Issue Brief

America's Health
Insurance Plans

The Essential Benefits Package Must Balance Affordability and Coverage for Small Businesses, Individuals, and Families

The Affordable Care Act (ACA) requires insurers to provide coverage for the "essential health benefits" (EHB) package—effective January 1, 2014. These requirements apply to qualified health plans in the exchange as well as health insurance plans offered in the small group and individual markets outside the exchange[1]. EHB requirements do not apply to health insurance coverage provided in the large group market (either fully-insured or self-funded) nor do they apply to "grandfathered" health plans.

Under the ACA, the EHB provisions require insurers to—

- Provide coverage for broad categories of services—as specified under the statute[2];
- Limit annual cost-sharing to specified amounts (e.g. annual OOP limits)[3]; and limit deductibles for plans in the small group market; and
- Meet minimum standards for actuarial value.[4]

The ACA also requires that the scope of the EHB package must be equal to the scope of benefits covered under a typical employer plan, as determined by HHS.

On November 20, 2012, the U.S. Department of Health and Human Services (HHS) released a proposed rule that details standards for health insurers related to coverage of essential health benefits and actuarial value. In addition, the rule proposes a timeline for qualified health plans to be accredited in the federally-facilitated exchange and provides an application process for the recognition of additional accrediting entities for purposes of certifying qualified health plans.

[1] Moreover, EHB requirements apply to Medicaid benchmark and benchmark-equivalent plans (for the Medicaid expansion population under the ACA), Multi-State plans administered by OPM, CO-OP plans, and—to the extent states establish a basic health program—plans offered under these state-administered plans for low- and moderate-income families with incomes between 133%-200% FPL.

[2] The EHB package shall include at least the following general categories and items and services within the categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance abuse disorder benefits, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

[3] ACA limits annual cost-sharing to amounts for HSA/high-deductible plans ($6,050 for individuals/$12,100 for families). Lower OOP limits apply to subsidized exchange coverage for low- and moderate-income families with incomes up to 400% FPL.

[4] ACA creates four benefit categories for the exchange and plans in the individual and small-group markets: (1) bronze plan with an actuarial value of 60%; (2) silver plan with an actuarial value of 70%; (3) gold plan with an actuarial value of 80%; and (4) platinum plan with an actuarial value of 90%. The ACA also creates a "catastrophic" high-deductible plan available to those under the age of 30.

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The proposed rule largely follows the intended regulatory approach outlined in the HHS Essential Health Benefits Bulletin, released on December 16, 2011. Under this approach—adopted by the proposed rule—states are provided broad flexibility to choose among alternative EHB packages. Specifically, states may select among several "benchmark" plan options, including:

- **The largest health plan by enrollment in any of the three largest small-group insurance products;**
- **Any of the largest three state employee health benefit plan options by enrollment;**
- **Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by aggregate enrollment; or**
- **The coverage plan with the largest insured commercial, non-Medicaid enrollment offered by a health maintenance organization (HMO) operating in the state.**

Consistent with the HHS Bulletin, the proposed rule provides that if a state does not make a benchmark selection, the default plan will be the largest plan by enrollment in the largest product in the state's small-group market.

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While AHIP supports the concept of state flexibility to select a benchmark as outlined in the HHS proposed rule, we believe that the EHB package must be affordable for small businesses and families and that affordability should be the cornerstone of HHS' consideration.[5] Ensuring that coverage is affordable is critical to promoting the broad-based participation that is necessary to achieve the health reform law's central goal: providing affordable, high quality coverage to tens of millions of Americans who are currently uninsured. Therefore, in defining EHB, HHS and the states must consider affordability to be the primary objective. As the non-partisan Institute of Medicine (IOM) noted in its recommendations to HHS:

"If cost is not taken into account, the EHB package becomes increasingly expensive and, individuals and small businesses will find it increasingly unaffordable. If this occurs, the principal reason for the ACA—enabling more people to purchase health insurance, and covering more of the population will not be met."[6]

The imposition of richer benefit packages will result in less affordable coverage for small employers, individuals, and families by forcing them to "buy up" coverage they may not want or need. Jonathan Gruber, a prominent health economist and policy expert, noted that the most important thing to consider is "the trade-off between our desire to make insurance generous and our desire to make it affordable."[7] He estimated that a 10% rise in the cost of the essential health benefits package would increase the federal government's cost by 14.5%, or $67 billion, and reduce the rate of the insured by 4.5%, or 1.5 million, through 2019.[8]

Many state departments of insurance and state exchange boards have begun requesting formal actuarial and economic forecasts of the impact of the ACA insurance reforms on their state. These independent studies have found that some provisions, including the EHB and actuarial value requirements, will result in higher premiums. The chart below catalogs the impact of the EHB requirements from these independent state studies.

[5] AHIP's comment letter to HHS can be found athttp://ahip.org/CommEHBAVAccPropReg12212012/

[6] IOM Report – *Essential Health Benefits: Balancing Coverage and Cost*. October 7, 2011.

[7] Aizenman, N.C. "Essential benefits a complex question in new health-care law." Washington Post. 14 January 2011. http://www.washingtonpost.com/wp-dyn/content/article/2011/01/14/AR2011011406172.html

[8] Gruber, Jonathan. "Economic and Political Considerations in Setting Essential Health Benefits." January 2011. http://www.washingtonpost.com/wp-dyn/content/article/2011/01/14/AR2011011406747.html

Individual Market: Independent State Studies Show "Buy-Up" Due to Federal EHB Requirement	
State	**Increase in Non-Subsidized Premiums**
Alaska[1]	– 3.2% average – 26%↑ for 12% of market
Colorado[2]	8%
Indiana[3]	20%-30%
Ohio[4]	20%-30%
Oregon[5]	8%
Maine[6]	33%
Maryland[7]	8%-10%
Minnesota[8]	8%-11%
Nevada[9]	– 3% average – 30%↑ for 10% of market
Wisconsin[10]	6%-7%

Scope of Benefits—

The ACA requires the HHS Secretary to ensure that the scope of benefits provided under the "essential health benefits" package be equal to the scope of benefits provided under a "typical employer plan." While the term "typical employer plan" is not explicitly defined in the statute, it is vitally important that the benefit package be comparable to benefits purchased by small employers, as small businesses and individuals will be the primary customers of exchange plan coverage. Research has shown that workers and families obtaining health insurance coverage in the individual and small group markets are especially price sensitive—as workers for small firms and individual purchasers tend to pay for a larger share of the premium cost. The imposition of a broader benefits package will result in millions of people purchasing coverage that is more comprehensive, but also more expensive than the coverage they have now.[9] According to HHS, many individuals and families purchasing coverage on their own do not currently have coverage for some of these services, such as maternity services (62%), substance abuse services (34%), mental health services (18%), and prescription drugs (9%).[10]

The Congressional Budget Office (CBO) found that "average premiums in the individual market would be 27 percent to 30 percent higher because a greater amount of coverage would be obtained."[11] This is largely due to the fact that individual plans "would cover a substantially larger share of enrollees' costs for health care (on average) and a slightly wider share of benefits."[12] CBO's updated estimates for the insurance coverage provisions of the Affordable Care Act found that, "because of the [EHB] bulletin, CBO and JCT now expect that the scope of benefits that will qualify as allowable health insurance expenses for the purpose of exchange subsidies will be slightly broader than previously estimated."[13]

Actuarial Value—

Actuarial value is a summary measure of a health insurance plan's benefit levels—measuring the relative percentage paid by a health benefits plan and its enrollees for a standard/average population. For example, a plan with an actuarial value of 60% means that the insurance plan would pay 60% of covered health care expenses—while the enrollee would pay 40% out-of-pocket in the form of copayments, co-insurance, and deductibles. The ACA requires that health insurance coverage sold to small-firms and individuals through the new state-based "exchanges" must be at one of four actuarial value levels or tiers: 60% AV (bronze plan); 70% AV (silver plan); 80% AV (gold plan); and 90% AV (platinum plan). Moreover, most individuals will be required to have insurance at least equal to the bronze level (60% AV) of coverage—in order to satisfy the individual coverage requirement.

[9] Implementation of the Affordable Care Act's Health Insurance Exchanges and Related Issues. Testimony for the House Ways and Means Subcommittee on Health by Daniel T. Durham, Executive Vice President, Policy & Regulatory Affairs, America's Health Insurance Plans, September 12, 2012.
[10] HHS ASPE Issue Brief on Essential Health Benefits: Individual Market Coverage. December 2011.
[11] CBO Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act. November 30, 2009.
[12] Ibid.
[13] CBO Updated Estimates for the Coverage Provisions of the Affordable Care Act. March 2012.

However, there is evidence to suggest that the minimum actuarial value of 60% may exceed the average value of a policy in a state's market—particularly for individually-purchased plans. For example, the non-partisan Congressional Budget Office (CBO) estimated that the average actuarial value of health insurance in the individual market ranged from 55%-60%.[14] Moreover, a recent study in Health Affairs found that over half (51%) of individual market enrollment was in plans with actuarial values below 60%.[15]

Providing states with flexibility to adjust the actuarial value for "bronze" coverage could help avoid disruptions in coverage and ensure that premiums are affordable—especially for price-sensitive, younger individuals who currently obtain coverage in the non-group market. Moreover, policies that help ensure that younger, healthier subscribers remain in the marketplace can help promote a more stable risk pool and make coverage more affordable for everyone.

Annual Limits on Deductibles in the Small Group Market

The ACA establishes limits on deductibles for health insurance plans in the small group market at $2,000 for individuals and $4,000 for families—effective January 1, 2014. Importantly, the proposed rule permits a health plan's annual deductible to exceed the amounts set forth under the ACA if the plan cannot reasonably reach the actuarial value of a given level of coverage. The current caps on deductibles raise serious concerns about affordability of coverage for small businesses and their employees and families. Research by the Kaiser Family Foundation estimated that annual deductibles for "bronze" level coverage would range from $3,475-$4,375 for single coverage—well exceeding the $2,000 limit set forth under the ACA.

By requiring many plans to lower deductibles, these caps could have the unintended consequence of pricing many small employers out of the marketplace and limiting access to affordable coverage options for small business workers and their families. In implementing the metal-level deductible requirements, we recommended that HHS adopt a "reasonableness" standard under which health insurers can exceed the deductibles in the small-group market. Under a reasonableness standard, an insurer may exceed the deductible limit in order to maintain typical plan cost-sharing features in the small-group marketplace (e.g. 20% co-insurance after the deductible is met). This type of flexibility can help ensure that affordable health insurance options are available to workers and their families and can help ensure that small businesses can continue to offer and maintain coverage for their employees.

Recommendations:

- **The scope of the essential health benefits should be comparable to the scope of benefits provided under a typical plan purchased by small businesses.**
- **States should have the flexibility to adjust the minimum actuarial value for health insurance coverage under the ACA to ensure availability of affordable health insurance options and avoid disruptions in coverage.**
- **HHS should adopt a "reasonableness" standard under which health insurers can exceed the deductibles in the small group market in order to maintain typical plan cost-sharing features.**

[14] CBO Key Issues in Analyzing Major Health Insurance Proposals – Chapter 3; December 2008.

[15] Jon R. Gabel et al. "More than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges As of 2014." *Health Affairs;* September 14, 2012.

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