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**BEWARE THE RUSH TO PRESUMPTION, PART A: Material
Omissions in Regulatory Analyses for the Affordable Care Act's
Interim Final Rules**

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Beware the Rush to Presumption, Part A:

Material Omissions in Regulatory Analyses for the Affordable Care Act's Interim Final Rules

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Abstract

Federal agencies issued eight major interim final regulations in 2010 to quickly implement major provisions of the Affordable Care Act. This paper finds that the regulatory impact analyses for these regulations were seriously incomplete, often omitting significant benefits, costs, or regulatory alternatives. Analysis of equity was cursory at best.

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1. Introduction

Scholars of health politics view the enactment of the Affordable Care Act (ACA)¹ as a historic achievement.² Because of the importance of this signature piece of legislation to President Obama’s legacy, one might have expected the highest level of care and diligence would be invested in writing the myriad rules required by the ACA. In her June 2011 testimony before the House Energy and Commerce Committee, U.S. Department of Health and Human Services (HHS) Assistant Secretary for Policy and Evaluation Sherry Glied assured legislators that HHS considered the full range of benefits and costs for these regulations and issued regulations only when benefits exceeded costs. “We’ve already weighed their benefits and costs and shown that their benefits considerably exceed their costs,” she stated.³

Our review of the eight major ACA regulations issued as “interim final rules” in 2010 suggests otherwise. These eight rules encompassed nearly all the major components of the ACA scheduled to go into effect prior to 2014. Executive Order 12866 requires agencies to consider a wide variety of alternative solutions and regulate only after determining that the benefits of the regulation justify its costs (including qualitative factors).⁴ We find, however, that the regulatory impact analyses (RIAs) for these regulations were seriously incomplete, often omitting significant benefits, costs, or regulatory alternatives. Analysis of equity was cursory at best.

In short, the regulatory analyses for these regulations were insufficient to guide decisions or inform the public. Based on these RIAs, we cannot tell whether the regulations will produce the promised benefits for the projected costs, whether alternative approaches could have produced greater benefits at lower costs, or even whether the regulations satisfy any well-defined concept of fairness.

1.1 The Regulations⁵

The ACA required agencies to put significant programs or requirements in place on very short deadlines, often within six months of the legislation’s enactment. The phrase “the Secretary shall”—designating items that require rules from the implementing agencies—appears 1,563

¹ The new health reform law consists of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), enacted March 23, 2010; and the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010). Throughout this paper, the combination of these laws will be referred to simply as the Affordable Care Act (ACA).

² James A. Morone, “Big Ideas, Broken Institutions, and the Wrath at the Grass Roots,” *Journal of Health Politics, Policy and Law* 36, no. 3 (2011): 375–85; Lawrence D. Brown, “The Elements of Surprise: How Health Reform Happened,” *Journal of Health Politics, Policy and Law* 36, no. 3 (2011): 419–27; Mark A. Peterson, “It Was a Different Time: Obama and the Unique Opportunity for Health Care Reform,” *Journal of Health Politics, Policy and Law* 36, no. 3 (2011): 429–36; and Jacob S. Hacker, “The Road to Somewhere: Why Health Reform Happened,” *Perspectives on Politics* 8, no. 3 (2010): 861–76.

³ House Energy and Commerce Committee, *The Views of the Department of Health and Human Services on Regulatory Reform: An Update* (testimony by Sherry Glied), 112th Cong., 1st sess., 2011.

⁴ Executive Order 12866, *Federal Register* 58, no. 190 (October 4, 1993): 51,735–44.

⁵ For the convenience of the reader, we repeat this summary of the regulations in our Part A, Part B, and Part C papers in this series.

times in the final legislation, dwarfing the number of regulations needed for any prior health care reform.⁶ This does not imply that more than 1,500 rules will be issued. More than 40 provisions in the ACA either required or permitted the issuance of implementing regulations.⁷ By the end of 2010, at least 18 final rules (some interim) had been issued.⁸ The Unified Regulatory Agenda issued in December 2010, lists 29 ACA-related actions in the proposed-rule stage along with an additional 24 long-term actions.⁹ Half of these were final rules expected to be issued after taking into account comments related to previously issued interim final rules.¹⁰ In addition to formal regulations, hundreds of guidance documents, frequently asked questions, forms, letters, and other subregulatory documents have been issued that further clarify and refine the rules issued.¹¹

Our analysis focuses on the eight major regulations issued rapidly as interim final rules in 2010. These regulations implement the principal aspects of the ACA that alter health care plans before 2014. All of these regulations were “economically significant” under Executive Order 12866, which governs regulatory analysis by executive-branch agencies; that is, they had costs, benefits, or other economic effects exceeding \$100 million annually.¹²

Table 1 lists and summarizes these major regulations. Six of the eight are “prescriptive” regulations: they affect the terms of contracts between health insurers, insured people, or medical-care providers. They do what most people imagine when they think of regulation. The regulations tell private parties what they must, may, and cannot do. Two of the regulations (shown in italics) outline the terms of spending programs authorized in the health care law. This is not unusual. Many federal agencies issue regulations to implement spending or revenue-collection programs. HHS, for example, annually issues numerous regulations that recalculate the rates Medicare and Medicaid will pay doctors, hospitals, skilled nursing facilities, and other health care providers. These are known as transfer or budget regulations.

⁶ Morone, “Big Ideas, Broken Institutions, and the Wrath at the Grass Roots,” 381.

⁷ Curtis W. Copeland, *Initial Final Rules Implementing the Patient Protection and Affordable Care Act (P. L. 111-148)* (Washington, DC: Congressional Research Service [CRS], 2010), 1.

⁸ *Ibid.*

⁹ Curtis W. Copeland, *The Unified Agenda: Implications for Rulemaking Transparency and Participation* (Washington, DC: CRS, 2009). Long-term actions refer to regulations under development that agencies do not expect to take action on in the next 12 months.

¹⁰ Curtis W. Copeland and Maeve P. Carey, *Upcoming Rules Pursuant to the Patient Protection and Affordable Care Act (P. L. 111-148)*, (Washington, DC: CRS, 2011).

¹¹ For examples, see Center for Consumer Information and Insurance Oversight, HHS, *Regulations and Guidance*, August 8, 2011.

¹² Executive Order 12866, 51,735–44.

Table 1: Summaries of Economically Significant Interim Final Health Care Regulations Issued in 2010

Regulation	HHS RIN*	Agencies	Principal Purpose
<i>Early Retiree Reinsurance Program</i>	0991-AB64	HHS	<i>Establishes a \$5 billion program to subsidize health insurance for early retirees between 2010 and 2014.</i>
Dependent Coverage for Children up to Age 26	0991-AB66	HHS, Labor, Treasury	Requires group health plans and health insurers to allow children up to age 26 to continue on their parents' health insurance plans.
Grandfathered Health Plans	0991-AB68	HHS, Labor, Treasury	Defines the extent of changes group health plans and health insurers can make without forfeiting their right to be considered "grandfathered" health plans exempt from some provisions of the Patient Protection and Affordable Care Act.
Preexisting-condition Exclusions, Limits, and So Forth	0991-AB69	HHS, Labor, Treasury	Establishes rules for group health plans and health insurers that implement various patient protections, such as limiting or eliminating preexisting-condition exclusions, placing dollar limits on benefits, and prohibiting rescissions of insurance coverage.
Coverage of Preventive Services	0938-AQ07	HHS	Requires group health plans and health insurers to cover costs of preventive care.
Claims Appeals and External Review Processes	0991-AB70	HHS, Labor, Treasury	Requires group health plans and health insurers to establish certain internal- and external-review processes for patients' claims and appeals.
<i>Preexisting-condition Insurance Plan</i>	0991-AB71	HHS	<i>Establishes a high-risk health insurance pool program to provide subsidized insurance to people with preexisting conditions until 2014.</i>
Medical Loss Ratio Requirements	0950-AA06	HHS	Requires health insurance issuers to expend a designated percentage of their revenues on medical care or quality-enhancing activities.

Note: Rules in italics are budget regulations.

* U.S. Department of Health and Human Services Regulation Identifier Number.

Source: Authors' notes based on the Notice of Proposed Rulemaking for each regulation. Each notice can be looked up by RIN at www.regulations.gov.

An interim final rule is a regulation that takes effect without first being issued as a proposal for public comment. The Administrative Procedure Act normally requires agencies to publish proposed rules in the *Federal Register*, provide the public with an opportunity to comment on the

proposal, and then issue a final rule that takes public comments into account.¹³ For an interim final rule, the agency writes the rule and announces when it will take effect. The agency may go back and change it later in response to public comment. An agency can issue an interim final rule if it determines that regular notice-and-comment rulemaking is “impractical, unnecessary, or contrary to the public interest.”¹⁴ Previous research finds that agencies are 50 percent more likely to issue an interim final rule when faced with a legislative deadline than when there is no deadline.¹⁵ For these eight economically significant health care regulations, the agencies cited the legislative deadlines to argue that it was impractical to issue proposed rules.

Each of the ACA interim final rules involved provisions of the law that took effect three, six, or nine months after enactment on March 23, 2010. In most cases, the law established deadlines when various provisions took effect but did not explicitly require agencies to issue regulations. The agencies chose to issue regulations rather than carrying out the law via other means, such as guidance or policy documents. Curtis W. Copeland of the Congressional Research Service (CRS) notes that, “the agencies’ use of rulemaking to accomplish the underlying statutory objectives does not appear to be either improper or unusual.”¹⁶

1.2 Principal Findings

Benefit estimates tended to be biased upward. Benefits appear to be overestimated for four regulations and underestimated for three. In general, upward biases in estimated benefits arose due to overestimating the size of the population of individuals or organizations that would benefit from regulation.

Benefit estimates were sometimes theoretically wrong. In some cases, the analyses blur the distinction between transfers (where one part of society transfers resources to another part of society) and efficiency benefits (which increase overall social welfare). Analysis of who gives and who receives transfers is important for evaluating equity, but confusing transfers with benefits just makes the analysis harder to understand.

Cost estimates were biased downward. Costs were underestimated for all eight regulations. In general, downward biases in estimated costs arose due to a failure to consider an entire category of costs. For example, none of the RIAs accounted for efficiency losses associated with the higher taxes required to finance regulations or subsidize some activity, despite the sizable potential magnitude of such costs. Likewise, the RIAs systematically excluded any consideration of moral hazard losses or the administrative costs associated with health-insurance coverage.¹⁷

¹³ Administrative Procedure Act (APA), Pub. L. No. 79-404, 60 Stat. 237 (June 11, 1946).

¹⁴ *Ibid.*, section 553(b).

¹⁵ Jacob E. Gersen and Anne Joseph O’Connell, “Deadlines in Administrative Law,” *University of Pennsylvania Law Review* 156 (2008): 943.

¹⁶ Copeland, *Initial Final Rules Implementing the Patient Protection and Affordable Care Act*, 4.

¹⁷ Moral hazard occurs when people are insured and so take greater risks or use more “free” services than they would have in the absence of such insurance. As its name suggests, administrative costs are the costs incurred by employers or insurance carriers to administer health benefits.

For most regulations, net benefit estimates were biased upward. In selected cases, this bias was large enough to call into question whether the benefits of new rules exceed their costs. However, such instances have no systematic pattern. Regulations with small benefits or costs were as prone to inaccurate estimates as regulations with large benefits or costs. In some cases, the regulations likely would have found that benefits exceed costs even if both had been calculated accurately.

The analyses ignored less-expensive alternatives that would be obvious to most health-policy analysts. For example, the Internal Revenue Service (IRS) has long-established rules defining dependency for tax purposes, and most employers rely on this IRS definition to define who can qualify for dependent coverage through an employer-sponsored health-benefits plan. In establishing rules regarding the extension of coverage to young adults up to age 26, the agency ignored the already tried-and-tested IRS rules and instead required plans offering dependent coverage to extend this to all children up to age 26 regardless of dependency status. The RIA did not even evaluate the IRS definition as an alternative.

Readers should recognize limitations on the scope of this study. This study does not assess whether accurately calculated benefits of these regulations exceed their accurately calculated costs, nor does it assess whether the benefits of issuing these regulations quickly exceeded the cost of doing so. We offer no recommendation on whether these regulations should have been adopted. We do not attempt to identify whether costs or inefficiencies stem from the regulatory decisions the agencies made or the decisions Congress wrote into the law.

The following sections drill down into the sources and methods used in the regulatory analyses for the eight interim final health care regulations. We assess how well the benefit and cost estimates account for categories of benefits and costs that are well known in the economics literature on health care regulation. We also examine how well the regulatory analyses examined plausible alternatives suggested by the academic literature or economic reasoning.

This approach allows us to identify whether an individual regulatory analysis appears to be biased in some fashion, to determine the direction of any such bias, and to provide a qualitative sense of how large this bias might be. A companion purpose is to determine whether there is a pattern to any biases for the regulations as a group. That is, do the interim final health care regulations appear to understate or overstate costs or benefits systematically? If so, does the potential magnitude of such biases appear to be large or small? Do such biases arise due to a failure to consider the full range of regulatory impacts, flaws in how these impacts are measured, or defects in estimating the size of the universe of organizations or individuals who benefit or bear costs related to regulation? Did the analyses include plausible alternatives that might have accomplished the legislation's goals more effectively or at lower cost? If benefit estimates, cost estimates, or analysis of alternatives are systematically biased, then—to the extent that the agency has discretion under the statute to choose among alternatives—low-quality analysis may have biased regulatory decisions.

Appendix 1 lists the questions we asked to assess the quality of each regulatory analysis. Appendix 2 contains a regulation-by-regulation assessment of cost estimates, benefit estimates, and alternatives. Below we summarize the general patterns that emerge.

2. Benefit Estimates

2.1 Potential Benefits of Health Care Reform

Key benefits health care reform could produce include improvements in health, cost reductions, and reductions in financial risk. A good regulatory analysis measures these benefits and estimates their value to consumers and the public.

These regulations could theoretically produce several major categories of benefits.

- Several of the rules mentioned “health benefits,” but none provided a formal estimate of lives saved or life-years saved or sought to quantify what such benefits might be if monetized. Based on what Medicare now pays for kidney dialysis, some have argued the value of a single added year of high-quality life might be as high as \$129,000.¹⁸
- For any tax savings, there would also be reductions in deadweight losses. The deadweight loss of taxation is the value of the reduction in output that occurs because taxes discourage production. Since 1992, the Office of Management and Budget (OMB) has required federal agencies doing cost-benefit analysis of any public investments that do not reduce federal spending to assign a shadow cost of 25 cents to every dollar of expenditures financed out of tax revenues.¹⁹ That is a plausible estimate of the average amount of lost output related to federal taxes, but because the excess burden increases in proportion to the square of tax rate, the marginal loss for each added dollar of tax revenue is much higher. A recent estimate shows that for federal taxes the marginal reduction in deadweight losses for every dollar of reduced taxes is approximately 44 cents.²⁰ It is worth noting that while deadweight-loss calculations have been used in evaluating major health programs, such as national health insurance,²¹ government-financed health spending in general,²² Medicare,²³ and Medicare Part D,²⁴ it is *not* standard practice in

¹⁸ Stefanos A. Zenios, Glenn M. Chertow, and C. P. Lee, “An Empiric Estimate of the Value of Life: Updating the Renal Dialysis Cost-Effectiveness Standard,” *Value on Health* 12, no. 1 (2008): 80–87.

¹⁹ Office of Management and Budget, *Circular A-94: Guidelines and Discount Rates for Benefit-Cost Analysis of Federal Programs*, 1992.

²⁰ Christopher J. Conover, “Congress Should Account for the Excess Burden of Taxation,” Cato Institute, *Policy Analysis* no. 669 (2010).

²¹ Edgar K. Browning and William R. Johnson, “Taxation and the Cost of National Health Insurance,” in *National Health Insurance: What Now, What Later, What Never?* ed. M. V. Pauly (Washington, DC: American Enterprise Institute Press, 1980); P. M. Danzon, “Hidden Overload Costs: Is Canada’s System Less Expensive?” *Health Affairs* 11 (Spring 1992): 21–43; and Joseph Newhouse, “Medical Care Costs: How Much Welfare Loss?” *Journal of Economic Perspectives* 6, no. 3 (Summer 1992): 3–21.

²² Katherine Baicker and Jonathan S. Skinner, “Health Care Spending Growth and the Future of U.S. Tax Rates” (National Bureau of Economic Research [NBER] Working Paper Series no. 16772, Cambridge, MA, 2011); and Congressional Budget Office, *Long-Term Projections for Health Care Spending* (Washington, DC: U.S. Congress, 2007).

RIAs to include a measure of deadweight losses when estimating the benefits or costs of regulations. Nevertheless, such losses are very real and well-recognized in the literature on social-welfare economics. Thus, while agency analysts might be excused for following standard practice by ignoring such costs, they are included in the analysis that follows in the interests of accuracy: their magnitude simply is too large to ignore, especially for budget regulations involving the allocation of billions of taxpayer dollars.

- Any kind of insurance creates moral hazard—a risk that individuals will engage in wasteful spending or other behavior because the insurance company is covering part of the cost. Several of these regulations seek to expand insurance coverage to new services or individuals. For every dollar of expanded coverage, there unavoidably will be moral-hazard losses, that is, care whose cost exceeds its dollar value to patients. For those on Medicare, such excess utilization has been estimated to be 28 percent of spending.²⁵ For the Medicare prescription-drug benefit added in 2003, moral hazard has been roughly estimated at 41 percent of the incremental increase in spending induced by expanded coverage.²⁶ Based on the results from the RAND Health Insurance Experiment in 1988, the equivalent moral-hazard losses for a typical, privately insured individual likely amount to only 10 percent of spending.²⁷ Another form of moral hazard relates to individual willingness to engage in preventive activities or health-promoting behavior. There is some evidence that Medicare coverage reduces prevention and increases unhealthy behaviors among elderly men;²⁸ this is confirmed in other work showing that Medicare generates small levels of moral hazard in alcohol consumption, smoking, and exercise among the elderly.²⁹ The grandfathering rules allow plans to avoid adopting more costly coverage. Such coverage would have been associated with greater moral hazard. Therefore, the avoidance of this increase in moral-hazard costs should count as a benefit of this regulation.
- Financial-risk reduction is another important benefit associated with health insurance. This refers not just to the risk of bankruptcy, but also to the risk of any appreciable financial loss as a result of large health care expenditures. Risk-averse individuals are willing to pay a risk premium above and beyond an actuarially fair premium (one in which the premium payment matches the individual's expected paid benefits) to avoid the financial uncertainty associated with medical expenditures. Here again, the benefit is

²³ Martin Feldstein, "Prefunding Medicare," (NBER Working Paper Series no. 6917, Cambridge, MA, 1999).

²⁴ Gary V. Engelhardt and Jonathan Gruber, "Medicare Part D and the Financial Protection of the Elderly" (NBER Working Paper Series no. 16155, Boston College, Center for Retirement Research, 2010).

²⁵ Amy Finkelstein and Robin McKnight, "What Did Medicare Do (and Was It Worth It)?" (NBER Working Paper Series no. 11609, Cambridge, MA, 2005).

²⁶ Mark V. Pauly, "Medicare Drug Coverage and Moral Hazard," *Health Affairs* 23, no. 1 (2004): 113–22.

²⁷ Emmet B. Keeler et al., *The Demand for Episodes of Medical Treatment in the Health Insurance Experiment* (Santa Monica, CA: RAND Corporation, 1988).

²⁸ Dave Dhaval and Robert Kaestner, "Health Insurance and Ex Ante Moral Hazard: Evidence from Medicare" (NBER Working Paper Series no. 12764, Cambridge, MA, 2006).

²⁹ Ahmed W. Khwaja, "The Dynamic Trade-off between Medical Expenditure Insurance, Moral Hazard, and Mortality Risk: A Life Cycle Analysis of the Effects of Medicare on Individual Incentives and Outcomes" (working paper, Duke University, Durham, NC, 2005).

mentioned in some RIAs but never quantified. For the elderly, the value of such risk reduction has been estimated to equal about 29 percent of Medicare spending.³⁰ Because so much of high-end costs for the uninsured are subsidized (for example, hospital uncompensated care), the estimated risk-reduction benefits of coverage for the average uninsured individual have been estimated to be only \$40–\$80 in 2001.³¹ Based on the rise in per-capita U.S. health spending since then, these figures are likely about \$67–\$134 in 2011.³²

The health care regulations also give rise to significant transfers of resources from some individuals to others. The distributional impact of a regulation arises from how benefits and costs are distributed across selected subpopulations of policy interest, such as small firms, minority populations, future generations, low-income households, children, or the elderly.³³ Circular A-4 instructs agencies to provide a separate description of the distributional effects of a rule rather than embedding this in the discussion of benefits or costs.³⁴ Distributional effects can usually be quantified if the underlying benefits and costs have been quantified.

In some cases, the health care RIAs separately identify transfers created by the interim final regulations. In other cases, the analysis generates confusion by labeling transfers as transfer benefits, which seems to imply that a mere transfer of resources is supposed to count as a benefit.

For example, some of the RIAs mistakenly included uncompensated-care savings as a benefit of expanded health insurance coverage rather than a transfer. Based on a careful study of all sources of financing health care for the uninsured (and a parallel analysis of how “uncompensated” costs are actually financed by hospitals), nearly two-thirds of care received by uninsured individuals is uncompensated.³⁵ Roughly one-quarter of this is shifted to private insurers, amounting to about 1 percent of private-insurance premiums, with the balance representing costs to taxpayers.³⁶ But this merely shifts who pays for a given medical service. In contrast to moral hazard, which represents additional care with costs that exceed the value to the patient, changes in uncompensated care are simply a transfer that do not affect the total amount of resources available to society. That said, transfers can impose real costs on society because they may alter behavior. Any social-welfare gains (for example, “increases in consumer surplus,” in the

³⁰ Finkelstein and McKnight, “What Did Medicare Do (and Was It Worth It)?”

³¹ Wilhelmine Miller, Elizabeth Richardson Vigdor, and Willard G. Manning, “Covering the Uninsured: What Is It Worth?” *Health Affairs Web Exclusive* (2004): W4-157–W4-167.

³² Calculated from data reported in Centers for Medicare and Medicaid Services, “National Health Expenditure Projections 2009–2019,” September 2010, <http://www.cms.gov/NationalHealthExpendData/downloads/NHEProjections2009to2019.pdf>.

³³ Scott Farrow, “Incorporating Equity in Regulatory and Benefit-Cost Analysis” (paper presented before the Society for Risk Analysis and Resources for the Future, “New Ideas for Risk Regulation” conference, Washington, DC, June 22–23, 2009); and Environmental Protection Agency, *Guidelines for Preparing Economic Analyses* (Washington, DC: Office of the Administrator, 2000).

³⁴ Office of Management and Budget, *Circular A-4* (September 17, 2003), http://www.whitehouse.gov/omb/circulars_a004_a-4.

³⁵ Jack Hadley, John Holahan, Teresa Coughlin, and Dawn Miller, *Covering the Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2008).

³⁶ Thomas P. Miller, “Healthcare Dreams, Healthcare Realities,” *The American*, July 16, 2009.

parlance of economists) or social-welfare losses (that is, deadweight losses) can and should be taken into account in the benefit and cost components of an RIA.

We examined whether each of the RIAs took these benefits into account where relevant, recognizing that in theory there may have been benefits excluded from the RIA that we, too, may have overlooked. We do believe we have accounted for the largest and most obvious such benefits. Moreover, since the same is true of our assessment of costs, we do not believe we ourselves have introduced a bias through this closer scrutiny. Nevertheless, an inherent limitation on our analysis is that we have not accounted and cannot account for “unknown unknowns.”

2.2 Biases in Benefit Estimates

None of the RIAs both quantified and monetized benefits. Unfortunately, this is not unusual. For the 66 major rules issued by the federal government in fiscal year 2010, only 20 quantified and monetized benefits.³⁷ Nevertheless, we can approximate the magnitude of quantified benefits based on information provided in the RIA about the number of people or organizations that would benefit or other information provided about the magnitude of selected benefits in nondollar terms. Using such information, we found the RIAs were more likely to overstate the magnitude of benefits than understate them. In some cases, benefits are overstated by as much as a factor of four or five. It appears that at least four RIAs overstated benefits and three understated benefits. However, even in cases where benefits were understated, there often was a corresponding understatement of costs that more than offset the underestimate of benefits. The net effect of this pattern is a bias favoring the regulations. (Citations for the estimates provided in this section are in Appendix 2.)

- **Early Retiree Reinsurance Program:** This rule fails to include health benefits (a relatively minor omission), a reduction in deadweight losses due to tax-financed uncompensated care (unlikely to exceed 8 percent of program spending), and financial risk-reduction benefits potentially amounting to 29 percent of program costs.³⁸ This is more than offset by the failure to consider the possibility of crowd-out: that most subsidies will go to plans that would have existed even without the subsidy (thereby crowding-out the intended beneficiaries, that is, those in plans that otherwise would have been terminated without this rule). Based on evidence from the Medicare Part D (drug-benefit) program, such crowd-out could be as high as 75 percent of spending,³⁹ meaning actual benefits would be only one-fourth as large as estimated in the RIA. Admittedly, Medicare Part D is quite different from the early retiree reinsurance program in that, in the former case, subsidies went to individuals: empirical evidence shows that crowd-out was largely the consequence of individual decisions to drop their previous prescription-drug coverage rather than decisions by employers to drop such prescription-drug plans in

³⁷ Office of Information and Regulatory Affairs (OIRA), *2011 Report to Congress on the Benefits and Costs of Federal Regulations and Unfunded Mandates on States, Local, and Tribal Entities* (Washington, DC: OMB, 2011), 3.

³⁸ Finkelstein and McKnight, “What Did Medicare Do (and Was It Worth It)?”

³⁹ Gary V. Engelhardt and Jonathan Gruber, “Does Medicare Part D Protect the Elderly from Financial Risk?” (working paper, Boston College, Center for Retirement Research, 2011).

light of the newly available Medicare drug subsidies.⁴⁰ However, Medicare Part D included subsidies to employers designed expressly to discourage such dropping of coverage. Altogether, accurately calculated benefits might have been about one-third as high as estimated.⁴¹

- **Dependent Coverage for Children up to Age 26:** This rule fails to include reduced deadweight losses associated with reductions in tax-financed uncompensated care (for example, trips to the emergency room that are not paid for by the patient), amounting to \$175 million a year, or about 8 percent of the premium costs of expanded dependent coverage for young adults.⁴² The RIA also fails to account for risk-reduction benefits of no more than \$67–\$134 per enrollee, which is roughly 2–4 percent of premium costs.⁴³ Thus, as a rough approximation, the RIA understated benefits by an amount equal to roughly 10 percent of premiums for previously uninsured individuals (about \$218 million annually).⁴⁴
- **Grandfathered Health Plans:** This rule fails to include benefits of less-expensive coverage, including decreased moral hazard, lower administrative costs, and lower efficiency losses related to tax subsidies for employer-sponsored insurance amounting collectively to perhaps \$1.6 billion in 2011 alone.
- **Preexisting-condition Limitations:** Based on the actual experience of the fraction of medically uninsurable individuals who obtain coverage through state high-risk pools, the number of children who will benefit appears to be overstated by a factor of three to five.
- **Coverage of Preventive Services:** The selective review of the literature provided in the RIA gives the uninformed reader a false impression of the extent to which preventive

⁴⁰ Helen Levy and David Weir, “Take-up of Medicare Part D: Results from the Health and Retirement Study” (NBER Working Paper Series no. 14692, Cambridge, MA, 2009).

⁴¹ That is, inclusion of risk-reduction benefits would have inflated the benefit calculation by 29 percent, accounting for deadweight losses would have added 8 percent, but accounting for crowding out would have reduced them by 75 percent (129 percent x 108 percent x 25 percent = 35 percent).

⁴² Just over three-fifths of uninsured medical care is uncompensated; average annual spending for uninsured nonelderly adults is 39 percent of spending by their privately insured counterparts; three-quarters of uncompensated care is publicly financed (see Hadley, Holahan, Coughlin, and Miller, *Covering the Uninsured in 2008*) and deadweight losses amount to 44 percent of federal taxes (Conover, “Congress Should Account for the Excess Burden of Taxation”). $(0.61) \times 0.39 \times 0.75 \times 0.44 = 8.0$ percent x \$3380 x 650,000 previously uninsured adults = \$174.8 million.

⁴³ The risk premium is the amount individuals are willing to pay above an actuarially fair premium amount to avoid facing uncertain future medical expenses. Because so much of high-end costs for the uninsured are subsidized (for example, hospital uncompensated care), the estimated risk premium for the average uninsured individual was estimated to be only \$40–\$80 in 2001 (Miller, Vigdor, and Manning, “Covering the Uninsured.”) Based on the rise in per-capita U.S. health spending since then, these figures likely are about \$67–\$134 in 2011, but presumably somewhat lower for young working adults under age 26. Table 5 in the RIA estimates the incremental premium cost per individual coverage will be \$3,380 in 2011. $\$67/\$3,380 = 2.0$ percent.

⁴⁴ \$174 million + $\$67/\$3,380 \times 650,000 = \$218$ million; this equals 9.9 percent of additional premium costs for previously uninsured individuals gaining coverage.

health services are cost-saving. Literature reviews consistently have concluded that most clinical preventive services typically are *not* cost-saving.⁴⁵

- **Claims Appeals and External Review Processes:** The analysis does not mention either increased trust in the health insurance system or greater fairness in how claims are adjudicated across different types of plans, but it is difficult to attach a dollar value to such intangible benefits. Moreover, it is conceivable that this rule or other components of the law would *decrease* trust in the health insurance system, a factor not taken into account in the present analysis.
- **Preexisting-condition Insurance Plan:** The analysis excludes the beneficial impact of a high-risk pool in reducing premiums in the individual market (by roughly 14 percent), thereby potentially resulting in greater numbers of individuals with insurance. The RIA also greatly overstates the magnitude of implied health benefits by citing two observational studies indicating mortality risk is 25 percent higher among the uninsured while ignoring a comprehensive literature synthesis suggesting there are no or very modest health benefits associated with being insured.⁴⁶ The RIA also overstates projected reductions in bankruptcy risk by as much as a factor of eight. Finally, the analysis incorrectly counts reductions in uncompensated care as a benefit rather than a transfer. It compounds this error by implicitly assuming *all* uncompensated-care costs are borne by private patients when the best evidence suggests that three-quarters are publicly financed.⁴⁷

3. Cost Estimates

3.1 Potential Costs of Health Care Reform

Many major categories of costs are simply the obverse of benefits—that is, adverse impacts that would occur if regulation led to an increase in taxes or the number of uninsured:

- Costs related to an increase in the number of uninsured would include forgone health benefits and financial-risk reduction.

⁴⁵ Alan Monheit et al., “State Policies Expanding Dependent Coverage to Young Adults in Private Health Individual Plans” (presented at the Academy Health State Health Research and Policy Interest Group Meeting, Chicago, IL, 2009); Finkelstein and McKnight, “What Did Medicare Do (and Was It Worth It)?”; William H. Dow, “The Introduction of Medicare: Effects on Elderly Health,” unpublished mimeo cited in Finkelstein and McKnight, “What Did Medicare Do (and Was It Worth It)?” 2002, 4; David Card, Carlos Dobkin, and Nicole Maestas, “The Impact of Nearly Universal Insurance Coverage on Health Care Utilization and Health: Evidence from Medicare” (NBER Working Paper Series no. 10365, Cambridge, MA, 2004); and Christopher J. Conover, “How Health Affects the Bottom Line for Businesses and Employers” (presentation at North Carolina Legislative Black Caucus Foundation Health Summit, Raleigh, NC, 2011).

⁴⁶ Helen Levy and David Meltzer, “What Do We Really Know about Whether Health Insurance Affects Health?” in *Health Policy and the Uninsured: Setting the Agenda*, ed. C. McLaughlin (Washington, DC: Urban Institute Press, 2004).

⁴⁷ Hadley et al., *Covering the Uninsured in 2008*.

- Apart from the transfer of resources from taxpayers to the government, all tax increases unavoidably would include deadweight losses.
- Most expansions in insurance coverage (number covered or increases in the generosity of coverage, such as through added benefits or reduced cost-sharing) unavoidably will be associated with some level of moral-hazard losses and administrative costs. The average administrative cost associated with private group health insurance is 11.1 percent for small groups (2–50 employees) and 7.0 percent for large groups.⁴⁸
- All regulation has some level of public administrative costs related to monitoring and enforcement, along with corresponding costs related to compliance. In some instances, compliance costs may be borne by public agencies, such as state and local governments subject to a rule. The RIAs invariably account for these costs in some fashion. We found no instance in which they were completely ignored, but the methodology for calculating these may result in systematically under or overstating such costs.
- Crowding out is another common consequence of budget regulations designed to expand health insurance coverage (for example, the Early Retiree Reinsurance Program and Preexisting-condition Insurance Plan). Crowd-out occurs whenever publicly financed coverage displaces private coverage that would have existed otherwise. For example, the Medicare Retiree Drug Subsidy program was found to result in a 75 percent crowd-out of both prescription-drug insurance coverage and prescription-drug expenditures of those ages 65 and older.⁴⁹ Instead of extending new drug coverage to those who otherwise would have lacked it, three-quarters of program spending went to covering costs that previously were being covered through voluntarily provided private coverage or out-of-pocket payments. In such instances, the program was merely transferring resources from taxpayers to individuals able and willing to finance their own prescription-drug costs rather than preserving drug-coverage plans that would have disappeared without the subsidy.

3.2 Biases in Cost Estimates

Once again, we cannot claim to offer an exhaustive evaluation of the cost components that should have been considered, but we have attempted to take into account all major obvious categories of costs. The RIAs were more likely to understate the magnitude of costs than to overstate them. All eight regulations appear to have understated the costs. In some cases, costs are understated by billions of dollars. The net effect of this pattern is to further contribute to the bias favoring regulation. (As with benefits, calculation methods and full citations to sources are in Appendix 2.)

- **Early Retiree Reinsurance Program:** This fails to account for deadweight losses of taxation amounting to 44 percent of estimated program costs (\$2.2 billion), moral-hazard

⁴⁸ Douglas B. Sherlock, *Administrative Expenses of Health Plans* (Gwynedd, PA: Sherlock Company, 2009).

⁴⁹ Engelhardt and Gruber, “Does Medicare Part D Protect the Elderly from Financial Risk?”

losses amounting to 28 percent of spending (up to \$5.6 billion), and administrative costs amounting to 7.0–11.1 percent of spending (\$1.4–\$2.2 billion). Together, these missing costs amount to roughly \$9.2–\$10 billion over four years (compared to the RIA-estimated annual cost total of \$39.8 million).

- **Dependent Coverage for Children up to Age 26:** The analysis treats premium costs as transfers, but this fails to account for moral-hazard losses equal to roughly 7 percent of health benefits, administrative costs equal to about 7.0–11.1 percent of premiums, and deadweight losses associated with the tax subsidy for employer-provided coverage amounting to approximately 13 percent of premiums. Together, these missing costs amount to roughly \$0.9 to \$1.0 billion a year (compared to the RIA-estimated cost total of \$10.4 million).
- **Grandfathered Health Plans:** This rule allows grandfathered health plans to avoid offering some of the expanded coverage mandated in the legislation. Thus, the benefits that do not occur because of this forgone coverage are a cost associated with this regulation. Because the RIA fails to account for these forgone benefits, costs appear to have been underestimated by several tens of millions of dollars. These forgone benefits, such as improved health and reduced financial risk, are distinct from the inherent costs associated with such coverage, such as moral-hazard and administrative costs.
- **Preexisting-condition Limitations:** The analysis treats premium costs as transfers, but this fails to account for the costs of moral hazard (7.2 percent of premiums), administrative costs (7.0–11.1 percent for group coverage and 16.4 percent for nongroup coverage), and tax-related efficiency losses related to tax subsidies (14.4 percent of premiums for employer-provided coverage).
- **Coverage of Preventive Services:** Costs of incremental use associated with expanded coverage are calculated using premiums, but the fraction of premiums used to pay benefits is actually a transfer. The RIA fails to calculate the costs of moral hazard (7.2 percent of premiums), administrative costs (7.0–16.4 percent), and tax-related efficiency losses related to tax subsidies (14.4 percent of premiums for employer-provided coverage).
- **Claims Appeals and External Review Processes:** The analysis fails to include administrative costs ranging from 7.0 percent for large groups to 16.4 percent for nongroup claims and deadweight losses associated with tax subsidies for employer-provided health benefits (14.4 percent of employer-sponsored insurance [ESI] premiums).
- **Preexisting-condition Insurance Plan:** The analysis fails to consider administrative costs borne by states (\$600–\$700 million), deadweight losses associated with the federal tax exclusion (\$2.2 billion), and moral-hazard losses of up to \$3.5 billion over three and one-half years.

- **Medical Loss Ratio (MLR):** The analysis fails to consider that some increases in medical spending may represent moral hazard or fraud, and hence they would count as waste rather than a benefit. Third-party payment creates moral hazard in general, but in addition, this rule may encourage an even greater-than-normal level of moral hazard or fraud either because the rule discourages investment in activities that might reduce claims or because it will encourage looser standards that result in approval of claims that would have been denied under current standards. For example, as written, a plan that was spending \$15 in administration for every \$100 in premiums would be in violation of the minimum required ratio if it elected to spend another \$1 to prevent \$5 in fraudulent claims. (That is, because \$5 in fraudulent claims never would be paid, its MLR would drop from 85 percent to 83 percent = $\$16/\96 , where $\$96 = \100 in prior premiums plus \$1 in fraud prevention minus \$5 in averted claims).

4. Net Benefit Estimates

In all of the RIAs examined, analysts concluded that the benefits of a regulation outweighed its costs even though there was no instance in which this claim was demonstrated empirically with quantitative estimates of benefits and costs. Unfortunately, this is not unusual: in their review of 34 new regulations issued in 2002, Hahn and Litan found that 70 percent failed to provide quantitative information on net benefits.⁵⁰ However, for at least three ACA rules, more accurate measurement of benefits and costs would almost certainly have reversed the presumption that benefits exceeded costs:

- **Early Retiree Reinsurance Program:** When the net effect of overestimated benefits and underestimated costs is taken into account, the benefits of this regulation no longer appear to exceed its costs. That is, benefits more likely will be only one-third as large as implied in the RIA, while costs were understated by about \$9–\$10 billion over four years.
- **Dependent Coverage for Children up to Age 26:** The RIA failed to demonstrate that lack of more extensive coverage for dependent adults under age 26 could be attributed to a market failure. Absent such a market failure, requiring plans to cover individuals who would not be covered voluntarily is, by definition, welfare reducing. Thus, on theoretical grounds alone, it is difficult to see how impartial analysts could conclude this rule had net benefits. Moreover, when the net effect of underestimated benefits (amounting to about one-twentieth of estimated premiums) and underestimated costs (21–23 percent of estimated premiums) is taken into account, the benefits of this regulation no longer appear to exceed its costs. That is, benefits appear understated by \$218 million overall, while costs were understated by at least \$875 million annually.
- **Preexisting-condition Insurance Plan:** When the net effect of overestimated benefits (\$1.5–\$3.0 billion) and underestimated costs (\$6.3 billion) over three and one-half years is taken into account, the benefits of a federally subsidized high-risk pool no longer

⁵⁰ Robert W. Hahn and Robert Litan, “Counting Regulatory Benefits and Costs: Lessons for the U.S. and Europe,” *Journal of International Economic Law* 8, no. 2 (2005): 483.

appear to exceed its costs. For benefits to have exceeded costs, net benefits per enrollee would have had to exceed \$15,750 in the original analysis; this is implausibly high given that the RIA estimates total spending per enrollee will be only \$15,000.

There were two other instances in which the elimination of biases in estimating benefits or costs at least raised legitimate questions about whether the net benefits of a regulation outweighed its costs:

- **Preexisting-condition Limitations:** Ignored net costs amount to about 28 percent of increased premiums or \$2.4 billion in a single year. The analysis provides no quantitative estimate of whether the benefits from expanded coverage would exceed this amount, so it is uncertain whether benefits exceed costs. That is, unless benefits originally exceeded costs by more than 28 percent, a more accurate accounting of costs may have concluded the rule was not cost effective.
- **Coverage of Preventive Services:** Ignored net costs amount to at least 20 percent of premiums. The analysis provides no quantitative estimate of whether the benefits from expanded coverage would exceed this amount, so it is uncertain whether benefits exceed costs. The analysis does not provide a convincing explanation for why insurers would not cover highly cost-effective preventive services in the absence of subsidies. If the benefits of such coverage exceeded its costs by 22 percent, this failure becomes that much more puzzling.

This does not imply that the remaining three regulations definitively passed a cost-benefit test. Because none of these regulations formally quantified the aggregate benefits of regulation into a single monetized amount, it is impossible to say with certainty whether benefits exceed costs. However, since the grandfathered health plans RIA underestimated benefits to a greater degree than it underestimated costs, the rule probably met a cost-benefit test. In contrast, while there was no apparent bias in estimating costs or benefits for the MLR rule, as explained later, the agency appears to have rejected a rule that could have provided an even greater net benefit.

There is also a great deal of uncertainty in measuring such benefits and costs, a point both conceded and extensively documented in most of the RIAs examined. These uncertainty bounds are large enough that a rule might pass a cost-benefit test using the high-end estimate of benefits in conjunction with a lower-bound estimate of costs, whereas it would fail such a test in an obverse assessment. This is not that unusual. In the words of two long-time scholars of regulation, “Most regulations either do not provide enough information to compare costs and benefits, or there is a large enough range of uncertainty in the agencies’ estimates to put the regulation in a grey area, where they neither unambiguously pass nor fail.”⁵¹ While much of this uncertainty is unavoidable, it certainly is possible to reduce the presence or magnitude of bias in whatever estimates are produced.

⁵¹ Ibid.

Our discussion of whether the RIAs show that these regulations pass a benefit-cost test is not intended as a normative claim that the regulations should have been adopted only if monetized benefits exceeded monetized costs. Ours is a factual claim. Section 1(b) of Executive Order 12866 clearly states that agencies should adopt a regulation “only upon a reasoned determination that the benefits of the intended regulation justify its costs.”⁵² Agencies can consider factors that are not quantified or monetized, but this is not a license for sloppy analysis. We find it hard to believe that an agency could make the “reasoned determination” required in the executive order if the analysis of benefits and costs is incomplete or biased. This review has demonstrated convincingly that such bias exists and that its magnitude too often is disturbingly large. As one scholar has noted, “The ACA’s effectiveness in achieving its goals depends on the executive branch maintaining a steady hand in countless regulatory determinations required under the new law.”⁵³ We can do better.

⁵² Executive Order 12866, section 1(b).

⁵³ Thomas L. Greaney, “The Affordable Care Act and Competition: Antidote or Placebo?” *Oregon Law Review* 89 (2011): 811–45.

Table 2: Assessment of Quality of Interim Final Health Care Regulations in 2010

Regulation	Annual Transfers (2010 dollars)	Annual Costs (2010 dollars)	Bias in Cost Estimate	Annual Benefits*	Bias in Benefit Estimate	Net Assessment
<i>Early Retiree Reinsurance Program</i>	\$1.25 billion	\$39.8 million	↓↓↓↓↓	Not estimated	↑↑	Probably not cost beneficial
Dependent Coverage for Children up to Age 26	\$5.275 billion (\$3.48–\$6.895 billion)	\$10.4 million	↓↓↓↓	Qualitative: Decreased cost-shifting, healthier population, greater job mobility	↓↓↓	Probably not cost beneficial
Grandfathered Health Plans	Qualitative: potential transfers from premium payers to service users; potential transfers from grandfathered to nongrandfathered plans	\$24.7 million	↓↓	Qualitative: Slower premium growth, continuity of coverage, greater plan certainty	↓↓↓↓↓	Uncertain
Preexisting-condition Exclusions, Limits, et al.	Qualitative: “small” transfer from premium payers in group market to those obtaining increased protections	\$4.9 million	↓↓↓↓↓	Qualitative: Improved health outcomes, improved worker productivity, reduced financial strain	↑↑	Possibly not cost beneficial
Coverage of Preventive Services	Qualitative: transfer of out-of-pocket costs to group health plans/insurers; “small” transfer from those using less preventive services to those using more	Qualitative: Increased costs due to higher use	↓↓↓↓↓	Qualitative: Reduced morbidity and mortality, increased productivity and savings from lower health costs	↑↑↑↑↑	Possibly not cost beneficial
Claims Appeals and External Review Processes	Transfer from plans/issuers to those receiving payments for denied benefits (amount not quantified)	\$51.6 million	↓↓	Qualitative: Benefits consistent with terms of plans	↓↓	Uncertain
<i>Preexisting-condition Insurance Plan</i>	\$1.43 billion	\$1.939 million	↓↓↓↓↓	Qualitative: Improved health outcomes, improved worker productivity	↑↑↑	Probably not cost beneficial
Medical Loss Ratio Requirements	\$287.8–\$310 million from shareholders/stakeholders to enrollees	\$34.7–\$37.4 million	↓↓↓↓	Qualitative: Increased transparency, increased quality of health care, improved health	0	Uncertain

*In cases where benefits are not quantified, the rule implies benefits must at least equal or exceed the amount of costs shown, or else the agency would have rejected the rule. Therefore, for purposes of evaluating the amount of bias, it is assumed that benefits just slightly exceed costs.

Note: ↑ denotes upward bias; ↓ denotes downward bias.

One arrow = bias under \$10 million. Two arrows = bias \$10–\$100 million. Three arrows = bias \$100–\$500 million.

Four arrows = bias \$500 million–\$1 billion. Five arrows = bias \$1 billion or more.

Rules in italics are budget regulations.

Source: Information on annual transfers, costs and benefits calculated by the agencies is from Curtis W. Copeland, *Initial Final Rules Implementing the Patient Protection and Affordable Care Act (P. L. 111-148)* (Washington, DC: CRS, 2010), Table 2. Columns estimating biases and net assessment are based on the authors’ calculations reported in the text of this paper.

5. Analysis of Alternatives

Another perspective on the quality of agency analysis and decisions emerges when we assess the alternatives the agencies considered. This provides some indication of whether agencies actually sought the most effective or least costly alternatives or merely crafted an analysis to support decisions made for other reasons.

Executive Order 12866 and OMB guidance clearly indicate that agencies should analyze a wide variety of alternatives. The order states that the RIA should include “an assessment, including the underlying analysis, of costs and benefits of potentially effective and reasonably feasible alternatives to the planned regulation identified by the agencies or the public (including improving the current regulation and reasonably viable nonregulatory actions), and an explanation of why the planned regulatory action is preferable to the identified potential alternatives.”⁵⁴ OMB Circular A-4 states, “You generally should analyze at least three options: the preferred option; a more stringent option that achieves additional benefits (and presumably costs more) beyond those realized by the preferred option; and a less stringent option that costs less (and presumably generates fewer benefits) than the preferred option.”⁵⁵ Even in cases where Congress appears to have tied the hands of the regulatory agency (for example, the Early Retiree Insurance Program explicitly mandates that the program subsidize 80 percent of an individual’s medical bills between \$15,000 and \$90,000), the agency has the prerogative to analyze alternatives outside the scope of current law:

You should also discuss the statutory requirements that affect the selection of regulatory approaches. If legal constraints prevent the selection of a regulatory action that best satisfies the philosophy and principles of Executive Order 12866, you should identify these constraints and estimate their opportunity cost. Such information may be useful to Congress under the Regulatory Right-to-Know Act.⁵⁶

An agency cannot estimate the opportunity cost of legislative constraints unless it has analyzed the effects of alternatives outside the scope of the legislation. Such analyses might either invite Congress to reconsider the approach hardwired into a statute or induce the public or interest groups to lobby Congress to make such alterations.

In general, we found that the analyses ignored less-expensive alternatives that would be obvious to most health policy analysts:

- **Dependent Coverage for Children up to Age 26:** The IRS has long-established rules defining “dependency” for tax purposes, and most employers rely on this IRS definition to define who can qualify for dependent coverage through an employer-sponsored health benefits plan. In its analysis of rules regarding the extension of coverage to young adults up to age 26, the agency ignored the already tried-and-tested IRS rules to require plans

⁵⁴ Executive Order 12866, section 6(a)(3)(C)(iii).

⁵⁵ OMB, *Circular A-4*.

⁵⁶ *Ibid.*, 17.

offering dependent coverage to extend this to all children up to age 26 regardless of dependency status even though the statute gave the secretary of HHS complete discretion with respect to how such dependents should be defined.

- **Grandfathered Health Plans:** These rules prohibited changes in coinsurance but allowed regulated changes in other forms of cost-sharing, such as copayments. The decision to entirely prohibit changes in coinsurance appears arbitrary and capricious. If copays can rise by medical inflation plus 15 percent, what is the rationale for limiting coinsurance changes to medical inflation plus 0 percent? About one-fifth of workers in employer-sponsored health plans nevertheless rely on coinsurance or a combination of coinsurance and copays for physician office visits.⁵⁷ Regulators apparently did not even consider an alternative that would have treated such plans similarly. The departments analyzed but declined to adopt a much more flexible actuarial equivalence standard that would have better met the letter and spirit of the president’s oft-repeated pledge, “If you like your health care plan, you can keep your health care plan.”⁵⁸
- **Preexisting-condition Limitations:** The departments missed an opportunity to estimate a significant opportunity cost of a legislative restriction: Congress’s decision to eliminate annual limits on coverage. In every other major domain of insurance—automobile, homeowner’s, personal liability, and so forth—annual limits on coverage are a standard feature.⁵⁹ Above a certain level—which will vary from individual to individual—the incremental benefits of coverage for extremely rare events simply are not worth the added expense. The RIA offers no evidence that market failure, rather than heterogeneous preferences, lies behind the current patterns of coverage.
- **Coverage of Preventive Services:** The agencies did not consider mandating a smaller range of preventive services, such as only those that produce net cost savings or produce health improvements at some specified cost per outcome. Since a small minority of preventive services produce net cost savings and a sizeable number produce health improvements only at very high cost, such alternatives could have accomplished much of the desired outcome at lower cost.
- **Claims Appeals and External Review Processes:** No alternatives were considered at all. This is an especially curious omission given that the departments are no doubt aware of at least three alternative models: state external review laws that are less restrictive than the proposed regulations, state external review laws that are more restrictive than the proposed regulations, and internal claims review processes mandated by the Employee Retirement Income Security Act (ERISA) for self-insured plans. A side-by-side

⁵⁷ Kaiser Family Foundation and Health Research and Educational Trust (KFF/HRET), *Employer Health Benefits 2011 Annual Survey*, 2011, exhibit 7.22.

⁵⁸ “Barack Obama Promises You Can Keep Your Health Insurance, but There’s No Guarantee,” PolitiFact.com, August 11, 2009, <http://www.politifact.com/truth-o-meter/statements/2009/aug/11/barack-obama/barack-obama-promises-you-can-keep-your-health-ins>.

⁵⁹ David M. Cutler and Richard Zeckhauser, “Extending the Theory to Meet the Practice of Insurance” (working paper, Harvard University and NBER, Cambridge, MA, 2004).

comparison of benefits and costs would have revealed which approaches accomplish the legislative objectives at least cost.

- Medical Loss Ratios:** This allows insurers to count antifraud expenditures as a contribution to the MLR only if those expenditures lead to recoveries. If a plan spends \$15 for every \$100 in premiums, it meets the minimum MLR requirement of 85 percent. If it elected to spend an additional \$1 for a fraud-prevention program that saved \$5, its MLR would drop to 83 percent (\$16/\$96; see page 15) and it would be financially penalized. The biggest cost saving from antifraud measures, however, comes from deterrence, that is, prevented fraud. But the RIA did not estimate the effect of allowing all antifraud expenditures to count against the MLR. Health insurance fraud reportedly accounts for 3–10 percent of health spending.⁶⁰ Yet, only 10 percent of this is detected each year and only ten cents of each fraudulent dollar billed is recovered.⁶¹ These figures suggest that the current system massively underinvests in fraud prevention/detection efforts, but the departments did not consider alternatives that would have encouraged greater fraud prevention.

6. Analysis of Distribution and Equity

Given the significant financial and sometimes life-or-death consequences of many health care decisions, issues of equity, fairness, and justice rightfully play a large role in health care policy debates. Section 1 of Executive Order 12866 directs agencies to consider distributive impacts and equity as well as economic, environmental, health, and safety effects.⁶²

The first step in assessing the equity of a regulation is understanding objectively how the regulation creates transfers between different individuals and groups of people. This is a question of fact, not opinion. OMB Circular A-4 directs agencies to analyze distributional effects separately from benefits and costs.⁶³

The second step involves normative judgment. Unlike benefits, costs, and distributional consequences, gains in equity are inherently subjective. Assessing whether a regulation increases or diminishes equity requires a value judgment about whether the resulting distributional consequences are fair or just. This in turn requires an ethical theory that provides criteria for deciding what is just or unjust. For example, some would regard cross-subsidies that provide less expensive coverage for those with preexisting conditions as an improvement in equity because individuals with preexisting conditions are especially disadvantaged. Others might not because the other policyholders who pay higher premiums to fund the cross-subsidies were not

⁶⁰ National Health Care Anti-Fraud Association website, “Anti-Fraud Resource Center: The Problem of Health Care Fraud,” 2011, http://www.nhcaa.org/eweb/Dynamicpage.aspx?webcode=anti_fraud_resource_centra&wpscode=TheProblemOfHC Fraud.

⁶¹ SAS, “Fraud Detection and Prevention,” 2011, <http://www.sas.com/industry/healthcare/insurer/fraud-detection.html>.

⁶² Executive Order 12866, section 1.

⁶³ OMB, *Circular A-4*, 12.

responsible for creating the preexisting conditions. These diverse perspectives are arguably rooted in different concepts of justice.

A thorough analysis of equity would explain the definition of equity employed and demonstrate empirically why the proposed regulation improves equity according to that definition. Most of the RIAs mention transfers created by the regulations. Some quantify them, occasionally misidentifying them as benefits or costs, as explained previously. Unfortunately, the notices of proposed rulemaking (NPRMs) and RIAs for these regulations offer only superficial assessments of equity when they mention it at all. None offer an explicit definition of equity grounded in an articulated theory of justice or fairness. The more typical approach, when equity is mentioned at all, is simply to assert that a transfer created by the regulation increases equity:

- **Early Retiree Reinsurance Program:** No discussion of equity is offered beyond repeating the standard boilerplate saying that Executive Order 12866 directs agencies to consider distributive impacts and equity.⁶⁴ It does not assess the fairness of a \$5 billion transfer from taxpayers to early retirees. The analysis mentions that early retirees sometimes have difficulty obtaining affordable insurance due to their age or chronic health conditions, and the reader might interpret this as an implicit claim that equalizing access to health insurance improves equity.⁶⁵ But the reader has to make this link; no explicit claim is made.
- **Dependent Coverage for Children up to Age 26:** The RIA calculates \$3.5–\$6.8 billion in transfers, which could take several forms. If the regulation increases insurance premiums, this will create a transfer from individuals with family coverage who do not have dependents aged 19–25 to individuals with family coverage who do have dependents aged 19–25 who opt for coverage. Costs may also be passed on to consumers in the form of price increases or to company shareholders in the form of lower returns.⁶⁶ The NPRM and RIA say nothing about the equity of these transfers, even though they may raise some novel equity issues. For example, is it fair for young, low-paid new hires to pay more for health insurance in their workplace so that older, higher-paid managers can put their young-adult children on the employer’s medical plan? The NPRM and RIA are silent on this issue.
- **Grandfathered Health Plans:** The analyses for these did not quantify transfers. The RIA notes that the regulation’s restrictions on cost-sharing could generate transfers from premium payers generally to people who use these services. If higher-risk plans relinquish grandfathered status, this could create transfers from nongrandfathered plans

⁶⁴ Office of the Secretary, HHS, “Early Retiree Reinsurance Program,” *Federal Register* 75, no. 86, May 5, 2010, 24,463.

⁶⁵ *Ibid.*, 24,450.

⁶⁶ Internal Revenue Service, Department of the Treasury; Department of Labor, Employee Benefits Security Administration; and Office of Consumer Information and Insurance Oversight, HHS, “Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 under the Patient Protection and Affordable Care Act,” *Federal Register* 75, no. 92, May 13, 2010, 27,127.

to grandfathered plans.⁶⁷ The NPRM and RIA say nothing about the equity of these transfers.

- **Preexisting-condition Limitations:** The analysis names some possible transfers but does not quantify them. The RIA explicitly states that distributional impacts and equity helped motivate the regulations. The RIA asserts in several places that requiring relatively healthy insured people to pay a slightly higher premium to provide a large increase in health and financial security for those with preexisting conditions is “a meaningful improvement in equity.”⁶⁸ There is no further discussion, so it is not clear what definition of equity the RIA employs or what results would satisfy that definition: Equalization of health? Equalization of financial burden? Improvement in the lot of the most vulnerable at any cost? Improvement in the lot of the most vulnerable as long as it does not cost too much?
- **Coverage of Preventive Services:** The RIA notes that the regulation will make preventive services more uniformly available and spread the cost among all insured. This will create transfers since plans currently take diverse approaches to coverage of preventive services. Consumers who use preventive services and pay for them out-of-pocket will gain; consumers who do not intend to use preventive services but pay for them in higher premiums will lose. Several estimates of premium increases are presented as costs. The RIA asserts the regulation will “distribute the cost of preventive services more equitably across the broad insured population” but offers no comment on the fairness of making some insured people pay for preventive services they do not want.⁶⁹ No explicit definition of equity is offered; the implicit definition appears to be that everyone has access to the same preventive services and everyone pays insurance premiums to cover the cost.
- **Claims Appeals and External Review Processes:** The RIA estimates appeals under the regulation would result in about \$25 million in claim-denial reversals. The resulting payment is a transfer from the insurance plan to the insured. “These transfers will improve equity, because incorrectly denied benefits will be paid.”⁷⁰ Thus, the definition

⁶⁷ Internal Revenue Service, Department of the Treasury; Department of Labor, Employee Benefits Security Administration; and Office of Consumer Information and Insurance Oversight, HHS, “Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule,” *Federal Register* 75, no. 116, June 17, 2010, 34,548.

⁶⁸ Internal Revenue Service, Department of the Treasury; Department of Labor, Employee Benefits Security Administration; and Office of Consumer Information and Insurance Oversight, HHS, “Patient Protection and Affordable Care Act; Requirements for Group Health Plans and Health Insurance Issuers under the Patient Protection and Affordable Care Act Relating to Pre-existing Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections; Final Rule and Proposed Rule,” *Federal Register* 75, no. 123, June 28, 2010, 37,206.

⁶⁹ Internal Revenue Service, Department of the Treasury; Department of Labor, Employee Benefits Security Administration; and Office of Consumer Information and Insurance Oversight, HHS, “Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act,” *Federal Register* 75, no. 137, June 19, 2010, 41,736.

⁷⁰ Internal Revenue Service, Department of the Treasury; Department of Labor, Employee Benefits Security Administration; and Office of Consumer Information and Insurance Oversight, HHS, “Interim Final Rules for Group

of equity is that the insured receives benefits he or she is entitled to under the insurance policy. This is probably the clearest definition of equity offered in the analysis of any of these regulations.

- **Preexisting-condition Insurance Plan:** The RIA asserts that the \$5 billion expenditure in this program “will yield a meaningful increase in equity” because it allows uninsured Americans with preexisting conditions to obtain affordable insurance.⁷¹ It notes the biggest beneficiaries will be “individuals who are especially vulnerable as a result of existing health problems and financial status.”⁷² Like the RIA for the Preexisting-condition Limitations regulation, this one conveys a vague impression that helping people with preexisting conditions must represent an improvement in equity without providing an explicit definition of equity or a limiting principle.

The RIA also hints at another equity issue when it points out that the federal subsidies may reduce the “hidden tax” associated with uncompensated care by approximately \$2–\$4 billion. It does not actually comment on the equity of paying for this care via explicit federal subsidies instead of regulatory cost shifting. Finally, the RIA ignores the opportunity to flag a significant equity problem. Subsidized insurance rates for people with preexisting conditions in the federal program will almost certainly be below the rates currently charged in the 35 state high-risk pools. But individuals do not qualify for the federal program unless they have gone without health insurance for six months. Thus, individuals in the states with high-risk pools will either have to stay in those pools and pay higher premiums or leave the state pool and go without insurance for six months to qualify for the federal program. The federal law arguably penalizes consumers who are currently in state high-risk pools, which appears to be a source of inequity worth commenting on.

- **Medical Loss Ratios:** The RIA calculates that the regulation could lead to \$587 million–\$1.5 billion in rebates from insurers to consumers, which is correctly labeled a transfer. The prospect of these rebates could induce insurance companies to increase the amount of money they spend on health care, leading to “less disparate MLRs and value to consumers across issuers and States.”⁷³ This appears to imply that equity requires that insurers expend the same percentage of premium income on medical services and quality improvement activities in every state. Why equal percentages of expenditures are equitable is not explained. Indeed, if we assume the real goal is to equalize health outcomes across states, the equity claim is questionable, because differences in costs, insured populations, or market characteristics across states might require unequal MLRs

Health Plans and Health Insurance Coverage Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act; Interim Final Rule,” *Federal Register* 75, no. 141, July 23, 2010, 43,338.

⁷¹ HHS, “Pre-existing Condition Insurance Plan Program; Interim Final Rule,” *Federal Register* 75, no. 146, July 30, 2010, 45,024.

⁷² *Ibid*, 45,025.

⁷³ Office of Consumer Information and Insurance Oversight, HHS, “Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordable Care Act; Interim Final Rule,” *Federal Register* 75, no. 230, December 1, 2010, 74,893.

to achieve the same outcomes for patients; equal MLRs could exacerbate inequality of outcomes.

One might perhaps assume that the departments skimmed in their analysis of benefits, costs, and alternatives because they decided to focus on analyzing important equity issues instead. The above summaries demonstrate that this is not the case. Analysis of equity in the NPRMs and RIAs is even less extensive than the analysis of benefits, costs, or alternatives. When the word “equity” appears at all, it is employed as a rhetorical embellishment rather than a serious category of analysis.

7. Conclusions

Despite the substantial flaws in these RIAs, HHS officials testified before the U.S. House Energy and Commerce Subcommittee on Oversight and Investigations that they carefully considered the benefits and costs of the regulations. HHS will not review health reform regulations as part of their review efforts under President Obama’s recent executive order requiring federal agencies to conduct retrospective regulatory reviews of potentially burdensome regulations that can be streamlined or eliminated. HHS officials say they already reviewed health reform regulations before implementing them and that not enough time has elapsed to warrant an additional review.⁷⁴ Given that retrospective review means doing an analysis after implementation to assess the actual benefits and costs created by the regulation after it was put in place, this is an understandable position for the administration to take. However, it also suggests that principal responsibility for correcting the flaws identified in the original regulatory analyses will lie with Congress.

The eventual process of modifying and finalizing each of these interim final rules is considered a rulemaking that must comply with Administrative Procedure Act requirements.⁷⁵ Perhaps all of the deficiencies identified in this study ultimately will be corrected in the process of issuing final regulations. There are several steps Congress could take to help ensure that the final versions of these regulations—and subsequent regulations implementing other provisions of the ACA—reflect a more careful assessment of their consequences.

7.1 Congressional Oversight

First, Congress might improve the quality of upcoming rules (including final versions of the interim final rules) through more diligent oversight. This can be conducted in a variety of ways, including oversight hearings or confirmation hearings for the heads of regulatory agencies; individual members of Congress may also meet with agency officials, write letters, or file public comments on rules.

⁷⁴ Sam Baker, “HHS Reg Review Won’t Include New Healthcare Reform Rules,” *The Hill*: Healthwatch blog, June 13, 2011, <http://thehill.com/blogs/healthwatch/health-reform-implementation/166125-hhs-reg-review-wont-include-new-health-reform-rules>.

⁷⁵ Michael Asimow, “Interim-Final Rules: Making Haste Slowly,” *Administrative Law Review* 51 (Summer 1999): 703–55.

Many of these activities may be more effective if they occur prior to the release of a proposed rule or interim final rule. That, in turn, presupposes that Congress knows when these rules are going to be issued. The *Unified Agenda of Federal Regulatory and Deregulatory Actions* is published twice a year (spring and fall) by the Regulatory Information Service Center (part of the General Services Administration). This report is provided to the Office of Information and Regulatory Affairs (OIRA). Because it generally accounts for each rule, flags those that are economically significant, and includes a timetable of projected dates for regulatory action,⁷⁶ the *Unified Agenda* provides a readily available mechanism for congressional committees to keep tabs on upcoming rules and to conduct oversight hearings to ensure that a solid rationale exists for reliance on the interim final rule procedure, for example, or to otherwise ensure that the quality of the RIAs is up to par.

However, this is not a foolproof mechanism. Currently, there is no penalty for issuing a rule without giving advance notice in the *Unified Agenda*.⁷⁷ Even so, the CRS recently found that the proposed rule section of the *Unified Agenda* had been used for about three-quarters of the significant rules published after OIRA review in 2008.⁷⁸ The December 20, 2010 edition of the *Unified Agenda* contains 29 ACA-related actions in the proposed-rule stage and 18 in the final-rule stage.⁷⁹ The rulemaking process is very fluid: only two of six upcoming ACA final rules that were promised for publication in December 2010 actually had been published by the end of that month.⁸⁰ Only four of the eight rules reviewed in this analysis were scheduled to have final rules published by a specified month:

- Dependent Coverage of Children up to Age 26: scheduled for April 2011 (not yet issued; the Spring 2011 *Unified Agenda* now lists this rule as a long-term action with no projected release date),⁸¹
- Coverage of Preventive Services: Department of Labor rules scheduled for April 2011 (issued August 1); with companion IRS rules to be issued in December 2011;
- Medical Loss Ratio Requirements: to be issued in December 2011 (the spring 2011 *Unified Agenda* notes a statutory deadline of December 2011, but this rule is now listed as a long-term action with no projected release date); and
- Preexisting-condition Exclusions: to be issued in December 2011 (the Spring 2011 *Unified Agenda* now lists this rule as a long-term action with no projected release date).⁸²

⁷⁶ Copeland and Carey, *Upcoming Rules Pursuant to the Patient Protection and Affordable Care Act*, 3.

⁷⁷ *Ibid.*, 4.

⁷⁸ Curtis W. Copeland, *The Unified Agenda: Implications for Rulemaking Transparency and Participation* (Washington, DC: CRS, 2009), 4.

⁷⁹ Copeland and Carey, *Upcoming Rules Pursuant to the Patient Protection and Affordable Care Act*.

⁸⁰ *Ibid.*

⁸¹ OIRA, “Unified Agenda,” 2011, <http://www.reginfo.gov/public/do/eAgendaHistory>. “Long-term actions” means the agency does not expect to issue a final rule within the next 12 months, therefore the date of final action is listed as “to be determined.”

⁸² *Ibid.*

According to the December 2010 *Unified Agenda*, final rules related to grandfathered health plans were to be issued by the end of 2011, but the Spring 2011 *Unified Agenda* now lists these as long-term actions. In the December 2010 *Unified Agenda*, the date of final rules related to claims appeals and external review processes is “to be determined,” but in the Spring 2011 *Unified Agenda*, a second interim final rule was projected to be issued in June 2011 (these were issued June 22).⁸³ Comments related to the Preexisting-condition Insurance Plan and Early Retiree Reinsurance Program are under review, but both were listed under “long-term actions” in the December 2010 and spring 2011 *Unified Agendas*.

7.2 Congressional Review Act

A very direct option would be for Congress to use the Congressional Review Act (CRA) to overturn the final versions of these rules if it believes the analysis is insufficient. However, only one rule has been overturned since the CRA was enacted in 1996.⁸⁴ This approach was attempted by Senator Mike Enzi (R-WY), who introduced a resolution on September 21, 2010, to disapprove the rule related to grandfathered health plans; it was defeated by a vote of 40–59.⁸⁵ This helps to illustrate that such legislation is difficult to pass in a Congress divided along party lines. Moreover, since the president can veto the congressional resolution of disapproval, the CRA is unlikely to overturn a rule issued by one of the president’s own Cabinet departments. Thus, indirect mechanisms such as congressional oversight may hold more promise.

7.3 Appropriations Language

Congress can and often has used the text of appropriations bills either to direct or preclude the development of particular proposed rules, to place restrictions on implementation or enforcement of certain provisions, or otherwise to restrict certain types of regulatory activity. This same mechanism can be used to require the use of certain procedures before or after a rule is issued.⁸⁶ Because of the urgency required in passing appropriations bills, such language can be used to steer the course of rulemaking even when the president is in the opposition party; historically, such provisions have appeared more often when Congress and the president are not of the same party.⁸⁷

Of course, if poor-quality analysis initially led to less-than-ideal regulations that later required revision, it is reasonable to ask whether the public would have been better served by a more deliberate process that gave regulatory agencies the opportunity to “get it right” in the first place.

⁸³ Internal Revenue Service, Employee Benefits Security Administration, and Office of Consumer Information and Insurance Oversight, “Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act,” HealthCare.gov Implementation Center, 2011.

⁸⁴ Curtis W. Copeland, *Initial Final Rules Implementing the Patient Protection and Affordable Care Act (P. L. 111-148)* (Washington, DC: CRS, 2010), 13.

⁸⁵ U.S. Senate S. J. Res. 39, *Providing for Congressional Disapproval under Chapter 8 of Title 5, United States Code, of the Rule Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act 2010*, 111th Cong., 2d sess. (2010).

⁸⁶ Curtis W. Copeland, *Congressional Influence on Rulemaking and Regulation through Appropriations Restrictions* (Washington, DC: CRS, 2008).

⁸⁷ *Ibid.*

This question implies more general issues of regulatory-process reform. We take these up in Part B of this series, which compares the quality of analysis for these interim final regulations with the quality of analysis for other economically significant regulations issued under the normal notice-and-comment process.⁸⁸

⁸⁸ Jerry Ellig and Christopher J. Conover, “Beware the Rush to Presumption, Part B: Substandard Regulatory Analyses for the Affordable Care Act’s Interim Final Rules” (working paper, Mercatus Center at George Mason University, Arlington, VA, 2012), <http://mercatus.org/publication/substandard-regulatory-analyses-for-the-affordable-care-acts-interim-final-rules>.

Appendix 1: Operational Evaluation Factors

1. Are there biases in the assessment of benefits?
 - A. Does the analysis incorporate the full range of important ultimate outcomes that affect citizens' quality of life? If not, how significant are the outcomes excluded relative to those included?
 - B. At the organizational or individual level, are all relevant outcomes measured using a valid and reliable method? If not, are the measures biased in a way that outcomes are overstated or understated? What is the approximate magnitude of this bias?
 - C. Does the analysis identify all parties who would receive benefits and provide unbiased measures of the universe of organizations and individuals who benefit? If not, are the measures biased in a way that outcomes are overstated or understated? What is the approximate magnitude of this bias?
 - D. Do any identified biases importantly affect the incidence of benefits identified in the RIA?
2. Are there biases in the assessment of costs?
 - A. Does the analysis incorporate the full range of important costs that would arise as a result of the regulation? If not, how significant are the costs excluded relative to those included?
 - B. At the organizational or individual level, are all relevant costs measured using a valid and reliable method? If not, are the measures biased in a way that costs are overstated or understated? What is the approximate magnitude of this bias?
 - C. Does the analysis identify all parties who would bear costs and provide unbiased measures of the universe of organizations and individuals who bear them? If not, are the measures biased in a way that costs are overstated or understated? What is the approximate magnitude of this bias?
 - D. Do any biases identified importantly affect the incidence of costs identified in the RIA?
3. Are there biases in the analysis of alternatives?
 - A. Are there obvious alternatives not considered?
 - B. Would any obvious alternatives have provided a less costly way to achieve the objectives of the regulation?

Appendix 2: Operational Evaluation of Each Regulation

Early Retiree Reinsurance Program

Overview

Section 1102 of the ACA provides \$5 billion for a temporary program of financial assistance to employers, unions, and state and local governments to pay a portion of the costs of maintaining coverage for early retirees age 55 and older who are not yet eligible for Medicare and their spouses, surviving spouses, and dependents. The program allows the secretary of HHS to reimburse sponsors for certain claims between \$15,000 and \$90,000 (with those amounts being indexed for plan years starting on or after October 1, 2011). The purpose of the reimbursement is to make health benefits more affordable for plan participants and sponsors so that health benefits are accessible to more Americans than they would be without this program. The program ends no later than January 1, 2014.

This interim final rule with comment period (75 FR 24,450), issued May 5, 2010 and effective June 1, 2010, was developed in response to the statutory requirement that an early retiree reinsurance program be established. The rule establishes the eligibility requirements and other conditions for operating this program between 2010 and January 1, 2014.⁸⁹ At that time, these individuals will be insured through either Medicaid or private insurance plans, which will no longer be able to exclude people due to preexisting conditions or price coverage based on health status. There will also be subsidies available to ensure that premiums are affordable regardless of family income.

However, due to the significant response among the employer community, the program ceased accepting applications on May 6, 2011.⁹⁰ A total of \$2.72 billion in payments had been made to approved plan sponsors through June 10, 2011, representing only reimbursement requests received through March 31, 2011.⁹¹ While the Early Retiree Reinsurance Program was intended to help shore up early retiree coverage in the short term, in the longer term, it was recognized from its inception that the combination of underwriting reform and new subsidies for individuals enrolling for coverage through the exchange would “create significant incentives for employers to drop coverage for early retirees.”⁹² This program has also been criticized as a giveaway to labor unions and favored companies such as General Motors and General Electric.⁹³ Among large firms, 41 percent with unionized workers offer retiree health benefits compared to only 21 percent of such firms with no union workers.⁹⁴ Thus, any program designed to subsidize such plans would have assisted union retirees disproportionately. As further illustration of the arguably lopsided distribution of benefits, only half of the ten largest corporations listed in the

⁸⁹ Office of the Secretary, HHS, “Early Retiree Reinsurance Program,” HealthCare.gov Implementation Center, 2010.

⁹⁰ Office of Consumer Information and Insurance Oversight, HHS, “Early Retirement Reinsurance Program: Reimbursement Update,” July 15, 2011, 1.

⁹¹ *Ibid.*, 111.

⁹² Paul Fronstin, “The Early Retiree Reinsurance Program: \$5 Billion Will Last about Two Years,” *EBRI Notes* 31, no. 7 (2010): 7.

⁹³ Matthew Boyle, “Republicans Question Obamacare’s \$5 Billion Early Retiree ‘Slush Fund,’” *Daily Caller*, April 2, 2011.

⁹⁴ KFF/HRET, *Employer Health Benefits, 2009 Annual Survey*, 2009.

Fortune 500 have received assistance through this program, three of which are heavily unionized.⁹⁵

Statutory Restrictions

- Section 1102(a)(1) requires the secretary of HHS to establish the program within 90 days of enactment of the law (June 21, 2010); the rule was made effective June 1.
- Section 1102(a) defines an “employment-based plan” as a “group benefits plan providing health benefits” that satisfies certain conditions; the rule interprets this to require reimbursement to a “sponsor” and adopts the identical definition of sponsor as is used under the Retiree Drug Subsidy program.
- Section 1102(a)(1) authorizes the secretary of HHS to provide reimbursement to participating employment-based plans; the rule clarifies that the recipient of such reimbursement is the sponsor.
- Section 1102(a)(2) defines “health benefits” as medical, surgical, hospital, prescription drug, and such other benefits as shall be determined by the secretary whether self-funded or delivered through the purchase of insurance or otherwise; the rule clarifies what types of benefits are included and excluded (for example, long-term care benefits).
- Section 1102(a)(2)(B) defines “group benefits plan providing health benefits” as a plan that is “maintained by one or more employers (including without limitations any State or local government or political subdivision thereof), employee organization, a voluntary employees’ beneficiary association, or a committee or board of individuals appointed to administer such plan; or . . . a multiemployer plan;” the rule defines the scope of sponsors eligible for reimbursement very broadly (see 1102[a] above).
- Section 1102(a)(2)(C) defines “early retirees” as individuals who are age 55 and older but are not eligible for coverage under Medicare and who are not active employees of an employer who is maintaining or currently contributing to the employment-based plan or of any employer who has made substantial contributions to fund such plan; the rule clarifies that eligible spouses, surviving spouses, and dependents of such retirees would be included under this definition even if such spouses/dependents are under age 55 or eligible for Medicare.
- Section 1102(b) requires that a plan be certified by the secretary and submit an application for the program before it can participate in the program; the rule defines “certified” to mean the sponsor and its employment-based health plan meet all statutory/regulatory requirements and the sponsor’s application to participate has been approved by the secretary.

⁹⁵ Office of Consumer Information and Insurance Oversight, “Early Retiree Reinsurance Program: Reimbursement Update,” July 15, 2011, http://cciio.cms.gov/resources/files/early_retiree_reinsurance_program_disbursements_through_june_10_2011.pdf. General Electric (no. 6), General Motors (no. 8), and Ford Motor (no. 10) rely on union labor. The other two Early Retiree Reinsurance Program (ERRP) recipients are ConocoPhillips (no. 4) and Bank of America (no. 9). Based on author’s analysis.

- Section 1102(b)(1)(B) requires the sponsor to submit “an application for participation in the program, at such time, in such manner, and containing such information as the Secretary shall require;” the rule spells out these requirements.
- Section 1102(b)(2)(A) requires plans to implement programs to generate cost savings for participants with chronic and high-cost conditions; the rule defines such a condition as one for which \$15,000 or more in health benefit claims are likely to be incurred in a plan year by any one participant. Sponsors must have programs and procedures in place that have generated or will generate such savings; they need not implement new programs merely to participate.
- Section 1102(c) requires the secretary, upon receipt of a valid claim, to make reimbursement in an amount of 80 percent of the portion of the health benefit costs attributable to claims that exceed \$15,000 but are below \$90,000 (the statute further specifies that these dollar amounts are to be adjusted each fiscal year using the Medical Care Component of the Consumer Price Index for all urban consumers); the rule clarifies that these dollar limits apply to cumulative claims for an individual, not to discrete health benefits or services.
- Section 1102(c)(1)(A) states that participating plans “shall submit claims for reimbursement to the Secretary which shall contain documentation of the actual costs of the items and services for which each claim is being submitted;” the rule details the documentation required.
- Section 1102(c)(1)(B) specifies that claims “shall be based on the actual amount expended by the participating employment-based plan involved within the plan year” and that any negotiated price concession be reflected in claims submitted; the rule defines a plan year and clarifies that reimbursement may not cover amounts that are included in post point-of-sale price concessions.
- Section 1102(c)(3) specifies that “a claim submitted . . . shall not be less than \$15,000 nor greater than \$90,000;” the rule clarifies that within any plan for a given plan year, only one threshold limit and cost limit applies per early retiree, even if they are covered by more than one benefit option by that sponsor.
- Section 1102(c)(4) requires that reimbursements “shall be used to lower costs for the plan. Such payments may be used to reduce premium costs for an entity” or reduce premium contributions or other out-of-pocket costs; the rule clarifies that funds may be used to lower health costs for all participants in a plan, not just retirees, and that they may not be used as general revenue of the sponsor.
- Section 1102(c)(6) requires the secretary to establish procedures to protect against fraud, waste, and abuse and to establish an appeals process to permit sponsors to appeal a determination made by the secretary with respect to claims submitted under the program; the rule requires sponsors to have policies and procedures in place to detect and reduce fraud, waste, and abuse and to produce information to the secretary to enforce this provision, and it further provides for a one-step appeals process.

- Section 1102(d) requires the secretary to conduct audits of claims data submitted by, or on behalf of, sponsors; the rule clarifies how this can be done without disclosing private health information protected under the Privacy Rule.
- Section 1102(f) authorizes the secretary to stop accepting applications based on the availability of funds; the rule clarifies that any particular claim may be denied in whole or in part based on the availability of funds and that such determinations are final, binding, and cannot be appealed.

Analysis of Benefits

A. *Does the analysis incorporate the full range of important ultimate outcomes that affect citizens' quality of life?* The identified outcomes include (a) lower health benefits costs for employers and plan members; (b) reductions in avoidable health spending that would otherwise result from delays in seeking care; (c) less household debt related to medical expenses; and (d) less uncompensated care from providers. The RIA did not attempt to either quantify or monetize any of these benefits, but it implicitly overstated benefits in the following ways. Both the reduction in health benefits costs for employers and plan members and the reduction in uncompensated care from providers are merely a transfer that should not have been included among the benefits listed.⁹⁶ A similar problem is that the RIA fails entirely to consider the possibility of crowd-out: most subsidies will go to plans that would have existed even without the subsidy (crowding out the intended beneficiaries, that is, those in plans that otherwise would have been terminated without this rule).

At the same time, the RIA implicitly understated some benefits. For example, since 75 percent of uncompensated care is financed by various levels of government,⁹⁷ there is a concomitant benefit associated with the reduction in deadweight losses required to raise the public treasury revenue used to finance uncompensated care. Note that while this benefit is ignored in the RIA, it is smaller in magnitude than the aggregate amount of uncompensated care that implicitly is included in the analysis.⁹⁸

The principal justifications for health insurance—especially for near-elderly individuals—are better health and lower financial risk, both of which also are excluded from the analysis. The reduction in household debt related to medical expenses is only one component of financial risk. That is, according to the theory of insurance, risk-averse households prefer to pay a premium for certainty rather than gamble on having to pay an amount that would greatly exceed the annual premium cost.⁹⁹ This would be true even for households not needing to go into debt to finance a large medical expenditure.

⁹⁶ In fairness, the RIA's Table 2-Accounting Statement correctly lists the \$5 billion in subsidies to employers as a transfer; this table includes no monetized estimate of benefits. Office of the Secretary, HHS, "Early Retiree Reinsurance Program," 24,465.

⁹⁷ Hadley, Holahan, Coughlin, and Miller, "Covering the Uninsured in 2008."

⁹⁸ Applying a marginal excess burden of 44 percent to the 75 percent of uncompensated care that is tax financed would produce an overall deadweight loss equal to one-third of uncompensated care losses. See Conover, "How Health Affects the Bottom Line for Businesses and Employers."

⁹⁹ David M. Cutler and Richard Zeckhauser, "The Anatomy of Health Insurance," in *Handbook of Health Economics*, ed. A. J. Culyer and J. P. Newhouse (Elsevier, 2000).

If not, how significant are the outcomes excluded relative to those included? After excluding a small amount of administrative costs, the ACA makes available nearly \$5 billion in reinsurance subsidies that will lower health benefits costs dollar-for-dollar until this fund is exhausted. This transfer—incorrectly identified implicitly as a benefit in the RIA—swamps all benefits in magnitude.

Of the total amount of medical care received by elderly uninsured in 2008, nearly 70 percent was uncompensated care.¹⁰⁰ For elderly adults, average annual spending for individuals who are uninsured all year is approximately 35 percent of the amount spent by their full-year insured counterparts.¹⁰¹ Consequently, uncompensated care for this group amounts to just under one-quarter of the cost of private coverage for those in that age category.¹⁰² Assuming three-quarters of this is publicly financed, the reduction in deadweight losses associated with lower uncompensated care would amount to under 10 percent of the premium cost of health insurance coverage for retirees.¹⁰³ But this is an upper-bound estimate since it assumes everyone losing retiree coverage would become uninsured.

Several studies have examined the impact of Medicare on mortality risk, suggesting that the program confers very modest reductions in mortality at best.¹⁰⁴ A more recent study that is methodologically superior to these earlier studies found no significant impact of Medicare on mortality risk.¹⁰⁵ It seems improbable that mortality gains would be greater for a near-elderly retired population (all of whom would have had relatively recent work experience) than for the elderly population on Medicare. Similarly, for the nonelderly, a comprehensive literature synthesis has concluded there are no, or only very modest, health benefits associated with obtaining health insurance coverage.¹⁰⁶ Therefore, the exclusion of health benefits from the analysis appears to be a relatively minor omission.

However, the dollar value of the risk-reduction benefits of Medicare has been shown to amount to 29 percent of Medicare program costs in its early years.¹⁰⁷ Thus, the exclusion of this benefit is nontrivial. However, based on evidence from the Medicare Part D (drug benefit) program, crowd-out could be as high as 75 percent of spending, meaning that actual benefits would be only one-fourth as large as estimated in the RIA.¹⁰⁸ Admittedly, Medicare Part D is quite different from the early retiree reinsurance program in that in the former case, subsidies went to individuals: empirical evidence shows that crowd-out largely was the consequence of individual decisions to drop their previous prescription-drug coverage rather than decisions of employers to drop such prescription-drug plans in

¹⁰⁰ Calculated by author from figures in Table A.1 reported in Hadley, Holahan, Coughlin, and Miller, “Covering the Uninsured in 2008.”

¹⁰¹ *Ibid.*, 82.

¹⁰² $35.1\% \times 69.3\% = 24.3\%$

¹⁰³ $24\% \times 75\% \times 44\% = 8\%$

¹⁰⁴ See, for example, Card, Dobkin, and Maestas, “The Impact of Nearly Universal Insurance Coverage on Health Care Utilization and Health;” and Benjamin Cook, Mary Beth Landrum, and Ellen Meara, “The Impact of Medicare on Elderly Health and Utilization” (unpublished working paper, 2002).

¹⁰⁵ Finkelstein and McKnight, “What Did Medicare Do (and Was It Worth It)?”

¹⁰⁶ Levy and Meltzer, “What Do We Really Know about Whether Health Insurance Affects Health?”

¹⁰⁷ Finkelstein and McKnight, “What Did Medicare Do (and Was It Worth It)?”

¹⁰⁸ Engelhardt and Gruber, “Does Medicare Part D Protect the Elderly from Financial Risk?”

light of the newly available Medicare drug subsidies.¹⁰⁹ However, Medicare Part D included subsidies to employers designed expressly to discourage such dropping of coverage. Altogether, accurately calculated benefits might have been about one-third as high as estimated.¹¹⁰

- B. *At the organizational or individual level, are all relevant outcomes measured using a valid and reliable method?* There is no attempt in the RIA to quantify any of the benefits.

If not, are the measures biased in a way that outcomes are overstated or understated?
Not applicable.

What is the approximate magnitude of this bias? Not applicable.

- C. *Does the analysis identify all parties who would receive benefits and provide unbiased measures of the universe of organizations and individuals who benefit?* The RIA identifies all categories of parties who hypothetically would receive benefits and provides plausible estimates of the number of organizations that would be affected by the rule based on real-world experience with Medicare's Retiree Drug Subsidy program targeting a very similar population.

If not, are the measures biased in a way that outcomes are overstated or understated?
The analysis fails to consider that much of the subsidy will be wasted on plans that would not have been withdrawn even were no subsidies available. Thus, it is quite possible the lion's share of the subsidies will not induce additional (retained) coverage but instead merely subsidize existing coverage.

What is the approximate magnitude of this bias? Not applicable.

- D. *Do any biases identified importantly affect the incidence of benefits identified in the RIA?*
The analysis concedes there is substantial uncertainty about the number of small businesses that might apply for benefits. It is unclear why the Retiree Drug Subsidy experience could not also provide a more concrete estimate of small business participation in the new subsidy program. The RIA assumes without explanation that 5 percent of sponsors for the new subsidy will be small entities; this equals 250 organizations of the RIA-estimated 150,000 small firms offering health benefits to early retirees—a penetration rate of under 0.008 percent. But the implied penetration rate for firms with 200 or more employees is 5.1 percent.¹¹¹ According to the data source used for the RIA, the average number of workers per large firm is about 62 times as great as the number in small firms, so it is unclear why the penetration rate should be 674 times as large. Thus, it would appear that the RIA may implicitly understate the potential participation of small firms by a substantial amount.

¹⁰⁹ Levy and Weir, "Take-up of Medicare Part D: Results from the Health and Retirement Study."

¹¹⁰ That is, inclusion of risk-reduction benefits would have inflated the benefit calculation by 29 percent; inclusion of deadweight losses would have inflated benefits another 8 percent at most, but accounting for crowding out would have reduced them by 75 percent ($129\% \times 108\% \times 25\% = 35\%$).

¹¹¹ This is calculated by the authors using as a numerator the 4,500 firms reported in Table 1 of the RIA minus 5 percent (250 firms) assumed to have fewer than 200 employees. The denominator is the total universe of such firms as reported in KFF/HRET *Employer Health Benefits 2009 Annual Survey*.

Analysis of Costs

A. *Does the analysis incorporate the full range of important costs that would arise as a result of regulation?* The analysis appears to have done a reasonably thorough job of accounting for all the recordkeeping and reporting costs associated with this rule. However, it has ignored three major components of costs that are relevant. These include (a) the efficiency losses associated with raising \$5 billion in federal revenue; (b) moral-hazard losses associated with whatever incremental coverage is induced by the availability of reinsurance subsidies;¹¹² and (c) any administrative costs associated with such coverage.

If not, how significant are the costs excluded relative to those included? Currently, the marginal excess burden of federal taxes is about 44 percent;¹¹³ this represents the lost output associated with various income, payroll, excise, and other taxes used to finance general expenditures by the federal government.

Moral-hazard losses represent the difference between the value of third-party provided health benefits and the actual cost of these benefits. For those on Medicare, the excess use encouraged by third-party payment for services amounts to 28 percent of spending.¹¹⁴

The average administrative cost associated with private group health insurance is 11.1 percent for small groups (2–50 employees) and 7.0 percent for large groups.¹¹⁵

B. *At the organizational or individual level, are all relevant costs measured using a valid and reliable method?* Recordkeeping and reporting costs associated with this rule seem to have been calculated in a reasonable fashion, but these amount to less than \$40 million a year. As noted earlier, the estimated number of small organizations that might participate may have been underestimated, in which case the estimated number of sponsors might be several multiples higher than estimated. Even so, the amount of costs excluded entirely almost certainly exceeds even an appropriately adjusted amount for recordkeeping and reporting.

If not, are the measures biased in a way that costs are overstated or understated? Costs are unequivocally understated by billions of dollars.

What is the approximate magnitude of this bias? The costs excluded from the analysis are substantial. The excess burden costs associated with the rule alone amount to \$2.2 billion, that is, the 44 percent excess burden times the \$5 billion in subsidies.¹¹⁶

In addition, failure to account for moral-hazard and administrative costs understates costs by roughly 35 percent for large firms and 39 percent for small firms.¹¹⁷ If the rule merely

¹¹² To the degree that this program simply subsidizes plans that would have continued to exist even without subsidies, there is no additional moral hazard. The moral hazard arises only in the case of plans that otherwise would have been terminated.

¹¹³ Conover, "Congress Should Account for the Excess Burden of Taxation."

¹¹⁴ Finkelstein and McKnight, "What Did Medicare Do (and Was It Worth It)?"

¹¹⁵ Sherlock, *Administrative Expenses of Health Plans*.

¹¹⁶ Conover, "Congress Should Account for the Excess Burden of Taxation."

¹¹⁷ Sherlock, *Administrative Expenses of Health Plans*. This assumes moral hazard is roughly equivalent to that of Medicare beneficiaries (that is, 28 percent of spending) and that the average administrative cost associated with private group health insurance is 11.1 percent for small groups (2–50 employees) and 7.0 percent for large groups.

results in a subsidy being provided to existing health plans for high-cost patients whose spending would have been covered anyway, then there would be no additional moral-hazard loss induced by the rule. However, the stated purpose of the rule is to encourage employers to retain, rather than drop, coverage for early retirees. The rule provides no estimate of either the number of individuals retaining coverage who might otherwise have lost it or of the cost of such coverage. As with any subsidy, it need not rise to 100 percent to be effective in changing firm behavior. Indeed, by design, this subsidy would be well below that level. That is, as a rough approximation, for the overall population, the \$15,000 spending threshold represents the amount spent by the 20 percent of people with the highest level of health spending.¹¹⁸ Technically, the subsidy is capped by statute at \$90,000 per person, but even if all plan spending for high-cost individuals were below this cap, employers would have to be willing to spend \$4 in premiums for every \$1 received in subsidies. Thus, if all of the subsidies provided support only to plans that otherwise would have been terminated, it is conceivable that \$5 billion in subsidies for high-cost cases could induce \$20 billion in “new” coverage (coverage that would otherwise have been dropped in the absence of these subsidies). If so, the moral-hazard losses associated with such coverage could be as high as \$5.6 billion. As a practical matter, regulators will be unable to distinguish between firms receiving a subsidy for coverage they would have kept anyway and firms that otherwise would have dropped early retiree coverage.

As with moral-hazard losses, administrative-cost figures must be applied to the premium amount of induced coverage rather than to the \$5 billion in subsidies being provided. Assuming \$20 billion in new coverage, such costs could be as low as \$1.4 billion or as high as \$2.2 billion.

Though the exact figures are uncertain, what should be clear is that excluded costs are many multiples of the costs accounted for by the RIA. Hypothetically, such excluded costs could exceed the entire amount of reinsurance subsidies, calling into question whether the rule’s benefits exceed its costs.

C. *Does the analysis identify all parties who would bear costs and provide unbiased measures of the universe of organizations and individuals who bear them?* The analysis entirely ignores the impact of the new subsidy program on the general public in terms of lost output related to the taxes used to finance it. The RIA likely understates the number of small firms participating relative to the number of large firms, giving a distorted picture of the distributional consequences of this rule.

If not, are the measures biased in a way that costs are overstated or understated? Costs to society are understated by not being measured at all. For firms that retain coverage that otherwise would have been dropped, costs per firm are understated due to the failure to account for moral-hazard and administrative costs. Because administrative costs are

For the equivalent moral hazard of Medicare beneficiaries, see Finkelstein and McKnight, “What Did Medicare Do (and Was It Worth It)?”

¹¹⁸ Calculated by authors from data reported in Steven B. Cohen and William Yu, “The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2006–2007,” in *Statistical Brief*, no. 278 (Rockville, MD: Agency for Healthcare Research and Quality, 2010).

about 50 percent higher for small firms compared to large firms,¹¹⁹ these costs are understated to an even greater extent for small firms.

What is the approximate magnitude of this bias? As codified above, the excluded costs of lost output to society are substantial—measured in billions of dollars.

D. Do any biases identified importantly affect the incidence of costs identified in the RIA?

The RIA likely makes the incidence of costs on small organizations smaller than it actually is.

Analysis of Net Benefits

When the net effect of overestimated benefits and underestimated costs is taken into account, the benefits of this regulation no longer appear to exceed its costs. That is, benefits more likely will be only one-third as large as implied in the RIA, while costs were understated by about \$9–\$10 billion. Correctly calculated benefits could exceed correctly calculated costs only if there were at least \$5.13 in benefits for every \$1 in costs under the original analysis.¹²⁰ This is not impossible, but certainly would be unusual; the analysis provided certainly would not lead an experienced analyst to conclude the ratio of benefits to costs was that high.

Analysis of Alternatives

A. *Are there obvious alternatives not considered?* The statute explicitly provides that the Early Retiree Reinsurance Program will pay 80 percent of claim costs between \$15,000 and \$90,000 and that this amount will be adjusted by the medical component of the consumer price index.¹²¹ The rule accepts these limits, and HHS states there is no alternative to implementing the program. The department rejected the alternative of restricting the program to specified chronic and high-cost conditions and instead opened the program to any condition for which the plan was likely to incur costs of at least \$15,000 for any one participant during the plan year. The rationale for this decision was that the subsidy program was supposed to be an inclusive program. Sponsors had already adopted plans prior to the effective date of the statute designed to cover what they thought were chronic and high-cost conditions, so they might have been unfairly penalized by a rule that defined such conditions more narrowly. The department also rejected an alternative requiring that a qualified actuary certify that a sponsor's estimate of projected costs was reasonable, on grounds that the only purpose of such projections was to let the agency know if and when to stop taking applications for the program (due to the cap on available funding); the expense of actuarial certification was not viewed as worth the incremental benefit of increased accuracy in knowing when to stop applications. No obvious sensible alternative was left out of this analysis.

¹¹⁹ Sherlock, *Administrative Expenses of Health Plans*.

¹²⁰ That is, properly measured benefits amount to only 35 percent of the levels implied in the analysis, while properly measured costs for large firms amount to \$1.79 for each \$1 of program costs (1+44%+28%+7%). Thus, unless originally measured benefits exceeded $\$1.79/\$0.35 = \$5.13$, it would not have been possible for the original rule to pass a benefit-cost test.

¹²¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), section 1102(c)(5).

- B. *Would any obvious alternatives have provided a less-costly way to achieve the objectives of the regulation?* As a practical matter, the program provides a subsidy capped at \$5 billion. Thus, any changes in how conditions were defined or eligibility for the program was structured may have affected the nature and number of sponsors who benefited, but would not have resulted in lower federal spending. Nevertheless, in principle, such alternatives might have affected incentives differently, which in turn could have had an impact on total social costs.

Dependent Coverage for Children up to Age 26

Overview

The ACA requires plans and issuers that offer dependent coverage to make the coverage available until a child reaches the age of 26. Both married and unmarried children qualify for this coverage.

These interim final rules with request for comments (75 FR 27,122), issued May 13, 2010, and effective July 12, 2010, were issued in response to the statutory requirement that the secretary shall issue such rules. The rules determine which children under the age of 26 are eligible to continue coverage on their parents' group or individual health insurance policy.¹²² The rules apply to all plans in the individual market and to new employer plans. They also apply to existing employer plans unless the adult child has another offer of employer-based coverage (such as through his or her job). Beginning in 2014, children up to age 26 can stay on their parents' employer plan even if they have another offer of coverage through an employer.

A single guidance document was issued on October 13, 2010, in connection with these rules.¹²³ There are varying estimates of the impact of this regulation. The Obama administration claims that "one million young adults gain health insurance in 2011 because of the Affordable Care Act," but this appears to be an exaggeration since it is based on a 3.5 percentage point reduction in the rate of uninsured among those ages 19–25, as reported by the National Health Interview Survey (NHIS).¹²⁴ That same survey shows that 1.2 percentage points of this gain in coverage was the result of an increase in public coverage, which could include Medicaid, Medicare, or military health care.¹²⁵ Therefore, at the most, the gain in private coverage was 657,000, but even this is an upper bound, as the NHIS does not distinguish between coverage obtained from one's own employer, own nongroup coverage, or dependent coverage on a parent's policy. The Gallup-Healthways Well-Being Index Survey likewise shows a 4.1 percentage point increase in the number of insured adults ages 18–25 between the first quarter of 2010 and the first quarter of 2011.¹²⁶ Applying this percentage gain to the number of individuals ages 19–25, this would equal 1.2 million who gained coverage.¹²⁷ This has the same problem as the NHIS, however, in that there is no way of telling from the survey results how this reduction in the uninsured rate was achieved.

In contrast, based on its annual survey of households, the Bureau of the Census reports about 400,000 adults ages 19–25 gained coverage between March 2010 and March 2011.¹²⁸ Since other

¹²² Internal Revenue Service et al., "Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage."

¹²³ Center for Consumer Information and Insurance Oversight, "Questions and Answers on Enrollment of Children under 19 under the New Policy That Prohibits Pre-existing Condition Exclusions," Center for Consumer Information and Insurance Oversight, HHS, October 13, 2010, <http://cciio.cms.gov/resources/files/factsheet.html>.

¹²⁴ R. A. Cohen and M. E. Martinez, "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–March 2011," National Center for Health Statistics, 2011.

¹²⁵ *Ibid.*, 13.

¹²⁶ Gallup-Healthways, "In U.S., Significantly Fewer 18- to 25-Year-Olds Uninsured," *Well-Being Index*, 2011.

¹²⁷ The Current Population Survey shows there were 29,692,000 persons age 19–25 in March 2011.

¹²⁸ The Census report shows that 346,000 adults ages 18–24 gained employer-based coverage between 2009 and 2010. See Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2010," in *Current Population Reports* (Washington, DC: U.S. Census

age categories (25–34 and 55–64) also gained employer-based coverage, this change cannot necessarily be attributed exclusively to the ACA, especially since the reported data do not indicate how much of this increase is related to gains in own employment-based coverage or gains in public coverage.¹²⁹ Thus, 400,000 should be interpreted as an upper bound on additional dependent coverage within this age group.

Two employer-based surveys provide a somewhat different picture. As of June 2011, employers reported that their health plan enrollment had increased an average of 2 percent due to ACA provision for dependent coverage of young adults.¹³⁰ This survey covers only employers with 10 or more employees.¹³¹ There were roughly 169 million individuals with employer-based health coverage as of March 2011,¹³² and 4.7 percent of workers covered by employer-based health plans are in firms with three to nine workers.¹³³ A 2 percent increase among the remaining 95.3 percent would imply coverage of about 3.2 million young adults. The KFF/HRET Employer Health Benefits 2011 Annual Survey found that an estimated 2.3 million adult children were enrolled in their parents' employer-sponsored health plan due to the ACA.¹³⁴ These employer-based figures are not entirely inconsistent with the figures based on household surveys. It is quite conceivable that many young adults dropped their own employer-based coverage or own nongroup coverage in favor of being added as dependents to a parent's policy less expensively. But if both sets of figures are correct, they imply that a substantial amount of the new dependent coverage (anywhere from 71 to 88 percent) was the result of already-insured dependents merely shifting their coverage rather than uninsured young adults gaining coverage.¹³⁵

Bureau, 2011), 83. The administration report on these figures asserts that for the 19–25 age group, the gain in coverage was “roughly 400,000.” See Assistant Secretary of Planning and Evaluation, “One Million Young Adults Gain Health Insurance in 2011 Because of the Affordable Care Act,” HHS, 2011.

¹²⁹ In 2011, the Bureau of the Census changed how it calculated the number with various sorts of coverage. Thus, while tabulations from the March 2011 Annual Social and Economic Supplement can be used to calculate dependent coverage through an employer for the 19–25 age group, they are not precisely comparable to the equivalent figures available from 2010. Apples-to-apples comparisons can be made from reported figures for those ages 18–24 in DeNavas-Walt, Proctor, and Smith, “Income, Poverty, and Health Insurance Coverage in the United States,” 83. For this group, 500,000 gained coverage between the March 2010 and March 2011 surveys. However, 218,000 of this increase were individuals who gained government health insurance (Medicaid, Medicare, or military health care). Thus, less than three-fifths of the gain in coverage can be attributed to gains in private health insurance coverage; even this might overstate the gain due to ACA if the gains in coverage were from own-employer plans or own purchases of nongroup coverage.

¹³⁰ Mercer, “US Employer Health Plan Enrollment up 2% under PPACA’s Dependent Eligibility Rule,” news release, August 1, 2011, <http://www.mercer.com/press-releases/1421820>.

¹³¹ Mercer, “In a Tough Year, Employers Hold the Line on Health Benefit Cost Increases,” news release, November 18, 2009, <http://www.mercer.com/press-releases/1364345?siteLanguage=100>.

¹³² DeNavas-Walt, Proctor, and Smith, “Income, Poverty, and Health Insurance Coverage in the United States.”

¹³³ KFF/HRET *Employer Health Benefits 2011 Annual Survey*, 2011.

¹³⁴ *Ibid.*

¹³⁵ The 71 percent figure is calculated assuming 657,000 uninsured individuals gained coverage out of 2.3 million who gained dependent coverage; 88 percent is calculated assuming 400,000 uninsured gained coverage out of 3.2 million who gained dependent coverage.

Statutory Restrictions

- Section 2714(a) of the ACA requires a group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children to continue to make such coverage available for an adult child until the child turns 26 years of age. However, “nothing in this section shall require a health plan or a health insurance issuer described in the preceding sentence to make coverage available for a child of a child receiving dependent coverage.”
- Section 2714(b) specifies, “The Secretary [of HHS] shall promulgate regulations to define dependents to which coverage shall be made available.”
- Section 2714(c) specifies that “nothing in this section shall be construed to modify the definition of ‘dependent’ as used in the Internal Revenue Code of 1986 with respect to the tax treatment of the cost of coverage.”
- Section 2301(a) of the Health Care and Education Reconciliation Act of 2010 specifies that for grandfathered health plans, this provision shall apply only if an adult child up to age 26 is not eligible to enroll in another eligible employer-sponsored health plan.

Analysis of Benefits

- A. *Does the analysis incorporate the full range of important ultimate outcomes that affect citizens’ quality of life?* The identified outcomes include (a) improved health outcomes due to greater use of preventive care and more timely access to care; (b) greater job mobility for these dependents; and (c) reduced cost-shifting of uncompensated care.

Greater job mobility per se is arguably a means to higher income or greater job satisfaction rather than an outcome in itself. Also, reduced cost-shifting per se is merely a transfer cost that alters who bears the burden of such care. However, since 75 percent of uncompensated care is financed by various levels of government,¹³⁶ there is a concomitant benefit associated with the reduction in deadweight losses required to raise the public treasury revenue used to finance uncompensated care. This benefit is ignored in the RIA, but it is smaller in magnitude than the aggregate amount of uncompensated care included in the analysis (and which instead should have been treated as a transfer). Likewise, an important purpose of insurance is to reduce the financial risks associated with uncertain medical costs—a benefit also excluded from the analysis.

If not, how significant are the outcomes excluded relative to those included? For the nonelderly, a comprehensive synthesis of prior studies concluded there are no, or only very small, health benefits associated with obtaining health insurance coverage.¹³⁷ One study has estimated that the annual health losses associated with lack of coverage—inclusive of mortality losses—amount to \$1,645–\$3,280 per uninsured.¹³⁸ However, most of these losses represent mortality losses whose magnitude is based in part on two studies

¹³⁶ Hadley, Holahan, Coughlin, and Miller, “Covering the Uninsured in 2008.”

¹³⁷ Levy and Meltzer, “What Do We Really Know about Whether Health Insurance Affects Health?”

¹³⁸ Miller, Vigdor, and Manning, “Covering the Uninsured.”

showing that mortality risk was 25 percent higher for the uninsured.¹³⁹ Since both studies included only individuals ages 25–64, it is unclear whether such large mortality gains can be extrapolated to young working adults ages 19–25. Most of the estimated value of health insurance derives from this mortality benefit. Moreover, the morbidity calculation is based on cross-sectional comparisons using statistical methods to account for differences between the uninsured and those with health insurance coverage. But the first study cited carefully considered whether any meaningful estimates of health differences could be obtained from such “observational” studies and concluded that they could not. Instead, the authors focused on experimental and quasi-experimental studies to obtain the most reliable estimates of the causal relationship between having coverage and changes in health status. An RIA arguably might include the second study’s much larger estimates of health benefits as an upper bound, but in light of the statistical limitations of cross-sectional comparisons (however well-massaged statistically), it would be inappropriate to claim such large benefits in a midrange estimate of impacts.

The evidence on “job lock” associated with employer-based health coverage is mixed.¹⁴⁰ Among working parents in near-poor households (who presumably would tend to face greater pressures to remain job locked than their counterparts at higher income levels), the modest increase in job mobility associated with their being provided publicly financed health coverage did not produce any significant increase in wages.¹⁴¹ This does not preclude an increase in job satisfaction, but suggests that whatever benefits are associated with job mobility are likely to be small.

Of the total amount of medical care received by the uninsured in 2008, nearly two-thirds was uncompensated care.¹⁴² For nonelderly adults, average annual spending for individuals who are uninsured all year is 39 percent of the amount spent by their privately insured counterparts.¹⁴³ Consequently, uncompensated care for this group amounts to about one-quarter of the cost of private coverage for those in that age category.¹⁴⁴ Assuming three-quarters of this is publicly financed, the reduction in deadweight losses associated with lower uncompensated care would amount to under 10 percent of the premium cost of expanded coverage for previously uninsured young adults.¹⁴⁵

One last benefit associated with insurance coverage excluded in the RIA is reduction of financial risk. Because so much of high-end costs for the uninsured are subsidized (for

¹³⁹ Peter Franks, Carolyn M. Clancy, and Marthe R. Gold, “Health Insurance and Mortality. Evidence from a National Cohort,” *Journal of the American Medical Association* 270, no. 6 (1993); and P. D. Sorlie, N. J. Johnson, E. Backlund, and D. D. Bradham, “Mortality in the Uninsured Compared with That in Persons with Public and Private Health Insurance,” *Archives of Internal Medicine* 154, no. 21 (1994).

¹⁴⁰ Inas Rashad and Eric Sarpong, “Employer-Provided Health Insurance and the Incidence of Job Lock: A Literature Review and Empirical Test,” *Expert Review of Pharmacoeconomics and Outcomes Research* 8, no. 6 (2008): 583–91.

¹⁴¹ Cynthia Bansak and Steven Raphael, “The State Health Insurance Program and Job Mobility: Identifying Job Lock among Working Parents in Near-Poor Households” (working paper, Institute for Research on Labor and Employment, 2005).

¹⁴² Hadley, Holahan, Coughlin, and Miller, “Covering the Uninsured in 2008.”

¹⁴³ Ibid.

¹⁴⁴ $39\% \times 65\% = 25\%$

¹⁴⁵ $65\% \times 39\% \times 75\% \times 44\% = 8.4\%$

example, hospital uncompensated care), the estimated risk premium for the average uninsured individual was estimated to be only \$40–\$80 in 2001.¹⁴⁶ Based on the rise in per-capita U.S. health spending since then, these figures are likely about \$67–\$134 in 2011, but presumably somewhat lower for young working adults up to age 26.¹⁴⁷

- B. *At the organizational or individual level, are all relevant outcomes measured using a valid and reliable method?* The RIA does not attempt to measure any outcomes. Instead, the lion’s share of analysis is devoted to estimating the number of young adults potentially affected by the rule. The RIA estimates the number of previously uninsured who would gain coverage in 2011 at 650,000; low, midrange, and high estimates are provided for 2011–13 (190,000–1.64 million). The analysis distinguishes between those who would switch coverage under the new rules and those who would gain coverage. These estimates generally are done systematically using reasonable and well-documented sources of data, taking into account differences in types of coverage across families as well as differences in regulation across states.

The estimates assume without evidence that enrollment rates will be (a) higher among dependents with nongroup coverage than among those who are uninsured; (b) higher among those in fair or poor health compared to those in excellent, very good, or good health; and (c) higher among dependents living at home compared to those not living with parents. The foregoing assumptions seem reasonable on theoretical grounds, but there is no empirical evidence explicitly provided to support the assumed differences in take-up rates between these various groups. Most importantly, there is no effort to translate any of the outcomes into quantitative estimates of mortality or morbidity reductions, higher income or job satisfaction, or uncompensated care savings.

If not, are the measures biased in a way that outcomes are overstated or understated?

Due to a calculation or reporting error, the number of uninsured dependents obtaining coverage in the midrange estimate is overstated by nearly 25 percent.¹⁴⁸ This error overstates the total with coverage by only about 10 percent but is indicative of the haste with which these estimates were put together.

Overall, the RIA assumptions result in a net enrollment rate among all uninsured adults aged 19–25 of 2.9 percent (low), 18.8 percent (midrange) and 32.2 percent (high). Based on the actual evidence presented in the RIA, these are arguably overstated since the RIA showing that “early experience in States that have extended coverage to dependents

¹⁴⁶ Miller, Vigdor, and Manning, “Covering the Uninsured.”

¹⁴⁷ Calculated from data reported in Centers for Medicare and Medicaid Services, 2011, National Health Expenditure Projections 2009–2019, September 2010, <http://www.cms.gov/NationalHealthExpendData/downloads/NHEProjections2009to2019.pdf>.

¹⁴⁸ This is based on Table 5 of the RIA. The RIA states that for individuals with nongroup policies, the same assumptions were applied in all three scenarios (low, midrange, and high): that 95 percent of those living at home and 85 percent of those living elsewhere would elect to obtain dependent coverage on their parents’ policy. In Table 5, the number of individuals with new dependent coverage who previously had nongroup coverage can be derived by subtracting the reported number of newly covered who were previously uninsured from the reported total of newly covered. For the low and high estimates in 2011, this subtraction yields an estimated 0.48 million nongroup subscribers who would obtain new dependent coverage. For the midrange estimate, this subtraction yields 0.59 million. Since this exceeds the total number of young adults with nongroup coverage potentially affected by the rule that is reported in Table 4 (0.55 million), it clearly is a mathematical miscalculation.

suggests that few uninsured children in these States shift to their parents' policy." Specifically, that study found no statistically significant impact on the uninsured rate among young adults in 15 states that had extended parental coverage to young adults.¹⁴⁹ Even if the change in the uninsured rate were significant, the point estimate indicated that only 0.9 percent of the uninsured obtained coverage. However, roughly one-half of those with employer-based coverage are in ERISA plans exempt from state regulation, but not exempt from the new ACA rules. Nearly half the state-years of experience used in the analysis were from states in the first year of implementation. One arguably could quadruple the net measured impact to correct for these study limitations, but even so, that would give a net expected enrollment rate of only 3.6 percent. The RIA notes that enrollment rates among people made newly eligible for Medicaid coverage have ranged from 10–34 percent, but the analysts also concede that the eligible populations have different socioeconomic compositions and the decision to obtain Medicaid is different from a decision to secure dependent coverage on a parent's employer-based health plan. An annual employer-benefits survey shows that between 77 percent and 90 percent of employees accept offers of family coverage (depending on the size of the employer-premium contribution). Analysts ultimately made assumptions about the fraction of individuals who would elect dependent coverage depending on their health status, producing a midrange estimate of 1.24 million newly covered in 2011 and a high estimate of 2.12 million.¹⁵⁰ Thus, whether the earlier-cited estimate of 2.3 million or 3.2 million who gained dependent coverage is correct, the RIA appears to have underestimated total participation to some extent. It is difficult to argue that this apparent underestimation indicated a flaw in the analysis or reasoning used. Conversely, its estimate that at least 190,000 uninsured would obtain coverage in 2011 (with a midrange estimate of 650,000) does not seem very far off the mark.

What is the approximate magnitude of this bias? Understating the number of young adults who would benefit affects the calculation of costs to the same degree. In this regard, these computations do not bias the assessment of whether the benefits of the rule exceed its costs. In contrast, failure to account for reductions in the excess burden of taxation associated with uncompensated care understates benefits by about \$283 per previously uninsured young adult, while failure to account for risk reduction understates these benefits an additional \$67–\$134. Taking into account the number of previously uninsured who would be covered, this implies benefits were understated by an amount exceeding \$200 million.¹⁵¹

- C. *Does the analysis identify all parties who would receive benefits and provide unbiased measures of the universe of organizations and individuals who benefit? If not, are the measures biased in a way that outcomes are overstated or understated? What is the approximate magnitude of this bias?* The RIA plausibly estimates that the likely beneficiaries will be young-adult dependents who are uninsured and those who have

¹⁴⁹ Monheit et al., "State Policies Expanding Dependent Coverage to Young Adults in Private Health Insurance Plans."

¹⁵⁰ "Newly covered" means having new dependent coverage. The figures shown include individuals who previously had some form of nongroup coverage as well as those without any prior coverage.

¹⁵¹ $(\$269 + \$67) \times 650,000$ previously uninsured = \$218 million.

nongroup coverage whose parents have employer-sponsored insurance. The analysis also identifies the beneficiaries of reductions in uncompensated care as including public programs and those with private health insurance regardless of whether they have newly covered dependents; however, these reductions in uncompensated care represent transfers rather than benefits.

- D. *Do any biases identified importantly affect the incidence of benefits identified in the RIA?*
Not applicable.

Analysis of Costs

- A. *Does the analysis incorporate the full range of important costs that would arise as a result of regulation?* The RIA treats the premium costs of new dependent coverage as a transfer. This is correct as far as benefits paid are concerned. But premiums include administrative costs that represent a true cost to society for providing this expanded coverage; thus, the rule implicitly overstates the size of the transfers and fails to account for these administrative expenses. Likewise, the RIA fails to account for moral-hazard losses and any efficiency losses associated with taxes used to subsidize the purchase of coverage. None of these cost measures is included in the RIA.

If not, how significant are the costs excluded relative to those included? The RIA estimates that more than 93 percent of previously uninsured individuals obtaining new coverage will acquire it through their parents' employer-sponsored insurance (ESI) policy. For those earning less than minimum wage, on average 7 percent of premiums for employer-based health coverage are subsidized through the tax exclusion; the subsidy for those with an annual income of \$10,000–\$20,000 is 20 percent, rising to 30 percent for those with \$30,000–\$40,000 in annual income and staying at about this level through incomes of \$75,000–\$100,000.¹⁵² Thus, 30 percent likely encompasses the range of income for most parents of young adults up to age 26 affected by this rule. Most of these subsidies are federal, but a portion relates to state and local income taxes. As noted in the previous section, the marginal excess burden of federal taxes is about 44 percent; the corresponding figures for sales taxes and property taxes—which make up the lion's share of revenue for state and local government—are 26 percent and 18 percent respectively.¹⁵³ Thus, the deadweight losses associated with these tax subsidies are approximately one-seventh of the premium costs of expanded coverage obtained through ESI (see below). Since 93 percent of coverage for formerly uninsured individuals will come from ESI, the net amount of deadweight losses not counted is about 13 percent of premiums for these individuals.

The average administrative cost associated with private group health insurance is 11.1 percent for small groups and 7.0 percent for large groups.¹⁵⁴ In the RAND Health Insurance Experiment, the moral hazard associated with a "typical" health insurance policy having a modest deductible and 25 percent coinsurance is slightly more than 7

¹⁵² Len Burman, Surachai Khitatrakun, and Sarah Goodell, "Tax Subsidies for Private Health Insurance: Who Benefits and at What Cost?" in *RWJ Synthesis Project* (Princeton, NJ: Robert Wood Johnson Foundation, 2009).

¹⁵³ Conover, "Congress Should Account for the Excess Burden of Taxation."

¹⁵⁴ Sherlock, *Administrative Expenses of Health Plans*.

percent of plan spending.¹⁵⁵ This is probably a more realistic figure to use than the 28 percent figure cited for nonelderly coverage.

At the organizational or individual level, are all relevant costs measured using a valid and reliable method? While loading fees and moral-hazard losses are embedded in the total premium cost of newly acquired coverage, the entire premium amount is incorrectly treated as a transfer. Failure to account for administrative costs and the efficiency losses arising from moral hazard considerably understates the true costs of expanded coverage. Similarly, deadweight losses associated with tax subsidies are ignored altogether.

If not, are the measures biased in a way that costs are overstated or understated? The analysis understates costs by its failure to include the administrative costs of new health coverage, moral-hazard losses associated with such coverage, and the deadweight losses associated with tax subsidies provided to employer-provided dependent health benefits.

What is the approximate magnitude of this bias? The cost that should have been measured directly consists of the 7 percent of health benefits arising from moral hazard plus the appropriate measure of administrative costs; together, these would amount to a total of roughly one-seventh to one-sixth of premiums for newly acquired coverage. Assuming the tax subsidy amounts to roughly 30 percent of premiums for parents of young adults and taking into account that deadweight losses are lower for most state and local taxes than for federal taxes, the net efficiency losses associated with these subsidies would be approximately one-seventh of premiums.¹⁵⁶ All told, the appropriately calculated cost should have been roughly 21–23 percent of gross premiums for those with new dependent coverage.

- B. *Does the analysis identify all parties who would bear costs and provide unbiased measures of the universe of organizations and individuals who bear them?* Yes.

If not, are the measures biased in a way that costs are overstated or understated? What is the approximate magnitude of this bias? Not applicable.

- C. *Do any biases identified importantly affect the incidence of costs identified in the RIA?* Not applicable.

Analysis of Net Benefits

The RIA provides no evidence of any sort of market failure in the provision of dependent coverage to young adults. On the contrary, the analysis documents that of 19.3 million young adults aged 19–25 whose parents have employer-based coverage, only 3.3 million are uninsured (which may be by choice). Had there been such a market failure, the agency decision to issue rules with a definition of dependent that was in stark conflict to the one used by the IRS might have been more understandable. Absent such a market failure, requiring plans to cover individuals who would not be covered voluntarily is welfare reducing by

¹⁵⁵ Keeler et al., “The Demand for Episodes of Medical Treatment in the Health Insurance Experiment,” Table 5.7; waste due to moral hazard equals \$29 of expected plan spending (calculated as \$557 in per-capita total expense minus \$154 in out-of-pocket expense); $\$29/\$403 = 7.2\%$.

¹⁵⁶ This assumes an average federal subsidy of 30 percent times deadweight losses of 44 percent and an average state/local subsidy of 5 percent times combined deadweight loss of 24 percent.

definition. Thus, on theoretical grounds alone, it is difficult to see how impartial analysts could conclude this rule had net benefits.

Apart from theory, when the net effect of underestimated benefits (amounting to \$218 million in 2011 or 5.2 percent of premiums for all those obtaining dependent coverage)¹⁵⁷ and underestimated costs (totaling 21–23 percent of estimated premiums) is taken into account, the benefits of this regulation no longer appear to exceed its costs.

Analysis of Alternatives

A. *Are there obvious alternatives not considered?* The RIA could have assessed the effect of allowing plans to use the IRS definition of “dependent” to determine which adult children would be covered. The statute states that “a group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age.”¹⁵⁸ The provision does not force plans that do not offer dependent coverage to begin offering it. It only requires plans with such dependent coverage to keep offering it up to age 26, as opposed to any earlier age that might previously have been used under the plan. From this construction alone, it can be inferred that Congress did not intend such coverage to apply to all young-adult children whose parents had health insurance coverage. Likewise, the term “continue” can be reasonably construed to suggest that Congress intended merely to alter the termination date of whatever dependent coverage was being offered at the time—inclusive of whatever conditions were attached to being defined as a dependent for purposes of such coverage. Until this rule became effective, the vast majority of plans had been using the IRS definition of dependent to determine which dependents were eligible for coverage under a parent’s policy. This meant that factors such as student status, residency, and financial support were taken into account in determining whether a child qualified for benefits. Thus, young adults who could not be claimed as dependents on a parent’s policy up to age 26 could not qualify for dependent coverage, hence there was nothing to “continue” until age 26.

Indeed, the statute gives the secretary explicit authority to “promulgate regulations to define the dependents to which coverage shall be made available.”¹⁵⁹ But if Congress wanted dependents to be defined as all adult children up to age 26, then it would appear there was no need for HHS to define this. An alternative construction certainly is possible. That is, virtually all children move, at some point, from being dependents in the narrower IRS sense to becoming young-adult children no longer in a dependent relationship. Thus, even for policies that extended coverage to adult dependent children—for example, those attending college full-time up through a maximum age of 23—one could argue that “continue” was intended to mean continue the dependent coverage they enjoyed as nonadult dependent children rather than as adult dependent children. But this alternative construction is not obvious: in the context of the ambiguity in the statute’s language, the agency surely had the flexibility to rely on the first

¹⁵⁷ Total premiums in 2011 equals 1.24 million newly covered times \$3,380, which equals \$4.191 billion.

¹⁵⁸ ACA, section 2714(a).

¹⁵⁹ *Ibid.*, section 2714(b).

construction, especially since Executive Order 12866 requires agencies to “avoid regulations that are inconsistent, incompatible, or duplicative with its other regulations or those of other Federal agencies.” The statute itself stated that “nothing in this section shall be construed to modify the definition of ‘dependent’ as used in the Internal Revenue Code of 1986 with respect to the tax treatment of the cost of coverage.”¹⁶⁰ Note that under a change in tax law included in the ACA, the value of any employer-provided health coverage for an employee’s child is excluded from the employee’s income through the end of the taxable year in which the child turns 26. This tax benefit applies regardless of whether the plan or the insurer is required by law to extend health care coverage to the adult child or the plan or insurer voluntarily extends the coverage.¹⁶¹

Yet, the analysis rejected the alternative of limiting the flexibility of plans to determine whether to cover children or which children to cover. The rule provides that if a plan elects to cover children, it must extend such coverage up to age 26 rather than any lower age limit selected by a plan. The rule prohibits the use of previously mentioned criteria such as student status, residency, or financial support in determining eligibility for benefits. Had the analysis identified a market failure, this might have made more understandable the agency decision to issue rules with a definition of dependent that was in stark conflict to the one used by IRS.

- B. *Would any obvious alternatives have provided a less-costly way to achieve the objectives of the regulation?* Allowing employers to continue to tie the definition of dependent health coverage to the IRS definition of “dependent” clearly would have been less costly than extending the rule to all young adults aged 19–25 regardless of dependency status. The RIA does not provide sufficient information to estimate how much this would have reduced the cost of the rule, but it unquestionably would have been a less expensive alternative than the one selected.

¹⁶⁰ Ibid., section 2714(c).

¹⁶¹ Center for Consumer Information and Oversight, HHS, “Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families,” 2011, http://cciio.cms.gov/resources/files/adult_child_faq.html.

Grandfathered Health Plans

Overview

The ACA exempts certain health insurance plans existing as of March 23, 2010 from the majority of new insurance reforms under the act. Grandfathered plans are subject to eight requirements: (1) uniform explanation of coverage documents, (2) medical loss ratio reporting and premium rebates, (3) prohibition on lifetime limits, (4) restriction on rescissions, (5) dependent coverage for children up to age 26, (6) prohibition on excessive waiting periods, (7) restricted annual limits, and (8) coverage for preexisting health conditions. Enrollment in a grandfathered plan meets the individual mandate requirements that become effective in 2014.

On April 12, 2010, HHS secretary Kathleen Sebelius sent a letter to the National Association of Insurance Commissioners (NAIC) requesting guidance on these rules by June 1, 2010.¹⁶² These interim final regulations with request for comments (75 FR 34,538), issued June 17, 2010, and effective June 14, 2010, define the extent of the changes group health plans and health insurers can make without forfeiting their right to be considered grandfathered health plans and exempt from some provisions of the ACA.¹⁶³

These regulations are intended to protect the ability of individuals and businesses to keep their current plan while providing important consumer protections that give Americans control over their own health care. The rule also is intended to provide stability and flexibility to insurers and businesses that offer health insurance coverage as the nation transitions to a more competitive marketplace in 2014, when businesses and consumers will have more affordable choices through exchanges.

On November 15, 2010, in response to comments, an amendment to the interim final rules with request for comment (75 FR 70,114) was issued, effective November 15.¹⁶⁴ The original regulation allowed only self-funded plans to change third-party administrators without necessarily losing their grandfathered-plan status. The amendment allows all group health plans to switch insurance companies and shop for the same coverage at a lower cost while maintaining their grandfathered status, as long as the structure of the coverage does not violate one of the other rules for maintaining grandfathered-plan status.

The KFF/HRET Employer Health Benefits 2011 Annual Survey found that 72 percent of firms reported that they had at least one health plan that was a grandfathered plan. All told, 56 percent of covered workers were enrolled in a grandfathered health plan, with those in small firms (3–199 workers) being somewhat more likely to be enrolled in a grandfathered health plan than covered workers in larger firms (63 percent versus 53 percent).¹⁶⁵ Firms whose workers were not in grandfathered plans were asked the reason for this. These reasons varied by firm size, with workers in small firms (3–199 workers) without grandfathered plans much more likely than

¹⁶² Kathleen Sebelius to National Association of Insurance Commissioners, “Requesting Guidance by June 1, 2010,” April 12, 2010.

¹⁶³ Internal Revenue Service et al., “Grandfathered Health Plan.”

¹⁶⁴ Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; and Office of the Secretary, HHS, “Amendment to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act,” *Federal Register* 75, no. 221, November 17, 2010, 70,114-122.

¹⁶⁵ KFF/HRET, *Employer Health Benefits 2011 Annual Survey*.

workers in large firms without such plans to be in a new plan that was not in effect when the ACA was enacted (63 percent versus 18 percent). Relative to their counterparts in large firms without grandfathered plans, such small firm workers were generally less likely to be in a grandfathered plan because of plan changes that had rendered the plan they chose ineligible for grandfathered-plan status. Workers in large firms who are not enrolled in grandfathered plans are more likely than workers in small firms to be in a plan where the deductibles or copays have changed (40 percent versus 24 percent) or where employee premium contributions have changed more than permitted by federal law (41 percent versus 15 percent). Among firms selecting some other reason, numerous firms responded that being grandfathered was administratively difficult or that being grandfathered would limit the firm's flexibility in the future.¹⁶⁶

Statutory Restrictions

- Section 1251 of the ACA provides that certain group health plans and health insurance coverage existing as of March 23, 2010 (termed “grandfathered health plans”) are subject only to certain provisions of the ACA.
- Section 1251(a)(1) specifies that nothing in the new law shall be construed to require an individual to terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on March 23, 2010.
- Section 1251(a)(3) specifies that for plan years beginning on or after March 23, 2010, provisions related to Section 2715 (requiring plans to provide members with a summary of benefits and a coverage explanation that accurately describes the benefits and coverage under the applicable plan) and Section 2718 (requiring plans to submit to the Secretary of HHS a report concerning their medical loss ratio) apply to grandfathered plans.
- Section 1251(a)(4)(A) specifies that for plan years beginning on or after September 23, 2010, grandfathered plans also are subject to provisions related to (i) Section 2708 (relating to excessive waiting periods); (ii) Section 2711 (relating to lifetime limits); (iii) Section 2712 (relating to rescissions); and (iv) Section 2714 (relating to extension of dependent coverage to young adults up to age 26).
- Section 1251(a)(4)(B) specifies that the provisions of section 2711 (relating to lifetime and annual limits) and section 2704 (relating to preexisting-condition exclusions) shall apply only to grandfathered health plans that are group health plans.
- Section 1251(b) permits family members of any individual in a grandfathered plan to enroll in such a plan if such enrollment is permitted under the terms of the plan in effect as of March 23, 2010.
- Section 1251(c) permits new employees and their families to enroll in a grandfathered health plan and to be given whatever exemptions are accorded such plans.
- Section 1251(d) specifies that plans subject to collective-bargaining agreements ratified prior to March 23, 2010, shall have grandfathered health plan status until the date on which the last of the collective-bargaining agreements relating to the coverage terminates. However, any coverage amendment made pursuant to such agreements that amends the

¹⁶⁶ Ibid.

coverage solely to conform to any ACA requirement shall not be treated as a termination of the agreement.

Analysis of Benefits

1. Are there biases in the assessment of benefits?

- A. *Does the analysis incorporate the full range of important ultimate outcomes that affect citizens' quality of life?* The cited benefits include (a) plan continuity; (b) reductions in the rate of premium growth (by not having to include some benefits and protections required by the legislation); (c) lower costs for Medicaid than if employers dropped coverage (if employers drop employer-based coverage, some fraction of these individuals might end up on Medicaid); and (d) fewer uninsured for the same reason. Most of the lower cost for Medicaid would represent a transfer from private health insurance to public health insurance. The only cost involved in such a shift would be the increase in use associated with the (typically) more comprehensive coverage available under Medicaid compared to most employer health plans.

Sponsors can hypothetically retain grandfathered status by continuing to offer whatever coverage was in effect on March 23, 2010, with limited changes specified in the rule to comply with ACA provisions, or they may elect to drop coverage altogether. Perhaps because an employer mandate will become effective in 2014, the RIA shows no indication that sponsors would drop coverage due to the rules (benefits [c] and [d] notwithstanding). Thus, the claimed benefits of grandfathered status in the RIA arise entirely because plan sponsors will not have to comply with various ACA provisions that make coverage more comprehensive and costly. In other words, the “benefits” of grandfathered status amount to avoiding the costs generally associated with coverage. Hypothetical benefits that might have been considered in the RIA, but were not, include: (a) less moral hazard;¹⁶⁷ (b) lower administrative costs; and (c) lower efficiency losses associated with tax subsidies for employer-provided health coverage, all of which are costs associated with complying with some of the other health care regulations issued under the ACA.

If not, how significant are the outcomes excluded relative to those included? Estimating the size of these benefits would entail estimating the difference in premiums employers would face under the new health care law compared to the lower premiums they would be permitted under grandfathered status. The RIA devoted the lion's share of analysis to determining the cumulative share of employer plans that would relinquish their grandfathered status by 2011, 2012, and 2013. Analytically, these calculations were based on the observed behavior of firms in 2008–2009 in terms of changes in (a) the employer share of premiums (which cannot decline by more than 5 percentage points); (b) copayments; and (c) out-of-pocket maximums. But the RIA did not attempt to estimate the net average difference in premiums for ACA-compliant plans and those with grandfathered status.

¹⁶⁷ While grandfathered plans are subject to the restrictions on lifetime and annual limits in coverage, they are not subject to provisions that will place income-related limits on the amount of cost-sharing plan members face. At the margin, these limits will increase moral hazard among plan members who face lower cost-sharing than they would have in a purely voluntary market.

The estimated number of employers affected seems to have been calculated using reasonable sources and methods. All told, the RIA projected that only 22 percent of employer plans would relinquish grandfathered status in 2011 (with a high-end estimate of 33 percent). This is consistent with the KFF/HRET survey figures showing that 72 percent of firms offered at least one grandfathered health plan. However, even using the RIA's estimate of 56.3 million policyholders who will remain in grandfathered plans, the RIA fails to provide even back-of-the-envelope calculations of potential premium differences between grandfathered and compliant plans. With the cost of family coverage exceeding \$15,000 a year,¹⁶⁸ it is plausible that this differential might be hundreds of dollars per year.

If the average premium differential per policyholder is even \$100 per year, this would imply a net premium savings of \$5.6 billion; applying plausible estimates of moral-hazard losses (7.2 percent), administrative costs (at least 7 percent), and tax-related efficiency losses (13.7 percent)¹⁶⁹ implies that at least \$1.6 billion in benefits was excluded from the analysis in 2011 alone. Of course, benefits from not having these costs in grandfathered plans should be counted as costs in plans that are not grandfathered.

- B. *At the organizational or individual level, are all relevant outcomes measured using a valid and reliable method? If not, are the measures biased in a way that outcomes are overstated or understated? What is the approximate magnitude of this bias?* Although one could not precisely replicate the estimates of the percentage of plans relinquishing grandfathered status based on the methodological description, the sources of data were well-documented and the estimates appear to be reasonable. An important limitation, however, is that all figures were expressed as a percentage of plans (with separate figures for small and large firms). It would have been more informative to show the percentage or number of workers whose plans might lose grandfathered status under the various assumptions tabulated. In the details of the paperwork-burden calculation, the analysts do estimate that 56.3 million policy holders in ERISA plans would retain grandfathered status in 2011, but it is virtually impossible to recover this figure from the information provided.¹⁷⁰ Another limitation is that there was no effort to quantify any of the relevant outcome measures, hence the issue of bias is moot.
- C. *Does the analysis identify all parties who would receive benefits and provide unbiased measures of the universe of organizations and individuals who benefit?* The analysis appropriately suggested that, qualitatively, limitations on allowed changes to cost-sharing

¹⁶⁸ KFF/HRET, *Employer Health Benefits 2011 Annual Survey*.

¹⁶⁹ Efficiency losses related to the tax exclusion were earlier estimated to be 14.4 percent of premium costs for employer-provided coverage. Using the RIA-reported number of individuals covered by employer-sponsored and nongroup plans and the estimated fraction of small employer, large employer, and nongroup plans that would relinquish grandfathered status (reported in Table 3 of the RIA; see Internal Revenue Service et al., "Grandfathered Health Plans," 34,553), the authors estimate 95.2 percent of individuals remaining in grandfathered plans in 2011 will be in employer-sponsored plans. Thus, the net amount of efficiency losses related to the tax exclusion would be 13.7 percent (14.4 percent times 95.2 percent).

¹⁷⁰ The RIA reports the total number of plan members (not subscribers) covered by small employers, large employers, and nongroup policies, along with the assumed percentage in each category that would relinquish grandfathered status in the years 2011–13. But no figure is provided on the average number of plan members per policyholder.

in grandfathered plans would result in wealth transfers to individuals using any additional services induced by such limitations. When limitations on preexisting conditions are fully prohibited outside of grandfathered plans and other related insurance reforms are adopted, plans with high-risk members will have a greater incentive to drop grandfathered status to take advantage of these new protections (since high-risk members would benefit most from these, groups with such individuals are more likely to be willing to pay the higher premiums required for such protection). Conversely, plans with relatively healthy (generally younger) members will have an incentive to remain grandfathered to avoid the added costs of these reforms. The net result will be a wealth transfer from nongrandfathered plans to grandfathered plans. However, there is no effort to quantify these effects.

If not, are the measures biased in a way that outcomes are overstated or understated?
Not applicable.

What is the approximate magnitude of this bias? Not applicable.

Do any biases identified importantly affect the incidence of benefits identified in the RIA?
No.

Analysis of Costs

- A. *Does the analysis incorporate the full range of important costs that would arise as a result of regulation?* The RIA midrange estimate is that 22 percent of employer plans would relinquish their grandfathered status by 2011, rising to 51 percent by 2013. Small plans were projected to be more likely than large plans to relinquish grandfathered plan status, which seems intuitively plausible. Yet, the KFF/HRET survey data showed the opposite. The RIA appears to have calculated in a reasonable and accurate fashion the annualized costs of notification and recordkeeping associated with the rule for ERISA-covered plans, but fails to calculate these for group and nongroup plans not covered by ERISA. However, none of the traditional costs (in this case, negative benefits) of insurance are considered even qualitatively. These would include loss of any health benefits or risk reduction associated with the coverage expansions required under the health care law.

Conversely, the ACA does require some insurance reforms to be adopted by even grandfathered plans, including prohibition of preexisting-condition exclusions, prohibition on excessive waiting periods, no lifetime or annual limits, and prohibition on rescissions, among others (although some of these provisions apply only to group health plans). None of these enhancements to coverage is costless, but the RIA makes no effort to incorporate such costs, including moral hazard, administrative costs, or efficiency losses related to tax subsidies. That said, some of these requirements entail separate rules (for example, preexisting conditions, dependent coverage up to age 26); in such cases, it is more appropriate to account for costs associated with such rules in the RIA of that separate rule rather than in the grandfathering rule.

A companion limitation is that the RIA recognizes that some employers may be willing to tolerate higher premiums as a way around taking actions that otherwise would cause them to lose grandfathered status. The analysis contemplates the possibility of net premium

increases (above and beyond those that otherwise would occur absent regulation) of 3 percent. The RIA reports how incorporating this flexibility in employer responses affects the central estimates of the percentage of plans relinquishing grandfathered status, but there is no effort to include the efficiency losses related to tax subsidies that would accompany such increases.

If not, how significant are the costs excluded relative to those included? The RIA estimates only \$21–\$22 million in employer-compliance costs associated with this rule. Using the RIA assumptions regarding the number of persons in small-group and nongroup plans and the percentage that would retain grandfathered status, it appears that these costs are understated by about one-third.¹⁷¹ In light of the magnitude of excluded costs as discussed in previous summaries, it is easily possible that these excluded costs would be several multiples of the narrow set of costs estimated in the RIA, but such costs might be several orders of magnitude higher depending on the aggregate premium impact of these rules—something the RIA does not provide.

- B. *At the organizational or individual level, are all relevant costs measured using a valid and reliable method?* The analysis seems to have done a reasonable job estimating the share of firms in two broad-sized categories as well as nongroup policies that would be affected by this rule.

If not, are the measures biased in a way that costs are overstated or understated? What is the approximate magnitude of this bias? Not applicable.

- C. *Does the analysis identify all parties who would bear costs and provide unbiased measures of the universe of organizations and individuals who bear them?* The RIA fails to include taxpayers.

If not, are the measures biased in a way that costs are overstated or understated? Costs are understated.

What is the approximate magnitude of this bias? Costs appear to be understated by at least tens of millions of dollars and possibly hundreds of millions of dollars.

Do any biases identified importantly affect the incidence of costs identified in the RIA?
No.

Analysis of Net Benefits

Since costs were underestimated by a lesser extent than benefits, this rule would pass a cost-benefit test assuming that it achieved net benefits under the original RIA (something the RIA failed to demonstrate empirically). However, if true, this calls into question whether the elements of the ACA that would apply to nongrandfathered plans could meet a cost-benefit test. That is, the only way the grandfathering rules could be cost beneficial is if the benefits

¹⁷¹ The RIA states there are 43.2 million covered through small employers, 16.7 million covered through nongroup policies, and 133.1 million covered through large employers (including various levels of government). In 2011, the fraction retaining grandfathered status is 70 percent, 42 percent, and 82 percent of each group, respectively. (Internal Revenue Service et al., “Grandfathered Health Plans,” 35,553). Using these assumptions, 25.4 percent of plan members in grandfathered plans will have their coverage through small-group or nongroup policies.

of not complying with these provisions (that is, the costs averted) exceeded their costs (that is, benefits forgone).

Analysis of Alternatives

A. *Are there obvious alternatives not considered?* For fixed-amount cost-sharing provisions in health plans other than copayments (deductibles and limits on out-of-pocket costs), the rule specifies that plans will lose grandfathered status if such provisions increase by more than medical inflation plus 15 percentage points relative to the base period (that is, whatever provisions were in effect on March 23, 2010). For copays (for example, \$15 per visit), the limit on increases is \$5 times (1 + medical inflation). The rule also limits reductions in the employer contribution rate toward premiums to 5 percentage points. However, any changes in percentage cost-sharing requirements (for example, coinsurance) result in loss of grandfathered status under the rule.

The department rejected five alternatives: (a) looser limitations on allowable changes in cost-sharing that would trigger loss of grandfathered status (for example, 25 percent plus medical inflation); (b) use of an annual allowance for cost-sharing increases above medical inflation as opposed to a one-time allowance of 15 percent; (c) use of a “substantially different” standard for determining when a plan would lose grandfathered status as opposed to discrete quantitative limits; (d) use of an “actuarial equivalence” standard in lieu of quantitative limits; (e) requiring employers to maintain premium contributions at the same dollar amount plus an inflation factor; and (f) specifying that self-insured plans would automatically lose grandfathered status if they changed third-party administrators.

The entire purpose of the grandfathering rules is to permit gradual implementation of reforms designed to expand access and improve quality of coverage. Thus, at some level, the selection of any particular quantitative limitations on changes in plans is arbitrary: tighter standards would accelerate the pace at which all health insurance coverage met the minimum coverage standards set forth in the health care law, whereas looser standards would slow that pace. Since none of the improvements in coverage standards is costless, looser standards by definition would have been less costly than the standards adopted. Rather than quibble about whether an inflation allowance of 17 percent might have been better than 15 percent, the analysis that follows focuses on logical consistency and arbitrariness.

From this perspective, two concerns arise. First, the decision to entirely prohibit changes in coinsurance appears arbitrary and capricious. By definition, a fixed coinsurance amount automatically adjusts for changes in medical inflation. If copays can rise by medical inflation plus 15 percent, what is the rationale for limiting coinsurance changes to medical inflation plus 0 percent? While the use of coinsurance in employer-based plans has declined over time, about one-fifth of such plans nevertheless rely on coinsurance or a combination of coinsurance and copays for physician office visits.¹⁷² There is no logical justification for why regulation should subject such plans to more restrictive standards than others, effectively tilting the playing field in favor of plans that

¹⁷² KFF/HRET, *Employer Health Benefits 2010 Annual Survey*, exhibit 7.20.

have adopted a copayment structure. Regulators apparently did not even consider an alternative that would have treated such plans similarly.

Second, by definition, an actuarial equivalence standard would have been less restrictive (hence less costly) than a rule-based quantitative standard. Actuarial equivalence means the net dollar value of the plan would be unchanged even though the particulars of coverage and cost-sharing might have changed. An actuarial equivalence standard would have permitted employers to make plan changes on a large number of margins of adjustment simultaneously. This approach arguably would have much better met the letter and spirit of the president's oft-repeated pledge, "If you like your health care plan, you can keep your health care plan."¹⁷³ What is most interesting is the agency's justification for rejecting this alternative: "The complexity involved in defining and determining actuarial value for these purposes, the likelihood of varying methodologies for determining such values unless the Departments promulgated very detailed prescriptive rules, and the costs of administering and ensuring compliance with such rules led the Department to reject that approach."¹⁷⁴

What is odd about this lament is that the state of Massachusetts has been effectively regulating an actuarial equivalence standard in its health plans since 2006.¹⁷⁵ For an even longer period, Medicare Part D has made use of an actuarial equivalence standard to encourage continued innovation in the private prescription-drug coverage market. Of perhaps greater importance, the ACA defines plans to be made under health insurance exchanges as platinum, gold, silver, or bronze using actuarial equivalency. That is, in addition to any specific "essential benefits" required by the law (for example, coverage of preventive services), a bronze-level plan provides benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided. The full actuarial value of benefits provided is simply the expected dollar amount that would be paid for covered services for a "standard" population if the plan covered these services at 100 percent (that is, no deductibles or other form of cost-sharing with the patient). Once this component of the law takes effect, platinum, gold, and silver plans will be required to be actuarially equivalent to 90 percent, 80 percent, and 70 percent coverage, respectively. Since actuarial equivalence simply represents coverage for an average plan member, it is conceivable that the actual percentage of a plan member's costs covered could be quite a bit lower if the plan were structured to provide less coverage for certain types of services (for example, physical therapy or hospital coverage). But if there were concerns about substantial changes to any particular category of medical benefits, it also is feasible to apply an actuarial equivalence standard category by category.¹⁷⁶

Even grandfathered plans are expected to comply with health insurance reform provisions such as (a) prohibition on preexisting-condition exclusions;* (b) prohibition on excessive waiting periods; (c) no lifetime limits; (d) no annual limits;* (e) prohibition on

¹⁷³ "Barack Obama Promises You Can Keep Your Health Insurance," PolitiFact.com.

¹⁷⁴ Internal Revenue Service et al., "Grandfathered Health Plans," 34,547.

¹⁷⁵ Chris L. Peterson, "Setting and Valuing Health Insurance Benefits," CRS, 2009, 1.

¹⁷⁶ Marisa Milton, "RE: An Alternative Actuarial Equivalence Model under Interim Final Rules Regarding Grandfathered Health Plans under the Patient Protection and Affordable Care Act," August 16, 2010.

rescissions; (f) extension of dependent coverage up to age 26; (g) development and use of uniform explanations of coverage documents and standardized definitions; and (h) for insured plans, bringing down the cost of health care coverage.¹⁷⁷ Only a handful of these insurance-reform provisions do not apply to grandfathered health plans (for example: coverage of preventive health services with no cost-sharing; internal and external appeal requirements; no restrictions on access to emergency, pediatric, obstetric, or gynecological care). The most important provision from which grandfathered plans are exempt is that individual and small-group plans cover a federally defined essential health benefits package, starting in 2014.¹⁷⁸

Because grandfathered plans are expected to comply with these provisions—some of which could have premium impacts in excess of 5 percent, depending on their plan design¹⁷⁹—the rule that the plans can only keep their grandfathered status if they limit premium increases to “medical inflation plus 15 percentage points” becomes a fairly restrictive limitation. It is unlikely most plans will be able to maintain this, so they will lose their status. Indeed, the expectation is that “eventually, if the ACA remains in effect, grandfathered plans will disappear.”¹⁸⁰

In the context of these substantial additions to the “floor” on private health insurance coverage, it is not clear why maximum flexibility could not have been provided to grandfathered plans to simply evolve over time in response to market pressures. This is especially true in the nongroup market, where two-fifths to two-thirds of policies terminate every year.¹⁸¹ Because newly purchased plans are not grandfathered, the natural turnover in this market quickly would have led to these products becoming subject to the same enhancements in coverage embedded in the plans being offered through the health insurance exchanges. Even in the group market, to the degree that more regulated coverage is desired by the public (that is, worth the added premium expenditures required), there would have been a natural migration of employees and nongroup plan purchasers toward employers and plans that had moved away from grandfathered coverage. To the degree such coverage is not preferred, rules that encourage grandfathered plans to disappear more rapidly than they would have otherwise will reduce rather than enhance social welfare.

¹⁷⁷ * Denotes provisions that do not apply to nongroup grandfathered health plans. Internal Revenue Service et al., “Grandfathered Health Plan,” 35,542.

¹⁷⁸ Timothy Stoltzfus Jost, “Loopholes in the Affordable Care Act: Regulatory Gaps and Border Crossing Techniques and How to Address Them” (Washington and Lee Public Legal Studies Research Paper Series, Lexington, VA, 2011), 12.

¹⁷⁹ For example, a plan with a \$250,000 annual limit that moves to an annual limit of \$2 million would experience a premium increase of 6.2 to 6.6 percent, according to the RIA Internal Revenue Service DoT, Employee Benefits Security Administration DoL, Office of Consumer Information and Insurance Oversight DoHaHS, “Patient Protection and Affordable Care Act; Requirements for Group Health Plans and Health Insurance Issuers under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections; Final Rule and Proposed Rule: Part III; National Archives and Records Administration,” *Federal Register* 75, no. 123 (June 28, 2010): 37,207.

¹⁸⁰ Jost, “Loopholes in the Affordable Care Act,” 20.

¹⁸¹ Adele M. Kirk, “The Individual Insurance Market: A Building Block for Health Care Reform?” Robert Wood Johnson Foundation, *Changes in Health Care Financing and Organization*, May 2008.

- B. *Would any obvious alternatives have provided a less-costly way to achieve the objectives of the regulation?* By imposing stricter limitations than necessary on what employers can do to manage the design of their benefit plans, the rules implicitly encourage many employers to forgo grandfathered status altogether. This will unnecessarily inhibit innovation in the private health insurance market (which has made a rapid evolution toward value-based purchasing in recent years) and hasten the day in which many discrete standards for coverage are set by regulators rather than the private market. By definition, this will increase costs since the private market has every incentive to seek out the least costly approach to providing high-quality health benefits.

Preexisting-condition Exclusions, Lifetime and Annual Limits, Prohibition on Discrimination, and Patient Protections

Overview

The ACA included a series of insurance-market reforms affecting plan design:

- **Preexisting-condition Exclusions.** Under the ACA, health plans, unless grandfathered, cannot deny or limit benefits or deny coverage for a child younger than age 19 simply because the child has a preexisting condition—that is, a health problem that developed before the child applied to join the plan. These protections apply to all types of insurance, except for individual policies that are grandfathered, and will be extended to Americans of all ages starting in 2014.
- **Lifetime and Annual Limits.** The law also prohibits the use of lifetime limits in all health plans and insurance policies issued or renewed on or after September 23, 2010. Starting in 2014, the ACA bans annual dollar limits.
- **Arbitrary Rescissions.** The law prohibits insurers and plans from rescinding coverage for individuals or groups of people, except in cases involving fraud or an intentional misrepresentation of material facts. There are no exceptions to this policy.
- **Restrictions on Choice of Providers.** The law requires health plans to allow members to designate any available participating primary care provider as their provider. A parallel requirement allows parents to choose any available participating pediatrician to be their children’s primary care provider. The law also prohibits insurers and employer plans from requiring a referral for obstetrical or gynecological (OB-GYN) care. These policies apply to all individual market and group health insurance plans except those that are grandfathered.
- **Access Barriers to Emergency Services.** The law prohibits health plans and insurers that cover emergency services from requiring preauthorization for such services or from charging higher cost-sharing (copayments or coinsurance) for emergency services that are obtained out of a plan’s network. Health plans also must allow out-of-network providers to provide such services and to reimburse them as if they were in-network providers. The law also establishes a prudent layperson standard to define emergency medical conditions. This policy applies to all individual market and group health plans except those that are grandfathered.

These interim final rules with request for comments (75 FR 37,188), issued June 28, 2010, and effective August 27, 2010, apply to group health plans and insurers and implement various patient protections, such as not excluding people with preexisting conditions from joining plans, not placing any dollar limits on benefits (per year or per event), and not allowing those plans to deny coverage to existing participants based on changing health status.¹⁸²

- **Preexisting-condition Exclusions.** These rules are intended to help children (and eventually all Americans) with preexisting conditions to gain coverage and keep it.

¹⁸² Internal Revenue Service et al., “Preexisting Condition Exclusions.”

- **Lifetime and Annual Limits.** These rules are intended to give financial protection to 100 million Americans who currently have coverage with lifetime limits, along with a smaller number who have coverage with annual dollar limits (8 percent of large employer plans, 14 percent of small employer plans, and 19 percent of individual market plans).¹⁸³ The rules phase out the use of annual dollar limits over the next three years until 2014, when the ACA bans them for most plans. These restricted annual dollar limits apply to all insurance plans except for individual market plans that are grandfathered. However, the law and regulations also allow HHS to grant temporary waivers from the restrictions on annual limits if compliance would result in a significant decrease in access to benefits or a significant increase in premiums.

Five guidance documents have been issued related to annual limits.¹⁸⁴ On June 17, 2011, the Centers for Medicare and Medicaid Services (CMS) issued guidance that revises regulations that “allow limited benefit, or ‘mini-med’ plans, to apply for or renew a temporary waiver from annual limit restrictions through 2013.” The CMS guidance “imposes new, more stringent disclosure requirements and requires health plans with waivers to tell consumers that their health care coverage is subject to an annual dollar limit lower than what is allowed under the law.” According to the guidance, “after September 22, 2011, no new applications or requests for extensions will be considered.”¹⁸⁵

- **Arbitrary Rescissions.** The rules require insurers and plans seeking to rescind coverage to provide at least 30 days’ advance notice to give people time to appeal.
- **Choice of Providers.** The rules are designed to improve access to primary and specialty care by removing network restrictions on choice of primary care and pediatric providers and removing preauthorization requirements for OB/GYN care.
- **Access Barriers to Emergency Services.** The rules are designed to avert financial hardship to those who get sick or injured when away from home or not near a network hospital. Some insurers will pay for health care provided only by a limited number of network providers while others require prior approval before receiving emergency care at hospitals outside their networks.

Statutory Restrictions

- Section 2704 specifies that group health plans and health insurance issuers offering group or individual health insurance coverage may not impose any preexisting-condition exclusion.
- Section 2711 specifies that group health plans and health insurance issuers offering group or individual health insurance coverage may not impose lifetime or annual limits on the dollar value of health benefits; the rule establishes the dollar value of annual limits for each year between 2010 and 2013.

¹⁸³ HealthCare.gov, Patient’s Bill of Rights, July 1, 2010, http://www.healthcare.gov/law/provisions/billofright/patient_bill_of_rights.html#NewConsumerProtectionsStarting.

¹⁸⁴ Center for Consumer Information and Insurance Oversight, “Regulations and Guidance.”

¹⁸⁵ Gary Cohen, “CCIIO Supplemental Guidance (CCIIO 2011 – 1D): Concluding the Annual Limit Waiver Application Process,” HHS, 2011.

- Section 2712 specifies that group health plans and health insurance issuers offering group or individual health insurance coverage may not rescind such plans or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.
- Section 2719(A) establishes three patient protections related to the choice of health care professionals:
 - *Choice of health care professionals.* The statute provides that if a group health plan or issuer offering group or individual coverage requires or provides for the designation of a participating primary care provider, then the plan or issuer must permit the participant or enrollee to designate any participating primary care provider who is available to accept the individual.
 - *Access to pediatric care.* The ACA requires a plan or issuer to permit the participant or enrollee to designate a physician who specializes in pediatrics as the child's primary care provider if such provider participates in the plan or issuer's network.
 - *Access to obstetrical and gynecological care.* The ACA prohibits a plan or issuer from requiring authorization or referral in the case of a female participant, beneficiary, or enrollee who seeks coverage for OB/GYN care provided by a participating health care professional who specializes in obstetrics or gynecology. The law also requires that such professionals agree to otherwise adhere to the plan's or issuer's policies and procedures, including those regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer. This provision applies only to a group health plan or coverage that provides coverage for OB/GYN care and requires the designation of a participating primary care provider by the enrollee, participant, or beneficiary. This provision is not meant to waive any exclusions of coverage under the terms and conditions of the plan or coverage with respect to obstetrical or gynecological care or to preclude the group health plan or issuer from requiring the obstetrical or gynecological provider to notify the primary care health care professional or the plan or issuer of treatment decisions.
- Section 2719(A) establishes three patient protections related to the coverage of emergency services:
 - The statute requires that if the plan or issuer provides or covers hospital emergency department services, it must cover them as follows: (a) without the need for any prior authorization; (b) whether or not the provider is a participating provider; (c) in the same manner as if there were no such requirements or any limitation on coverage that is more restrictive than if the providers had a contractual relationship; and (d) at the same cost-sharing requirements (with certain exceptions) as for in-network services.
 - The statute also adopts a prudent layperson standard for the definition of "emergency medical condition."

- It defines “emergency service” with respect to an emergency medical condition as (a) a medical-screening examination within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such condition, and (b) within the capabilities of the staff and facilities available at the hospital, including such further medical examination and treatment as required under the Emergency Medical Treatment and Active Labor Act to stabilize the patient.

Analysis of Benefits

- A. *Does the analysis incorporate the full range of important ultimate outcomes that affect citizens’ quality of life?* Qualitative benefits include: (a) increased access to health care; (b) improved health outcomes (reductions in morbidity and mortality); (c) improved worker productivity; (d) reduced expenditure risk; (e) reduced job lock; (f) decreased malpractice claims; (g) improved medication adherence; (h) better health promotion; (i) reduced administrative and time burdens for providers and patients through removal of referrals and prior authorizations; (j) reduced uncompensated care; and (k) improved equity. Benefits (a), (g), and (h) are means to achieving improved health outcomes, hence they do not really require separate consideration. This list appears to encompass all the major outcomes that might be affected by the rule; however, reductions in uncompensated care represent a transfer rather than a benefit. What should have been counted instead are the deadweight losses associated with taxes used to finance uncompensated care, but these are less than the aggregate amount of uncompensated care mistakenly included in the analysis.

If not, how significant are the outcomes excluded relative to those included? Not applicable.

- B. *At the organizational or individual level, are all relevant outcomes measured using a valid and reliable method?* There is no effort to measure all these outcomes in order to arrive at an aggregate estimate of benefits. Instead, for each individual regulation (for example, the prohibition of preexisting-condition exclusions and the elimination of lifetime and annual limits), the RIA focused on estimating the number of people who potentially will benefit from these changes. Then, at the very end, for each major outcome cited above, relevant literature is cited to indicate the rough magnitude of potential effects for the overall regulations without attempting to derive an exact quantitative estimate of benefits either in terms of raw outcomes (such as mortality reductions) or in terms of the dollar value of such benefits.

If not, are the measures biased in a way that outcomes are overstated or understated? Not applicable.

What is the approximate magnitude of this bias? Not applicable.

- C. *Does the analysis identify all parties who would receive benefits and provide unbiased measures of the universe of organizations and individuals who benefit?* The RIA appropriately identifies the parties who would receive benefits. However, the estimated number of uninsured children with preexisting conditions who will gain coverage appears to be substantially overstated, as explained below. The remaining estimates of individuals

benefiting from various restrictions on plan benefits and patient protections appear to be derived in a reasonable and unbiased fashion.

If not, are the measures biased in a way that outcomes are overstated or understated?
The number benefiting from this rule appears to be overstated.

What is the approximate magnitude of this bias? It is widely agreed that the medically uninsurable constitute about 1 percent of the nonelderly population, including both children and adults under age 65.¹⁸⁶ The RIA’s method of calculating the number of such children includes all those with self-reported fair or poor health or who are taking three or more medications. There are 540,000 such children aged 0–19 who are uninsured, which is 0.7 percent of the total number of children in that age group reported in the RIA. Thus, the estimated size of the target population seems about right.

The RIA assumes that half of such uninsured children with parents who have nongroup coverage and 15 percent of those whose parents are uninsured would gain coverage under the new rules even though the rules do nothing to make coverage more affordable. (Starting January 1, 2014, health premium subsidies will be available, but the RIA is limited to the time period prior to then.) The RIA notes that two-thirds of the uninsured are in families below 200 percent of the federal poverty level, so the 15 percent assumption implies that nearly half of the uninsured children in the remaining families would gain coverage. There is no empirical support provided in the RIA for these particular assumptions; moreover, they yield the result that 51,000 (9.4 percent) of the target population would gain coverage. Such a high enrollment rate would appear to belie the experience of high-risk pools in the 34 states that have them, where it is estimated that even though such pools are theoretically open to all individuals with preexisting conditions, only 8 percent of the target population of medically uninsurable individuals enrolls in such pools.¹⁸⁷ This low enrollment rate persists despite the fact that high-risk pool premiums are heavily subsidized in some states. For example, in Minnesota, pool premiums are set at 125 percent of standard rates, resulting in 54 percent participation of the target population.¹⁸⁸ In contrast, in states where premiums are 200 percent of standard rates, risk-pool enrollment generally amounts to 1–4 percent of the medically uninsurable population. This suggests that even when preexisting-condition restrictions are removed entirely, a sizable fraction of this population would not be able to afford the premiums for coverage. The RIA observes that these children have health costs that are about three times the average for those without such conditions. In a private market where such coverage is accurately priced—that is, where premiums are 300 percent of standard rates rather than the 125–200 percent level seen in existing state high-risk pools—it would appear that a penetration rate in the low single digits would be far more plausible.

D. *Do any biases identified importantly affect the incidence of benefits identified in the RIA?*
No.

¹⁸⁶ Austin B. Frakt, Steven D. Pizer, and Marian V. Wrobel, “High-Risk Pools for Uninsurable Individuals: Recent Growth, Future Prospects,” *Health Care Financing Review* 26, no. 2 (2005).

¹⁸⁷ *Ibid.*

¹⁸⁸ *Ibid.*

Analysis of Costs

- A. *Does the analysis incorporate the full range of important costs that would arise as a result of regulation?* The RIA includes both the costs of notification and recordkeeping requirements as well as the cost and transfer effects of higher premiums associated with the various enhancements to coverage. As noted in the discussion of dependent coverage for young adults, treating the premium costs as transfers is generally correct, except that it understates costs related to health benefits administration, moral-hazard losses, and any tax subsidies related to employer-provided health benefits. None of these three cost measures is included in the RIA.

If not, how significant are the costs excluded relative to those included? Administrative costs range from 7.0 percent for large-group plans to 11.1 percent for small-group plans to 16.4 percent for nongroup plans.¹⁸⁹ As explained under dependent coverage for young adults, moral-hazard losses are likely 7.2 percent and the deadweight losses associated with tax subsidies related to expanded employer-based coverage are likely approximately one-seventh of the premium costs of expanded employer-based coverage.

- B. *At the organizational or individual level, are all relevant costs measured using a valid and reliable method?* The RIA appears to have used reasonable methods for estimating the costs of notification and recordkeeping requirements as well as the cost and transfer effects of higher premiums associated with the various enhancements to coverage, including preexisting-condition exclusions, elimination of annual and lifetime limits, elimination of rescissions, choice of health care professionals, and coverage of emergency services. However, premium costs are expressed as a percentage of premiums rather than an aggregate dollar amount. Thus, there is no straightforward way for the reader to discover the aggregate transfers associated with this rule. In the case of elimination of rescissions, the premium impact is stated to be small without providing a percentage figure. In contrast, for emergency services, the impact is asserted to be “less than one-tenth of one percent of premium.”¹⁹⁰

If not, are the measures biased in a way that costs are overstated or understated? There is no obvious bias in the estimated costs of notification and recordkeeping requirements. Assuming the transfer effects of higher premiums associated with the various enhancements to coverage were correctly estimated, overall costs have been understated to the degree that administrative costs, moral-hazard losses, and deadweight losses were ignored.

What is the approximate magnitude of this bias? Assuming that moral-hazard losses are approximately 7.2 percent of health benefits, that administrative costs range from 7.0–16.4 percent of premiums depending on firm size and type of plan, and that tax-related efficiency losses are about 14.4 percent of group premiums, costs are understated by

¹⁸⁹ Sherlock, *Administrative Expenses of Health Plans*.

¹⁹⁰ Internal Revenue Service et al., “Preexisting Condition Exclusions,” 37,213.

about 28 percent.¹⁹¹ In 2010, total private health insurance premiums in the United States were \$822 billion,¹⁹² so this would imply an underestimate of nearly \$2.4 billion.¹⁹³

- C. *Does the analysis identify all parties who would bear costs and provide unbiased measures of the universe of organizations and individuals who bear them?* With the exceptions noted earlier under benefits, the RIA uses reasonable and well-documented sources and methods to estimate the number of organizations and individuals potentially affected by these rules.

If not, are the measures biased in a way that costs are overstated or understated? Based on expert input, the RIA assumed that private insurers will not charge more than 200 percent of the standard rates for the coverage of children with preexisting conditions (even though average costs for such children are three times as large as for their counterparts without preexisting conditions). This seems plausible, although it is worth noting that premiums in Florida's high-risk pool are set at a maximum of 250 percent of the standard rates.¹⁹⁴ To the extent insurers charge premiums above 200 percent of the standard rates, more of the cost of coverage for high-risk individuals will be borne by those purchasing coverage rather than the general pool of insured individuals. These are transfer effects, however, not costs.

What is the approximate magnitude of this bias? Not applicable.

Do any biases identified importantly affect the incidence of costs identified in the RIA? No.

Analysis of Net Benefits

Accurately measured participation would have been only 21 percent of the levels estimated.¹⁹⁵ The RIA ignored net costs amounting to about 28 percent of premiums. The analysis provides no quantitative estimate of whether the benefits from expanded coverage

¹⁹¹ According to the RIA, elimination of preexisting-condition restrictions would increase premiums by about 1 percent in the nongroup market and have negligible effects on premiums in the group market; the removal of annual and lifetime limits would increase premiums about 1 percent in the nongroup market and 0.5 percent in the group market; restrictions on rescissions would not add more than a few tenths of 1 percent and patient protections less than one-tenth percent. *Ibid.*, 37,216. Excluding those with Medigap coverage, there is roughly one person covered by individual insurance for every 11 covered through employer-based health plans; see Christopher J. Conover and Thomas P. Miller, "Why a Public Plan Is Unnecessary to Stimulate Competition" (AEI Working Paper No. 162, Washington, DC, 2010). Thus, the weighted average increase in premiums would be just over 1 percent (that is, $[11/12] \times [0 + 0.005 + 0.003 + 0.001] + [1/12] \times [0.01 + 0.01 + 0.003 + 0.001]$), of which four-fifths would represent group coverage and one-fifth nongroup coverage. Applying these shares to the amount of premium costs underestimated for group premiums (7.2 percent moral hazard, approximately 8 percent administration, 14.4 percent deadweight losses) and nongroup premiums (7.2 percent moral hazard, 16.4 percent administration) yields an underestimate of 0.29 percent, which is 28 percent of the weighted average increase in premiums associated with these various reforms.

¹⁹² Sean P. Keehan et al., "National Health Spending Projections through 2020: Economic Recovery and Reform Drive Faster Spending Growth," *Health Affairs* 30, no. 8 (2011): 1,594–1,605.

¹⁹³ 0.029 percent times \$822 billion = \$2.40 billion.

¹⁹⁴ Frakt, Pizer, and Wrobel, "High-Risk Pools for Uninsurable Individuals."

¹⁹⁵ The maximum participation rate in high-risk pools with premiums capped at 200 percent of standard rates is 4 percent; assuming participation is only half this level in pools where premiums average 300 percent of standard rates yields a predicted participation rate of 2 percent, which is 21 percent of the 9.4 percent rate used in the RIA.

would exceed this amount, so it is uncertain whether benefits exceed costs. That is, unless benefits per participant originally exceeded costs by more than 28 percent, a more accurate accounting of costs might have concluded the rule was not cost effective.

Analysis of Alternatives

A. *Are there obvious alternatives not considered?* The only alternatives explicitly considered relate to the use of different annual benefit maximum-limit thresholds, culminating in a rule that would have phased in higher limits over a three-year period rather than all in a single year. This phased approach was viewed by the agency as being the fairest while also minimizing the impact on premiums in any given year.¹⁹⁶ The rule also established a waiver program to prevent the loss of coverage for enrollees in low-benefit health plans (so-called mini-med plans); this was also intended to mitigate the impact of immediately eliminating out-of-pocket limits. As of the end of June 2011, a total of 1,471 one-year waivers had been granted to plans whose enrollment totaled 3.2 million, representing about 2 percent of all Americans who have private health insurance. On June 17, 2011, CMS introduced a process for plans that have already received waivers and want to renew those waivers for plan or policy years beginning before January 1, 2014.¹⁹⁷ These waivers have been criticized as “crony politics” favoring vested interests such as unions:¹⁹⁸ more than half of those enrolled in waived plans belong to unions¹⁹⁹ even though only 13.1 percent of U.S. workers are represented by unions.²⁰⁰ That said, many of the 216,399 workers in plans that were denied waivers also are in union plans.²⁰¹

This rule provided an opportunity for the agency to reassess Congress’s decision to eliminate annual limits on coverage. In every other major domain of insurance—automobile, homeowner’s, personal liability, and so forth—annual limits on coverage are a standard feature.²⁰² Above a certain level—which will vary from individual to individual—the incremental benefits of coverage for extremely rare events are simply not worth the added expense. Whether from a societal level or individual level, it is not particularly rational to eliminate entirely the financial risk associated with one particular contingency (an accident or very expensive illness) while retaining a financial risk associated with contingencies that might actually be more probable. The RIA offers no evidence that market failure rather than heterogeneous preferences lie behind the current patterns of coverage.

¹⁹⁶ Internal Revenue Service et al., “Preexisting Condition Exclusions,” 37,207.

¹⁹⁷ HealthCare.gov, “Annual Limits Policy: Protecting Consumers, Maintaining Options, and Building the Bridge to 2014,” news release, June 17, 2011, <http://www.healthcare.gov/news/factsheets/annuallimit06172011a.html>.

¹⁹⁸ Jordan Fabian, “Healthcare Reform Waivers Part of ‘Crony Politics,’ Pawlenty Says,” *The Hill*, May 18, 2011.

¹⁹⁹ This includes 1,012,614 in multiemployer Taft-Hartley plans and 607,346 in non-Taft-Hartley union plans. This is a lower-bound estimate, as there are also union plans listed among the self-insured employer plans and health reimbursement arrangements given waivers. See various lists of approved waiver applicants at HealthCare.gov, “Annual Limits Policy.”

²⁰⁰ Bureau of Labor Statistics, “Table 1. Union Affiliation of Employed Wage and Salary Workers by Selected Characteristics,” economic news release, 2011, <http://www.bls.gov/news.release/union2.t01.htm>.

²⁰¹ Center for Consumer Information and Insurance Oversight. “Annual Limits Waiver Applicants Receiving Denial Letters,” Center for Consumer Information and Insurance Oversight, HHS, August 19, 2011, http://cciio.cms.gov/resources/files/denials_081911.pdf.

²⁰² Cutler and Zeckhauser, “Extending the Theory to Meet the Practice of Insurance.”

No alternatives were analyzed for preexisting-condition exclusions, prohibitions on rescissions, greater choice of health care professionals, or prohibition on preauthorization requirements for emergency services. Shortly after the passage of the ACA, a dispute arose over how to interpret the preexisting-condition exclusion as it applied to children under 19, which was to become effective on September 23, 2010. As written, the law merely required insurers to cover preexisting conditions if a child was given health insurance, but this theoretically permitted insurers to deny coverage to such children. The requirement that all individuals (children and adults) with preexisting conditions be offered coverage (a so-called guaranteed-issue requirement) was not to become effective until 2014.²⁰³ On March 29, 2010 (less than a week after the ACA became law), Secretary Sebelius wrote a letter to Karen Ignagni, the head of America's Health Insurance Plans (the major health insurance industry trade group) stating, "I am preparing to issue regulations in the weeks ahead ensuring that the term 'preexisting-condition exclusion' applies to both a child's access to a plan and to his or her benefits once he or she is in the plan. These regulations will further confirm that beginning in September 2010: children with preexisting conditions may not be denied access to their parents' health insurance plan."²⁰⁴ Accompanying the letter was a statement from the chairmen of the three House committees responsible for health policy that read, "We have been assured by the Department of Health and Human Services that any possible ambiguity in the underlying bill can be addressed by the Secretary with regulation." In short, the secretary unilaterally imposed a guaranteed-issue requirement on insurers effective in 2010 even though the law did not explicitly provide for this until 2014. The rule writers did not consider an alternative approach that would have adhered to the letter of the law as enacted. Instead, the letter written by Secretary Sebelius two months before the rule's release appears to have foreclosed any further analysis inconsistent with how the administration's political appointees wanted the law to be interpreted.

- B. *Would any obvious alternatives have provided a less-costly way to achieve the objectives of the regulation?* The phased-in approach to removing annual limits is less expensive than the alternative of immediately removing them. No market failure was documented to explain why the various insurance reforms or protections required by the rule have not seen universal adoption among group and nongroup health plans. Absent such evidence, the rule simply supplants the judgment of bureaucrats for plan subscribers when it comes to determining what constitutes the best value for the money. Thus, any alternatives that were less restrictive than the ones imposed by the rule still would have met the objectives of the legislation (albeit less completely) at a lower cost.

²⁰³ Huma Khan, "In Controversy over Coverage for Kids with Pre-existing Conditions, Who's to Blame? The New Law or the Insurance Companies?" ABC News's Political Punch, March 30, 2010, <http://abcnews.go.com/blogs/politics/2010/03/in-controversy-over-coverage-for-kids-with-preexisting-conditions-whos-to-blame-the-new-law-or-the-i>.

²⁰⁴ Letter from HHS Secretary Kathleen Sebelius to Karen Ignagni, March 29, 2010, http://abcnews.go.com/images/Politics/Letter_Sebelius_to_Ignagni_100330.pdf.

Coverage of Preventive Services

Overview

The ACA requires health plans to cover specified preventive services without any cost-sharing. These requirements do not apply to grandfathered plans and issuers.

These mandatory interim final rules with requests for comments (75 FR 41,726), issued July 19, 2010, and effective September 17, 2010, require group and nongroup health plans to cover the costs of specified preventive health services.²⁰⁵

These rules are intended to promote the use of preventive health services by removing financial barriers to their use. Two guidance documents have been issued related to these regulations. Amendments to interim final rules with request for comments were issued on August 1, 2011, and made effective for plans starting August 1, 2012.²⁰⁶ These rules incorporated new health plan coverage guidelines supported by the Health Resources and Services Administration (HRSA). These are based on an Institute of Medicine (IOM) study commissioned by HHS to review what preventive services are necessary for women's health and wellbeing and should be considered in the development of comprehensive guidelines for preventive services for women. HRSA is supporting the IOM's recommendations on preventive services that address health needs specific to women and that fill gaps in existing guidelines. However, the amended rules specify that group health plans sponsored by certain religious employers and group health insurance coverage in connection with such plans are exempt from the requirement to cover sterilization and contraceptive services. Nevertheless, many of these groups view this exemption for "religious employers" as too narrowly defined, since rules say, "The inculcation of religious values [must be] the purpose of the organization."²⁰⁷ That is too narrow to include hundreds of Catholic universities, elementary and secondary schools, hospitals, and social-service organizations such as Catholic Charities.²⁰⁸ Some Catholic agencies have said the rule will force them to drop all health coverage, which in turn may force some of them to close. Catholic health institutions reportedly employ 750,000 people nationwide.²⁰⁹ It remains to be seen whether the rule will be amended in light of the many concerns voiced by Catholic agencies, which had until September 30, 2011, to file comments. Statutory restrictions include:

- Section 2713(a) specifies that group and nongroup health plans shall, at the minimum, provide coverage for and shall not impose any cost-sharing requirements for:
 - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);
 - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved;

²⁰⁵ Internal Revenue Service et al., "Coverage of Preventive Services."

²⁰⁶ Ibid.

²⁰⁷ Ibid., 46,623.

²⁰⁸ John Garvey, "HHS's Birth-Control Rules Intrude on Catholic Values," the *Washington Post*, September 30, 2011.

²⁰⁹ Anne Rodgers, "Catholic Agencies Fight Birth-Control Proposal," *Pittsburgh Post-Gazette*, September 26, 2011.

- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by HRSA;
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the USPSTF). The rule clarifies the circumstances under which cost-sharing is waived and further specifies that plans are not required to provide coverage of preventive services delivered by an out-of-network provider.
- Section 2713(a) further clarifies that for the purposes of the ACA, other than the recommendations issued in or around November 2009, the current recommendations of the USPSTF regarding breast-cancer screening, mammography, and prevention shall be considered the most current.²¹⁰
- Section 2713(a) also provides that nothing in the ACA shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by USPSTF or to deny coverage for preventive services not recommended by the Task Force; the rule clarifies that cost-sharing is permitted for such additional services that go beyond Task Force recommendations.
- Section 2713(b) requires the secretary to establish a minimum interval between the date on which a recommendation by the USPSTF, ACIP, or HRSA is issued and the plan year its coverage becomes required; however, this interval “shall not be less than 1 year;” the rule defines this interval.
- Section 2713(c) allows the secretary to develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to use value-based insurance designs.

Analysis of Benefits

- A. *Does the analysis incorporate the full range of important ultimate outcomes that affect citizens’ quality of life?* The outcomes cited or implied are: (a) reductions in morbidity and mortality due to prevention, reduced transmission of illnesses, delayed onset, and earlier treatment of disease; (b) increased productivity and fewer sick days for adults and children; (c) savings resulting from lower health costs; and (d) a more equitable distribution of preventive services costs. No important outcome appears to be omitted.

If not, how significant are the outcomes excluded relative to those included? Not applicable.

- B. *At the organizational or individual level, are all relevant outcomes measured using a valid and reliable method?* There is no effort to comprehensively measure health benefits. A table of the potential lives saved if the use of eight preventive services were

²¹⁰ This provision was inserted to circumvent newly issued USPSTF guidelines recommending that women should begin having routine mammograms at age 50 rather than at age 40. David M. Herszenhorn, “Senate Blocks Use of New Mammogram Guidelines,” the *New York Times*’s Prescriptions Blog, December 3, 2009, <http://prescriptions.blogs.nytimes.com/2009/12/03/gop-amendments-aim-at-new-cancer-guidelines>.

increased to 90 percent is provided. But for four services, this would entail more than doubling the current use rates and an increase of 7–42 percentage points for the remainder. The analysis concedes use is “unlikely” to increase to 90 percent. Based on evidence (no citations are provided) showing that the use of preventive services is 3–30 percentage points higher for high-income, insured individuals compared to their uninsured counterparts, the analysis concludes that a “reasonable assumption” is that the average increase in the use of preventive services will be on the order of 5–10 percentage points for “some of them.”

There is no effort to comprehensively calculate cost savings. Literature is cited showing that most childhood immunizations are cost saving, as well as discussing aspirin use and tobacco use screening or intervention. These are expressed in terms of savings per dollar of expenditure and savings per smoker, though, so there is no way even to impute with the information given what the overall impact on premiums would be. Rather than fully quantifying cost savings for the full range of preventive services, the RIA calculates potential savings using obesity reduction as an illustration. Using a variety of well-documented literature, the RIA builds a synthetic estimate of potential savings based on chaining together a series of assumptions about the fraction of obese patients who would increase their use of dietary counseling, the impact of counseling on weight loss, the impact of weight loss on costs, and so forth.

If not, are the measures biased in a way that outcomes are overstated or understated?

There is nothing obviously wrong or biased about how this synthetic estimate is assembled, but clearly its reliability is much lower than empirical studies showing that intervention X led to cost reduction Y. The RIA also could lead the naïve reader to believe that cost savings can typically be expected from the increased use of clinical preventive services since there is no effort to provide any context for the very positive findings presented. Literature reviews have concluded that most clinical preventive services typically are not cost saving—a conclusion that might well surprise readers of the RIA given the selective handful of studies examined.²¹¹

What is the approximate magnitude of this bias? Not applicable.

- C. *Does the analysis identify all parties who would receive benefits and provide unbiased measures of the universe of organizations and individuals who benefit?* Unlike most of the other rules reviewed, there is no systematic effort to quantify the number of individuals who would benefit. Table 2 in the RIA does provide a compilation of estimates for eight high-impact preventive services, identifying particular population groups (such as men ages 40 and over) and the estimated percentage of each group that is using that particular preventive service. However, the table does not list the number of individuals in each of the target population groups. Similarly, the analysis of the distributive impact of the new rule alludes to some individuals having no coverage for certain preventive services, while others face large coinsurance or deductibles associated

²¹¹ Monheit et al., “State Policies Expanding Dependent Coverage to Young Adults in Private Health Insurance Plans;” Finkelstein and McKnight, “What Did Medicare Do (and Was It Worth It)?;” Dow, “The Introduction of Medicare;” and Card, Dobkin, and Maestas, “The Impact of Nearly Universal Insurance Coverage on Health Care Utilization and Health.”

with use of such services. There is no effort even roughly to quantify the overall fraction of individuals falling into these various categories, or how these categories are distributed by group versus nongroup coverage or small firms versus large firms, and so forth, except qualitatively (for example, coverage is less generous in nongroup plans compared to group plans).

If not, are the measures biased in a way that outcomes are overstated or understated?

Not applicable.

What is the approximate magnitude of this bias? Not applicable.

- D. *Do any biases identified importantly affect the incidence of benefits identified in the RIA?* There is extremely limited discussion of the incidence of benefits. Because there already is widespread coverage of preventive services in the private health insurance market, some Americans will experience substantial reductions in out-of-pocket spending for preventive services whereas others will see very little change in out-of-pocket costs. But there is not even a qualitative indication of how many people are in either group.

Analysis of Costs

- A. *Does the analysis incorporate the full range of important costs that would arise as a result of regulation?* The RIA includes only the cost and transfer effects of higher premiums associated with the expanded coverage of preventive services. These costs are calculated using premiums rather than by the more conventional approach of measuring the costs of moral hazard (7.2 percent of premiums), administrative costs (7.0–16.4 percent depending on the type of coverage and size of the employer), and tax-related efficiency losses related to tax subsidies (14.4 percent of premiums for employer-sponsored coverage). Because the expected benefits of medical-services use are not explicitly measured on the benefits side (that is, they are catalogued only qualitatively), the inclusion of premiums used to finance these expanded benefits technically overstates the net amount of measured costs imposed by the rule. The analysis included no projection of possible job losses related to the impact of the rule on Catholic agencies, although in fairness, the IOM had not yet determined that contraceptive and sterilization services would be covered at the time the RIA was performed.

If not, how significant are the costs excluded relative to those included? The use of premium costs may overstate actual costs by an amount likely greater than the other costs excluded from the analysis. However, the section on the need for federal regulatory action offers only three theoretical justifications for the underprovision of preventive health service benefits in the private health insurance market (discussed below). These justifications are questionable. If there is no market failure, then it is inaccurate to presume that mandating coverage for such services will improve social welfare. On the contrary, in the absence of any market failure, the fact that preventive services are not universal can be attributed to heterogeneity in preferences. In fact, the absence of universal coverage for preventive care could be viewed as a rational response based on the available literature. In that case, mandating coverage will result in a net loss of welfare for those who have already demonstrated by their behavior that whatever benefits are associated with such coverage were not worth the added premiums required.

The first justification offered in the RIA is that health insurers lack the incentive to cover services whose benefits may be realized only after an individual is no longer enrolled. But since health insurers behave as agents of individuals, it is not clear why individuals would nevertheless not demand such services so long as future benefits outweigh their premium costs.

The RIA also argues that individuals are less likely to take up preventive health services because benefits do not accrue immediately. But unless individuals are irrational in their time preferences—a claim not advanced in the rule’s analysis, hence no documentation for it is offered—the mere fact that benefits occur in the future implies that rational individuals should discount to some extent future benefits, else they implicitly (and illogically) will be treating \$1 of future savings as the equivalent of \$1 in today’s costs. This case for market failure is undercut substantially by the later observation in the RIA that over 85 percent of employer-sponsored insurance plans cover preventive health services with no deductible. The RIA fails to consider what differentiates employer-sponsored plans that do and do not cover preventive services. Given heterogeneity in preferences, there’s no a priori reason to believe that the 15 percent that elect not to include preventive services can be attributed to market failure rather than differences in taste across employees (the same sort of differences in taste that lead some employees to self-select into employment arrangements with more generous vacation or sick-leave benefits than others). If the majority of employees in a company desire preventive health benefits (and are willing to pay the premiums required for them), that company typically can be expected to add such benefits, as failure to do so risks losing employees to competitors that already cover preventive health services.

The third justification for federal action, according to the RIA, is that some of the benefits of preventive services—the analysis provides no estimate of how many—accrue to society as a whole. Because the RIA has not established a convincing case for why employers or their employees should voluntarily leave a large surplus of net benefits on the table by not purchasing preventive services, it is reasonable to assume that the premium costs of coverage outweigh the aggregate direct benefits that would accrue to employees from having such coverage. In short, every dollar of premiums paid (inclusive of administrative costs) would be associated, at best, with no more than \$1’s worth of preventive benefits, else it would be irrational not to purchase such coverage. Only the societal spillover benefits conceivably could justify government compulsion to purchase such coverage. Thus, the analytic issue, which is never addressed, is whether the hidden costs of mandatory coverage—roughly 7.2 percent in moral-hazard losses and tax-related efficiency losses of 14.4 percent—exceed such benefits. Altogether, the RIA has understated the appropriate costs to consider by at least 20 percent.

If the analytical claim is that there are benefits external to the individual because of shared health care costs, then the issue is one of sharing health care costs. As the analysis above shows, if sharing costs is done voluntarily, it is unlikely to be a problem. If it is forced sharing of costs through federal mandates, then there is no market failure associated with the externality; it is a government failure that creates the externality.

- B. *At the organizational or individual level, are all relevant costs measured using a valid and reliable method?* Premium increases are expressed per person or as a percentage of premiums. There is no effort to report this as an aggregate dollar cost; moreover, the estimates provided regarding the types of plans that would be affected and number of individuals with each type of coverage are insufficient for even an analyst, much less the average reader, to approximate the magnitude of this aggregate impact. Where documentation is provided, the sources and methods for calculating discrete impacts appear reasonable (for example, \$24 in reduced out-of-pocket costs for those already covered by employer-sponsored preventive benefits). However, discrete estimates too often are reported without any sourcing or underlying calculations, for example, “the Departments estimated that adding coverage for genetic screening and depression screening would increase insurance benefits an estimated 0.10 percent.”²¹²

If not, are the measures biased in a way that costs are overstated or understated? It is difficult to determine this. The RIA codified a series of specific preventive services that must be adopted under these regulations. These include more than 44 preventive health service benefits recommended by the USPSTF, and various other recommendations regarding immunizations and guidelines for pediatric preventive care issued by other federal agencies. The analysis separately (and appropriately) distinguishes between increased costs resulting from currently uncovered preventive services, such as genetic testing for the BRCA gene, and those resulting from induced demand for preventive health services arising from the elimination of cost-sharing. It is asserted that premiums will increase approximately 1.5 percent for enrollees in nongrandfathered plans, but no one could independently generate this estimate from the paucity of analytic assumptions and data provided.

What is the approximate magnitude of this bias? No way of determining this.

- C. *Does the analysis identify all parties who would bear costs and provide unbiased measures of the universe of organizations and individuals who bear them?* The RIA accounts for those in grandfathered plans and individual plans that would be affected by the rule. It does not account for the hidden impact on taxpayers, nor does it attempt to determine whether the rule would have a disproportionate effect on lower-income workers and individuals.

If not, are the measures biased in a way that costs are overstated or understated? By virtue of ignoring deadweight losses borne by taxpayers and moral-hazard losses borne by all with private health insurance coverage, costs generally are understated. Also, the analysis conceded the evidence base for individual plans was weaker than that of the group market, “making detailed estimates of the size of this effect difficult and highly uncertain.” The analysis indicated the impact will be “larger” in the individual compared to the group market, but provided no concrete quantitative estimate of how much larger the impact might be.

What is the approximate magnitude of this bias? This cannot be determined.

²¹² Internal Revenue Service et al., “Coverage of Preventive Services.”

- D. *Do any biases identified importantly affect the incidence of costs identified in the RIA?* In general, it is reasonable to assume that provision of preventive health service benefits is greater among higher-income workers. Since the cost of health benefits ultimately is borne by workers, the rule would be expected to have a regressive impact on its own, with any adverse effects, such as increased unemployment, concentrated among the lowest-paid workers. While some of this would be mitigated by the subsidies available to small firms and individuals, low-wage workers in firms ineligible to purchase subsidized coverage through the health insurance exchanges would appear to be adversely affected the most. This point is not addressed even qualitatively in the RIA.

Analysis of Net Benefits

The RIA ignored net costs amounting to at least 20 percent of premiums. The analysis provides no quantitative estimate of whether the benefits from expanded coverage would exceed this amount, so it is uncertain whether benefits would exceed costs if these were calculated more accurately. The analysis does not provide a convincing explanation for why insurers would not cover highly cost-effective preventive services in the absence of subsidies. If the benefits of such coverage exceed its costs by 22 percent, this failure becomes that much more puzzling.

Analysis of Alternatives?

- A. *Are there obvious alternatives not considered?* The department rejected three alternatives: (a) waiving cost-sharing for an entire office visit, not just the preventive service(s) provided in that visit that are billed separately; (b) for visits without separate billing for preventive services, waiving cost-sharing for the entire visit even when the primary purpose of the visit was not preventive in nature; (c) imposing the identical waiver of cost-sharing requirements on in-network and out-of-network preventive services. The interim final rule does not require plans to provide preventive services coverage through out-of-network providers, and it also permits differential cost-sharing for such services on grounds that insurers and plans use such differences to promote use of in-network providers. Waiving cost-sharing for out-of-network services might have undercut the incentive of providers to participate in insurer networks, leading to higher costs.

All of the rejected alternatives would have resulted in higher costs. The statute explicitly codified which preventive services for which cost-sharing should be waived, including a long list of grade A and B recommendations from the USPSTF, recommendations of ACIP that have been adopted by the director of the Centers for Disease Control and Prevention, and various comprehensive guidelines supported by HRSA for infants, children and adolescents. The department did not challenge this master list even though hypothetically it might have done so. For preventive services that are literally self-financing—that is, those with cost savings that exceed their costs—the market failure case is substantially stronger than where the incremental health benefits from a

preventive service require added spending.²¹³ In the latter cases, in light of heterogeneity in preferences, failure to include a preventive service may simply reflect the rational judgment that the benefits for the average plan member do not outweigh the added premium costs required. If they did, it would not make economic sense for a private plan not to include that service.

The RIA actually discussed some of the preventive services that have been found to save more in medical spending averted than they cost to provide. Many vaccines are good examples. This rule provided a good opportunity for the agency to better explain to Congress and the public that most preventive services do not result in net cost savings to the medical system. There is little downside in promoting those that do, whereas using regulations to encourage the coverage of services that do not lead to cost savings runs the risk of reducing social welfare to the extent that it is heterogeneity of preferences rather than market failure that contributes to the pattern of incomplete coverage of such services across health plans.

- B. *Would any obvious alternatives have provided a less-costly way to achieve the objectives of the regulation?* The number of preventive services that can be expected to result in net medical savings is much smaller than the number that confers demonstrable health benefits, but at a higher premium cost, to plan members. Using the Tufts–New England Center Cost-Effectiveness Registry, a database containing the results of thousands of cost-effectiveness studies, the authors have calculated that among all studies involving U.S. patients concerning primary prevention published from 2000–2010 and having a quality of five or better, only 32 were cost saving and improved health. The remaining 207 studies either produced cost savings at the expense of health or cost extra money to confer health benefits. Sixty-three of these studies achieved health gains at a cost exceeding \$100,000 per added year of life—a threshold generally viewed as exceeding the range that might be considered to be cost effective.²¹⁴ This clearly is not the entire universe of preventive health services (as such cost-effectiveness studies go back decades), but it is illustrative of how relatively few save the medical system any money. Thus, failure to consider a sensible restriction on which services merited inclusion under the rule greatly added to the rule’s cost.

²¹³ An important caveat is that preventive services that are self-financing on average are not necessarily self-financing for all population subgroups. Thus, even for normally self-financing benefits, it may be rational for a firm to forgo coverage of such services depending on the characteristics of workers in that organization.

²¹⁴ Conover, “How Health Affects the Bottom Line for Businesses and Employers.”

Internal Claims, Appeals, and External Review Processes

Overview

The ACA provides consumers with the right to appeal decisions made by their health carrier to an outside, independent decision maker, regardless of the state of residence or type of health insurance. Prior to the ACA, ERISA had internal appeals requirements for insured and self-insured employer-sponsored health plans; the ACA modified these and extended them to nongroup health plans as well. Prior to the ACA, ERISA did not impose any particular type of external or independent medical review on health plans, although most states imposed such requirements on fully insured plans. (ERISA preempted states from imposing such requirements on self-insured plans). The ACA established external review requirements for all types of plans, including both fully insured and self-insured group health plans and nongroup plans.²¹⁵

These interim final regulations with request for comments (75 FR 43,330), issued July 23, 2010, and effective September 21, 2010, require nongrandfathered plans and issuers to comply with a state external review process or the federal external review process.²¹⁶ This will ensure more uniform internal and external review processes for patients' claims and appeals. As such, the costs incurred by compliance with this rule are largely in support of greater equity, that is, perceived fairer processes for claim resolution.

The rules specify that state laws that meet or exceed the consumer protections in the NAIC Uniform External Review Model Act will apply to carriers subject to state law. The NAIC amended this model during the Spring 2010 National Meeting. These amendments were adopted as guidelines under the NAIC's model-laws process. In addition, until January 1, 2014, a state may operate an external review process under federal standards similar to the required consumer protections outlined in the interim final rules.²¹⁷

If HHS determines that a state has neither implemented the required consumer protections nor implemented a process that meets the federal standards that are similar to the required consumer protections, issuers in the state will have the choice of participating in either the HHS-administered external review process or contracting with accredited independent review organizations. This guidance also phases in the use of multiple independent review organizations for the plans that use them starting the following year as a way of ensuring that the external review is unbiased.

HHS is adopting this approach to permit states to operate their external processes under standards established by the secretary until January 1, 2014, to avoid unnecessary disruption while states work to adopt the consumer protections set forth in the July 2010 regulations. Starting in 2014, the appeals process will be more closely aligned across all types of plans.

Nine separate guidance documents have been issued in connection with these rules. Additionally, an amendment to these interim final rules with request for comments was issued June 24, 2011,

²¹⁵ Christine Eibner et al., *Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010 (ACA)* (Santa Monica, CA: Rand Corporation, 2011).

²¹⁶ Internal Revenue Service et al., "Internal Claims and Appeals."

²¹⁷ Center for Consumer Information and Insurance Oversight, HHS, "External Appeals," 2011, <http://cciio.cms.gov/programs/consumer/appeals/index.html>.

and made effective July 22, 2011 (comments due by July 25).²¹⁸ These rules are intended to respond to feedback from a wide range of stakeholders on the interim final regulations and to assist plans and issuers in coming into full compliance with the law through an orderly and expeditious implementation process.

Statutory Restrictions

Section 1001 of the ACA makes amendments to the Public Health Service Act:

- Section 2719(a)(1) requires group health plans to implement an effective appeals process for coverage determinations and claims denials under which the plan or issuer must, at the minimum, (a) have an internal appeals process; (b) provide notice to enrollees of the available internal and external appeals process and the availability of any consumer assistance or ombudsman to assist them; and (c) allow an enrollee to review their file, to present evidence and testimony as part of the appeal, and to receive continued coverage pending the outcome; the rule specifies the manner and form of such notifications.
- Section 2719(a)(2) requires group health plans to provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) established by the secretary of Labor (in 29 CFR 2560.503-1) and update them in accordance with any additional standards established by the secretary of Labor; the rule indicates that the Department of Labor is considering further updates to these standards and expects to issue future regulations related to them.
- Section 2719(a)(2) likewise requires an issuer offering individual coverage and any other issuers not subject to the existing regulations to provide an internal claims and appeals process that initially incorporates the procedures set forth under applicable law (as of March 23, 2010) and updates them consistent with standards established by the secretary of HHS; the rule provides such updated standards.
- Section 2719(b) requires that a group health plan and issuer offering group coverage (1) comply with the applicable state external review process for such plans and issuers that, at the minimum, includes the consumer protections in the NAIC's Uniform External Review Model Act and is binding on such plans or (2) implement an effective external review process that meets the minimum standards established by the secretary of HHS through guidance and that is similar to the above process, if (a) the state has no established external review process or (b) a plan is self-insured and not subject to state insurance regulation; the rule provides standards for determining which process applies as well as guidance regarding each process.
- Section 2719(c) permits the secretary of HHS to deem the external review process of a group plan or issuer in operation on March 23, 2010, to be in compliance with the applicable process established above, as determined appropriate by the secretary; the rule clarifies that such a determination may be either permanent or temporary.
- Section 1004(a) of the ACA makes these requirements effective on September 23, 2010.

²¹⁸ Internal Revenue Service et al., "Internal Claims and Appeals."

Analysis of Benefits

- A. *Does the analysis incorporate the full range of important ultimate outcomes that affect citizens' quality of life?* The statement of benefits is quite muddled compared to the other regulations reviewed. The claimed benefits of a more uniform, rigorous, and consumer-friendly system of claims and appeals processing include: (a) payment of previously denied benefits, (b) greater certainty and consistency in handling claims and appeals, and (c) efficiency gains resulting from improved access to information about how claims and appeals are adjudicated. Such gains result from replacing a patchwork quilt of different claims and appeals processes that varied by type of plan and state of residence with a more standardized system (that presumably is easier for health plans and consumers to understand or explain); such a system may make consumers more accepting of cost management, thereby culminating in reductions in unnecessary expenditures.

If not, how significant are the outcomes excluded relative to those included? One would think that a standardized claims and appeals system would result in a fairer system of adjudication in which similar situations are treated similarly. Likewise, it arguably would increase trust in the system. Some of the items listed above appear to be means toward these latter outcomes.

- B. *At the organizational or individual level, are all relevant outcomes measured using a valid and reliable method?* Due to data limitations and lack of effective measures, there was no effort to quantify expected benefits. The entire analysis of benefits is conducted using armchair reasoning rather than providing any empirical analysis. For example, the analysis speculates that if workers perceive the potential for the inappropriate denial of benefits, they will discount the value of such benefits to take this risk into account. This may result in fewer benefits being provided since workers will undervalue health benefits relative to the wage concessions that would be needed to finance them.

Elsewhere, the analysis states, "The Departments believe that excessive delays and inappropriate denials of health benefits are relatively rare," without offering any empirical evidence this is so.²¹⁹ Moreover, if this speculation were true, this would imply that the value of health benefits would be discounted only a small amount to account for such a small risk. But this undercuts the claim that "to the extent that delays and inappropriate denials occur, substantial harm can be suffered by participants, beneficiaries, and enrollees."²²⁰

If not, are the measures biased in a way that outcomes are overstated or understated?
Not applicable.

What is the approximate magnitude of this bias? Not applicable.

- C. *Does the analysis identify all parties who would receive benefits and provide unbiased measures of the universe of organizations and individuals who benefit?* In the cost section, the RIA uses credible sources and methods to estimate the total number of claims that would be approved and denied, along with the disposition of appeals for employer-

²¹⁹ Internal Revenue Service et al., "Internal Claims and Appeals," 43,341.

²²⁰ Ibid.

sponsored plans (public and private) and nongroup plans for the years 2011, 2012, and 2013.

If not, are the measures biased in a way that outcomes are overstated or understated? What is the approximate magnitude of this bias? Not applicable.

- D. *Do any biases identified importantly affect the incidence of benefits identified in the RIA?*
No.

Analysis of Costs

- A. *Does the analysis incorporate the full range of important costs that would arise as a result of regulation?* The RIA systematically assesses each step in the claims and appeals process, comprehensively accounting for all notification and other process costs associated with each step.

If not, how significant are the costs excluded relative to those included? Not applicable.

- B. *At the organizational or individual level, are all relevant costs measured using a valid and reliable method?* In sharp contrast to the purely speculative assessment of benefits, the cost analysis is heavily sourced and relies on credible sources and methods to calculate the number of claims and appeals by type and the relevant costs generated at each stage in the process. The analysis accounts for the cost of internal reviews, external reviews, fair and full reviews, recordkeeping, and start-up costs, as well as the impact of reversals on claims payments. Payments for previously denied claims generally are treated as transfers, that is, costs with identical offsetting benefits. However, this understates net costs since such claims still would have some claims-administration costs that do not have offsetting benefits. (For purposes of analysis, it seems reasonable to assume that there should not be excess use, that is, moral hazard, associated with claims given this level of scrutiny.) Likewise, any payment of claims that otherwise would be denied ultimately will impact premiums for coverage; thus, exclusion of deadweight losses associated with tax subsidies for employer-provided coverage adds further to the amount of understated costs.

If not, are the measures biased in a way that costs are overstated or understated? Except for the exclusion of administrative costs and deadweight losses, all costs appear to be measured in a plausible manner. Other researchers have found that administrative costs range from 7.0 percent for large-group plans to 11.1 percent for small-group plans to 16.4 percent for nongroup plans.²²¹ Marginal deadweight losses for employer-sponsored insurance were previously shown to be 14.4 percent.

What is the approximate magnitude of this bias? Not applicable.

- C. *Does the analysis identify all parties who would bear costs and provide unbiased measures of the universe of organizations and individuals who bear them?* The RIA systematically estimates the number of individuals by plan type (private ESI, government ESI, and nongroup) who will have claims denied, as well as the number of appeals by type (medical and administrative) and whether these were upheld or denied, assigning

²²¹ Sherlock, *Administrative Expenses of Health Plans*.

different time estimates and different labor rates, all of which appear to be appropriately selected and documented with credible sources.

If not, are the measures biased in a way that costs are overstated or understated? Not applicable.

What is the approximate magnitude of this bias? Not applicable.

- D. *Do any biases identified importantly affect the incidence of costs identified in the RIA?*
No.

Analysis of Net Benefits

It is uncertain how much benefits have been underestimated. In contrast, costs appear to have been underestimated by at least 20 percent. Consequently, it is uncertain whether a more accurate measurement of these would have reversed the agency's conclusion that the rule provides a net benefit.

Analysis of Alternatives

- A. *Are there obvious alternatives not considered?* The analysis did not consider any alternatives, which is one further measure of the haphazard manner in which this rule was issued. Currently there are at least four sets of standards for internal claims and appeals and external review processes. First, the NAIC has established a set of standards under a Uniform Model Act that the rule essentially makes the de facto national standard going forward. Second, all but six states already had enacted state external review laws (although thirteen states applied these only to selected segments of the market, such as managed-care plans); some of these are less restrictive than the NAIC Uniform Model Act (which provides a second set of standards to consider), while others are more restrictive (which provides a third set of standards). Fourth, self-insured plans covered by ERISA are subject to an internal claims review process that is regulated by the U.S. Department of Labor.

One might have expected the RIA to articulate these various standards and compare them side by side in terms of procedural requirements, time frames, and perhaps even estimated costs for a typical appeal. This would have permitted policymakers and the public to see inside the black box and consider how these various standards compare and contrast. It would have allowed an explicit consideration of the incremental costs associated with adopting one standard over another and would have encouraged discussion or analysis of whether more expensive standards were worth their added cost. None of this was done, so we have no way of knowing whether the rule ultimately selected the least-cost alternative for achieving its objectives.

- B. *Would any obvious alternatives have provided a less-costly way to achieve the objectives of the regulation?* The RIA implicitly assumes that more review requirements are always better, that is, that bringing all states up to the NAIC standard will produce benefits that exceed the cost of displacing less-restrictive standards. It has not arrived at this conclusion by examining those less-restrictive standards and demonstrating how or why they are flawed, nor has it even compared the standards in terms of their incremental benefits or asked whether the marginal cost of the most restrictive standard has any

reasonable relationship to its incremental benefits. In short, an interested policymaker or member of the public would have no plausible way of determining whether a less-costly, reasonable alternative was left on the table or of determining how much regulatory costs could have been reduced were another option considered.

Preexisting-condition Insurance Plan

Overview

The ACA required that within 90 days of enactment (June 23, 2010), all Americans and legal immigrants with a preexisting condition who have been uninsured for at least six months be eligible to buy an insurance plan through a high-risk health insurance pool without waiting periods related to their preexisting condition. The law set some basic conditions for which pools can qualify for assistance and appropriated \$5 billion to subsidize such pools.

This interim final rule with comment period (75 FR 45,014), issued July 30, 2010, and effective July 30, 2010, establishes a temporary high-risk health insurance pool program to provide subsidized insurance to eligible individuals until January 1, 2014.²²² At that time, these individuals will be insured either through Medicaid or private-insurance plans, which will no longer be able to exclude people due to preexisting conditions or price coverage based on health status. There also will be subsidies available to ensure that premiums are affordable regardless of family income.

Under the rule, HHS proposed allocating funds for the program by using a formula almost identical to the formula used for the Children’s Health Insurance Program (CHIP). Specifically, funds are allotted to states using a combination of factors including nonelderly population, nonelderly uninsured, and geographic cost as a guide.

As under CHIP, HHS intends to reallocate allotments after a period of not more than two years based on an assessment of state actual enrollment and expenditure experiences. This proposed reallocation aims to ensure that the capped amount of federal funding is allocated to states based on both the initial formula and performance.

Seven guidance documents have been released under this rule. Currently, HHS, with the help of the U.S. Office of Personnel Management and the U.S. Department of Agriculture’s National Finance Center, runs the Preexisting-condition Insurance Plan (PCIP) in 23 states and the District of Columbia. The federal government contracts with a national insurance plan to administer benefits in those states. The other 27 states have state-based programs.²²³ Although the actuary for CMS had reported that the \$5 billion in funding for this program might be exhausted as early as 2011,²²⁴ this possibility never materialized. Instead, as of September 30, 2011, the plan had only 37,624 enrollees,²²⁵ far below the 200,000–400,000 individuals the RIA projected would participate.²²⁶

Consequently, revised rules were issued on June 17, 2011, to remove a requirement that applicants obtain a letter from an insurer denying coverage before they could enroll. This requirement was viewed as time-consuming and a financial burden on some applicants since

²²² HHS “Pre-Existing Condition Insurance Plan Program.”

²²³ HealthCare.gov, “Pre-Existing Condition Insurance Plan Introduction,” 2011, <https://www.pcip.gov/LearnMore.html#ProgramChanges>.

²²⁴ David S. Hilzenrath, “Report: In Senate Plan, Insufficient Funding for Those with Preexisting Conditions,” *Capitol Briefing*, December 13, 2009.

²²⁵ HealthCare.gov, “State by State Enrollment in the Pre-Existing Condition Insurance Plan, as of September 30, 2011,” news release, November 18, 2011, <http://www.healthcare.gov/news/factsheets/2011/11/pcip11182011a.html>.

²²⁶ HHS, “Pre-Existing Condition Insurance Plan Program.”

many insurers require payment of the first month's premium upon application.²²⁷ Under the revised rules, PCIP applicants can now simply submit a letter dated within the past 12 months from a doctor, physician assistant, or nurse practitioner stating that they have or have had a medical condition, illness, or disability. Starting July 1, premiums were also reduced by as much as 40 percent in 17 states and the District of Columbia to better conform to the standard rates charged for coverage.²²⁸

Statutory Restrictions

- Section 1101(a) requires the secretary of HHS, to establish a temporary, national high-risk pool program no later than June 21, 2010, to provide health insurance coverage for eligible individuals from the date of establishment until January 1, 2014.
- Section 1101(b) permits the secretary to implement the program directly or through contracts with eligible entities, defined as state or nonprofit private entities. As a precondition for a state contract, a state must agree not to reduce the annual amount it expends for the operation of one or more state high-risk pools below the level of the previous year.
- Section 1101(c) requires qualified high-risk pools to (a) provide coverage to all eligible individuals without any preexisting-condition restrictions; (b) provide coverage for at least 65 percent of plan costs; (c) limit out-of-pocket costs to the maximum levels permitted for high-deductible health plans (that is, \$5,950 for individuals); (d) have premiums set at 100 percent of standard rates, allowing them to vary only according to the adjusted community-rating rules established under the ACA, except that rates can vary by age in a range of four to one (versus three to one under the ACA); and (e) meet any other requirements set by the secretary.
- Section 1101(d) defines an eligible individual as (a) a citizen or national of the United States or one who is lawfully present in the United States, (b) one who has been without qualified health insurance coverage during the preceding six months, and (c) one who has a preexisting condition as determined by HHS; the rule defines such conditions.
- Section 1101(e) requires HHS to establish criteria for determining whether insurers and group health plans have discouraged individuals from remaining enrolled in prior coverage based on health status. It requires issuers and employers who engage in such behavior to reimburse the program for such individuals who subsequently enroll in the program. Such determinations are to be based on criteria established by HHS and must include at least the following circumstances: (a) offering of money or other financial considerations for disenrolling from prior coverage, and (b) in cases where the premium for prior private coverage exceeds the premium under the new HHS program: (1) the prior coverage is a policy no longer being actively marketed by the insurer, or (2) the prior coverage is one for which duration or health status can be considered in determining renewal premiums; the rule further defines these criteria.

²²⁷ Michelle Andrews, "U.S. Health Plans Cut Premiums for Consumers with Pre-existing Conditions," the *Washington Post*, July 4, 2011.

²²⁸ These premium reductions occurred only in states with federally run pools; no premium adjustment was needed in six states since their premiums already conformed to standard rates. See *Ibid*.

- Section 1101(f) requires HHS to establish an appeals process to enable individuals to appeal determinations under this program as well as procedures to protect against fraud and abuse; the rule establishes such processes.
- Section 1101(g) appropriates \$5 billion to cover claims and administrative costs of the high-risk pool that are in excess of premiums collected, gives HHS the authority to stop taking applications for participation in the program to comply with this funding limit, and also provides for HHS to make “such adjustments as necessary” to eliminate any remaining deficit after such funds are spent.
- Section 1101(g)(3) requires HHS to develop procedures to provide for the transition of program enrollees into plans offered through an exchange, including allowing for an extension of coverage after the risk-pool provision is terminated, if HHS deems this necessary to avoid a lapse in coverage.
- Section 1101(g)(5) specifies that the ACA supersedes existing state laws or regulations (other than state licensing laws or laws relating to plan solvency) with respect to qualified high-risk pools established in accordance with this provision.

Analysis of Benefits

- A. *Does the analysis incorporate the full range of important ultimate outcomes that affect citizens’ quality of life?* The listed benefits include: (a) reductions in mortality and morbidity, (b) reductions in medical-expenditure risk, (c) increases in worker productivity due to improved worker health and reductions in job lock, and (d) decreases in uncompensated care losses currently borne by private insurance plan members. This is a complete listing of benefits associated with high-risk pools, except that the latter category is a transfer. As noted in previous discussions, the analysis should have instead simply included the deadweight losses associated with taxes used to finance uncompensated care losses borne by the public sector.

One other important benefit of a high-risk pool is that it reduces premiums in the individual market by removing a high-risk group that would otherwise be covered by premiums in the individual market and by removing a substantial degree of risk selection from that market. Much of this is a transfer. However, in the current voluntary market for individual coverage, insurers must build a risk premium into their rates to reflect the likelihood that those who are sickest will be most motivated to seek coverage while those who are the healthiest are given the least incentive. Medical underwriting and preexisting-condition exclusions help protect carriers against this risk, but inevitably plan members will know more about their own health than insurers. With those with the highest expense removed from the pool, this risk is considerably lower. Hence the size of the needed risk premium is correspondingly smaller.

If not, how significant are the outcomes excluded relative to those included? Of the total amount of medical care received by the uninsured in 2008, nearly two-thirds was uncompensated care.²²⁹ This fraction arguably would be higher for high-cost individuals

²²⁹ Cook, Landrum, and Meara, “The Impact of Medicare on Elderly Health and Utilization.”

since their spending is two to three times as high as those without preexisting conditions. Three-quarters of uncompensated care for uninsured individuals is financed by federal, state, and local government through a variety of funding mechanisms.²³⁰ Thus, exclusion of deadweight losses associated with tax-paid uncompensated-care costs is a sizable amount, arguably equivalent to more than one-fifth of all spending by the medically uninsurable. Similarly, a high-risk pool that removes the 1 percent of highest-cost cases will reduce premium costs in the individual market by 14 percent.²³¹ This cost obviously does not disappear, but this transfer has distributional implications and may result in larger numbers of individuals being able to afford nongroup coverage.

- B. *At the organizational or individual level, are all relevant outcomes measured using a valid and reliable method?* The RIA does not explicitly quantify any of the outcomes listed. It cites about half a dozen pieces of literature demonstrating that public or private health insurance is associated with either mortality or morbidity reductions. It cites two reviews of the literature that conclude that such reductions are nontrivial (for example, the uninsured have a 25 percent higher mortality risk).²³² Yet, it fails to include an equally comprehensive literature synthesis that concludes that for the nonelderly there are no or only very modest health benefits associated with obtaining health insurance coverage.²³³ This latter synthesis concludes that the observational studies that make up the lion's share of such literature to date are not very informative in demonstrating a causal link between coverage and improved health. For example, while it may be true that the uninsured have a 25 percent higher mortality risk, this may result from their being more willing than others to take gambles in other domains of their life, resulting in greater mortality due to automobile accidents, sporting injuries, or other risky behavior. Providing them coverage would not necessarily have much effect on such risk-taking behavior. On the contrary, just as mandatory seatbelt laws have been found to increase risky driving,²³⁴ it is conceivable that providing such individuals with coverage would increase their propensity for taking risks. When the focus is restricted to the handful of experimental and quasi-experimental studies from which causal inferences are more credible, the estimated magnitude of health gains associated with health insurance coverage is much lower.

The RIA cites several studies indicating that about half of bankruptcies are related to high medical expenses and that uninsured families reported difficulties in paying medical bills. But again, this literature leaves a misleading impression. First, the RIA ignores another study suggesting that only 27 percent of bankruptcies are primarily related to medical debt.²³⁵ Second, the RIA analysis did not point out that in the study showing half of

²³⁰ Ibid.

²³¹ Conover, "Congress Should Account for the Excess Burden of Taxation."

²³² Institute of Medicine, Committee on the Consequences of Uninsurance, *Care Without Coverage: Too Little, Too Late*, (Insuring Health) (Washington, DC: National Academy Press, 2002); and Institute of Medicine, op. cit. J. Hadley, "Sicker and Poorer: The Consequences of Being Uninsured," *Medical Care Research and Review* 60 no. 2 (2003): 3S–75S.

²³³ Levy and Meltzer, "What Do We Really Know about Whether Health Insurance Affects Health?"

²³⁴ P. Asch et al., "Risk Compensation and the Effectiveness of Safety Belt Use Laws: A Case Study of New Jersey," *Policy Sciences* 24, no. 2 (1991): 181–97.

²³⁵ Cutler and Zeckhauser, "The Anatomy of Health Insurance."

bankruptcies are medically related, only one-quarter of those categorized as having medical bankruptcies were uninsured at the time they filed for bankruptcy.²³⁶ Third, as noted earlier, because so much of uninsured spending is covered through uncompensated care rather than family out-of-pocket spending, the actual amount of risk-loss associated with lack of coverage (measured in dollar terms) is not very large.

The RIA cites evidence that increased worker access to health insurance is associated with improved worker health. It alludes to productivity improvements related to elimination of job lock, but does not cite any of the many studies documenting the amount of job lock attributable to employer-based coverage.

The RIA estimates that if 200,000–400,000 people enrolled in PCIP, this could reduce uncompensated-care costs for privately insured plan members by \$2–\$4 billion in 2013. The RIA states that increased insurance protection resulting from the patient protection regulations could result in reductions in insurance premiums of “up to \$1 billion in 2013.” In the next sentence, it states that assuming PCIP enrollment of 200,000–400,000, “the effect on uncompensated care could be over twice to four times as high as prior estimates associated with the patient protections.”²³⁷ This implies that each program member would otherwise generate \$10,000 in uncompensated-care losses passed on to privately insured subscribers. Since three-quarters of uncompensated care is financed through taxpayers, this would imply that each member would otherwise generate \$40,000 a year in uncompensated care alone. Since uncompensated care amounts to nearly two-thirds of spending by the uninsured, this implies that each member generates total medical spending of \$60,000 a year. This is implausibly large, as the average 2009 expense per high-risk pool member (exclusive of administrative costs) in the 35 states with such pools was only \$10,600.²³⁸

It seems more likely that \$10,000 represents the estimated total amount of uncompensated care per member enrolled in the program. This would imply total annual spending per capita of \$15,000.

If not, are the measures biased in a way that outcomes are overstated or understated? Altogether, even though no formal estimate of net health benefits is provided, the implied health gains codified in the RIA appear to be overstated, as are the financial risks associated with being uninsured.

What is the approximate magnitude of this bias?

If the total spending per person is \$15,000, as estimated above, the claimed reduction in uncompensated costs for privately insured plans would be only one-quarter of the \$2–\$4 billion figure used in the RIA, that is, between \$500 million and \$1 billion. This amount would represent transfers rather than benefits. That said, there are three dollars of tax-

²³⁶ David U. Himmelstein et al., “Medical Bankruptcy in the United States, 2007: Results of a National Study,” *American Journal of Medicine* 122, no. 8 (2009): 741–46; and KFF/HRET, *Employer Health Benefits 2010 Annual Survey*.

²³⁷ HHS, “Pre-existing Condition Insurance Plan Program,” 4,5028.

²³⁸ Calculated by the authors from data reported by the National Association of State Comprehensive Health Insurance Plans (NASCHIP), “Total Expenses by Pool 2009, 2010,” 2011, http://naschip.org/portal/index.php?option=com_dms&task=view_document&id=14&Itemid=0.

financed uncompensated care losses for every dollar in privately financed, uncompensated care losses. The RIA appears to account for the latter, but none of the former. But these tax-financed, uncompensated care losses also are transfers. Only the deadweight losses associated with these tax-financed expenditures should be counted as costs. These would amount to about one-third of total uncompensated care losses.²³⁹ It is difficult to translate the overestimate of health benefits and reduction in financial risks into dollar terms.

- C. *Does the analysis identify all parties who would receive benefits and provide unbiased measures of the universe of organizations and individuals who benefit?* The RIA assumes there will be 200,000–400,000 enrollees based on Congressional Budget Office estimates. If costs per enrollee are \$15,000 (as suggested above), this implies a total annual cost of \$3–\$6 billion, which is consistent with the \$12.5–\$14.3 billion total cost figure from 2010–13 cited below.

If not, are the measures biased in a way that outcomes are overstated or understated?
Not applicable.

What is the approximate magnitude of this bias? Not applicable.

- D. *Do any biases identified importantly affect the incidence of benefits identified in the RIA?*
No.

Analysis of Costs

- A. *Does the analysis incorporate the full range of important costs that would arise as a result of regulation?* The RIA accounts for total federal costs of \$5 billion, which purportedly will equal 35–40 percent of the total program costs. This implies a program total of \$12.5–\$14.3 billion, with the balance of revenues coming from patient premiums. However, most of this is a transfer with each dollar of costs having an identical amount of offsetting benefits.

Federal administrative costs are estimated to be \$1.9 million; the RIA does not estimate state administrative costs, since these can be financed through the federal subsidy. However, the figure is relevant for correctly calculating the program's net cost. The RIA ignores the deadweight loss from federal taxes needed to raise \$5 billion in subsidies. It also excludes any moral-hazard losses associated with coverage for high-risk individuals. (Even though they have higher-than-average medical spending, there is no theoretical reason to think they are less susceptible to moral hazard than other insured individuals.)

If not, how significant are the costs excluded relative to those included? Based on the experience of existing state pools, administrative costs should be about 5 percent of total premiums or roughly \$600–\$700 million.²⁴⁰ The deadweight loss associated with federal subsidies is 44 percent, or \$2.2 billion.²⁴¹ Moral hazard for Medicare beneficiaries was 28

²³⁹ This assumes that three-quarters of uncompensated care losses are publicly financed and that deadweight losses amount to 44 percent of tax revenues, so $44\% \times 75\% = 33\%$.

²⁴⁰ In 2009, total pool expenses for the 35 states with high-risk pools were \$2.177 billion, of which \$109.4 million (or 5.0 percent) was spent on administration, see NASCHIP, "Total Expenses by Pool 2009, 2010." Applying this percentage to total estimated program costs of \$12.5–\$14.3 billion yields \$600–\$700 million.

²⁴¹ Conover, "How Health Affects the Bottom Line for Businesses and Employers."

percent of program costs versus only 10 percent of paid benefits for those with typical private coverage. Since average spending for the elderly exceeds \$15,000,²⁴² it would appear participants in the preexisting-condition program are likely closer to the elderly in terms of use patterns and average annual spending. Conservatively assuming total program costs are \$12.5 billion, moral-hazard losses might be about \$3.5 billion.

- B. *At the organizational or individual level, are all relevant costs measured using a valid and reliable method?* At the individual level, average annual costs appear to be \$15,000, but this is not entirely certain given the opaque manner in which program costs are described.

If not, are the measures biased in a way that costs are overstated or understated? The \$15,000 amount is more than 40 percent higher than the average annual costs of those enrolled in state high-risk pools. Given that the federal government is subsidizing 35–40 percent of premiums, the \$15,000 figure is not entirely implausible. Unlike state high-risk pools, where premiums are anywhere from 125–250 percent of standard risks—that is, the rate charged to individuals in a given age/sex category who do not have a preexisting condition—the federal program will charge plan members only 100 percent of standard risks. This means the pool will be much more affordable even for individuals with much higher-than-average expenditures. Consequently, average spending per plan member might well exceed the level observed in state high-risk pools.

What is the approximate magnitude of this bias? Not applicable.

- C. *Does the analysis identify all parties who would bear costs and provide unbiased measures of the universe of organizations and individuals who bear them?* Yes.

If not, are the measures biased in a way that costs are overstated or understated? Not applicable.

What is the approximate magnitude of this bias? Not applicable.

- D. *Do any biases identified importantly affect the incidence of costs identified in the RIA?*
No.

Analysis of Net Benefits

When the net effect of overestimated benefits and underestimated costs (\$6.3 billion) is taken into account, the benefits of a federally subsidized high-risk pool no longer appear to exceed its costs. At a projected annual enrollment of 200,000 persons, a proper adjustment of costs would reduce net benefits by \$31,500 per person over four years. Even with a more optimistic enrollment figure of 400,000, such an adjustment would reduce per-capita net benefits by nearly \$16,000—and this does not even account for the further reduction in net benefits that would result from a more accurate calculation of benefits. Leaving aside the overestimate of benefits, benefits could exceed properly estimated costs only if the original analysis considered there to be at least \$2.30 in benefits per \$1 of costs.

²⁴² Centers for Medicare and Medicaid Services, “NHE Fact Sheet,” November 4, 2011, https://www.cms.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp.

Analysis of Alternatives

A. *Are there obvious alternatives not considered?* The analysis considered only two alternatives: (a) using guidance rather than rules and (b) using uniform eligibility standards for all preexisting-condition insurance plans rather than letting states determine who has a preexisting condition and is eligible for coverage. The law specifies the eligibility criteria to be used for participation in these plans, including (a) being a lawful citizen or national who is lawfully present in the United States, (b) having had no creditable coverage for at least six months (being uninsured),²⁴³ and (c) having a preexisting condition. The rule does not revisit these core eligibility requirements but instead specifies the documentation and verification procedures states can or may require to establish that a given individual meets all three eligibility screens. As one example, the rule uses the definition of preexisting conditions established under the Health Insurance Portability and Accountability Act (HIPAA). This seems like a sensible choice, since the alternative of having two federal definitions of preexisting conditions would appear to have been needlessly confusing.

The rule also relies on existing statutes and regulations that define creditable coverage as including participation in an existing state high-risk pool, though. Analysts could have, and arguably should have, flagged the substantial equity problems posed by this definition since it essentially penalizes both the 35 states that had earlier established high-risk pools and the individuals participating in them. Most state high-risk pools charge premiums equal to 105–250 percent of the standard rate for coverage if that individual did not have the preexisting condition (depending on the state, such standard premiums could vary by age and gender, among other factors). In contrast, the programs created by the federal law are restricted to charging a “standard rate for a standard population.”²⁴⁴ Thus, even in the 15 states that provided income-related subsidies for pool participants, it almost invariably will be far less expensive for subscribers to enroll in a federally subsidized high-risk pool than in a state pool.²⁴⁵ Moreover, with the exception of Alabama and South Dakota, whose risk pools are open to those made eligible by HIPAA (that is, those who lost group coverage involuntarily and have no other insurance options), all other state risk pools had preexisting-condition waiting periods of at least three months; most required waits of six to twelve months.²⁴⁶ Consequently, the requirement that individuals lack coverage for at least six months means that current state-pool enrollees will be trapped in inferior arrangements unless they are willing to accept a lapse in coverage.²⁴⁷

²⁴³ Creditable coverage includes plans with reasonably comprehensive coverage, such as a typical employer-based plan, Medicare, or Medicaid. A single-disease plan, such as one that covers only cancer, would not count as creditable coverage.

²⁴⁴ ACA, section 1101(c)(2)(C)(iii).

²⁴⁵ Len M. Nichols, “Implementing Insurance Market Reforms under the Federal Health Reform Law,” *Health Affairs* 29, no. 6 (2010): 1,152–57.

²⁴⁶ *Ibid.*

²⁴⁷ Mark Merlis, “Health Coverage for the High-Risk Uninsured: Policy Options for Design of the Temporary High-Risk Pool,” *Policy Analysis*, no. 2, National Institute for Health Care Reform, 2010, 9.

The inequity from the state perspective arises because the new high-risk pools will be subsidized by the federal government, whereas state high-risk pools are not. Since the statute also includes a maintenance-of-effort provision to ensure that states do not reduce the average amount of subsidies per participant in existing state high-risk pools, one can infer that Congress fully intended to penalize such states in exactly the fashion described.²⁴⁸ Had the RIA flagged this problem and perhaps articulated the magnitude of the financial penalty imposed (which would vary from state to state depending how much the high-risk pool premiums exceed standard rates), the resultant public comments would have provided Congress with targeted feedback regarding the public's view of this inequity and allowed a reconsideration of it.

- B. *Would any obvious alternatives have provided a less-costly way to achieve the objectives of the regulation?* On April 2, 2010, HHS Secretary Sebelius sent a letter to all governors and independent insurance commissioners signaling her intent to build on existing state programs and asking states to indicate by April 30 whether they would cooperate with HHS to create risk pools.²⁴⁹ This letter included five options for states, ranging from operating a new high-risk pool alongside a current state high-risk pool to the sole federal operation of the program. States not opting out must comply with federal regulations to create an exchange by March 23, 2012. If they fail to do so or are not making adequate progress by January 1, 2013, then HHS has the authority to organize a federal version or contract directly with a local nonprofit entity to run an exchange within a state or among several states. Thus, it appears the agency gave states enough flexibility to implement the program in the least costly way feasible. The only caveat is that having two parallel high-risk pools in 35 states, each with different eligibility criteria and rules about how they were managed, was potentially confusing to some potential recipients and may have been more administratively cumbersome. That said, to have folded existing pools into the new federal program would have resulted in crowding out existing state subsidies with federal subsidies. In light of the capped subsidy of \$5 billion, this would not have changed total program spending, but it would have meant fewer new medically uninsurable individuals could be served.

²⁴⁸ ACA, section 1101(b)(3).

²⁴⁹ Office of the Secretary, HHS, "Sebelius Continues Work to Implement Health Reform, Announces First Steps to Establish Temporary High Risk Pool Program," news release, April 2, 2010, <http://www.hhs.gov/news/press/2010pres/04/20100402b.html>.

Medical Loss Ratio Requirements

Overview

The ACA requires health insurance issuers offering individual or group coverage to submit annual reports to the secretary on the percentages of premiums that the coverage spends on reimbursement for clinical services and activities that improve health care quality; these fractions are called medical loss ratios (MLRs). MLRs require insurance companies to spend at least 80 percent or 85 percent of premium dollars on medical care, with the review provisions imposing tighter limits on health insurance rate increases. If they fail to meet these standards, the insurance companies will be required to provide a rebate to their customers starting in 2012.

The new law also directs the NAIC to establish uniform definitions and standardized methodologies for determining what services constitute clinical services, quality improvement, and other nonclaims costs for carrying out this provision.

The law allows the secretary to adjust the MLR standard for a state if it is determined that meeting the 80 percent MLR standard may destabilize the individual market. In order to qualify for this adjustment, a state must demonstrate that requiring the insurers in its individual market to meet the 80 percent MLR has a likelihood of destabilizing the individual market and resulting in fewer choices for consumers.

This interim final rule with request for comments (75 FR 7,464) implements the definition and methodology associated with the calculation of the MLR provisions of the ACA and the calculation of the rebate to consumers for plans that do not satisfy the MLR.²⁵⁰

Five guidance documents have been issued regarding this rule. As of November 30, 2011, one territory and 17 states had requested MLR waivers; HHS approved six (GA, ME, NH, NV, KY, and IA) and denied requests from Delaware, Louisiana, and North Dakota (no decision was required for Guam since all plans in the market affected by the rules are deemed to be in compliance due to the small size of that market). All remaining requests are pending.²⁵¹ Aetna, Pekin, American Community Mutual, Cigna, and Guardian Life have all left the individual market in Indiana over the past year, citing the MLR rule as their reason for departure.²⁵²

Statutory Restrictions

- Section 2718 of the Public Health Service Act (PHSA) was added by Sections 1001 and 10101 of the ACA.
- Subsection (a) of the new Section 2718 of the PHSA requires health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs effective in plan year 2010.
- Subsection (b) of the new Section 2718 of the PHSA states that a health insurer offering group or individual health insurance coverage must provide an annual rebate to each

²⁵⁰ Office of Consumer Information and Insurance Oversight, HHS, “Medical Loss Ratio Requirements.”

²⁵¹ Center for Consumer Information and Insurance Oversight, HHS, “Medical Loss Ratio,” 2011, <http://cciio.cms.gov/programs/marketreforms/mlr/index.html>.

²⁵² Letter from Robyn S. Crosson to Gary Cohen, “Indiana’s Request for Adjustment to Medical Loss Ratio Standard,” July 26, 2011, http://www.in.gov/idoi/files/IN_MLR_Application_Clarification.pdf.

enrollee under such coverage if the ratio of the amount of premium revenue expended by the issuer on certain costs to the total amount of premium revenue is less than 85 percent for plans in the large-group market and 80 percent for plans in the individual and small-group markets. This requirement to provide rebates is effective on January 1, 2011.

- Paragraph (3) of that subsection states, “The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.”

Analysis of Benefits

- A. *Does the analysis incorporate the full range of important ultimate outcomes that affect citizens’ quality of life?* The stated benefits are: (a) selection of higher-value coverage by consumers due to greater transparency; (b) improved health arising from increased investment in quality-improving activities stimulated by inclusion of such activities in the MLR; and (c) less disparate MLRs across issuers and states (equity). In light of well-documented geographic variations in health expenditures that affect the numerator of the MLR, it is not clear why the latter is presumed to be a benefit. But no obvious benefits have been excluded.

If not, how significant are the outcomes excluded relative to those included? Not applicable.

- B. *At the organizational or individual level, are all relevant outcomes measured using a valid and reliable method?* No effort was made to quantify the listed benefits.

If not, are the measures biased in a way that outcomes are overstated or understated? Not applicable.

What is the approximate magnitude of this bias? Not applicable.

- C. *Does the analysis identify all parties who would receive benefits and provide unbiased measures of the universe of organizations and individuals who benefit?* The RIA identifies transfer costs of roughly \$1 billion during the 2011–13 period resulting from rebates paid by insurers for plans that do not conform to minimum MLR standards. These are counted as savings to consumers and reduced profit for insurers.

If not, are the measures biased in a way that outcomes are overstated or understated? There is no obvious bias in the size of the calculated rebates.

What is the approximate magnitude of this bias? Not applicable.

- D. *Do any biases identified importantly affect the incidence of benefits identified in the RIA?* No.

Analysis of Costs

- A. *Does the analysis incorporate the full range of important costs that would arise as a result of regulation?* Added costs include: (a) increased spending on quality-improving activities, (b) increased spending on medical care, and (c) potential market disruption if some insurers limit plan offerings due to MLR restrictions or exit a market entirely. The rule presumes some level of so-called X-inefficiency, which is the failure of a firm or other organization to get the maximum possible output from the inputs it uses or to produce its output with the minimum use of inputs. But the RIA offers no evidence

supporting this presumption. If insurance companies already are conducting their businesses efficiently, then any movement away from that will create inefficiency. Excluded from consideration is the possibility that the regulation itself will create inefficiency. For example, because the rule requires broker fees to be counted as administrative costs, this has culminated in some carriers reducing such fees by as much as 50 percent in response to the rule.²⁵³ Consequently, consumers may make worse value for the money choices to the extent that the MLR restrictions reduce the role of brokers in facilitating the selection of appropriate coverage or will dissipate administrative efficiencies offered by brokers.²⁵⁴ The analysis also implicitly presumes all increases in medical care spending are valuable; it does not consider the possibility that the rules will motivate insurers to approve claims for services of questionable value simply so they can show they are spending the required percentage of premiums on medical care. Additionally, the rule counts spending on fraud detection as administrative costs unless such costs are offset by fraud recoveries. Yet, the most effective antifraud measures prevent fraud from occurring rather than merely recovering claims paid for fraudulent activities. By counting fraud-prevention efforts as administrative expenses, the rule discourages such activities. In short, the rule rewards plans that waste money on bloated benefits, fraud, or wasted spending.

If not, how significant are the costs excluded relative to those included? How much inefficiency might result from this rule is speculative, but even a 1 percent loss in efficiency would imply a welfare loss measured in tens of billions of dollars.²⁵⁵ The value of brokers has been documented in independent studies by the Center for Studying Health System Change and Congressional Budget Office.²⁵⁶ CBO has further stated that “because many small firms and individuals may find brokers’ services valuable, policymakers might consider allowing such services to be used in conjunction with [a buy-in option to the Federal Employee Health Benefit Plan].”²⁵⁷ If MLR restrictions result in the loss of broker services in some areas, this may result in small firms dropping coverage due to the lack of in-house staff capable of performing the functions brokers now perform.

- B. *At the organizational or individual level, are all relevant costs measured using a valid and reliable method?* The RIA concludes that one-time administrative costs related to reporting, record retention, and rebate payment and notification requirements will amount to 0.02 percent of total premiums for accident and health coverage, and total annual ongoing administrative costs will equal less than 0.01 percent of such premiums.

²⁵³ Arthur D. Postal, “NAIC Panel Seeks More Info before Backing Agent MLR Exemption,” *Property Casualty 360*, 2011.

²⁵⁴ NAIC, “The Comparative Roles of Navigators and Producers in an Exchange: What Are the Issues?” 2011.

²⁵⁵ Total expenditures on private health insurance, inclusive of administrative costs, are projected to be \$850.3 billion in 2011; see Centers for Medicare and Medicaid Services, “National Health Expenditure Projections 2010–2020,” January 2011, 7, <https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf>.

²⁵⁶ Engelhardt and Gruber, “Does Medicare Part D Protect the Elderly from Financial Risk?,” and Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (Washington, DC: U.S. Congress, 2008).

²⁵⁷ Bansak and Raphael, “The State Health Insurance Program and Job Mobility.”

If not, are the measures biased in a way that costs are overstated or understated? The analysis relies on limited data in states that already limit MLRs and on industry experts to select the assumptions used to drive the analysis. There is a great deal of uncertainty in the resultant figures but no obvious bias in how these assumptions were selected or the magnitude of results. Even the estimates of recordkeeping and other administrative costs reflect much more uncertainty than in similar estimates for the other rules examined.

What is the approximate magnitude of this bias? Not applicable.

- C. *Does the analysis identify all parties who would bear costs and provide unbiased measures of the universe of organizations and individuals who bear them?* The RIA appears to have used reasonable sources and methods to identify the number of plans and individuals that would be affected by the rule, including imputation procedures to account for limitations in the data sources used for analysis.

If not, are the measures biased in a way that costs are overstated or understated? There is no obvious bias in calculating the number of organizations and individuals that might be impacted by the rule.

What is the approximate magnitude of this bias? Not applicable.

- D. *Do any biases identified importantly affect the incidence of costs identified in the RIA?*
No.

Analysis of Net Benefits

Because neither costs nor benefits appear to have been underestimated, this rule is cost-beneficial only to the extent that the original analysis is correct. Unfortunately, in analytical terms, one cannot determine with certainty from the RIA that this rule meets a net benefit test. Moreover, even if the original rule met a cost-benefit test, the agency rejected an alternative that would have provided an even greater net benefit. Logically, the rule discourages plans from investing in fraud-prevention activities, as the following illustration shows. If a plan spends \$15 for every \$100 in premiums, it meets the minimum MLR requirement of 85 percent. But if it elects to spend an additional \$1 for a fraud-prevention program that saves \$5, its MLR would drop to 83 percent (\$16/\$96; see page 15), and it would be financially penalized. This would appear to encourage inefficiency rather than efficiency.

Analysis of Alternatives

- A. *Are there obvious alternatives not considered?* The department considered and accepted a proposal by NAIC to adopt a credibility adjustment for small plans, reportedly saving approximately \$300 million relative to the cost of the rule as published.²⁵⁸ The department also considered and adopted NAIC's proposal to exclude payroll taxes and Social Security taxes from the denominator when calculating MLRs, reportedly saving nearly \$50 million in rebates that issuers otherwise would have paid. The department also considered and accepted NAIC recommendations regarding the definition of quality-improving activities, rejecting both narrower and broader definitions in the process.

²⁵⁸ Office of Consumer Information and Insurance Oversight, HHS, "Medical Loss Ratio," 74,917.

Finally, the department rejected the alternative that MLRs be aggregated to the national level for multistate health plans. The rationale was that health insurance is regulated at the state level, and it is important for consumers in each state to receive value for their insurance premium. The first justification is ironic insofar as the entire federal health care law does a great deal to take health insurance regulation out of the hands of the states and place it in the hands of the federal government. This is a process that began in 1974 with the preemption of state regulation of self-insured health plans under ERISA. The trend continued under HIPAA with the expansion of various small-group and nongroup market health insurance reforms. The ACA extends such reforms further, including rules that affect eligibility for benefits, the scope of coverage, various consumer protections related to standardizing information and appeals processes, and the MLR rules themselves, which arguably are a backdoor way to regulate prices in the health insurance market.

The rule followed NAIC model legislation in allowing all costs of fraud discovery to be counted as quality-improving activities (and hence counted as benefits rather than administrative costs) only to the extent that such costs are offset by recoveries. But fraud that is prevented by definition cannot be recovered. Generally, it is much more administratively efficient to prevent fraud than to pay and chase after the fact. Clearly, the analysis ignored an important alternative: counting all antifraud activities as a contribution to the MLR.

Another obvious alternative not examined is to rely on better informing consumers about the MLR of the plan they are in rather than supplanting the judgment of consumers about what ratio is acceptable. If the fundamental justification for this rule is lack of transparency in pricing, arming consumers with information arguably could achieve the same objectives at a much lower cost.

- B. *Would any obvious alternatives have provided a less-costly way to achieve the objectives of the regulation?* The RIA states that allowing multistate plans to aggregate their MLRs to the national level would have saved \$268 million in rebates, would have reduced the required number of reports by 29 percent, and would have cut the estimated one-time and ongoing administrative costs of reporting by 49 percent.²⁵⁹

Health insurance fraud reportedly accounts for 3–10 percent of health spending.²⁶⁰ Yet, only 10 percent of this is detected each year and only \$0.10 of each fraudulent \$1 billed is recovered.²⁶¹ These figures suggest that the current system massively underinvests in fraud prevention and detection efforts. Thus, discouraging incentives to prevent fraud has the potential to cost the health system tens of billions of dollars.

Giving better information to consumers presumably would not reduce the administrative costs of compliance, since the same sort of information would need to be reported. It would eliminate premium rebates, which would save a small amount on administrative costs, but the rebates themselves are simply transfers, so this would not appreciably affect the cost of the rule. The potentially much larger cost imposed by this rule relates to its putting small plans at a competitive disadvantage. As with many products and insurance

²⁵⁹ *Ibid.*, 74,917.

²⁶⁰ National Health Care Anti-Fraud Association, “The Problem with Health Care Fraud.”

²⁶¹ SAS, “Fraud Detection and Prevention.”

services, smaller companies may try to compete by offering superior customer service rather than the lowest price. The MLR rules will shrink the margins of adjustment on which plans compete and will tilt the playing field in favor of those with the greatest economies of scale, even if these are achieved at the expense of more hands-on customer service.