

Protecting High-Risk, High-Cost Patients: “Essential Health Benefits,” “Actuarial Value,” and Other Tools in the Affordable Care Act

Timely Analysis of Immediate Health Policy Issues

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In Summary

- Today’s private health insurance often suffers from multiple shortcomings including benefit limits and exclusions, coverage denials, premiums that vary greatly by health status, risk selection, and lack of clear information on plans.
- The Affordable Care Act (ACA) will dramatically reduce these problems in both the nongroup and small group markets, with reforms that establish benefit standards, require readily understandable and comparable information from plans, and prohibit many long-standing market practices designed to avoid enrolling those with high health needs and to limit the payment of legitimate claims.
- The Department of Health and Human Services’ (HHS) proposed approach to implementation would benefit from refinement, reinforcement, and reevaluation both at initial implementation and over time, to minimize risk selection and discrimination that may remain a part of even much-improved insurance markets.

Background

HHS’s proposed approach to implementing two key ACA requirements—“essential health benefits” (EHBs) and insurance plan actuarial value (AV)—reflects an effort to balance two competing goals: consistent protection across consumers and accommodation of variation—whether in experience across states, insurance benefit design, or in the needs and preferences of individual consumers. But our analysis shows that these rules, even in combination with the law’s additional insurance protections, may not ensure that the highest-need consumers receive predictable and adequate insurance protection. Insurers able to avoid the very sick population, whose care accounts for a large share of spending, may reap substantial financial benefits. Although risk-adjusted payments can mitigate this powerful incentive, consumer protection will be strongest with policies designed to minimize, not encourage, risk selection.

Essential Health Benefits

Under the HHS guidance, states are given flexibility to define EHBs within 10 service categories, choosing benefits from one of 10 designated plans (without regard to cost-sharing requirements). Thus, states’ initial choices of benchmark benefits will be based on some of the most popular plans sold today, while eliminating the least protective plans from the market. Guidance suggests that insurers would be permitted to deviate from benefits in the state benchmark plan as long as the package offered is “actuarially equivalent” to the benchmark package.

However, actuarial equivalence is not constructed to measure benefit changes that have little impact on average spending but a substantial impact on spending for a small number of patients. As a result, the more insurers can vary benefits based on actuarial equivalence, the greater the potential that risk selection is likely to occur. One example is illustrated by the coverage of oral cancer drugs, which have virtually no effect on actuarial equivalence because so few people use them, but have a great effect on covered costs for particular patients. To discourage risk selection through benefit design, HHS could require evidence on the effect of benefit changes on high-risk populations to assess the actuarial equivalence of any proposed substitutions for benchmark benefits. And it could require—or, at a minimum, allow—states to limit the number of variations from benchmark benefits that plans can offer.

Actuarial Value

AV is a measure of the relative generosity of health insurance plans intended to enable consumers to compare the average cost-sharing for an average population across different plans. Under the ACA, AV will be used to classify plans into one of the law’s cost-sharing tiers (bronze, silver, gold, and platinum) and to guide calculation of premium tax credits and application of the law’s cost-sharing subsidies. HHS proposes to standardize AV calculations to reflect standard populations and standard use and cost in each state.

Standardization isolates cost-sharing from other differences among plans, like payment rate differences and utilization review features, and ensures consistency. But these other differences among plans could also give rise to out-of-pocket costs for high-cost patients. HHS can refine its AV calculations to reflect the impact of in-network or innovative cost-sharing designs, and counting any cost-sharing resulting from such cost-sharing structures toward the annual out-of-pocket cap. Tracking and evaluating experience will ensure affordable access for lower income enrollees, whose cost-sharing subsidies may not be as broad as expected.

Other Tools

Additional policies may be needed to reinforce EHB and AV rules, to alert consumers to specific plan characteristics that will determine their access to expected benefits. These include easy-to-understand plan summaries, effective network adequacy rules, and standards for “wellness incentives” and other innovative cost sharing features.

The ACA’s requirement for risk-adjusted payments to plans aims to minimize incentives to select risks by preventing both overpayment of plans that avoid the sick and underpayment of plans that cover them. Further, the explicit prohibition on benefit designs that discriminate against high-cost patients allows enforcement of appropriate access. Effective risk-adjustment and anti-discrimination rules will be essential to minimizing plans’ pursuit of risk selection practices.

Ongoing Monitoring and Reevaluation

Finally, effective protection of high-cost and even average-cost patients will require a reevaluation of EHB, AV, and all other rules as the ACA implementation goes forward. Explicitly limiting the proposed benchmark for EHB determination to two years reflects recognition of the uncertainties regarding the adequacy, effectiveness, and impact of the initial approach. Collection and comparison of benchmark benefits across states would inform next steps in the definition of EHBs. Though not explicitly limited, other rules will similarly benefit from assessment of experience and appropriate modifications, in order to avoid unintended consequences and promote adequate coverage.

Conclusion

The ACA will improve the nongroup and small group insurance markets for everyone in them, including the high-risk population. But insurance reforms, guided by requirements for EHBs, AVs, and other tools provided by the ACA, are and will remain a work in progress. This analysis suggests the way these tools—working together and reevaluated over time—can help ACA implementation actually progress toward its goals of effective, affordable insurance protection, especially for the highest-need, highest-cost patients.

