Health Law and Policy Update: March 9, 2012

This week's updates

Headlines of the week

Health reform law approaches second anniversary
As passage of national health reform approaches its second anniversary on March 23, the Patient Protection and Affordable Care Act already has made health care more sensible and secure for Coloradans. **Because of the law, insurance companies are no longer allowed to deny insurance to children with pre-existing conditions**. The prohibition applies to both job-based health insurance and health insurance purchased in the individual market. The same protection will be extended to adults in 2014.

According to the Colorado Health Access Survey, 12.5 percent of uninsured Coloradans do not have insurance because of a pre-existing condition. That was a slight decrease from the 14.2 percent who listed pre-existing condition as the reason for lack of insurance in 2008-09, suggesting that policy changes like the prohibition on excluding children with pre-existing conditions has been effective.

During the next several weeks, Health Law and Policy Update will feature some key facts about health reform to arm advocates and the public with clear facts about the law.

Basics of health reform haven't reached many people

Many people remain confused about basic provisions of the nation's health reform law even as the Patient Protection and Affordable Care Act approaches its second anniversary this month, as Public News Service reported in a story released Monday.

A national poll commissioned by the Kaiser Family Foundation found gaps in public knowledge about health reform such as the incorrect belief among more than half of respondents that the law establishes a government-run insurance plan. Part of the confusion could come from the gradual phase-in of many provisions of the law, Colorado Center on Law and Policy Health Care Attorney Adela Flores-Brennan told Public News Service.

One in three Americans has a hard time paying medical bills
A new survey shows difficulty paying medical bills is widespread across the nation. During the first half of 2011, one in three people lived in a family that had trouble paying medical bills during the previous year, were paying a medical bill over time or had a medical bill that they were not able to pay at all, the National Center for Health Statistics found.

The survey demonstrates people with incomes just more than the federal poverty level were the most likely to struggle with medical bills. Among respondents in that "near-poor" category, 45.8 percent had difficulty paying for medical care. Coverage of the survey is available from NPR.

Senate Bill 12-134, the Hospital Payment Assistance Act, addresses the issue and helps working families who cannot afford insurance to responsibly pay their hospital bills. The bill is awaiting a final vote by the

Colorado Senate, after which it will begin hearings in the House. Follow developments with the bill between editions of Health Law and Policy Update at CCLP's Hospital Payment Assistance Program action center.

Advancing the debate

Essential Health Benefits: Excessive benefit design flexibility should be avoided

This is the fourth in a series of pieces from CCLP regarding the development of the Essential Health Benefits Package in Colorado. Previous pieces were published Feb. 3, Feb. 10, and Feb. 24.

The U.S. Department of Health and Human Services (HHS) issued a bulletin in December that proposed a process for states to establish an Essential Health Benefits (EHB) package as part of implementing the Patient Protection and Affordable Care Act (ACA). The bulletin suggests that instead of a single standard for defining the EHB, the department will allow states to benchmark to a "reference plan" based on a currently available health plan in the state, modified as needed to meet the EHB requirements found in the ACA. At the heart of the proposed design is granting states and insurance issuers a great deal of flexibility to construct the EHB and make ongoing modifications. HHS justifies the approach by arguing that allowing increased flexibility will allow insurers to balance coverage and cost in a manner that suits the markets where they are located. However, granting states and especially insurance carriers excessive flexibility in plan design carries great risks.

First, allowing each state to define its own EHB package based on an existing benchmark plan in the state could lead to unnecessary variation in insurance products among states. Under the proposed method of selecting an EHB, the selected plan would reflect both the scope of services and limits offered by a "typical employer plan" in that state. That is likely to create widely varying coverage from state to state, as services offered in many health plans (including mandated services) vary depending on the types of employers located in that state and the health of the people served. That could have a substantial effect on people moving between states. Moreover, the federal government will likely have to expend far more administrative resources regulating 50 EHB designs to ensure they comply with minimum coverage requirements under the ACA.

Second, and more concerning, is the suggestion in the HHS bulletin that insurance issuers may have the flexibility to adjust or substitute benefits, including both the specific services covered and any quantitative limits, provided the issuer continues to offer coverage for all 10 mandatory EHB categories in the ACA. Permitting insurance carriers to deviate from the benchmark benefits chosen by the state could weaken the ACA's EHB provision. The EHB standard is intended to ensure a consistent, minimum level of benefits across all non-grandfathered, fully insured plans in the individual and small-group insurance markets so consumers can make an apples-to-apples comparison of plan options and to prevent insurers from adopting benefit designs intended to attract healthier people and deter enrollment by those in poorer health. The proposal for "benefit design flexibility" would undermine those goals.

The HHS proposal to allow insurers to deviate from a state's essential health benefit standard is likely to be used by insurers to limit benefits in ways that would harm or shift costs to enrollees with high-cost or specialized health needs. Beginning in 2014, the ACA requires insurers to take all applicants, prohibits insurers from charging people higher premiums due to health status, sex and other characteristics, and limits the effect of customers' ages on their premiums. With those requirements in place, insurers that can no longer reject high-cost enrollees or charge more for people with pre-existing conditions are likely to adopt other methods to reduce exposure to large or certain types of health claims.

In particular, if the flexibility is allowed, it is likely insurers will increase their use of "internal plan limits," such as restrictions on the number of visits for a particular service, to reduce costs. Insurers could scale back coverage in one area (perhaps by placing stricter limits than the benchmark on a service more likely to be used by people with greater health care needs) and make up for it by increasing coverage in another benefit. Even if insurers must show each category of their benefits is equal in actuarial terms to

each of the 10 benefit categories in the benchmark, there would still be significant room for insurers to design that benefit category in problematic ways.

The Colorado Center on Law and Policy opposes allowing insurers to have any role in setting or altering the EHB standard. It is unclear what advantage, if any, the proposed flexibility holds for consumers. If insurers can substantially vary the details of the benefits they cover from a state's chosen benchmark benefits standard, consumers will have a difficult time comparing the features of different plan options and making informed decisions about coverage. In addition, some insurers would likely exercise the flexibility to impose problematic benefit restrictions (such as visit limits) that would shift costs to people with significant or rare health care needs. Insurers would thus be able to construct plans in ways that discourage enrollment by high-cost people or attract enrollment by people who are less costly to cover.

If insurer flexibility is allowed, oversight and enforcement procedures should be required to ensure benefit design is compliant with the ACA and is consumer-focused.