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Obamacare and Insurance Benefit Mandates: Raising Premiums and Reducing Patient Choice

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A set of provisions included in the Patient Protection and Affordable Care Act (PPACA)[1] gives the U.S. Department of Health and Human Services (HHS) sweeping new powers to impose a wide range of detailed benefit requirements on employer-sponsored health plans and major medical policies sold by health insurers. This will effectively make all health insurance benefits uniform—depriving patients of choices—increase the cost of coverage for tens of millions of Americans, and stifle insurance innovation.

Summary. The new law[2] adds a number of health care services that insurers must cover and in some cases restricts the ability of insurers and employer self-insured health plans to impose limits on the amount of services patients can consume. This combination will drive up health plan costs and premiums for both individual insurance and employer-group coverage. Specifically, the law:

Section 1001(5) of PPACA requires that, effective for plan years starting in the fall of 2010, health insurers and employer plans must cover numerous preventive services with no enrollee cost-sharing.[3] The required preventive services include (1) items or services with "a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force," (2) immunizations recommended by "the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved," and (3) for women, infants, children, and adolescents, additional "preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration."

Section 1001(5) prohibits health insurers and employer plans from setting lifetime coverage limits "on the dollar value of benefits" effective for plan years starting in the fall of 2010 and prohibits plans from setting annual coverage limits starting in 2014.[4]

Section 1302(c) limits deductibles for employer plans in the small-group market to $2,000 for self-only coverage and $4,000 for family coverage, indexed after 2014 to the growth in average per capita premiums. It limits total cost-sharing for any health plan to the levels specified for High Deductible Health Savings Account plans (HD/HSA plans), which in 2010 was $5,950 for self-only coverage and $11,900 for family coverage.

Section 1302 grants HHS authority to set and periodically revise an "essential health benefits package" of minimum health insurance coverage requirements. Section 1302(b)(1) instructs the Secretary of HHS to define the essential health benefits, which "shall include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emer-

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gency services; hospitalization; maternity and newborn care; mental health and substance use disorder 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." Starting in 2014, Section 1201(4) of PPACA requires all commercial health insurance plans to provide coverage for the essential health benefits package, and Section 1513 imposes fines on firms with 50 or more workers that fail to offer their employees an employer-sponsored plan with at least the essential benefits package.[5]

Impact. The new federal benefit requirements represent a blatant assertion that Congress and federal bureaucrats know best how to design health insurance policies. The effects will be one-size-fits-all coverage—so that patients are not "confused" by having choices—and elimination of employers' freedom to design their own self-insured plans. It also extends an open invitation to medical providers to lobby Congress and HHS to incessantly expand the "essential benefits." The more benefits providers are able to have deemed "essential," the more insurers, employers, and patients will have to pay for these services. The result will be higher premiums for tens of millions of Americans.

An Ever-Expanding Federal Minimum Benefits Package. PPACA's benefit-setting provisions will result in a uniform federal minimum health insurance benefit package dictated by HHS from 2014 onward. Because PPACA also instructs HHS to "periodically update" this minimum benefit package, insurers and employers will likely need to alter their plans each year so as to remain compliant with a constantly evolving set of coverage mandates imposed by HHS.[6]

Broad Discretionary Authority for HHS. PPACA grants more discretionary authority to unelected federal officials to micromanage health insurance coverage than state legislatures have ever granted to state insurance regulators.[7] How HHS chooses to exercise that new authority will determine how intrusive and costly the new benefit mandates become.

While HHS could, in theory, take a restrained approach to setting minimum benefit standards, it is more likely that it will sooner or later impose increasingly detailed standards that result in higher plan costs. Greater regulation is the more likely outcome for two main reasons: (1) The Obama appointees at HHS are philosophically predisposed to favor such an approach, and (2) special-interest provider and patient groups have a natural incentive to lobby for more coverage requirements.

1. Congress cannot build sound market-based health care reform on the foundation of a flawed health care law. Therefore, the health care law must be repealed in its entirety.

   The House of Representatives has taken a major step towards full repeal of the Patient Protection and Affordable Care Act (PPACA—otherwise known as "Obamacare"). Until full repeal occurs, Congress must continue to focus on the core failures and consequences of PPACA and block its implementation to allow time to achieve repeal and lay the groundwork for a new market-based direction for health care reform.
2. Patient Protection and Affordable Care Act of 2010, Public Law 111–148, and Health Care and Education Reconciliation Act of 2010, Public Law 111–152.
3. New Section 2713 of the Public Health Service Act (42 U.S. Code § 300gg-13) as added by PL 111–148 § 1001(5). Effective date is in Section 1004.
4. New Section 2711 of the Public Health Service Act (42 U.S. Code § 300gg-11) as added by PL 111–148 § 1001(5) and further amended by §10101(d). Effective date is in Section 1004.
5. Efective date is in Section 1253, which was redesignated as Section 1255 by Section 10103(f)(1) and Section 1513, which adds a new Section 4980H to the Internal Revenue Code.
6. PL 111–148 § 1302(b)(4)(H).
7. The closest parallel is arguably the Maryland Health Care Commission, which, among other duties, was tasked by the state's Health Insurance Reform Act of 1993 with designing and annually updating a minimum standard health benefit package for that state's small-group market. However, even in that case, Maryland law sets some limits on benefit-setting by the commission, while PPACA imposes no equivalent limits on HHS. More information can be found at the commission's Web site at *http://mhcc.maryland.gov.*

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Costly Mental Health Coverage Requirements. The existing mental health parity statute does not require health plans to offer mental health and substance use disorder benefits; it only requires parity with other benefits *if* mental health benefits *are* offered.[8] However, Section 1302 of PPACA *will* require all plans to provide such benefits starting in 2014. Thus, the combined effect is that PPACA will require coverage of mental health benefits, while the existing mental health parity law significantly restricts the ability of plans to use financial incentives or treatment limitations (such as annual limits on the number of covered visits) to control the volume of those services.

That is likely to prove very expensive, since services that aim to modify patient behavior—such as dietary habits, addictions, or manifestations of certain mental illnesses—involve repeated treatments where effectiveness is difficult to evaluate. Without limits on the number of visits, patients are encouraged to consume more services, and practitioners are induced to provide more, regardless of the incremental value of the extra services.

New Uncertainty and Legal Jeopardy for Employers and Insurers. In drafting the provisions requiring coverage of preventive services, Congress managed to achieve the paradoxical feat of being simultaneously overly prescriptive and unsettlingly vague. Subsequent regulations issued by HHS have not clarified the situation.

For example, one of the new preventive care requirements is that plans pay for "intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease." The regulations provide no further clarification, stating only, "Nothing prevents a plan or issuer from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in paragraph (a)(1) of this section to the extent not specified in the recommendation or guideline."[9] Thus, employers and insurers are left to determine how much of those services, and which patients, the law requires them to pay for, with the potential for costly litigation if a beneficiary disputes their interpretation. This example is just one of more than half a dozen instances of such ambiguity in the new preventive care requirements.

What is clear, however, is that significant penalties could be imposed on insurers and employer health plans if they fail to comply with HHS benefit dictates. The existing federal health insurance statute—now amended by PPACA to include the new benefit mandates—contains an enforcement section that provides for fines of up to "$100 for each day for each individual with respect to which such a failure occurs."[10] Thus, for a plan with just 100 enrollees, the potential fines could be as much as $10,000 per day.

An Invitation to Special-Interest Lobbying. As experience with insurance benefit mandates at the state level shows, providers and patient groups can be expected to exert pressure on HHS and Congress to expand the scope of the federal minimum coverage requirements. To the extent that HHS or Congress bows to that political pressure, health insurance premiums will escalate still further after 2014.

Shifting that dynamic from state governments to the federal government means that the cost of coverage will increase significantly in those states that have so far successfully resisted provider lobbying for benefit mandates. In addition, self-insured employer plans will no longer be exempt from benefit mandates. Unlike state laws, the new federal benefit mandates will apply to both commercial insurers and self-insured employer plans.

Major Premium Increases. In general, the premium increases resulting from the new federal benefit-setting will be the product of three factors:

1. Mandated reductions in enrollee cost-sharing will mean that insurers must pay more of the cost

8. 42 U.S. Code § 300gg-5 (§2705 of the Public Health Service Act, which was redesignated as §2726, to become 42 U.S. Code § 300gg-26, by PL 111–148 § 1001(2) (PPACA)).
9. 45 Code of Federal Regulations § 147.130(a)(4).
10. 42 U.S. Code § 300gg-22(b)(2)(C).

for services they already cover, thus shifting those costs from patients to plan premiums.

2. Prohibiting enrollee cost-sharing for specific services will stimulate greater use of those services, further increasing premiums.
3. Premiums will also increase to the extent that new federal regulations require plans to cover benefits or services that were previously excluded or subject to plan limitations.

A New Direction. Like many other provisions in the new health care law, the federal benefit mandate provisions are unprecedented, unwarranted, and undesirable. When fully implemented, they will likely exceed in scope and detail the mandated health insurance benefit requirements of even the most regulatory-oriented state governments.

Instead of the federal government regulating health insurance benefits, state governments should make their insurance markets more responsive to patients' needs and preferences by enacting their own health insurance reforms. A particularly good move would be to create new incentives for insurers, doctors, and hospitals to provide value and for consumers to seek better value in health insurance and medical care.[11]

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11. See Edmund F. Haislmaier, "Health Care Reform: Design Principles for a Patient-Centered, Consumer-Based Market," Heritage Foundation *Backgrounder* No. 2128, April 23, 2008, at *http://www.heritage.org/research/reports/2008/04/health-care-reform-design-principles-for-a-patient-centered-consumer-based-market*; Robert E. Moffit, "State Health Reform: Six Key Tests," Heritage Foundation *WebMemo* No. 1900, April 23, 2008, at *http://www.heritage.org/Research/Reports/2008/04/State-Health-Reform-Six-Key-Tests*; Gregg Girvan, "Utah's Defined-Contribution Option: Patient-Centered Health Care," Heritage Foundation *Backgrounder* No. 2445, July 30, 2010, at *http://www.heritage.org/Research/Reports/2010/07/Utahs-Defined-Contribution-Option-Patient-Centered-Health-Care*.