Principles for Essential Health Benefits Advocacy

The Affordable Care Act (ACA) makes a number of changes to private health insurance plans. One important protection is the establishment of a package of essential health benefits (EHB). Prior to the ACA, federal law did not establish a minimum level of benefits that must be available in all health plans. The EHB will set a floor on what many health plans must cover. The EHB provision in the ACA lists only broad categories that must be covered and leaves the task of defining in greater detail what the EHB must cover within those categories to the Secretary of Health and Human Services (HHS).

This EHB will apply to all new policies sold in the individual and small group markets beginning in 2014 as well to Medicaid benchmark or benchmark equivalent coverage (i.e., coverage that has historically been less generous than traditional Medicaid and that will be available to many newly eligible individuals in 2014). The ACA requires new plans in the individual and small group market to offer the EHB. The EHB also has the potential to set a new unofficial standard for large group plans.

In October, the Institute of Medicine (IOM) released a report outlining the criteria that HHS might use to determine the EHB package. The panel delivered a high level outline for selecting benefits with a strong recommendation that cost consciousness be its guiding principle. Shifting the focus from robustness to predefined cost parameters, as suggested by the IOM, could leave many Americans underinsured.

Given the wide-ranging implications that the EHB will have on consumers, we suggest the following principles to unite consumer groups in their advocacy for a robust EHB:

1. The EHB defined through federal regulation should be as specific possible. Insurers cannot be left to determine all the details of the EHB at the state level. This would undermine the entire purpose of the EHB. Ultimately, the Secretary has the responsibility of ensuring that the EHB meets the needs of consumers. Insurers should not be given wide discretion in how the EHB is implemented. To the extent that discretion is granted, insurers must define publicly what services are included and excluded. Additionally, insurers need to outline how coverage decisions are made and by whom. Advocates will play an important role in their states to monitor how insurers implement the EHB and to raise consumer awareness about the ACA's new appeal rights that can be used to challenge benefit denials.

2. The EHB development process must be conducted in public and be fully transparent to consumers. While advocates may differ on the scope, duration, and amount of services included in the EHB, they can agree on the importance of a public, thoughtful, and deliberative development process that legitimizes consumer input. This process cannot be rushed at the expense of allowing consumers to play a meaningful role in the development process.

Additionally, the annual redetermination of the EHB must be also transparent and involve consumers. According to the ACA, the Secretary will revisit the EHB annually and has discretion in determining whether or not it should be revised. The Secretary should clearly outline the redetermination schedule and create a redetermination process that allows consumer input to play a meaningful role every time the EHB is revisited.

Finally, any determinations of benefit inclusion and/or exclusion as a result of the development or redetermination process should be clearly explained to consumers in plain language. Consumers have a right to fully understand the policy choices being made by HHS related to the EHB.

3. The EHB development process should be driven by consumers. HHS should clearly articulate the tradeoffs being considered between different benefits and actively encourage consumers to give their views on those tradeoffs. All advocates can agree that this type of public process aimed at producing a robust EHB with broad public support is in the interest of consumers. In fact, it is the only equitable way to determine the EHB.

In order to have a truly consumer-driven development and redetermination process, consumer input must be solicited in a way that demonstrates it is valued by HHS. Challenges exist in gathering and analyzing consumer input, particularly in the first year of implementation. Therefore, a detailed mechanism for consumer input must be devised as a part of EHB development and redetermination. The Secretary should consider interviews, surveys, and/or small group discussions that are nationally representative as a channel for consumer input that will play an ongoing role in benefit design. Consumer assistance programs also are a valuable tool in informing future policy and will be instrumental in reevaluating the EHB annually.

4. Despite the fact the EHB cannot include everything of value to consumers, its benefits must be robust. No insured person should be underinsured. When Congress included the EHB in the ACA, they intended for all Americans to have access to a robust benefits package, giving them health care security. Underinsuring consumers is both unjust and shortsighted—it places consumers at risk of medical debt, reduces the likelihood of preventive medical care, and increases the chance of a missed or late diagnosis. These effects can be devastating for families and costly to the health care system as a whole.

Additionally, the Secretary should seek to design an EHB that is as comprehensive as possible while working within the framework established by the ACA. To the best of her ability, the Secretary should work to minimize instances in which some consumers could receive less generous coverage as a result of the tradeoffs made to create a comprehensive yet feasible EHB.

5. The EHB should be affordable for consumers. Health insurance must be affordable. As the economy recovers, families continue to struggle and live on tight budgets. Affordability should be defined as the percentage of income a household can devote to health care while still having sufficient income to address other necessities. Affordability is vital to the success of the ACA and the EHB. Families should not be placing themselves in financial straits by obtaining health insurance coverage.

6. The array of benefits in the EHB should be fair to everyone but should also be designed to address the needs of vulnerable populations. The ACA demands balance among the ten benefit categories in the EHB and contains an anti-discrimination clause to prevent exclusion and harm to any one group. The Secretary must make equity a priority.

Furthermore, the EHB will be a source of coverage for a diverse population including many traditionally underserved groups. The projected Exchange population is older, less educated, lower income, more racially diverse, and speaks English as a second language more often than the private insurance market.[1] Additionally, the majority of this population will transition from being uninsured. Many will need to address previously unmet health care needs. The Secretary must consider the needs of vulnerable populations as she defines the EHB. These may include but are not limited to care coordination, translation services and transportation.

The development of the EHB is of one of the hardest issues facing advocates and policymakers as ACA implementation moves forward. It is our belief, however, that these principles can unite advocates around a shared vision of the EHB that sufficiently meets the needs of consumers while respecting the complexity of the issue.

[1] The Henry J. Kaiser Family Foundation, A Profile of Health Insurance Exchange Enrollees. (Washington, DC: The Henry J. Kaiser Family Foundation, 2011), 3. http://www.kff.org/healthreform/upload/8147.pdf.