



The Essential Health Benefits Process: What Advocates Need to Know Now

What are Essential Health Benefits and Who Will Define Them?

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 to the Secretary of Health and Human Services (HHS) the task of defining in greater detail what the EHB must cover within the following categories:¹

- Ambulatory patient services (i.e., services provided on an outpatient basis)
- 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 (i.e., services and items used to restore functional capacity, minimize limitations on physical and cognitive functions, or maintain or prevent deterioration of functioning)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

This brief focuses on how the process for developing the EHB and the opportunities for consumers to share their views on what constitutes an appropriate standard for this minimum level of benefits. This package 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).

Which Plans Must Include the EHB?

For Plan Years Beginning January 1, 2014 or Later		Must Provide Essential Health Benefits	
Exchange Plans	Small Group	Yes	
	Non-Group	Yes	
Non-Exchange Plans	New Plans	Self-Insured	No
		Large Group	No
		Small Group	Yes
		Non-Group	Yes
	Grandfathered Plans	Basic Health	Yes
		Self-Insured	No
		Large Group	No
		Small Group	No
	Non-Group	No	

As discussed in further detail later in this document, the EHB holds the potential to have a significant impact beyond the plans listed in the above table.

How Will the EHB be Defined?

The Process Required by the ACA

In defining – and later updating – the EHB, the Secretary must ensure that the scope of benefits is equal to the scope of benefits provided under a “typical employer plan.” To define a typical employer plan, the ACA tasked the U.S. Department of Labor (DOL) with conducting a survey of employer-sponsored plans. DOL submitted a [report](#) of their findings to HHS on April 15, 2011. However, DOL relied on existing data sources, which are limited and not detailed, so the resulting report offers only a partial view of what a typical employer plan covers. For example, DOL reviewed summary plan information which included very general descriptions of benefits that are provided to employees. So while the DOL report provides a useful overview of the variation among employer plans, it provides little clarity on what is typical in employer benefits. Some benefits may be specifically excluded, but in many cases they were simply not mentioned. For example, diabetes care management (i.e., educating patients about how to manage their diabetes) was not mentioned in plan documents for more than 70 percent of participants in the survey but that does not necessarily mean the benefit is not covered.

The ACA includes other requirements that the HHS Secretary must meet in establishing the EHB. The Secretary must ensure that the benefits reflect an appropriate balance among the different categories, do not discriminate against individuals because of their age, disability, or expected length of life, and take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.²

HHS Process Beyond the ACA Requirements

The HHS Secretary has also enlisted the help of the Institute of Medicine (IOM), an independent non-profit that regularly undertakes studies mandated or requested by Congress and federal agencies. The IOM has been asked to make recommendations on an appropriate framework for the Secretary's work, recommending the criteria and methods she might apply in defining and updating the EHB. In HHS's request to IOM, it asked IOM to consider a range of questions in its ultimate recommendation to the Secretary:

- At what level of specificity should the EHB be framed? How are issues of time, duration, frequency, scope, and specific services best addressed?
- What defines and distinguishes a medical service from a non-medical service? How should this distinction be considered and applied in the context of defining the EHB?
- How can a federal standard for benefits coverage best reconcile state and regional variations in practices and benefits coverage patterns, including variations in state mandated benefits? How much flexibility should be given to states or to exchanges?
- What can be learned from the practices of employers who offer multiple plans about plan design, consistency, and fairness?
- Considering the varying health needs of diverse populations, what policy principles and criteria should be taken into account to prevent discrimination? How can these considerations best be balanced against the content of a typical employer plan and the cost of insurance coverage?
- Assuming that insurers continue to have a role in deciding exactly which services to pay for, what information is needed to monitor the decisions that are made, how should that information be collected, and how should that information be used, if at all, in updating the definition of the EHB? What are the roles of exchanges, states and the federal government in this task?
- What criteria should be used to adjust the EHB over time and what should the process be for their modification? How can we ensure that over time modifications to the EHB are consistent with initial benefit design but reflect evolving science?

The IOM's Committee on Determination of Essential Health Benefits has 17 members and has held two public meetings: January and March, 2011. The agenda and materials used for those meetings can be found on the IOM's [website](#). There is also an online form for public comment on how to define the EHB. The IOM is expected to submit their recommendations to HHS in early October 2011.

Finally, HHS said that they will seek public comment on the EHB, informed by the IOM's recommendations, beginning this fall. Although HHS hasn't provided further details on that

process, they are expected to hold town hall meetings that will give the public an opportunity to comment. Following these meetings, a proposed regulation – which should also include a request for public comment – will likely be released. **These opportunities represent the best chance for advocates to weigh in with the Secretary on the EHB.**

What Are Issues of Concern for Consumer Advocates?

1. Comprehensiveness Versus Cost

One of the key challenges in defining the EHB will be how to balance comprehensiveness of coverage with the cost of insurance. A more comprehensive definition for the EHB will increase the federal government's cost for subsidies for those who qualify and for individuals who must pay for coverage out-of-pocket. However, an EHB that is less comprehensive runs the risk of leaving consumers underinsured even if it proves less costly in the short-term.

2. Insurer Discretion to Make Coverage Decisions

Another issue will be how much discretion HHS leaves to insurers in coverage decisions. For example, if the Secretary determines that physical therapy to treat lower back pain is a covered benefit, she could determine the minimum number of physical therapy sessions that must be covered to treat the condition or she could leave that to the discretion of insurers. The level of detail included in the EHB will affect consumers' access to care. If the definitions leave considerable discretion to insurers, consumers may need to use the ACA's [new appeal rights](#) to challenge denials of benefits.

3. The Use of the DOL Employer Plan Survey

A third issue will be how the DOL survey of employer plans is used. As previously mentioned, because of the limits of the survey, there is no clear picture of a typical employer plan. This raises a number of concerns for consumers. Benefits not specifically mentioned in the documents provided by employers may be undervalued for the EHB. Also, employers have broad discretion to interpret key terms and provisions of the plan, so actual coverage details may not be known until a claim is submitted. In order to set a meaningful standard for coverage, the EHB should prohibit broad variation across insurers and plans.

4. State Coverage Mandates

Lastly, state coverage mandates raise an additional challenge. The ACA allows states to continue to mandate benefits beyond the EHB; however, the state must cover the additional costs associated with those mandates for all individuals enrolled in qualified health plans (QHPs) regardless of whether they qualify for subsidized coverage or not.³ For many state mandates, this cost burden will be an insurmountable hurdle. At this time, it is unclear how states will cover those costs.

Conclusion

The ACA requires new plans in the individual and small group market to offer the EHB, however the implications of this new benefit standard will reach beyond those plans. The EHB has the potential to set a new unofficial standard for large group plans in addition to its impact on Medicaid discussed earlier. At the most basic level, how the EHB is defined will have significant

implications for consumer access to care, and federal – and potentially state – costs under the ACA.

To be a part of this debate, advocates should weigh in at two critical junctures:

- 1. with HHS during the town hall meetings this fall**
- 2. when the Secretary releases the proposed EHB regulation**

The Secretary's decision will shape the work advocates will face on the state level. Once the EHB is finalized, states can consider requiring coverage for state mandated services not included in the EHB. Given state budget constraints, it will be difficult to get states to commit to funding the cost of state mandates that go beyond the EHB. For more information about strategy considerations for advocates around the EHB, please see Community Catalyst's [Essential Health Benefits: A Federal Strategy Guide for Advocates](#).

¹ Affordable Care Act, Pub. L. No. 111-148, § 1302(b)(1) (2010).

² Affordable Care Act, Pub. L. No. 111-148, § 1302(b)(4) (2010).

³ Affordable Care Act, Pub. L. No. 111-148, § 1311(d)(3) (2010). The ACA does not differentiate between subsidized and unsubsidized QHPs here but there is a possibility that HHS will find a way to limit state obligations to cover costs associated with additional state mandates to subsidized QHPs.