

# The Implications of Eliminating Essential Health Benefits: An Update

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NOVEMBER 2020

## Introduction

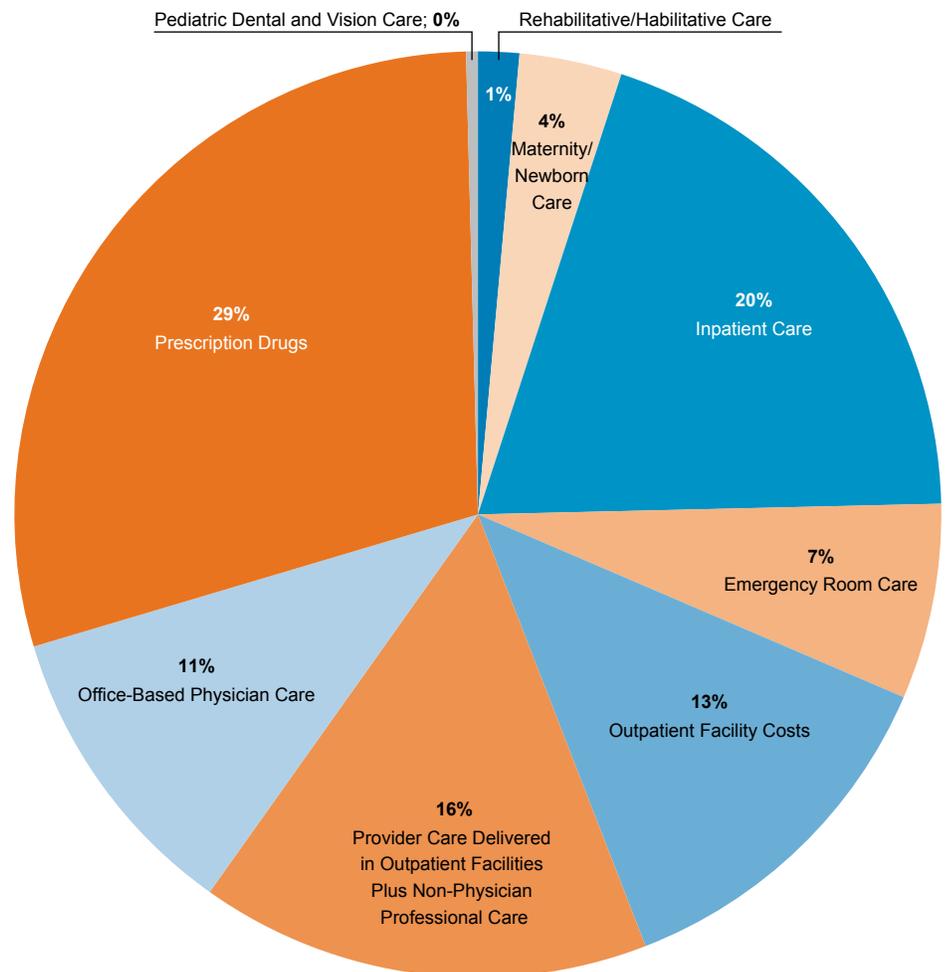
The Affordable Care Act (ACA) requires private nongroup (also called individual market) insurers to cover 10 essential health benefits: ambulatory patient services; emergency services; hospitalization; pregnancy, maternity, and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care). The law includes these benefits to ensure enrollees have adequate coverage for medically necessary services.<sup>1</sup> In addition, the law prohibits insurers from placing annual or lifetime dollar limits on coverage for these benefits. Before implementation of these rules on January 1, 2014, nongroup insurers typically limited benefits considerably to reduce their risks of enrolling people with disproportionately high medical needs.<sup>2,3</sup> For example, nongroup policies commonly either excluded prescription drugs entirely or placed stringent limitations on coverage, excluded maternity care entirely or charged more than the average cost of a typical birth to include such coverage, and rarely covered any mental health and substance use disorder treatment.

By requiring all nongroup insurers to cover these benefits, consumers do not have to assess differences in covered services when evaluating plan choices, and insurers cannot exclude certain benefits

to lower their premiums and attract healthier-than-average enrollees. It also means the cost associated with each benefit is spread across all enrollees and, through federal subsidies, all taxpayers.

The additional premium cost for providing each benefit when all plans are required to include them is much smaller than the cost associated with having only people who need certain essential health

## Essential Health Benefits as Shares of a Nongroup Premium, 2020



Source: Analysis based on data from the 2020 CCIIO Actuarial Value Calculator, Silver, and 2017 MEPS-HC by Actuarial Research Corporation.

benefits pay for them on their own. And requiring that these benefits be covered by nongroup insurance means they are broadly available and affordable when needed. Still, the requirement that these essential benefits be included in ACA-compliant nongroup insurance coverage increases premiums beyond what they would be if people could purchase plans covering fewer benefits. This had made the requirements somewhat controversial and spurred interest in reducing or eliminating them among some insurers and policymakers; some have proposed allowing states to use waivers to reduce or eliminate essential health benefit requirements.

Here, we update earlier work that evaluated the effect of particular essential health benefit requirements on ACA-compliant nongroup insurance premiums and estimated the implications of removing them for people who use those services.<sup>4</sup> Using more recent data on annual premiums and health care spending by service, we find the following about typical nongroup insurance premiums:

- Office-based and outpatient hospital care account for almost 40 percent of premiums, or \$2,291 out of a typical \$5,883 annual silver premium for a 40-year-old in 2020.<sup>5</sup>
- Inpatient care accounts for another 20 percent of premiums, or \$1,154 of that same silver premium.
- Prescription drugs account for 29 percent of premiums, or \$1,718 of the example premium. They are second only to office-based physician care in the share of enrollees who use the service during the year: more than half of people enrolled in nongroup insurance use prescription drugs. Most enrollees use at least one generic drug, whereas 28 percent of all enrollees use at least one brand-name, nonspecialty drug, and 3 percent use at least one specialty drug.<sup>6</sup>
- Maternity and newborn care and rehabilitative and habilitative care account for very small fractions of nongroup premiums, about 4 percent and 1 percent. These services account for \$211 and \$84 of the typical premium described earlier. However, excluding these

services from coverage would leave people needing these services to finance large health care bills on their own, about \$16,850 per person per year for maternity/newborn care and \$2,530 per person per year for rehabilitative/habilitative care.

- Eliminating categories of care that account for even a small fraction of premiums leads to very high costs for people needing to finance that care themselves.

## Data and Methods

This analysis is based largely on the federal government's Actuarial Value (AV) Calculator for exchange plans<sup>7</sup> and data from the 2017 Medical Expenditure Panel Survey Household Component (MEPS-HC), using both the full-year consolidated file (HC-201) and event-level files (HC-197A-I) when needed. Though the AV Calculator is specific to nongroup health insurance plans, MEPS-HC provides information for all civilian, noninstitutionalized people. Except for comparisons by coverage type, the MEPS-HC data were tabulated to exclude people with either Medicare or Medicaid and to identify people covered by private nongroup plans, which include coverage through the ACA marketplaces and other ACA compliant individual market plans.

We examined health care spending from both data sources, partitioned into services intended to replicate essential health benefits as closely as possible. We obtained information on use of covered services from the MEPS-HC data. For hospital inpatient, outpatient hospital, and emergency room care, we separate costs associated with facility fees from those for providers. Physician office visit costs and usage for preventive, primary, and specialty care were partitioned based on data in the MEPS event files, but they were presented separately in the data underlying the AV Calculator. Though specific identifiers for generic, brand-name, and specialty drugs were partitioned in the AV Calculator, they were not available in the MEPS-HC or the prescription drug event file. Therefore, to examine both spending and usage from a single source, we use a simplifying assumption that drugs costing fewer than \$50 per prescription are generic and those costing \$1,000 or more are

specialty; we consider the remainder brand-name, nonspecialty drugs.

Having obtained average costs and use by service, we then computed the approximate share of benefits paid for the covered services and adjusted this total benefit amount up to a typical silver marketplace premium for a 40 year old in 2020, \$5,883. In general, we maintained the service partition as shown in the AV Calculator and used the MEPS-HC data for the share of people who used a given service, because the latter is not part of the AV Calculator.

Spending and use for mental health and substance use disorders could not be easily identified separately in the MEPS-HC, and the data in the event files were sparse. The AV Calculator estimates outpatient spending on these services is 1.6 percent of total spending. Inpatient and prescription drug costs associated with mental health and substance use disorder care are indistinguishable in the data from inpatient and prescription drug costs associated with other conditions. If inpatient care and prescription drugs for mental health and substance use disorder care could be separated from general medical care, mental health and substance use treatment would likely account for more than 1.6 percent of premium costs. However, it would be difficult to identify and exclude such care from general inpatient and prescription drug coverage in the data.

## Results

In 2020, a typical nongroup marketplace premium for a 40-year-old, single enrollee is just under \$5,900 (table 1). This premium includes both costs associated with medical claims and administrative expenses. After computing the share of claims associated with each type of service, we applied those percentages to this dollar value to compute the amount of the premium associated with each type of service.

We find that the largest shares of a nongroup premium are attributable to prescription drugs (29 percent or \$1,718) and inpatient care (20 percent or \$1,154). Benefits that account for the smallest shares of premium cost are:

**Table 1. Essential Health Benefit Costs as Shares of a Nongroup Insurance Premium for a Single, 40-Year-Old Enrollee, 2020**

| Type of service   | Incremental premium cost per year | Share of premium | Share of nongroup enrollees who use the service | Additional premium cost if only users finance costs now covered by insurance* |
|---|-----------------------------------|------------------|---|---|
| Rehabilitative/habilitative care  | \$84                              | 1%               | 3%  | \$2,528   |
| Maternity/newborn care  | \$211                             | 4%               | 1%  | \$16,852  |
| Inpatient care  | \$1,154                           | 20%              | 3%  | \$33,295  |
| Emergency room care   | \$402                             | 7%               | 9%  | \$4,521   |
| Outpatient facility care  | \$744                             | 13%              | 13%   | \$5,616   |
| Provider care in outpatient facilities + nonphysician professional care | \$925                             | 16%              | 43%   | \$2,160   |
| Office-based physician care   | \$622                             | 11%              | 58%   | \$1,065   |
| Preventive  | \$226                             | 4%               | 39%   | \$584   |
| Primary   | \$194                             | 3%               | 28%   | \$697   |
| Specialty   | \$202                             | 3%               | 28%   | \$721   |
| Prescription drugs  | \$1,718                           | 29%              | 54%   | \$3,170   |
| Generic   | \$286                             | 5%               | 50%   | \$571   |
| Brand-name  | \$1,014                           | 17%              | 28%   | \$3,665   |
| Specialty   | \$418                             | 7%               | 3%  | \$14,358  |
| Pediatric dental and vision care  | \$24                              | 0%               | 7%  | \$356   |
| <b>Total cost of essential health benefits</b>                          | <b>\$5,883</b>                    | <b>100%</b>      |   |   |

\*These estimates represent the premium cost associated with each essential health benefit if it was no longer required to be included in all nongroup insurance plans and only people using that type of care bought insurance for it. While such benefits would not be available in separate policies in reality, these calculations represent the average financing burden that would fall on people needing different types of care in a particular year should these costs no longer be spread broadly across the larger nongroup insured population.

Source: Analysis based on data from the 2020 CCIIO Actuarial Value Calculator, Silver, and 2017 MEPS-HC by Actuarial Research Corporation.

- rehabilitative and habilitative care, which account for only 1 percent of the premium (\$84) when combined;
- maternity and newborn care, which account for just 4 percent (\$211);
- pediatric dental and vision care, benefits not considered essential for adults, which account for less than 1 percent (\$24); and
- emergency room care (including facility charges), which accounts for 7 percent (\$402).

More people use physician care in office-based settings (58 percent) than any other essential health benefit; this benefit accounts for 11 percent of the premium. Breaking out physician care costs by types of services, we find that expenses are quite evenly split between services for preventive care, primary care, and specialty care, each accounting for 3–4 percent of the premium dollar.

Prescription drug coverage accounts for the largest share of premium expenses (29 percent) and is used by the second

highest share of enrollees (54 percent). Pre-ACA nongroup coverage often excluded this benefit, or offered it for generic drugs only or with stringent limits on the number of prescriptions fillable. Brand-name drugs constitute most prescription drug spending, accounting for 17 percent of the premium dollar, compared with 7 percent for specialty drugs and 5 percent for generics. Only 3 percent of nongroup enrollees use specialty drugs (i.e., drugs without generic alternatives generally used by people with serious medical conditions). If only those needing specialty drugs in a given year bought coverage that included them, the additional premium cost for that small population would be \$14,358. Without access to such coverage, these expenses could reach into the hundreds of thousands of dollars for some people, depending on their specific conditions and needs.

Only about 1 percent of nongroup insurance enrollees use benefits for maternity and newborn care, another benefit generally excluded from pre-ACA

nongroup insurance plans. If only pregnant women were to purchase coverage for those benefits, their additional premium costs would be \$16,852, compared with the \$211 premium cost when these expenses are spread across all people with nongroup coverage.

Inpatient care, used by only 3 percent of nongroup enrollees annually, adds substantially to premiums, \$1,154 for a typical 40-year-old enrollee. Inpatient care is also associated with very high expenses should a person need it, and high costs are often incurred unexpectedly. If insured inpatient care costs were divided evenly across only those who used it each year—a practical impossibility—each person would incur costs exceeding \$33,000. The variation in care needed would lead to some people paying much more than this average estimate if they had to pay for such care on their own, out-of-pocket. These amounts would certainly constitute barriers to needed care for many people. Even average insured expenses for emergency room care, which, as noted

above, are incurred by less than 10 percent of nongroup enrollees, would amount to more than \$4,500 per person using these services in a given year.

## Discussion

No individual can consistently and accurately predict their medical needs for the coming year. Thus, expecting people to purchase insurance coverage each year only for the services they anticipate needing is illogical, and, in fact, conceptually inconsistent with the principle of insuring against uncertain events. In practice, removing particular benefits from the essential health benefit requirements would likely eliminate coverage for such benefits in the nongroup insurance market entirely or would lead to services being covered with substantial limits. If any particular benefit were voluntary for the insurer, any single insurer that included the benefit would attract users of that benefit to their plan. This would, in turn, lead to higher costs and premiums for that plan, thus dissuading others from enrolling. This was generally the case for benefits like mental health services, substance use disorder treatment, prescription drugs (especially brand-name and specialty

drugs), and maternity care before the ACA. Consequently, people needing those services were left to finance them on their own or go without them.

Health insurance coverage affordability remains an issue, as evidenced by policymakers' and others' interests in improving and extending financial assistance for coverage in the nongroup marketplaces. However, affordability concerns are also the rationale some use for supporting elimination of some essential health benefits from nongroup insurance coverage requirements. As this analysis shows, premiums can be reduced by excluding particular benefits, but doing so does not address affordability when people need such services; in fact, such exclusions raise the cost for those needing care and would frequently mean they cannot access it.

About two-thirds of premiums are attributable to care considered core components of insurance: professional and facility costs for inpatient, outpatient, emergency room, and office-based care. Excluding prescription drug coverage, maternity care, rehabilitative and habilitative, or mental health and substance use disorder treatment would

lead to lower premiums but would place thousands of dollars of additional costs, on average, on people needing those services and leave others with significant unmet medical need. For example, more than half of current nongroup enrollees use prescription drug benefits in a single year, meaning the value of coverage excluding such benefits would be significantly reduced for most people. The variation in spending around these averages means people with the greatest health care needs would face the greatest financial barriers to accessing necessary health care for benefits excluded from the insurance package.

Health insurance is intended to spread the risk of medical expenses across a population, making access to needed services affordable and accessible. Because of significant year-to-year uncertainty in individuals' and families' medical needs, coverage for a reasonably broad array of essential services spreads these costs over time and across a heterogeneous population. Doing otherwise poses significant risk to people who have unanticipated medical needs and can place prohibitive financial burdens on those with significant health problems.

## ENDNOTES

- <sup>1</sup> Fully insured, small-employer plans are also required to cover these essential health benefits.
- <sup>2</sup> Claxton G, Cox C, Damico A, Levitt L, Pollitz K. Preexisting conditions and medical underwriting in the individual insurance market before the ACA. Henry J. Kaiser Family Foundation. 2016. <https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/>. Published December 12, 2016. Accessed October 5, 2020.
- <sup>3</sup> Claxton G, Levitt L, Pollitz K, Damico A. (2013). *Why Premiums Will Change for People Who Now Have Nongroup Insurance*. Henry J. Kaiser Family Foundation. <https://www.kff.org/health-reform/perspective/why-premiums-will-change-for-people-who-now-have-nongroup-insurance/>.
- <sup>4</sup> Blumberg LJ, Holahan J. The implications of cutting essential health benefits: An analysis of nongroup insurance premiums under the ACA. Urban Institute. 2017. <https://www.urban.org/research/publication/implications-cutting-essential-health-benefits-analysis-nongroup-insurance-premiums-under-aca>. Published July 10, 2017. Accessed October 5, 2020.
- <sup>5</sup> The premium level used here to describe the dollar amount devoted to particular benefits out of a premium is from a representative nongroup market plan (Florida BlueSelect silver 1736S plan ID 16842FL0120080 in area FL08) taken from the 2020 HIX Compare dataset, sponsored by the Robert Wood Johnson Foundation and available at <https://hixcompare.org/individual-markets.html>. Though premiums for people ages 27 and 50 are published, the premium for a 40-year-old enrollee is calculated from the standard age curve, as found in Lorenz S. *Guidance Regarding Age Curves and State Reporting*. Washington: U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight; 2016. <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Guidance-Regarding-Age-Curves-and-State-Reporting-12-16-16.pdf>.
- <sup>6</sup> Because of data limitations described in the methods section, we proxy prescription drug tiers by assuming drugs costing fewer than \$50 per prescription are generics, those costing \$1,000 or more fall into the specialty category, and the remainder are brand-name, nonspecialty drugs.
- <sup>7</sup> *Final 2020 Actuarial Value Calculator Methodology*. Washington: U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight; 2019. <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2020-AV-Calculator-Methodology.pdf>. We used the silver continuance tables, including prescription drugs, for this analysis. As the user guide explains, “The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of the actuarial value for a given plan design. This version of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.”

***The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.***

## ABOUT THE AUTHORS & ACKNOWLEDGMENTS

Linda J. Blumberg is an Institute Fellow and Jessica Banthin is a Senior Fellow in the Urban Institute’s Health Policy Center. The authors thank Actuarial Research Corporation for providing actuarial and technical assistance for this project. The authors are also grateful for comments and suggestions from John Holahan. Rachel Kenney provided editorial assistance.

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