

Are essential health benefits here to stay?

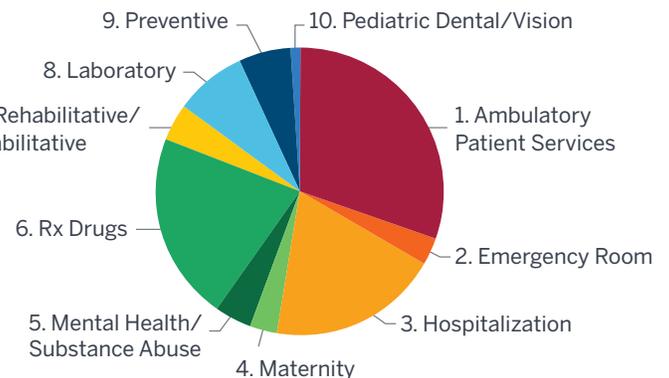
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The current political environment has raised the potential for various features of the Patient Protection and Affordable Care Act (ACA) to be repealed or replaced. Among the many other reforms included in the ACA, the law required that each state determine a comprehensive set of benefits that included 10 categories of healthcare services, called essential health benefits (EHBs). All individual and small group commercial plans offered in a state had to cover that state's EHBs beginning January 1, 2014. The March 6, 2017, version of the House bill, the American Health Care Act, does not affect the current statutory requirements to cover EHBs in the individual and small group markets. However, this provision is subject to change depending on how the bill progresses, so the fate of EHBs is uncertain. The 10 EHB categories of service are listed below, and their estimated relative costs are illustrated in Figure 1. In the authors' opinion, based on a review of the benefits that were commonly excluded from coverage in the pre-ACA individual market, services in **bold** are most vulnerable to removal.

1. Ambulatory patient services (outpatient care you get without being admitted to a hospital)
2. Emergency services
3. Hospitalization (like surgery and overnight stays)
4. **Pregnancy, maternity, and newborn care** (both before and after birth)
5. **Mental health and substance use disorder services, including behavioral health treatment** (this includes counseling and psychotherapy)
6. Prescription drugs
7. Rehabilitative and **habilitative** services and devices (services and devices to help people with injuries, disabilities, or chronic conditions to gain or recover mental and physical skills)
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. **Pediatric services, including oral and vision care** (note that adult dental and vision coverage aren't essential health benefits)

FIGURE 1: TYPICAL RELATIVE COSTS FOR THE EHB CATEGORIES IN THE COMMERCIAL MARKET



Notes: Though the EHB categories are not mutually exclusive categories, Figure 1 shows the approximate breakdown of relative benefit costs by the 10 categories. Cost relativities shown are approximated based on the 2017 Milliman Commercial Health Cost Guidelines™. They will vary by geographic area, demographics, and other factors.

Understanding market conditions prior to the ACA is crucial to predicting the impact of healthcare reform proposals. This article discusses how consumer choices are affected by mandating benefits, explores the potential effects on premiums, and identifies areas to watch as new health reforms are proposed.

Background on state-mandated benefits

Before the ACA, the small group and individual insurance markets were regulated almost totally by states. One important way that states varied in their regulation was in the types of services that insurance plans were required to cover.¹ Some states mandated very few services. Other states required health plans to provide a comprehensive set of services, including inpatient and outpatient facility costs, physician visits, laboratory, and imaging. Finally, some states passed other coverage mandates—coverage for specific services associated with, for example, maternity, mental health, substance abuse, obesity, autism, chronic conditions, and rare conditions.

¹ See also: <http://kff.org/state-category/health-insurance-managed-care/pre-aca-state-mandated-health-insurance-benefits/>.

The driving motivation for such mandates is to protect the health and financial well-being of people in need of these services. For example, applied behavioral analysis (ABA) has been shown to be an effective treatment for children with autism, but the treatment can be as much as 40 hours a week and can last multiple years. If paid out of pocket, ABA costs would be unmanageable for most families, so having these services covered under EHBs has an enormous financial benefit. However, it forces consumers not using these benefits to subsidize their costs. For certain benefits, the increase in premiums is negligible, but one or more relatively expensive mandates can lead to a reduction in access to affordable premiums. Starting in 2014, the EHBs covered many of these services either across all states under the 10 required categories of service, or on a state-specific basis under the state-selected EHB benchmark.²

A benefit has different costs depending on whether it is funded by just those who will use the benefit or by the entire risk pool. As an example, in Figure 2 we illustrate how the pediatric dental benefit impacts consumer costs, depending on how it is offered.

Opposing interests among consumers

The vast majority of Americans get their insurance through their employer or through public programs, such as Medicaid or Medicare. In these cases, individuals do not have a choice in the benefits covered under their insurance plan, as this choice is made for them by their employer, Medicaid, or Medicare. The individual market³ is comprised of people who do not have insurance through their employer or through public programs, and is the focus of this discussion about consumer choice.

2 Cosway, R. (November 2012). Essential Health Benefits: Review of the State Employee Benchmark Plans and Illustration of Possible Variation in Essential Health Benefits by State. Milliman Healthcare Reform Briefing Paper. Retrieved February 23, 2017, from <http://us.milliman.com/uploadedFiles/insight/healthreform/pdfs/essential-health-benefits.pdf>.

Shopping for health insurance in the individual market is different from buying other products. Even though it is possible that you might gain a substantial amount of weight in the next few years, there is no reason to buy clothes ahead of time to prepare for that possibility. However, if a consumer wanted to manage healthcare risk with an insurance product prior to the ACA, the coverage needed to be in place before the disease or accident occurred because there was no guarantee that the consumer would pass underwriting and be able to purchase affordable coverage after developing an ongoing health condition. This complicates the idea of consumer choice—we may know what services we want now, but we also must understand what services we might want later. Requiring a comprehensive, standardized set of healthcare services within the individual market reduces choice for consumers. However, it also protects them from a broad range of health risks and makes shopping for insurance less complicated.

An added advantage of EHBs is that consumers have access to in-network pricing for a comprehensive range of services. Health insurers spend a lot of time negotiating discounts with their network providers, medical equipment sources, and pharmacy benefit managers. Such discounts can be as high as 80% off of billed charges. This is particularly important for high-deductible health plans (HDHPs), where such discounts will directly impact out-of-pocket costs.

3 The individual market is accessible to individuals through marketplaces and directly through the carrier off of the marketplaces. Under the ACA, advance premium tax credits (tax credits) and cost-sharing subsidies are only available to consumers who enroll through the marketplaces. The individual market includes a mix of low-income families and adults who chose early retirement. About 12.7 million individuals enrolled in marketplace plans in 2016, with almost 10.5 million of these individuals qualifying for some type of premium tax credit. The distribution of enrollment by age includes 19% of enrollment under age 25, 54% between ages 26 and 54, and 27% over age 55. Source: <https://aspe.hhs.gov/system/files/pdf/187866/Finalenrollment2016.pdf>.

FIGURE 2: PEDIATRIC DENTAL BENEFIT AND CONSUMER COSTS

PEDIATRIC DENTAL BENEFIT	PEDIATRIC DENTAL BENEFIT IN A PRODUCT OFFERED ONLY TO CHILDREN	PEDIATRIC DENTAL BENEFIT IN A PRODUCT OFFERED TO ADULTS AND CHILDREN
Illustrative Monthly Premium Impact *	\$30 children only	\$5 all members
Winners	Adults do not have to pay anything toward the benefit that they are not able to use.	By having everyone contribute to the cost for this benefit, the cost for children to have this benefit is lower.
Losers	Children pay the full cost of the premium for the benefit.	Other participants in the single risk pool pay the cost for the benefit even though only children will use this benefit.
Pre-ACA or ACA Option?	This is generally how the market operated pre-ACA.	This is an example of how the market operates under the ACA and in states where it was mandated prior to the ACA.

* Costs will vary by geographic area, provider, and other factors.

On the other hand, fewer mandated benefits can promote access to more affordable insurance premiums. For example, before the ACA, there were only 11 states that mandated maternity care coverage for all individual plans.⁴ For states that didn't have this mandate, insurers could offer plans with and without maternity. Theoretically, only women who were planning on getting pregnant would enroll in plans with maternity coverage, assuming availability of those plans and an awareness of their existence. Other consumers could enroll in the cheaper plans without maternity coverage.

How removing benefit mandates will impact premiums

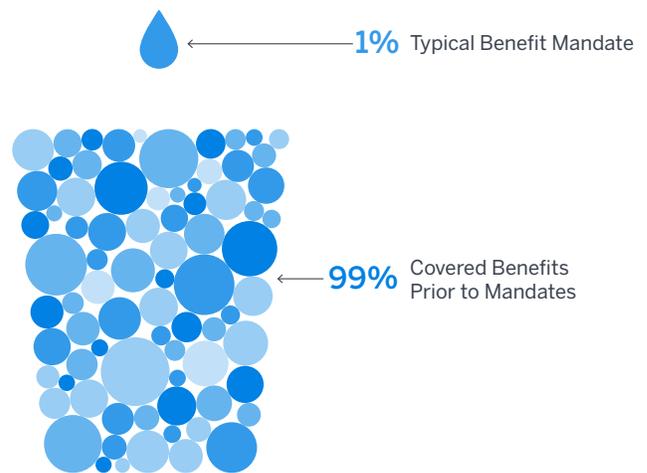
In general, consumers, especially healthy consumers, will be attracted to the lowest-priced plans. Removing certain benefits becomes an area where insurance companies can compete, and this approach works in two ways:

- **Actuarial adjustment.** Fewer services means a lower price. There is an actuarial adjustment factor that can be applied to a group's premium when a service is removed. For a given risk pool, we have found through many state-mandate studies and cost modeling that the adjustments to premiums to cover certain fringe benefits (for example, acupuncture, applied behavior analysis for autism, or adult hearing aids) are generally quite low. Figure 3 illustrates a typical mandate cost relative to benefits covered prior to mandates (<1%) to demonstrate the size of the necessary actuarial adjustment.
- **Plan selection.** The much larger adjustment comes when segmentation of the market occurs in response to removing certain services. That is, people who believe they have little or no use for such services will select lower-cost plans without these benefits. Such people often are healthier or low healthcare utilizers, allowing carriers to lower prices on these plans even further. (The ACA moderates selection differences between plans within the same market by using risk adjustment along with the EHBs. With risk adjustment, the risk pool is at the market level, not the carrier or plan level. A full discussion of risk adjustment is beyond the scope of this article, but this illustrates how EHBs are intertwined with other aspects of the law.⁵)

4 Kaiser Family Foundation. Pre-ACA State Maternity Coverage Mandates: Individual and Small Group Markets, 2010. State Health Facts. Retrieved February 23, 2017, from <http://kff.org/other/state-indicator/pre-aca-state-maternity-coverage-mandates-individual-and-small-group-markets/?currentTimeframe=0>.

5 For a comprehensive discussion of risk adjustment in the ACA, see <http://us.milliman.com/uploadedFiles/insight/2015/federal-risk-adjuster-considerations.pdf>.

FIGURE 3: ACTUARIAL ADJUSTMENT FOR A TYPICAL MANDATE



Note: Illustrative values shown refer to benefit mandates for certain fringe benefits and do not include benefit mandates that cover maternity and prescription drugs.

The table in Figure 4, on page 4, presents three scenarios that illustrate how a maternity services mandate can affect the individual market. Scenario 2 demonstrates the impact of selection and Scenario 3 demonstrates the impact of the actuarial adjustment for this particular benefit.

What will be the fate of EHBs?

What finally happens to the EHBs is an open question, but areas to watch are:

- **ACA replacement.** A federal ACA replacement could offer EHB-like coverage, for example, if all consumers are allowed to enroll in Federal Employee Health Benefits (FEHB) plans, which offer comprehensive coverage and, in fact, were proposed as possible EHB benchmarks under ACA.
- **State law.** Even if EHBs are no longer mandated at the federal level, existing state-mandated benefits will remain. States could also pass new bills mandating something comparable to EHBs.
- **Competition across state lines.** If ACA is repealed and interstate sales are allowed, plans regulated by states that have more state-mandated benefits may find it hard to compete on price with plans from states that have fewer state-mandated benefits.
- **Consumer demand.** Now that they have had access to EHBs, will consumers in the individual and small group markets want to keep them, or will they insist on lower-priced plans with leaner coverage?

FIGURE 4: MATERNITY SERVICES MANDATE AND THE INDIVIDUAL MARKET

PRENATAL/DELIVERY BENEFITS IN THE INDIVIDUAL MARKET *	SCENARIO 1: VIRTUALLY NO AFFORDABLE COVERAGE FOR PRENATAL/DELIVERY BENEFITS AVAILABLE IN THE MARKET	SCENARIO 2: INSURANCE AVAILABLE BOTH WITH AND WITHOUT PRENATAL/DELIVERY BENEFITS	SCENARIO 3: MANDATED COVERAGE FOR PRENATAL/DELIVERY BENEFITS
Illustrative Financial Impact **	\$15,000 out-of-pocket for prenatal care and delivery.	25% to 70% differential in premiums between market segments (adults under 40).	\$8 to \$14 increase in monthly premiums if adding this benefit to a single risk pool.
Winners	More affordable premiums for those not needing this benefit.	More affordable premiums for those not needing this benefit.	By having everyone contribute to the cost for this benefit, the cost for pregnant women to have this benefit is lower.
Losers	Pregnant women pay out of pocket, seek public assistance, or forgo medical care.	Women wanting coverage pay much higher premiums for coverage.	Other participants in the single risk pool pay the cost for the benefit even though only pregnant women will use this benefit.
Pre-ACA or ACA Option?	With the exception of states that mandated coverage for prenatal/delivery benefits, the individual market operated in one of these two ways pre-ACA.		This is an example of how the market operates under the ACA and in states where coverage was mandated prior to the ACA.

* This example only considers benefits associated with uncomplicated prenatal/delivery. In all scenarios, we assume complications associated with pregnancy and delivery would be a covered benefit.

** Costs will vary by geographic area, provider, and other factors.

- Risk adjustment.** Under ACA, a wide variety of cost-sharing designs (i.e., the metallic tier levels) can be offered in the same market because risk adjustment mitigates risk selection issues among plans. Risk adjustment would continue to mitigate risk selection even if there are no EHB requirements, but with unintended consequences. If EHB requirements are removed but risk adjustment is retained, carriers would be incentivized to cover only the services that drive risk scores to avoid paying transfers to other issuers due to artificially low risk scores. However, we think it is more likely that the methodology will become increasingly complex, with alterations to ensure that carriers are only reimbursed for benefits they cover. If both EHB requirements and risk adjustment are removed, carriers would go back to attracting the healthiest and lowest-utilizing consumers by offering low-priced plan designs with high cost-sharing and only state-mandated benefits; consumers interested in richer plans will find few or no affordable choices.

A careful review of pre-ACA market conditions is important to evaluating the impacts of removing federally mandated EHBs. Based on the pre-ACA individual market, it is likely that, if the ACA is repealed, individual health plans will again compete for the lowest-risk segment of the market, and will only provide comprehensive health coverage equivalent to the EHBs if mandated by state or federal law.

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