

The Implications of Cutting Essential Health Benefits: An Analysis of Nongroup Insurance Premiums Under the ACA

Linda J. Blumberg and John Holahan

Timely Analysis of Immediate Health Policy Issues

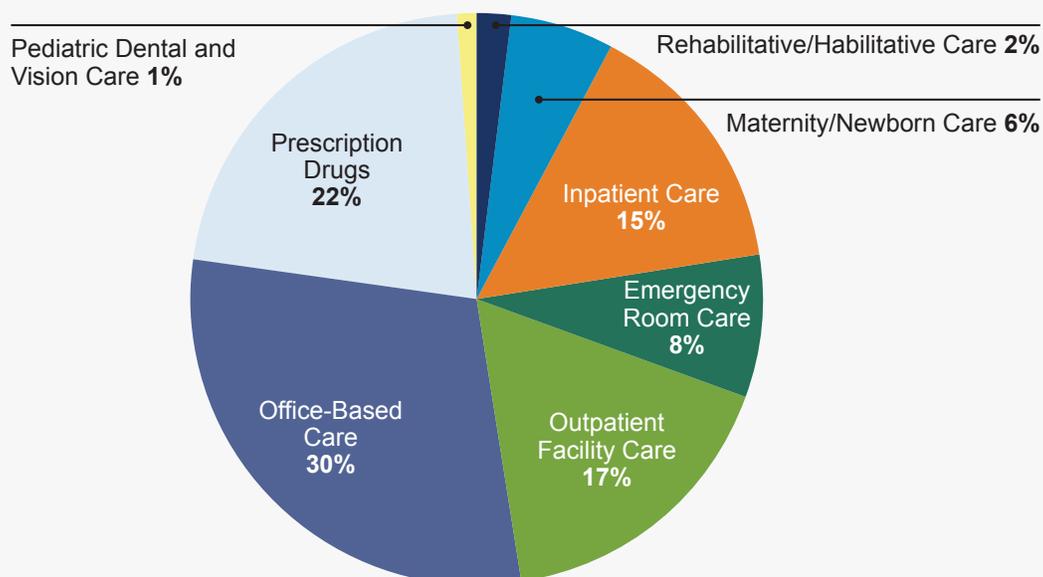
JULY 2017

In Brief

The essential health benefit requirements for private nongroup insurance continue to be hotly debated amid the ongoing congressional effort to repeal and replace the Affordable Care Act (ACA). We use data from the Medical Expenditure Panel Survey Household Component (MEPS-HC) to estimate the share of nongroup insurance premiums attributable to the health service categories in the requirements. We find that the largest shares of ACA-compliant nongroup insurance premiums can be attributed to the costs of office-based care (30%), prescription drugs (22%), outpatient facility care (17%), and inpatient care (15%). Coverage for these services is generally seen as fundamental to insurance. The benefit requirements targeted for cuts account for much smaller shares of premiums: Maternity and newborn care accounts for just 6 percent of total premium dollars, habilitative/rehabilitative care for 2 percent, and pediatric dental and vision care for 1 percent. But eliminating these benefits from insurance packages would lead to very high increases in costs for people who need those types of care.

The ACA has a reasonably comprehensive list of essential health benefit requirements, but it also addresses coverage richness through policies on cost-sharing requirements, tying marketplace premium assistance to plans with reasonably high deductibles but with lower requirements for low-income people. This approach reduces coverage comprehensiveness by an alternate route. Health insurance is, at its core, a mechanism for pooling health care risk across a population. As this analysis shows, the per-person costs of insuring essential benefits are reasonably low when the costs are spread broadly across a large population with diverse health care risks. Placing the costs fully on the users of health care can make those services unaffordable for those who need them.

Essential Health Benefits as a Share of Total Nongroup Premiums, 2017



Introduction

The American Health Care Act (AHCA), passed by the U.S. House of Representatives on May 4, 2017 and the Better Care Reconciliation Act (BCRA) being debated in the Senate have heightened the debate over essential health benefit (EHB) requirements for nongroup (i.e., individually purchased) health insurance. Currently the Affordable Care Act (ACA) requires all nongroup and fully insured small group insurers to include each of 10 EHBs defined in the law: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder (MH/SUD) services, including behavioral health treatment; 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. Some insurers and ACA critics blame the EHB requirements for high unsubsidized premiums and have proposed eliminating some or all of the prescribed benefit categories.¹ Maternity care, substance use disorder treatment, and rehabilitative/habilitative care are the most frequent targets of benefit cuts.²

We analyze a typical silver level (70% actuarial value³) marketplace plan, breaking out the share of premiums associated with various EHBs. We rely on data from the Medical Expenditure Panel Survey Household Component (MEPS-HC), which allows us to divide claims into the following categories of care: rehabilitative/habilitative care; maternity/newborn care; inpatient care (facility and provider costs separately); emergency room care (facility and provider costs separately); care provided in an outpatient facility (facility and provider costs separately); office-based care (physician preventive care, physician primary care, physician specialty care, other provider care separately); prescription drugs (generic, brand name/nonspecialty, and specialty separately); and pediatric dental and vision care.

We estimate the average share of premiums associated with each of these categories of care and estimate the share

of nongroup insurance enrollees who use care of that type. This analysis allows us to compare the average premium cost associated with each service type and how that cost would change if only people using that type of care financed the portion currently covered by ACA-compliant insurance coverage. Data from other sources also provide some indication of the share of outpatient claims attributable to mental health and substance use disorder care; we provide that information separately.

Data and Methods

This analysis is based largely upon data from the 2014 Medical Expenditure Panel Survey Household Component (MEPS-HC), using both the full-year consolidated file (HC-171) and event-level files⁴ when needed. The data were parsed to identify people covered by nonemployer private plans, which include coverage through the ACA marketplaces and other private health insurance; we refer to these two groups as having nongroup health insurance.

We examined health care spending and use for these covered people, partitioned into services that map to the EHB services as closely as possible. For inpatient and outpatient hospital and emergency room care, costs associated with facility fees were separated from those for providers. Physician costs and use for preventive, primary, and specialty care were partitioned based on data in the event files. Although specific identifiers for generic, brand name, and specialty drugs were not available in the MEPS-HC or in the prescription drug event file, we used a simplifying assumption that mapped drugs costing less than \$50 per prescription to the generic category and those costing \$1,000 or more to the specialty category; the remainder were considered brand name, nonspecialty drugs.

Once we had average cost and use by service, we computed the approximate share of benefits paid for the covered services and then adjusted this total benefit amount up to the average silver marketplace premium in 2017, approximately \$4,700. This adjustment allowed for inflation and benchmarking, as well as an applicable premium load

to benefit costs, to reach actual 2017 per capita spending on premiums.

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. To estimate the share of total nongroup premiums attributable to these services, we used the Center for Consumer Information and Insurance Oversight (CCIIO) Actuarial Value Calculator⁵ (AVC) and Health Care Cost Institute (HCCI) data⁶ on employer-sponsored insurance plans. Both showed that approximately 1 percent of premium costs are associated with these outpatient services. Inpatient and prescription drug costs associated with MH/SUD care are indistinguishable in the data from other costs associated with inpatient and drug care. If inpatient care and prescription drugs for MH/SUD care could be separated from general medical care, MH/SUD treatment would account for more than 1 percent of premium costs. However, it would be difficult to exclude such care from general inpatient and prescription drug coverage.

Our analysis differs from a recent, related one by Milliman⁷ in the following ways:

- We rely on publicly available health care spending data for the private nongroup market specifically. The Milliman analysis uses the 2017 Milliman Commercial Health Cost Guidelines, a proprietary data set of employer-based insurance data.
- The Milliman data provide specific quantitative estimates for only two categories of services (pediatric dental care and maternity care). We provide estimates for an array of additional services—all those that could be credibly analyzed using the MEPS-HC. The Milliman analysis includes a pie chart that breaks out relative costs for the eight other ACA essential health benefits but does not show their actual quantities.

Our analysis uses data for the population most likely to be directly affected by changes to essential health benefit requirements under the AHCA or the BCRA: people with private nongroup

insurance. In addition, we provide much more detail on the share of premium costs attributable to specific benefits and services. Still, both analyses reach the same general conclusions.

Results

In 2017, the average nongroup marketplace premium is approximately \$4,700 (Table 1). This includes both claims paid (as benefits) and administrative costs. We divide that premium proportionately based on the share of total claims paid for each category of service. The largest shares of ACA-compliant nongroup insurance premiums can be attributed to the costs of office-based care (30%), prescription drugs (22%), outpatient facility care (17%), and inpatient care (15%). Maternity and newborn care accounts for just 6 percent of total premium dollars, habilitative/rehabilitative care for 2 percent, and pediatric dental and vision care for 1 percent. A separate analysis of data from the HCCI and the CCIO AVC indicates that outpatient care for mental health and substance use disorders account for approximately 1 percent of outpatient care (not shown). Preventive care and primary care delivered in physician offices accounts for 9 percent and 4 percent of premiums, respectively. Approximately 8 percent of premiums pays for physician office specialty care, and 9 percent pays for care delivered by other health professionals in physician offices. The largest share of prescription drug costs is attributable to brand name, nonspecialty drugs (12% of premium costs, 56% of covered drug costs); generic drugs account for only 2% of total premium costs.

Although prescription drugs account for 22 percent of ACA-compliant premium dollars, 56 percent of enrollees use at least one prescription a year. Office-based care, which accounts for 30 percent of premium dollars, is used by more than 71 percent of enrollees in the nongroup market. But inpatient care, which accounts for 15 percent of premium dollars, is used by just 4 percent of the insured population in a year.

The far right column of the table shows the average cost that users of each service

would have to pay if the costs associated with that service were averaged only over users, instead of over all those insured in the market. These costs should be compared with the cost per insured person when all those covered in the ACA-compliant nongroup insurance market share in the costs equally, whether or not they use that type of care (the first column of numbers in the table). For example, maternity and newborn care accounts for \$278 (or 6%) of the typical ACA-compliant silver premium, but each person using that type of care would have to pay \$13,888 on average if they were financing those costs separately from the rest of the insurance pool. Emergency room care adds \$376 to the premium, but those using it would have to pay \$4,251 to cover those costs separately. Rehabilitative and habilitative care adds \$96 to the premium, but financing that care separately would cost \$2,247 per user on average. Non-maternity-related inpatient care adds approximately \$720 to the average premium, but users of this care would pay more than \$19,000 to cover it separately. Pediatric dental and vision care adds \$43 to the average premium but would cost \$453 per child user if financed separately.

People use different types of services every year, so their needs in the coming year cannot be accurately predicted at the start of a plan year. Thus, it is unrealistic to expect people to purchase specific additional coverage with other users alone. Before the nongroup insurance market reforms of the ACA, only a small fraction of nongroup insurance policies covered maternity care, for example, but the additional cost of that coverage often exceeded the costs associated with a typical birth. Likewise, policies that offered more generous coverage for prescription drugs charged much higher premiums, expecting that those purchasing the policy would be substantial users of that benefit.

But in practice, eliminating a benefit from the essential health benefit requirements would likely eliminate coverage for that benefit in the nongroup insurance market. Any single insurer would be averse to offering a benefit on their own because doing so would attract users of that care,

increasing the insurer's costs relative to its competitors. Users would not be able to average their costs even with other users, leaving those with the greatest needs with the highest health care costs.

Discussion

Health insurance affordability is a focal issue in assessments of the ACA and in debates over potential replacements such as the AHCA or BCRA. Premiums are an important component but not the sole determinant of affordability. Eliminating benefits from a plan's coverage can reduce premiums, but it increases the cost of using that type of care for people who need it. The benefits that usually account for large shares of an ACA-compliant nongroup insurance premium are those considered fundamental to health insurance, including office-based care, inpatient hospital care, and outpatient facility care. Prescription drugs, which were either excluded from or very limited in pre-ACA nongroup insurance policies, account for approximately 22 percent of premium costs by our estimates. But eliminating prescription drug coverage from benefit packages could limit access to drugs for most people insured through the nongroup insurance market in any given year, reduce access to lifesaving treatments, and it could lead to higher physician and hospital care costs. Maternity/newborn care, rehabilitative/habilitative care, and outpatient care for mental health and substance use disorder treatment are also potentially on the chopping block and account for small percentages of the overall premium, but their removal would lead to extremely large cost increases for people who need those types of care. Limited access to such services could lead to higher inpatient or office-based care costs because of later complications.

The ACA has a reasonably comprehensive list of essential health benefit requirements, but it also addresses coverage richness through policies on cost-sharing requirements. For example, the ACA individual mandate is satisfied by bronze (60% actuarial value) nongroup coverage. These policies have an average deductible of over \$6,000 in

2017. This approach reduces coverage comprehensiveness by an alternate route.

Health insurance is a mechanism for pooling health care risk across a population. The per-person costs of insuring essential benefits are reasonably low when the costs are spread broadly

across a large population with diverse health care risks. But placing those costs fully on the users of care can make those services unaffordable for those who need them. Because people cannot predict which services they will need and when, health insurance spreads those costs across users and non-users,

such that benefits are affordable and therefore accessible to enrollees when and if the need should arise. Peeling back covered benefits erodes the financial protection that health insurance is designed to provide.

Essential Health Benefits as a Share of Total Nongroup Premiums, 2017

Type of Service	Incremental Premium Cost per Year, 2017	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	\$96	2%	4%	\$2,247
Maternity/Newborn Care	\$278	6%	2%	\$13,888
Inpatient Care	\$720	15%	4%	\$19,071
Facility	\$609	13%	4%	\$16,121
Provider	\$111	2%	3%	\$3,647
Emergency Room Care	\$376	8%	9%	\$4,251
Facility	\$317	7%	9%	\$3,588
Provider	\$59	1%	7%	\$794
Outpatient Facility Care	\$776	17%	13%	\$5,755
Facility	\$696	15%	13%	\$5,162
Provider	\$80	2%	8%	\$942
Office-Based Care	\$1,389	30%	71%	\$1,947
Physician Preventive Care	\$422	9%	40%	\$1,066
Physician Primary Care	\$195	4%	32%	\$607
Physician Specialty Care	\$369	8%	29%	\$1,251
Other Provider Care	\$402	9%	39%	\$1,038
Prescription Drugs	\$1,023	22%	56%	\$1,836
Generic (Rx < \$50)	\$114	2%	n.a.	n.a.
Brand Name, Nonspecialty	\$576	12%	n.a.	n.a.
Specialty (Rx >= \$1,000)	\$333	7%	n.a.	n.a.
Pediatric Dental and Vision Care	\$43	1%	10%	\$453
Total Cost of EHBs	\$4,700	100%		

Source: Authors' analysis of 2014 Medical Expenditure Panel Survey Household Component, aged to 2017.

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 a Senior Fellow and John Holahan is an Institute Fellow in the Urban Institute's Health Policy Center. The authors would like to thank Actuarial Research Corporation for providing actuarial and technical assistance for this project. The authors are also grateful for comments and suggestions from Sabrina Corlette and Kevin Lucia, and to Vicky Gan for copyediting.

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector. For more information specific to the Urban Institute's Health Policy Center, its staff, and its recent research, visit <http://www.urban.org/policy-centers/health-policy-center>.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

For more than 40 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working with others to build a national Culture of Health enabling everyone in America to live longer, healthier lives. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.

- 1 See, for example: Fox M. What are 'essential benefits' in GOP health care bill debate? *NBC News*. March 24, 2017. <http://www.nbcnews.com/health/health-care/gop-health-care-debate-what-are-essential-benefits-n737646>.
- 2 Alonso-Zaldivar R. Trump health pick Seema Verma says maternity coverage should be optional. *Chicago Tribune*. February 16, 2017. <http://www.chicagotribune.com/lifestyles/health/ct-trump-health-pick-says-maternity-coverage-should-be-optional-20170216-story.html>. Luby T. Essential health benefits and why they matter. *CNN*. Updated March 24, 2017. <http://www.cnn.com/2017/03/22/politics/essential-health-benefits-obamacare-freedom-caucus/index.html>. Sullivan P. What the GOP's plan to kill essential health benefits means. *The Hill*. March 23, 2017. <http://thehill.com/policy/healthcare/325381-what-the-gops-plan-to-kill-essential-health-benefits-means>. Andrews M. GOP considers trimming health law's 10 essential benefits. *NPR Shots*. February 22, 2017. <http://www.npr.org/sections/health-shots/2017/02/22/516465156/gop-seeks-reduction-in-health-law-s-10-essential-benefits>.
- 3 Actuarial value (AV) is the proportion of claims paid by an insurance plan over a standard population. A 70 percent AV plan pays, on average, 70 percent of claims submitted, leaving the policyholder responsible for the remaining 30 percent.
- 4 Event-level files were the 2014 office-based medical provider visit file (MEPS HC-168G) and the 2014 prescribed medicines file (MEPS HC-H168A).
- 5 The CCIIO Actuarial Value Calculator allows users to value the metal tier of a specific health insurance plan and includes data on the underlying distributions of service by metal tier. Centers for Medicare & Medicaid Services. Center for Consumer Information & Insurance Oversight website. <https://www.cms.gov/ccio/resources/regulations-and-guidance/>.
- 6 Health Care Cost Institute. Health Care Cost Reports website. <http://www.healthcostinstitute.org/report/>.
- 7 Bayram R, Dewey B. *Are Essential Health Benefits Here to Stay?* Seattle: Milliman; 2017. <http://us.milliman.com/uploadedFiles/insight/2017/essential-health-benefits.pdf>.