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Balancing adequacy and affordability?: Essential Health Benefits under the Affordable Care Act

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ABSTRACT

The Essential Health Benefits provisions under the Affordable Care Act require that eligible plans provide coverage for certain broadly defined service categories, limit consumer cost-sharing, and meet certain actuarial value requirements. Although the Department of Health and Human Services (HHS) was tasked with the regulatory development of these EHB under the ACA, the department quickly devolved this task to the states. Not surprisingly, states fully exploited the leeway provided by HHS, and state decision processes and outcomes differed widely. However, none of the states took advantage of the opportunity to restructure fundamentally their health insurance markets, and only a very limited number of states actually included sophisticated policy expertise in their decisionmaking processes. As a result, and despite a major expansion of coverage, the status quo ex ante in state insurance markets was largely perpetuated. Decisionmaking for the 2016 revisions should be transparent, included a wide variety of stakeholders and policy experts, and focus on balancing adequacy and affordability. However, the 2016 revisions provide an opportunity to address these previous shortcomings.

1. Introduction

In the United States, the regulation of commercial health insurance has traditionally been the domain of the states (see [32]). However, the Affordable Care Act (ACA) significantly changes the American healthcare system in numerous ways and it directly affects the operation of state insurance markets through its various provisions [22]. One of the most visible areas of this most recent federal initiative is the requirement that health plans sold in insurance marketplaces must offer a variety of services, including ambulatory patient services, prescription drugs, and emergency services, termed *Essential Health Benefits* (EHB). Although the Department of Health and Human Services (HHS) was tasked with the regulatory development of these EHB under the ACA, the department quickly devolved this task to the states. This assessment sheds light on the development and implementation of the EHB, a topic that has received little attention in the media and scholarly literature.[1] Moreover, it also provides background on the development of insurance benefit packages in the United States and offers and outlook to the upcoming EHB revisions in 2016.

From a policy perspective, the development and implementation of the EHB afforded policymakers an excellent opportunity to set healthcare priorities and to make fundamental decisions for their health insurance markets about how to balance coverage and affordability. Ideally, these

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[1] The scant existing literature mostly focuses on the legality of the approach taken by HHS [1] or provides background information [36,27,46].

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decisions should have been based on policy expertise, i.e. a sound understanding of opportunity costs. Not surprisingly, states fully exploited the leeway provided by HHS, and state decision processes and outcomes differed widely. However, none of the states took advantage of the opportunity to restructure fundamentally their health insurance markets, and only a very limited number of states actually included sophisticated policy expertise in their decisionmaking processes. As a result, and despite a major expansion of coverage, the status quo ex ante in state insurance markets was largely perpetuated. However, the 2016 revisions provide an opportunity to address these previous shortcomings.

2. Insurance regulation prior to the Affordable Care Act

Insurance regulation in the United States is rather complex because it generally involves an intricate combination of state and federal jurisdictions. Perhaps the most visible case of health insurance regulation can be found in the form of insurance mandates, i.e. the minimum insurance benefit packages that insurance plans have to provide.[2] These mandates are often considered as an easy, relatively uncontroversial instrument for extending insurance coverage because they avoid the pitfalls of direct provision of public goods such as deadweight losses [19,44]. Specifically, mandates avoid incurring costs due to the marginal excess tax burden (METB) that would be the result from direct governmental provision [4]. Other common rationales in support of the establishment of mandates include imperfect information of consumers, information asymmetries, adverse selection, preventative cost savings, and suboptimal selection of coverage (see [21,19]). From a legislative perspective, mandates are attractive because they do not affect state budgets directly but instead externalize costs [44]. However, opponents of mandates prominently cite moral hazards as their most common concern [21,39].

As mentioned previously, states have been the primary regulators of commercial health insurance in the United States [32]. With regard to insurance mandates, the State of Pennsylvania was the first to require minimum benefits in the form of coverage for osteopaths and dentists in 1949 [35]. Since then, the number of mandates has increased dramatically; particularly in the 1980s and 1990s, states added mandates at a rapid rate [30,29]. More recently, in the period just prior to the enactment of the ACA, i.e. between 2004 and 2010, the number of mandates grew from about 1800 to a total exceeding 2100 across the states [5,6].[3]

In addition to the states, and despite the self-imposed restrictions of the McCarran–Ferguson Act of 1945, the federal government has also increased its regulatory involvement.[4] The three most prominent forays into the regulation of health insurance by the U.S. Congress include the *Employee Retirement Income Security Act* (ERISA) of 1974, the *Consolidated Omnibus Budget Reconciliation Act* (COBRA) of 1985, and the *Health Insurance Portability and Accountability Act* (HIPAA) of 1996. While diverse in their subject matter, they impose a variety of restrictions and mandates with regard to continuation of coverage, portability, and renewability. Most recently, the *Affordable Care Act of 2010* adds to the national list of mandatory coverage mandates [14].

The combination of state and federal regulations of health insurance has led to markedly different benefit packages – and processes to determine these packages – across the four major types of health insurance in the U.S.: Medicare, Medicaid, commercial insurance, and self-insurance. With regard to Medicare, the benefits are fully determined by federal statutes. Similarly, companies choosing to self-insure under ERISA are also subject only to federal jurisdiction. In both cases, specific benefit packages are developed through regulatory policymaking by HHS under the Administrative Procedures Act (APA), allowing for (limited) public and expert involvement.[5] On the other hand, individual states generally take preeminence with regard to the regulation of commercial insurance, confined only by the limited restrictions of the aforementioned statutes. The development of benefit packages by the states is driven by legislative policymakers and implemented by state regulatory entities like the departments of insurance [37]. A significant overlap in jurisdiction occurs for the Medicaid program. While states are required to provide certain benefits (as laid out by Title XIX of the Social Security Act and implemented through HHS regulations), they are offered significant leeway with regard to so-called optional benefits [45]. Benefit packages are specified by states in their state Medicaid plans, subject to HHS approval. Processes for altering Medicaid benefits, so-called state Medicaid plan amendments, differ widely across the states; however, in most states the process is regulatory and does not require legislative approval [38,41].[6]

In the U.S., the most proactive, albeit quite limited, effort to develop and implement healthcare priorities can be found in the Oregon Health Plan [28,42]. However, the process of determining specific benefit packages in the United States generally appears rather ad hoc and driven by immediate political considerations. Moreover, in this process, only a very limited number of states require any kind of analysis with regard to medical effectiveness or financial impact [33,35]. Hence, the situation differs markedly from other developed nations like New Zealand, Israel, the

[2] Insurance mandates are generally separated into three major categories: provider, benefit, and coverage mandates [21]. Provider mandates require that insurance plans include coverage for certain types of providers such as dental hygienists or chiropractors. A minimum level of service, e.g. in terms of cost or days for certain services, is stipulated by benefit mandates. Finally, requirements regarding certain classes of individuals, e.g. dependent or foster care children, are addressed by coverage mandates. See [21] for additional information.

[3] Ranging from a low of 13 for Idaho to a high of 69 for Rhode Island.

[4] The McCarran–Ferguson Act generally exempts the regulation of insurance from federal interference. It was passed by Congress in response to *United States v. South-Eastern Underwriters Association* in which the Supreme Court rules that the federal government could regulate insurance based on the Commerce Clause.

[5] For more information on rulemaking under the APA see [31].

[6] Note that states may also alter their Medicaid programs through so-called waivers, in which the federal government may permit states to abdicate certain normally required benefits [45].