

The Department of Health and Human Services (HHS) will give states more flexibility to implement health reform. Approach will help ensure consumers have quality, affordable coverage starting in 2014.

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The Department of Health and Human Services today released a bulletin outlining proposed policies that will give states more flexibility and freedom to implement the Affordable Care Act.

The Affordable Care Act ensures all Americans have access to quality, affordable health insurance. To achieve this goal, the law ensures that health insurance plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges (Exchanges), offer a comprehensive package of items and services, known as “essential health benefits.”

The bulletin released today describes an inclusive, affordable and flexible proposal and informs stakeholders about the approach that HHS intends to pursue in rulemaking to define essential health benefits. HHS is releasing this intended approach to give consumers, states, employers and issuers timely information as they work toward establishing Exchanges and making decisions for 2014. This approach was developed with significant input from the public, as well as reports from the Department of Labor, the Institute of Medicine, and research conducted by HHS.

“Under the Affordable Care Act, consumers and small businesses can be confident that the insurance plans they choose and purchase will cover a comprehensive and affordable set of health services,” said HHS Secretary Kathleen Sebelius. “Our approach will protect consumers and give states the flexibility to design coverage options that meet their unique needs.”

Under the Department’s intended approach announced today, states would have the flexibility to select an existing health plan to set the “benchmark” for the items and services included in the essential health benefits package. States would choose one of the following health insurance plans as a benchmark:

- One of the three largest small group plans in the state;
- One of the three largest state employee health plans;
- One of the three largest federal employee health plan options;
- The largest HMO plan offered in the state’s commercial market.

The benefits and services included in the health insurance plan selected by the state would be the essential health benefits package. Plans could modify coverage within a benefit category so long as they do not reduce the value of coverage. Consistent with the law, states must ensure the essential health benefits package covers items and services in at least ten categories of care,

including preventive care, emergency services, maternity care, hospital and physician services, and prescription drugs. If a state selects a plan that does not cover all ten categories of care, the state will have the option to examine other benchmark insurance plans, including the Federal Employee Health Benefits Plan, to determine the type of benefits that will be included in the essential health benefits package.

The policy proposed today by HHS would give states the flexibility to select a plan that would be equal in scope to the services covered by a typical employer plan in their state. States and insurers would retain the flexibility to evolve the benefits package with the market as innovative plan designs are developed and advancements in care become available, and meet the needs of their citizens.

“More than 30 million Americans who newly have insurance coverage in 2014 will have a comprehensive benefit package,” said Sherry Glied, PhD, assistant secretary for planning and evaluation. “In addition to assuring comprehensive coverage for the newly insured, many millions of Americans buying their own insurance today will gain valuable new coverage, including more than 8 million Americans who currently do not have maternity coverage, and more than 1 million who will gain prescription drug coverage.”

The bulletin issued today addresses only the services and items covered by a health plan, not the cost sharing, such as deductibles, copayments, and coinsurance. The cost-sharing features will be addressed in future bulletins and cost-sharing rules will determine the actuarial value of the plan.

Public input on this proposal is encouraged. Comments are due by Jan 31, 2012 and can be sent to: EssentialHealthBenefits@cms.hhs.gov.

For the essential health benefits bulletin, visit:
<http://cciio.cms.gov/resources/regulations/index.html#hie>

For a fact sheet on the essential health benefits bulletin, visit:
<http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>

For a summary of individual market coverage as it relates to essential health benefits, visit:
<http://aspe.hhs.gov/health/reports/2011/IndividualMarket/ib.shtml>

For information comparing benefits in small group products and state and Federal employee plans, visit: <http://aspe.hhs.gov/health/reports/2011/MarketComparison/rb.shtml>

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Note: All HHS press releases, fact sheets and other press materials are available at
<http://www.hhs.gov/news>.

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