The Heritage Foundation
LEADERSHIP FOR AMERICA

ISSUE BRIEF

No. 3907 | APRIL 10, 2013

Obamacare's Essential Benefits Regulation Creates Disparities Among States

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The Department of Health and Human Services (HHS) has issued final rules for Obamacare's essential health benefits (EHB) package, setting up yet another new source of conflict over Obamacare, this time among the states.[1]

HHS has adopted a "state benchmark plan" approach for setting the EHB package. The result of this decision is that the EHB package will now vary from state to state. While Administration officials tout this approach as offering less market disruption and more flexibility, it will also have the effect that some states will receive more in Obamacare subsidies than others.

This is because, in trying to implement one part of Obamacare, the Administration is tripping over another part of the law.

More State Benefit Mandates Equal More Federal Subsidies. Beginning in 2014, Obamacare requires all non-grandfathered health insurance plans in the individual and small group markets to cover the EHB package. The law also says that if a state imposes benefit mandates beyond those required by the federal EHB package, then the state must pay the extra cost for subsidizing those extra benefits in the exchange.

This paper, in its entirety, can be found at
http://report.heritage.org/ib3907

Produced by the Center for Health Policy Studies

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However, the HHS regulations implementing the EHB package specify that, at least for the first two years, the EHB package in each state will be determined by a benchmark plan, which for most states will be their largest small group plan.[2] Since those benchmark plans already exist and they already cover state-mandated benefits, those state benefit mandates will now be part of the "essential benefits" that insurers will have to cover. That, in turn, means that when insurers offer their policies in the exchanges, the cost of those state benefit mandates will be paid for with federal subsidies.

Of course, this design gives every state an incentive to add more benefit mandates, knowing that federal taxpayers will be picking up most of the tab. To prevent that, HHS drew a line in the EHB regulation that essentially "grandfathers" all state benefit mandates enacted before December 31, 2011. That means states will pay the additional cost *only* for any state benefit mandates enacted *after* 2011.

The effect will be disparities among states, as the package of "essential" benefits will be more generous in some states than in others. Of course, those differences will also be reflected in plan premiums.

Yet the amount paid by those receiving Obamacare's exchange subsidies will not vary by state—despite individuals in one state receiving more generous (and more costly) coverage than individuals in another state. The reason is that the Obamacare subsidies are based on the recipient's income, not the cost of the available coverage.[3]

The way the Obamacare exchange subsidies work is that the recipient pays no more than a specified percentage of income for coverage, with the rest of the premium picked up by federal taxpayers. The

subsidies are tied to the second-lowest-cost silver plan (the reference plan) in the state's exchange and will be set on a sliding scale.

For example, a couple at 250 percent of the federal poverty level (annual income of $37,825) will pay no more than 8.05 percent of their income—$2,383 (or $198 a month)—in premiums for the reference plan. That will hold true regardless of whether they live in a state where the premium for the reference plan is $10,000, one where it is $15,000, or one where it is $20,000.

Thus, in a state with a more generous—and therefore more expensive—EHB package, there will be a greater federal subsidization of premiums by Obamacare, creating inequalities among states. While it is true that in many cases the differences may be modest, those differences could be significant in cases where states require coverage for expensive treatments.

For example, the EHB package will require coverage for autism spectrum disorders in 24 states and for "applied behavior analysis based therapies" for autism spectrum disorders in another four states. However, in the remaining 22 states, those services will not be part of the required essential benefits. Similarly, the required essential benefit coverage will include bariatric surgery in four states, bone marrow transplant in five states, chiropractic care in 10 states, infertility treatments in nine states, and private-duty nursing in two states.[4]

EHB Controversy Exacerbated. Beyond cost, some of these benefit mandates are controversial for other reasons as well. For example, there are questions about the long-term value of bariatric surgery for obesity, particularly relative to patient risks. In the case of autism and related conditions, given that treatments consist principally of educational and behavioral therapies, it can reasonably be argued that they should be funded through social service programs rather than through acute care health insurance. In the case of infertility treatments, many individuals consider some of the procedures used to be immoral and thus strongly object to being forced to subsidize them through their health insurance.

Yet the Administration's EHB regulation now effectively deems these and other controversial treatments to be "essential"—but *only* in those states that previously mandated them. Furthermore, the Administration's approach exacerbates existing mandated benefit controversies by introducing the new dynamic of federal funding discrimination derived from a policy that freezes in place prior disparities among the states.

To understand how that could spark new conflicts over Obamacare, consider the example of infertility treatments. Infertility treatments will be part of the required essential benefit coverage in Illinois but not in any of the adjoining states of Indiana, Wisconsin, Iowa, Missouri, or Kentucky. If lawmakers in one or more of those adjoining states were to now mandate coverage for infertility treatment, their *state's taxpayers* would have to cover the extra cost of the exchange subsidies. Yet in Illinois *federal taxpayers* will pick up the extra subsidy cost.

More Obamacare Consequences. Thus, the effect of this policy is to reward states that previously enacted excessive benefit mandates (driving up the cost of health insurance) while penalizing states that took a more restrained approach in the past (keeping health insurance more affordable).

It also means that if a hypothetical couple in the above example lives in one of the five states adjoining Illinois and wants coverage for infertility treatments, they can get it with federal subsidies by moving across the state line to Illinois.

Of course, HHS could eliminate these disparities by crafting a single national EHB package—which is what the architects of Obamacare intended and expected. Yet doing that would shift special

1. *Federal Register*, Vol. 78, No. 37 (February 25, 2013), pp. 12834–12871, http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf (accessed April 9, 2013).
2. Forty-one states and the District of Columbia plan to use their largest small group plan as the benchmark. See Appendix A of the final rule for the complete list.
3. 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, Sec. 1401.
4. Each state's EHB benchmark plan and list of benefits can be found here: U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, "Additional Information on Essential Health Benefits Benchmark Plans," http://cciio.cms.gov/resources/data/ehb.html (accessed April 2, 2013).

interest lobbying over benefits from state capitals to Washington while also exacerbating other problems with Obamacare.

For example, Obamacare's insurance rating rules will increase premiums. Yet a national EHB package would raise premiums even more in states that currently have fewer benefit mandates. Also, Obamacare's "public utility" approach to regulating insurers will drive industry consolidation, resulting over time in fewer and larger health insurers.[5] A national EHB package would reinforce and accelerate that trend by further limiting the ability of insurers to differentiate themselves from their competitors.

Contrasting the coverage of prescription drugs in the Federal Employee Health Benefits Program (FEHBP) versus in Medicare illustrates why letting insurers design benefit packages in response to consumer demand and innovations in medical treatment is preferable to government benefit setting.

Since its inception in 1960, the FEHBP has been a very competitive market, with participating insurers allowed wide latitude in designing their benefit packages. Over time, prescription drug coverage in FEHBP plans became widespread and increasingly sophisticated in response to consumer demands and a changing pharmaceutical market. In contrast, adding drug coverage to Medicare literally took an act of Congress and occurred only in 2003.

Fundamental Error. Believing that politicians and bureaucrats will make better decisions than individuals and business is a fundamental error underlying the essential benefits and numerous other provisions in Obamacare.

There is simply no good solution to these problems short of Congress reversing its policy mistake of granting HHS benefit-setting authority. The better policy is to let consumer demand in a competitive market drive insurance benefit design.

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5. Edmund F. Haislmaier, "Health Care Consolidation and Competition after PPACA," testimony before the Subcommittee on Intellectual Property, Competition and the Internet, Committee on the Judiciary, U.S. House of Representatives, May 18, 2012, http://judiciary.house.gov/hearings/Hearings%202012/Haislmaier%2005182012.pdf (accessed April 9, 2013).