Essential Health Benefits: The Secretary's Joystick (5/3/11)

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Beginning in 2014, the Patient Protection and Affordable Care Act (PPACA) hands the Secretary of the U.S. Department of Health and Human Services a joystick – the Essential Health Benefits package – with the potential to rocket small-business health insurance premiums skyward. EHB is the menu of goods and services that must be covered under all exchange-purchased insurance plans and non-grandfathered small-group and individual insurance plans. By vesting one set of hands with control over EHB, small business faces permanent administrative uncertainty. At the same time, the brunt of EHB appears largely to bypass big business, unions, and governments.

EHB, Ban on Limits, Actuarial Value

Beginning in 2014, PPACA (§1302) makes EHB a mandatory feature of most insurance plans purchased by America's 6 million small businesses and 15 million self-employed individuals. Exceptions initially include businesses with more than 100 employees and those with grandfathered policies. The EHB requirements apply to policies purchased both in exchanges and in non-exchange small-group or individual markets.

In the small-group and individual markets, annual or lifetime coverage limits on all EHB items are forbidden. And plans must have an actuarial value (AV) of at least 60 percent, meaning the plan's total reimbursements must be at least 60 percent of the total qualifying health care costs incurred.

Section 1302 empowers the Secretary of HHS to define EHB, but gives little specificity beyond requiring that EHB include 10 general categories (e.g., ambulatory patient services) and "the items and services covered within the categories;" the Secretary is to also assure that EHB includes "benefits typically covered" by a "typical employer plan." The meaning of these words in quotation marks is left to the Secretary (and future Secretaries) to define and redefine. The fluid definitions and concentrated discretion mean uncertainty, which carries a financial cost for small business.

State Mandates as Precedent

The Council for Affordable Health Insurance lists 2,156 state mandates in 2010. These included benefit mandates (e.g., reimbursement for smoking cessation), provider mandates (e.g., reimbursement for services provided by acupuncturists), and covered-person mandates (e.g., inclusion of stepchildren under family policies).

Some mandates are less controversial than others. But every mandate benefits some patients. The problem is that mandates, no matter how well-intentioned, mean higher costs.

At least with state mandates, the legislative process restrains proliferation. Typically, a new mandate has to wend its way through a state legislature, with attendant impact estimates, public hearings,

recorded votes, and so forth. Disease groups and provider groups can lobby for additional covered benefits, but so can groups representing consumers and taxpayers. In the end, legislators have to weigh both costs and benefits of mandates or else incur the wrath of financially pressed voters. Importantly, with state mandates, cross-state comparisons provide evidence of how the mandates affect costs and health outcomes. One can measure the difference in costs between Rhode Island's 69 mandates and Idaho's 13 mandates.

For small business, a perpetual irritation is the fact that state mandates apply mostly to small businesses and individuals (including the self-employed). Most big businesses, labor unions, and governments are self-insured, and, therefore, exempt under ERISA. EHB appears to compound this inequity.

Federal Mandates under PPACA

Effectively, §1302 creates national benefit mandates. Most small-group and individual policies must cover the entire EHB package, with no coverage limits and an AV of 60 percent or higher. States will still have the discretion to add additional mandates on top of the EHB package. In contrast, plans obtained in the self-insured and fully-insured large-group (over 100) markets apparently do not have to include all EHB items. They can't impose annual or lifetime coverage limits on any EHB services that they do cover, but it appears that they can omit EHB items from their coverage. This would seem to create a powerful motive to omit EHB items that are rare, but terribly expensive – a luxury small business will not share.

Unlike most state benefit and provider mandates, designing and altering the EHB package will require no legislative action. PPACA specifies simply that the Secretary of HHS "shall define the essential health benefits" after commissioning some data collection from the Labor Department. (In the current process, HHS also turned to the Institute of Medicine for advice in crafting the EHB.) Since EHB is national, there will be no cross-state comparisons of costs and health effects of the actual EHB with any other design. According to the law:

> "The Secretary shall ensure that the scope of the [EHB] is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary." … In defining [EHB], the Secretary shall … ensure that such essential health benefits reflect an appropriate balance among the categories … so that benefits are not unduly weighted toward any category."

The Labor Department's survey of April 2011 cites problems with employer plan data. The document notes, for example, variation in how plans define items such as "infertility treatments." The report warns: "Unfortunately, this review indicated that it is not possible to produce reliable data for many of the services due to the lack of detail that characterizes many plan documents. Services may or may not be covered when they are not mentioned in plan documents." Hence, the Secretary will have to layer subjective judgment on top of inadequate data.

But even if the data were adequate, the vagueness of PPACA's instructions creates considerable uncertainty for small business. How is the Secretary to define a "typical employer?" Should a shoe store's employee plan depend on the "typical" coverage offered by an investment bank, a white-shoe law firm, a federal agency, or a union shipyard? Or, since EHB affects small businesses most directly,

should the shoe store's requirements square with other small firms in the fully insured market? The Secretary's thoughts apparently carry the day.

What are "benefits typically covered?" Suppose 1/3 of the employers surveyed offer "Cadillac" coverage (high-end), while 1/3 offer what we can call "Corolla" coverage (middle-of-the-road), and 1/3 offer "Kia" coverage (bare-bones, but decent). Does the Secretary decide that since 2/3 of employers offer Corolla coverage or better, then that should define the EHB? Businesses with Cadillac or Corolla plans will be relatively unaffected. Only those companies with the Kia policies will see their premiums rise, and it's likely that these will include many small businesses and perhaps especially start-ups. In other words, those hardest hit will be the incubators of America's job growth.

How finely will the Secretary define the required benefits? The Secretary's wide discretion is described in a bulletin from the American Cancer Society:

> "While it requires coverage for each of [ten] categories of benefits, the law does not name the specific services that must be covered or the amount, duration, and scope of covered services. The Secretary will define the specific benefits within each of the categories and will update the package to address gaps or to respond to changing medical practices. … [W]ill the Secretary determine how many counseling sessions are covered for smoking cessation, or whether medications are included, and which ones? Or will a plan be permitted to decide the number of covered sessions and medications? The Secretary will need to make critical decisions about the level of discretion to leave to health plans. … While the law enumerates certain considerations that must be taken into account, the Secretary retains wide authority in making determinations on covered services. And while the law requires an opportunity for public comment, it does not define a procedure for involving stakeholders like cancer patients, clinicians, or experts in cancer care. Advocates, therefore, will need to seek out opportunities to weigh in to make sure important benefits are included."

As an example of the lobbying to come, a Cancer Society spokesman wrote, "If a patient requires chemotherapy every week for a year… they should not be hindered by an arbitrary rule about only getting 35 visits." In contrast, America's Health Insurance Plans urged HHS not to get into "the details of each category of care" and suggested that HHS permit restrictions on the number of visits in certain situations to hold down costs. Medical merits aside, these two policies have very different cost impacts. And small business shares the Cancer Society's concern that the law defines no procedure to involve stakeholders – including small business.

Section 1302 also requires the Secretary to update the EHB at least annually. When a new benefit is added, will outstanding insurance contracts have to comply immediately? If so, then insurers are going to have to build extra margins of safety into their premiums, and costs will rise.

Conclusion

The Essential Health Benefits package is a ganglion of uncertainty for small business. Disease and provider lobbies, with admirable intent, will tout the benefits of expanded coverage and ignore the costs. Small business will wonder how "typical coverage" is defined and who the "typical employers" are against whom they are measured. The jobs and the wages of their employees will depend on the whims

of whoever happens to be Secretary of HHS at the time. They will look with envy as big business, labor unions, and governments go unscathed. And with certainty, their premiums will rise.

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