News Alert – December 19, 2011

Consumer advocates fear "race to bottom" as states allowed to define "essential health benefits"

Consumer advocates were disappointed with new guidance released by the Department of Health and Human Services (HHS) on December 16th that will let states instead of the federal government define the minimum package of "essential health benefits" that the Affordable Care Act (ACA) requires all health plans to cover by 2014.

States and health plans have been anxiously awaiting the proposed rule on essential benefits that HHS pledged to issue by the end of 2011. Many had delayed a decision on whether to create or participate in the new health insurance exchanges authorized by the ACA until they knew what benefits HHS would require plans to cover.

However, defining essential benefits is likely to incite a highly contentious political debate during an election year. As a result, the Obama Administration reportedly has been seeking a "middle ground" that would outline the parameters of coverage, while putting the political bulls-eye on both Republican and Democratic governors to decide what benefits will be covered.

The initial guidance HHS released for public comment makes clear that coming regulations will still place strict limitations on how states can define essential benefits. Specifically, the only existing plans that could serve as a state essential benefit "benchmark" are one of the state's three largest small group plans, one of its three largest state employee health plans, one of its three largest federal employee health plans, or the largest HMO plan offered in the state's commercial market.

Any plan selected by a state must also cover all ten required categories of care set forth in the ACA, or the state will have to select coverage of the uncovered categories from other benchmark health plans, such as the popular Federal Employee Health Benefits Plan (FEHBP). These categories include preventive, emergency, maternity, hospital, and physician services, as well as prescription drugs.

Plans can still modify coverage within a benefit category so long as they do not reduce the value of coverage. Future regulations will also require states to pay for any state-mandated coverage beyond their essential benefits package.

HHS delayed discussion of cost-sharing limitations until later guidance. Recommendations furnished earlier this fall by the Institute of Medicine (IOM) urged HHS to take premium cost into account in making this determination, but did not suggest what specific benefits should be included. Consumer groups like Families USA have urged CMS to consider all out-of-pocket costs, and not just premiums.

http://online.wsj.com/article/SB10001424052970203733304577102853112696874.html?mod=ITP_pageone_1

http://www.bloomberg.com/news/2011-12-19/obama-health-insurance-decision-passes-political-hot-potato-to-states.html

http://www.denverpost.com/news/ci_19566835