

SUMMARY

Health and Human Services (HHS) Bulletin sets guidelines for defining Essential Health Benefits (EHB). It ingeniously allows each State to have a say in its own EHB definition, yet provides a method to bring closure to the process should any State not reach an agreement. It also allows States to add benefits, but at their own expense. With federally providing premium assistance to lower income enrollees, it is important that only minimum State EHB premiums be supported.

The bulletin will likely require every State to add or enhance some services that are not now offered to small groups and individuals. This may lead to a premium increase for small groups and individuals not eligible for premium assistance. Until actuarial efforts identify these costs, this remains an unanswered issue. Everyone is concerned about higher costs, but Insurers have added concerns about adverse selection. The Affordable Care Act (ACA) mitigates this concern by reinsurance and risk adjustment provisions in the act.

The most controversial provision may be granting the States benefit design flexibility. This provision offers a significant potential for mischief depending on how much “flexibility” HHS allows. Some insurers have had success in the past in circumventing parity within a category like mental health using quantitative limits. To extend flexibility to adjusting benefits between categories seriously complicates the issue.

Any substitution service must be actuarially equivalent, but what happens when actuaries from health insurers and HHS disagree on the equality of the benefits added versus dropped. This provision may be OK if it also provides HHS the final word on which substitutions will be permitted as occurs in arbitration. An insurer makes its best offer. HHS may suggest changes, but when it makes its decision to accept or reject the offer, that is the end of all discussion.

The intention of this bulletin is to address only benefit costs and not other subjects. However, as EHB will increase direct costs, mention should at least be made of other ACA steps that will have an offsetting downward effect on costs. Some of these are mentioned in the latter part of this document.

DISCUSSION – ESSENTIAL HEALTH BENEFITS BULLETIN – A REGULARITY APPROACH

This section includes brief statements and explanations of EHB bulletin provisions each followed by a COMMENT segment – favorable, unfavorable, or simply explanatory.

A last section relates to provisions in ACA that directly affect EHB’s attempt to balance coverage and cost. More insurers are concerned over adverse selection than costs. ACA blunts these concerns through reinsurance and risk adjustment plans that dramatically reduce insurers getting trapped with adverse selection populations. Adverse selection is a zero sum game, and historically, insurers have gone to great lengths to avoid insuring higher risk groups and individuals.

A. Incorporate Plans Offered by Small Employers

The intended approach to EHB incorporates plans typically offered by small employers and benefits that are covered across the current employer marketplace. The goal is an approach that will:

1. *Encompass the 10 categories of services identified in the statute;*
2. *Reflect typical employer health benefit plans;*
3. *Reflect balance among the categories;*
4. *Account for diverse health needs across many populations;*
5. *Ensure there are no incentives for coverage decisions, cost sharing or reimbursement rates to discriminate impermissibly against individuals because of their age, disability, or expected length of life;*
6. *Ensure compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);*
7. *Provide States a role in defining EHB; and*
8. *Balance comprehensiveness and affordability for those purchasing coverage.*

HHS proposes that EHB be defined by a benchmark plan selected by each State, which plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a “typical employer plan” in that State. Being similar to the Children’s Health Insurance Plan (CHIP) that every State runs, this approach resolves many start up issues.

COMMENT: States already have more than 1,600 health benefit mandates. Rather than bending those to one Federal essential benefits standard, it makes sense to start with each State’s current benefit packages. By starting with benchmark plans State-by-State, EHB presents minimal disruption of current coverage for people in each State. Being similar in concept to CHIP, States will also have a template to follow, easing the setup of insurance exchanges. It may be necessary for States to tweak the benchmark policy to add any missing ACA essential health benefits, but having a benchmark for a starting point greatly simplifies the compliance process.

B. Four Benchmark Plan Types – (8 Options)

1. Select from plan(s) with largest enrollment from within

- a. Largest plan by enrollment from the three largest small group products offered by private insurers or,
 - b. Any of the 3 largest State employee plans or,
 - c. Any of the 3 largest Federal employee plans or,
 - d. The largest insured commercial non-Medicaid HMO in the State
2. Default if none selected – the private plan with the greatest number of enrollees from group “a” above.

COMMENT: Not only does HHS allow some differences in coverage but it also defines options from which States can choose. It includes small group FFS, PPO, and HMO private health insurance plans as well as State employee plans and Federal government plans. If a State does not choose any of these eight plans, the benchmark plan defaults to the largest by enrollment private FFS or PPO plan in the state. The method avoids the long complex process of starting from ground zero in selecting an essential health benefits plan.

C. Defraying the Cost of Additional Benefits

State mandated benefits that exceed national essential benefits may be included in the State’s EHB, but the State must bear the costs of these benefits in excess of the EHB.

COMMENT: Since the government will be subsidizing part of the premiums for some, this provision protects residents in other States from supporting a set of benefits greater than the essential health benefits. At the same time, residents of a State with more benefits will not have a benefit taken away if that State opts to continue coverage at that State’s expense.

D. Benchmark Plan Approach and the 10 Benefit Categories

One of the challenges is balancing two tests from the ACA

1. Benefits from a “typical employer” plan
2. Ensuring coverage of all 10 service categories

Some benchmark plans do not routinely cover habilitative services or pediatric oral and vision services. HHS approach is to supplement these benefits from other benchmark plans in sequence, first private plans, then State, and finally Federal plans to meet condition 2 above. This forces a conclusion to a State’s EHB definition, regardless of a State’s cooperation.

COMMENT: Not every State will have all 10 service categories of essential health benefits (EHB) in its benchmark plan. This provision offers an efficient way to resolve any shortcomings. While the path to an approved EHB health insurance plan is clear, the added benefit costs may make premiums more expensive to unsubsidized enrollees. And

some will object to that. This may be the hardest issue to resolve, but other ACA reforms may mitigate some concern.

Politicians and economists have long argued that simplifying the tax code by eliminating deductions and exemptions could lead to a lower basic tax rate and a fairer tax structure. While few dispute this, many doubt the identical logic might also apply to covered health care benefits. Simplification with fewer exceptions does not necessarily increase overall costs. But it does level costs to a fairer playing field.

Plans not offering all EHB may see some cost increase for previously missing services, but it would not be dollar-for-dollar. Not all enrollees use all services, and the cost of the minority who incur illness would be spread over all enrollees.

E. Habilitation Options

NAIC and Medicaid definitions include the concept of “keeping” or “maintaining” function, but this concept is virtually unknown in commercial insurance. HHS seeks comment on the advantages and disadvantages of including maintenance of function as part of the definition of habilitative services. HHS is considering two options if a State plan does not include coverage for habilitative services:

1. Offer Habilitative services at parity with rehabilitative services, or
2. As a transitional approach, plans decide which habilitative services to cover. HHS evaluates them, and further defines habilitative services in the future.

COMMENT: No opinion as fundamental definitions of what constitutes habilitation need resolution.

F. Additional Pediatric Oral and Vision Options

The State may select supplemental benefits from either:

1. The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment; or
2. The State’s separate CHIP program.

COMMENT: With many companies offering dental and Vision options, forecasting costs should be predictable. Since coverage is essential only for infants and children and not for adults, this mitigates the added costs to offer coverage.

G. Mental Health and Substance Use Disorder Services and Parity

While these services have been included in small group policies, they usually included limits. In general, plans do not mention behavioral health treatment as a category of services in plan documents. EHB requires plans to include coverage

for mental health and substance use disorder services including behavioral health treatment consistent with the Mental Health Parity and Addiction Equity Act.

COMMENT: Since many larger group and government plans cover this service, the amount this benefit adds to cost should be a predictable amount. There is no leeway in exceptions to the small group and individual market so concerns may arise if added costs are more than nominal.

H. Benefit Design Flexibility

Similar to CHIP, HHS proposes that a health insurance issuer have some flexibility to adjust benefits, including both the specific services covered and any quantitative limits provided they continue to offer at least baseline coverage for all 10 statutory EHB categories.

COMMENT: This provision offers a significant potential for mischief depending on how much “flexibility” HHS allows. Some insurers have had success in the past in circumventing parity within a category like mental health using quantitative limits. To extend this flexibility to adjusting benefits between categories seriously complicates the issue.

Any substitution services must be actuarially equivalent, but what happens when actuaries from health insurers and HHS disagree on the equality of the benefits. This provision may be OK if it also provides giving HHS final word on whether a substitution will be permitted, as occurs in arbitration. An insurer makes its best offer. HHS may suggest changes, but when it makes its decision to accept or reject the offer in its entirety, that is the end of all discussion.

I. Updating Essential Health Benefits

HHS will assess whether enrollees have difficulties with access for reasons of coverage or cost, changes in medical evidence or scientific advancement, market changes not reflected in the benchmarks and affordability of coverage.

COMMENT: No provision regarding medical treatments should be cast in stone given the accelerating changes in health care delivery. Research and Science may result in new treatments that shift from what people consider discretionary today to an essential benefit tomorrow. What is controversial or experimental now may become common in the future.

OTHER ACA STEPS THAT AFFECT EHB DESIGN

“Evidenced Based” Delivery Drives Down Costs

Compensation for medical providers may also affect the essential services list. ACA has already initiated significant Medicare reimbursement changes that should bend the cost curve downward. There have been three insurance provider payment models in widespread use.

- 1) FFS - Fee for service (current Medicare and some plans from private insurers)
- 2) PPO - Preferred Provider Organizations that offer discounts to use preferred hospitals and doctors
- 3) HMO – Health Maintenance Organizations that have a flat capitation fee to cover all medical costs.

Plans 1 and 2 are both service-based plans. In many respects, they are “cost plus” plans. The more services rendered, the more the reimbursement. Over the years, payment for service has proved somewhat costly as providers incur little risk. Plan 3, HMO capitation payments, puts all the risk on providers, a full pendulum swing in the other direction.

ACA Medicare creates a fourth insurance model that directly involves providers – Accountable Care Organization (ACO). As defined in act: *“The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries”*

ACO’s consist of networks, partnerships, group practices, and other providers and suppliers that meet conditions which include (A) a form of legal structure to distribute payments, (B) being jointly accountable for quality, cost, and overall care of Medicare beneficiaries and (C) promoting evidence-based medicine. The joint accountability makes ACO’s look similar to HMO’s. However, HMO’s employ fixed capitation fees for enrollees. ACO instead pays for services in amounts that mimic PPO payments, varying with type and severity of illness.

The key difference, however, is that when providers reduce costs, they get to share in the savings instead of turning all savings over to Medicare. At reporting periods, actual payments are compared to what would have occurred under straight FFS. The ACO receives a share of any savings as bonus. Providers finally have a meaningful incentive to lower costs as they get rewarded for their efforts. It adds experiences to improve evidence-based medicine which shows promise of both lower costs and higher quality.

Finally, nothing prohibits insurers from shadowing Medicare. Since roughly half of all health care costs are Medicare, most areas will have ACO’s set up to service those beneficiaries. Insurers don’t have to set up any new structures. They can

directly proceed negotiating with ACO's for the sharing of cost savings in the private market just like Medicare does.

Addressing the Effect of Risk on Overall Costs

The HHS Bulletin provides guidelines for defining Essential Health Benefits (EHB). A key challenge is balancing benefits from a "typical employer" plan and ensuring coverage of all 10 service categories. The focus is on costs but not risk.

Actuaries can look back and derive costs from any list of benefits. Looking forward, however, requires not just cost but risk assessment not addressed by the bulletin. Historically, insurers have gone to great lengths to avoid insuring higher risk groups and individuals. The term often used is "Adverse Selection" risk and it is essentially a zero sum game. One insurer's gains are another insurer's loss.

The HHS bulletin ought to at least mention the risk insurers will incur and how it might bear on EHB. All risk has two components: **Probability** risk and **Severity** risk.

Probability risk is the chance that an incident will occur. Health insurers mitigate this risk by creating complex benefit plans and excluding applicants with pre-existing medical conditions. Insurers are very concerned about the probability risk of adverse selection. Insuring too many sicker enrollees could even bankrupt an insurer. Managing probability risk is where insurers focus their efforts.

It should be pointed out, however, that more than half of all insured workers are covered under employer self insured plans where insurers act only as "third party administrators" Insurers mostly process claims while incurring zero risk. As self-insured plans are generally grandfathered, most reform applies to less than half of the population in private plans.

Severity risk is the cost of an incident once it occurs. Health insurers mitigate this risk primarily by negotiating discounts from providers. The unsustainable growth in provider costs suggests insurers have had limited success here. Employers who self-insure and assume all risk have been nudging insurers towards greater efforts to hold down medical costs. However, these plans are custom tailored for employers and are not included in small group or individual plans. For any market area, however, provider costs are fairly uniform and have not been a critical competitive factor among insurers.

By banning insurers from excluding those with pre-existing conditions, ACA increases insurers' probability risk. Besides passing on higher severity risk costs, insurers will want to increase premiums further to cover added probability risk.

ACA Programs to Mitigate Adverse Selection Risk

At the same time important parts of ACA will sharply reduce insurers' probability risk to below historical levels. While not yet quantified, lower probability risk will offset some higher EHB costs and should be considered when defining EHB.

ACA reduces insurers' probability risk with two programs: **Reinsurance** and **Risk Adjustment**. Together, these two provisions greatly reduce the adverse selection risk from the small group and individual markets. A major reduction in combined risk should also translate into lower premiums.

Transitional High Risk Reinsurance Program

First, ACA requires States to have high risk plans and that all group health plans whether insured or self-insured must pay into the plan. Since self-insured plans cover more than half of all workers, and insured group plans cover the great majority of the rest, the program supplies a very wide base of funding.

The unique aspect is that only those in the individual market are eligible for benefits. Covering the extremely high costs of an unfortunate few thus translates to a small premium when spread over the many. Almost by definition, the individual group pool is higher risk than other pools. The very sick are less likely to be working and covered under a group plan.

After decades of adverse risk being carried on the backs of individuals, that risk is now reversed, taken off the backs of individuals and spread over the remaining general population. Employer receipts into the plan are initially supplemented by the government.

Risk Corridors and Risk Adjustment Program

Second, ACA creates a risk adjustment plan. After removing high risk enrollees, there still will be risk differences among insurers. ACA mitigates differences by requiring insurers with favorable risk pools to pay into the plan and allowing those with adverse risk pools to draw from it.

After adjustments, insurers retain some savings and incur some costs. Insurers incurring adverse selection receive graduated payments from the risk corridor plan to recover much though not all of their higher costs. In a mirror fashion, insurers incurring favorable selection pay a graduated amount into the risk corridor plan in a similar manner that allows them to retain some savings. As structured, the plan should be self-sustaining at no cost to taxpayers.

Unlike the high risk reinsurance plan, this program applies only within the small group and individual markets. The overall risk level of the small group market may be similar to

the total population. However, the volatility between one or another group is greater due to smaller size of every group in this market. To compensate, insurers add some premium to cover the added volatility. Reduce that volatility risk and the “volatility” premium can go down.

Increased competition in the health insurance market that arises from these ACA provisions may provide impetus to extend the life of those programs. In the unlikely event little benefit is apparent, they sunset after three years.

ACA Steps to Enlarge the Risk Pool

Flip a coin and there is a 50% chance of winning but also a 50% chance of losing. One is not likely to risk much on a single toss of the coin. One could easily lose a bundle. But flip a coin a thousand times, and the wins and losses tend to cancel out. You won't win much but you won't lose much. The volatility factor goes down with every added flip.

Likewise, as one enlarges the “pool” of insured people, the probability of losing a bundle from costly medical incidents goes down. ACA permits enrollment in exchanges only to individuals and small groups. However, ACA allows States to merge these two groups, as well as to merge with other States, into a single market. Like the coin toss, an enlarged pool drives down insurance risk. Across the U.S. the potential State Insurance Exchange pools exceed 68 million people.

ACA Steps to Standardize, Simplify and Streamline

ACA includes a series of provisions to reduce the complexity of current health insurance policies. It requires a standard format and use of terms; large fonts and page limits on contracts. The result of this and EHB is that Exchange insurers will offer very similar plans or only a single plan that cover essential health benefits. All of this simplifies plan selection and allows customers to focus on service and price.

With greater uniformity and less complexity in benefits and documentation, insurers may shift some of their small group and individual markets to direct on-line selling. A similar change occurred in the travel industry. Despite complaints from travel agents, agents still exist though fewer in numbers.

Focus Moves from Risk Aversion to Cost Reduction

The combined effect of standardized health benefit plans, high risk reinsurance, risk adjustment plans, and enlarged population pools all contribute to greatly reducing the impact of adverse selection. It also removes insurers' biggest excuse of needing higher premiums to cover risk. Technology and streamlined marketing owing to less complex plans can help drive down administration expense.

Finally, these changes can also affect insurers' focus. Rather than spending effort avoiding adverse selection, they can focus instead on how to lower medical costs for everyone. Insurers are trying all sorts of programs to lower costs. For example, Medicare is piloting ACO's as a way to reduce costs while maintaining quality. Private insurers could piggy back on those efforts.

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In mid career, Andrew Kurz was Sr. VP Finance and CFO of Blue Cross & Blue Shield, Wisconsin. He was responsible for all actuary, treasury, accounting and risk management.

Mr. Kurz is now retired and has been deeply involved in researching and analyzing health care issues. He has worked with advocacy groups favoring reform and has documented many findings on the website www.healthreformtrends.com.

Mr. Kurz served as VP at a time most health insurers were non-profit and operated at medical loss ratios above 90%, very high in today's terms. Under the guise that State reserve requirements were limiting growth, many non-profit insurers converted to for-profit. That allowed them to issue stock that increased reserves. With greater reserves, they could expand their business. In reality, some growth occurred but overhead grew far faster. What ensued over decades was an erosion of premium dollars applied to medical costs.

APPENDIX / SOURCES

Affordable Care Act – Full text – 974 pages

<http://www.healthcare.gov/law/full/>

Transition High Risk Reinsurance Plans

TITLE I—Subtitle D, PART 5, Sec. 1341 Transitional reinsurance program for individual market in each State

Risk Corridors and Risk Adjustment

TITLE I, Subtitle D, PART 5, Sec. 1342 Establishment of risk corridors for plans in individual and small group markets.

Merging Small Groups into individual market in Exchanges.

TITLE I, Subtitle D, PART 2—SEC. 1311, (B), (2) Merger of Individual and Shop Exchanges.

State Flexibility Relating To Exchanges.

TITLE I, Subtitle D, PART 3— State Flexibility Relating To Exchanges Sec. 1322, (A), Establishment of Program ...

Accountable Care Organizations Authorization

TITLE III, Subtitle A, PART 3—Encouraging Development of New Patient Care Models; Sec. 3022. Medicare Shared Savings Program.

Institute of Medicine of the National Academies

<http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx>