficult given continuing budget constraints at both the federal and state levels. It will also be essential for an appeals process to be established in every state, through the state department of insurance or other appropriate agency, regarding the coverage of EHBs to ensure fair and non-discriminatory practices.

As noted earlier, state-established basic health programs, Medicaid, and multi-state plans will use the EHB package as the basis for determining the benefits and services that will be covered. Our understanding of these programs is that these plans will, in essence, "piggy-back" off of the EHB definition, as determined by HHS. It is not clear how these programs will work if each state defines its own set of EHBs, especially with the multi-state plan program. For example, since there is a high likelihood of a federal exchange operating in several states, how will HHS or the Office of Personnel Management, which will be operating the multi-state plan program, determine which states' EHB package will apply? We urge HHS to address these operational issues as it moves forward in the rulemaking process on EHBs.

In conclusion, the AMA appreciates this opportunity to provide input on the Bulletin, and we look forward to continuing to work with HHS on implementation of the EHB package.

Sincerely,



James L. Madara, MD