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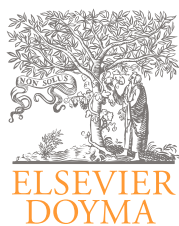
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## Original Article

# Allocating responsibility for health care decisions under the United States Affordable Care Act<sup>☆</sup>



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### ABSTRACT

This article summarizes the major elements of the ACA's insurance reforms and how they affect responsibility for making decisions about the health care that people receive. A key example of the difficulty of allocating decision making responsibility is the effort to define a minimum benefit package for insurance plans, called essential health benefits. While the ACA should achieve its goal of near-universal access to care, it leaves in place a multiplicity of processes and decision-makers for determining individual treatment. As a result, decisions about what care is provided are likely to remain, much as they are today, divided among government agencies, private insurers, private employers, and the courts.

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## A distribuição da responsabilidade por decisões em saúde ao abrigo do Affordable Care Act americano

### RESUMO

Este artigo resume os elementos principais das reformas no sistema de seguros de saúde introduzidas pelo Affordable Care Act (ACA) nos EUA e discute como estas afetam a distribuição de responsabilidade pelas decisões ao nível da prestação de cuidados de saúde. Em particular, o esforço de definição de um pacote de benefícios mínimos nos planos de seguros de saúde, denominado Essential Health Benefits, constitui um exemplo fundamental da dificuldade de atribuição e delimitação de responsabilidade pela tomada de decisão a este nível. Desta forma, enquanto o ACA procura atingir o seu objectivo de proporcionar um acesso o mais universal possível aos cuidados de saúde por parte da população americana, deixa no terreno uma multiplicidade de processos e decisores para a determinação de cada tratamento individual. Em consequência, as decisões acerca dos cuidados de saúde prestados em cada situação permanecerão, provavelmente, a ser divididas pelas entidades que já

#### Palavras-chave:

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hoje as tomam na prática – agências governamentais, seguradoras privadas, empregadores privados e tribunais.

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On 23 March 2010, United States President Barack Obama signed legislation that promises to bring the United States into the community of nations that ensure access to health care for all their citizens.<sup>1</sup> The Patient Protection and Affordable Care Act of 2010, commonly known as the Affordable Care Act or ACA, is a lengthy statute – 974 pages – that reforms both public and private health insurance, authorizes experiments to control costs and promote health, and funds multiple research initiatives. The ACA's best known and most controversial provisions regulate the health insurance industry for the purpose of making insurance available to almost all those residing in the country. Much of the controversy focused on whether the federal government had the power to require individuals to obtain health insurance.<sup>2</sup> The United States Supreme Court has held that the ACA is constitutional,<sup>3</sup> but implementing the ACA's requirements is raising questions about how to decide what health care is actually provided in a reformed system.

This article summarizes the major elements of the ACA's insurance reforms and how they affect responsibility for making decisions about the health care that people receive. A key example of the difficulty of allocating decision making responsibility is the on-going effort to define a minimum benefit package for insurance plans, called essential health benefits. I argue that this effort is laudable and necessary, but hampered by both conceptual and practical obstacles. If such obstacles cannot be overcome, the care that people get is likely to vary with the particular type of public or private health coverage they have. While the ACA should achieve its goal of near-universal access to care, decisions about what exactly care is provided are likely to remain, much as they are today, divided among government agencies, private insurers, private employers, and the courts.

## Health insurance reforms under the Affordable Care Act

Access to health care in the US has long depended on having health insurance coverage to pay for care.<sup>4</sup> This is why, historically, efforts to expand access to health care have focused on increasing not the direct provision of care, but eligibility for public health benefit programs and private health insurance plans.<sup>5-9</sup> The Affordable Care Act's primary goal, therefore, is to enable all citizens and legal residents to obtain either public or private health insurance.<sup>10</sup>

The ACA changes the regulation of health insurance in five ways. First, it extends federal regulation to almost all private health insurance companies. Historically, state governments licensed and regulated private insurance of all kinds.<sup>11</sup> The federal government began to impose some requirements on private group health insurance policies with the enactment of the Health Insurance Portability and Accountability Act

of 1996, but did not establish federal licensure or extensive regulation.<sup>12</sup> The ACA still does not create federal licensure for private insurers, but it does specify extensive requirements, most importantly, the entirely new requirement that private insurers must sell (or issue) a policy to any person who wants to buy one ("guaranteed issue"), regardless of the person's health status or risks.<sup>1(1201)</sup> Related provisions forbid insurers from excluding coverage for medical conditions that the person already has, dropping coverage after a person gets sick,<sup>1(1201)</sup> providing less coverage on the basis of mental health conditions,<sup>1(1311)</sup> disability or age,<sup>1(1302)</sup> and placing financial limits on benefits.<sup>1(1001)</sup> The ACA requires insurers to spend at least 80 percent of their premiums on health care for enrollees (the "medical loss ratio").<sup>13</sup> The federal government will also provide financial assistance to states to improve their ability to review insurance premium rates and enforce compliance with the law.

These new requirements for insurers made the ACA's second insurance reform almost imperative: the "minimum coverage" requirement that all citizens and lawful residents obtain health insurance coverage or pay a penalty.<sup>1(1501)</sup> In a voluntary private insurance market where insurers are required to cover anyone who wants a policy, many individuals would wait until they became ill before buying insurance. This could force insurers to charge unaffordably high premiums to remain solvent. Requiring individuals to buy insurance when they are healthy provides sufficient revenues to charge reasonable premiums to all. In effect, the premiums operate like a tax on individuals. There are exceptions to the minimum coverage requirement (also known as the "individual mandate") for very low-income people who could not afford even otherwise reasonable premiums, as well as individuals who do not believe in medical care for religious reasons.

Individuals can obtain coverage from either public or private programs, so coverage will be distributed among many different insurance systems. About 47.5 million people were covered by Medicare, the federal health benefit program for people over 65 and those with permanent disabilities, in 2010.<sup>14</sup> An additional 9 million people were covered by other federal government programs, such as the Indian Health Service, the Department of Defense (for those in military service), and the Veterans Administration Health Service (for military veterans) in 2011.<sup>15</sup> Almost 62.6 million people are covered by Medicaid, a federal program for low-income populations, which is funded by both the federal and state governments and administered by the states pursuant to federal standards.<sup>14,16</sup> These government programs covered 33.2 percent of the U.S. population.<sup>17</sup> Private and government employers who voluntarily offer group health insurance to their employees enrolled about 155.5 million people in their plans in 2011, representing 55.1 percent of the population.<sup>15</sup> About 7 percent of Americans (18.9 million) purchased health

insurance directly from insurance companies.<sup>15</sup> These existing programs left about 49 million Americans (15.7% of the population; nearly 18% of those under age 65) without insurance in 2010.<sup>a</sup> The need to enable this uninsured population to obtain coverage led to the other major insurance reforms.

The third reform is the ACA's requirement that health insurance exchanges be established as a sort of marketplace where individuals and small businesses can buy insurance.<sup>1(1311)</sup> (Indeed, the new term for an exchange is "marketplace.") People who are currently uninsured and not eligible for any other health plan can buy health insurance through this exchange. (They are also free to buy directly from an insurance company.) The federal government will provide subsidies (on a sliding scale) to individuals with incomes between 100% and 400% of the Federal Poverty Level to enable them to pay the premiums.<sup>b</sup> Most of these exchanges be organized and run by the states, although the federal government has the authority to operate a federal exchange in states that fail to create their own.<sup>1(1311)</sup> The exchanges are primarily virtual – a website with information about the different health plans available, such as one that has existed in the state of Massachusetts since 2007.<sup>18</sup> The states are free to decide whether their exchanges will have legal authority to impose requirements on health plans that are in addition to the federal requirements noted above.<sup>19</sup> This means that plans may differ, especially in price, from state to state.

Currently, private employers have no legal obligation to provide health insurance to their employees. The fourth reform encourages private employers to do so. The ACA imposes a relatively modest fee on large employers (without health plans) whose employees receive a federal subsidy to buy insurance through the health insurance marketplace.<sup>1(1513)</sup> The goal is to have employers reimburse the federal government for some of the government's expenses in making insurance available, primarily to low-wage employees. Small employers, who often cannot were to afford employee group health insurance, are exempt from the penalty, but can receive a tax credit for creating employee health plans.<sup>1(1421)</sup>

The last reform addresses the rest of the uninsured, who cannot afford to buy insurance in a health insurance marketplace, primarily because they are not eligible for federal subsidies. This group included workers in private sector solo or small businesses with fewer than 100 employees and non U.S. citizens in 2011.<sup>14</sup> The ACA amends the Medicaid statute to make everyone with an income below 138% of the Federal Poverty Level eligible for Medicaid health benefits.<sup>1(2001),18</sup> The federal government will pay for 100% of the cost of adding this group to Medicaid, ultimately paying 90% by 2016. The US Supreme Court held that the states are not obligated to comply with this new eligibility standard,<sup>3</sup> so many people living in

states that decide not to comply may be left without affordable coverage.

These insurance reforms were designed to move at about 20 million uninsured individuals into either Medicaid (10 million) or private health insurance (10 million through a health insurance exchange or employer plan).<sup>20</sup> That would leave uncovered only undocumented residents, people who are exempt from the individual mandate, and those who would rather pay a penalty than buy insurance. With some states opting out of the Medicaid expansion, federal actuaries now estimate that about 6 million fewer people than originally estimated will become covered by Medicaid and about 3 million more than originally estimated will obtain private coverage through exchanges.<sup>21</sup> This would mean that about 17 million people without insurance could be covered.

Whatever the numbers turn out to be, when the ACA becomes fully implemented, it should transform the American health insurance system, as complicated as it is, into one that functions more like the social insurance systems in Western European countries. With almost everyone in the system, the US will face the kind of pressure that European countries face to determine what health care all the different health plans should cover.

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### Essential health benefits under the ACA

The ACA attempts to create some uniformity in benefit coverage in private insurance plans. The Act requires insurers to cover "Essential Health Benefits" (EHB) in all plans that they offer to sell on a health insurance exchange or in the individual and small group market (but excluding grandfathered plans of large employers).<sup>22</sup> EHB benefits must be similar in scope to a "typical employer plan" and must include the following ten categories of medical services: ambulatory; emergency; in-patient hospitalization; maternity and newborn; mental health and substance abuse; prescription drugs; rehabilitation; laboratory; preventive; and pediatric (including oral and vision care).<sup>1(1302)</sup> The federal Secretary of Health and Human Services is charged with defining EHB, and is required to take the following specific "considerations" into account.<sup>1(1302)</sup> The categories must be balanced, without giving undue weight to any one. Coverage should not discriminate on the basis of age, disability or expected length of life. EHB should take into account the needs of diverse groups, including women, children and people with disabilities. Benefits should not be denied on the basis of age, expected length of life, present or predicted disability, degree of medical dependency, or quality of life.

This general definition of EHB is quite comprehensive, and the "considerations" make it difficult to narrow the categories or to make decisions about how they might apply to individual patients. Not surprisingly, the Secretary has avoided trying to list specific benefits. Instead, on 25 February 2013, she issued a rule granting the states the opportunity to decide what benefits plans will cover in their states.<sup>23</sup> A state may choose one of several existing health plans sold to small employers in that state (called a "benchmark plan"), and the benefits covered by that plan will be deemed to qualify as EHB. However, the

<sup>a</sup> Numbers add to more than 100%, because some people are eligible for more than one program. For example, Medicaid covers low-income elderly Medicare beneficiaries for nursing home care.

<sup>b</sup> Eligibility for government subsidies is often based on the federal poverty guidelines or level (FPL), amounts that are updated annually. For 2013, the FPL is US\$ 11,490 for an individual and \$23,550 for a family of four.

benchmark plan must be supplemented if it fails to cover any of the 10 required categories.<sup>20</sup>

The decision to consider the terms of existing small employer plans as covering EHB is both understandable and disappointing. It had the advantage of allowing insurers to meet the 2013 deadline for submitting plans to the exchanges without having to develop entirely new plans. (Plans that take effect after 31 December 2013 must cover EHB.) It also provides some continuity for individuals and small businesses that are already covered by existing plans. At the same time, it fails to critically analyze whether these benchmark plans actually cover essential health benefits.

While ACA states that essential health benefits should be similar in scope to the benefits covered by a “typical employer plan,” it does not distinguish between large employer plans and small employer plans. Small employer plans typically offer fewer benefits and more limited coverage of those benefits than large employer plans in order to keep premiums affordable. A small group of enrollees can be subject to large variations in risk from year to year. To counter rising premiums, companies have increased the amounts that employees pay for health plans – both the employee’s share of premiums and deductibles and co-payments for receiving care. Thus, a typical small employer plan usually has a lower actuarial value than a large employer plan. Moreover, a small employer may have few affordable choices, so its plan may not cover the benefits that employees prefer.

Since the majority of people who will be entering the market are individuals and employees of small businesses, it makes some sense to use a small business plan as a benchmark. However, insurers can combine these new “consumers” into larger pools resembling large employer groups offering better coverage at lower prices. This suggests that if the benchmark plan is to set the standard for EHB, it should offer better coverage than today’s typical small employer plan. Arguably, however, this puts the cart before the horse. The Secretary should define EHB first. Then insurers could design plans to cover those benefits.

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### Essential health benefits – conceptual questions

What counts as essential care is a question that has vexed policy makers for decades.<sup>24</sup> A threshold question is: essential for whom? An individual’s view of what is essential care may differ from a societal perspective. Moreover, different individuals may have different opinions on what is essential. Some may value quality of life more than length of life, while others prefer the opposite.<sup>25</sup> Some may prefer care that maintains or restores normal function, while others simply want to survive, regardless of disability.<sup>26</sup> Some may think of health care as limited only to services that diagnose, treat or cure disease, while others may include services to prevent illness or even achieve optimal health status. Furthermore, an individual’s own view may vary, depending upon whether she is answering as a consumer buying insurance or a patient in need of care for herself or a loved one.<sup>27</sup>

Societal level views of essential care also vary.<sup>c</sup> Indeed, one could question whether some societies accurately or adequately represent any consensus on the part of their populations. Where governments act honestly, EHB could properly be based on many different factors, such as population size, age distribution, and available resources. What is essential to any society may also depend on its need for economic growth, which may favor services that preserve productivity, or participation in civic life, which may favor other services, or some other human function. But, even the best-intentioned societal definition may conflict in whole or in part with the views of individuals or groups within the population.

This variation in possible definitions suggests that one size will not fit all. Perhaps the Secretary should not be faulted for devolving responsibility for defining EHB to the states. At the same time, state-level decisions may prove unsuitable for their own target populations, while prolonging inconsistency across states.

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### Essential health benefits – practical problems

Paradoxically, variation in EHB definitions can perpetuate a problem that the EHB requirement itself was intended to resolve. Historically, the fact that different insurers covered different benefits meant that people with the same medical condition would not necessarily receive the same treatment. The variation among the several public benefit programs and hundreds of private insurance plans can provoke complaints of unfair rationing, especially if a person who is denied treatment believes that the denial was not based on medical need, but on an insurer’s profit targets.<sup>28,29</sup> More uniform coverage of the same benefits could avoid the rationing charge by assuring that everyone is subject to the same rules. The knowledge that resources are being used for a public purpose, such as providing needed education or services for children, can increase public acceptance of limits as a shared sacrifice. On one hand, the breadth of the statutory definition of EHB will make it difficult to limit the total package of benefits. On the other hand, the Secretary’s decision to use state-based benchmark plans to define EHB means that the details of each benefit category will continue to vary, so that individuals can still complain of unfair treatment, thereby threatening public acceptance.

Although a major impetus for the Act was the growing cost of care,<sup>30</sup> the ACA does not expressly require either reductions or changes in the method of payment for health care. Instead, supporters believe that, once everyone is insured, the country will have no choice but to take affirmative steps to control costs. Since most of the ACA’s reforms do not take effect until 2014, noticeable cost control is unlikely for many years. For the

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<sup>c</sup> Such challenges confront the National Health Service in the United Kingdom, for example, which has not defined the meaning of “a comprehensive health service.” As discussed by C. Newdick in *Health care rights and NHS rationing: turning theory into practice*, in this issue, interpretation is delegated to local health authorities, resulting in the risk of “post-code” rationing, in which different health authorities make different decisions about the same issues. NICE was created to smooth out some of these differences, but the challenge remains.

next several years, and probably much longer, the rising cost of care will significantly affect the kind of care that insurance covers.

In practice, insurers still bear primary responsibility for controlling costs, but their options are limited. In principle, insurers could reduce their own administrative costs and profits, but for-profit companies are under pressure from investors to increase profits.<sup>31</sup> One ACA skeptic argues that the ACA's requirement that insurers spend at least 80% of premiums on benefits could backfire by encouraging insurers to increase premiums and cover more services for the purpose of preserving executive compensation and profit levels.<sup>32</sup> The requirement that insurers cover EHB, however defined, constrains insurers' ability to limit benefits as a way to control costs. The ACA also limits the permissible extent of cost-sharing for patients, another traditional way to shift costs.<sup>1((1302(c))</sup>

This leaves payments to providers as the primary target for cost control. There is little dispute that such payments have grown faster than the cost of living or that most provider prices can appear to be arbitrary.<sup>33</sup> The ACA authorizes experiments to encourage providers to work together to provide care more efficiently at lower prices. So far, similar experiments have mixed results. Moreover, providers have little incentive to reduce their own incomes. More than 20 years ago, Congress enacted a law requiring Medicare to reduce payments to physicians, but under pressure from physicians Congress has repeatedly delayed enforcement of that law, including in 2013.<sup>34</sup> If enforced, the law would have required a reduction in physician payments of more than 26 percent in 2013.<sup>35</sup>

These practical problems suggest that the process of defining essential health benefits is not likely to dramatically change insurance benefits beyond what the ACA mandates in its other provisions. Most insurance plans and benefit programs define benefits in quite general terms, much like the statutory definition of EHB. The question, then, remains: exactly which services are included and excluded in each category?

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### Essential health benefits – who decides?

While the ACA intends to provide more uniform coverage of Essential Health Benefits, the decisions most important to patients – what treatment will his or her own insurance pay for – remain with the insurer for the foreseeable future. Because the US has so many different insurance plans, both the decision maker and the law governing the determination of claims for treatment also vary.

Federal government programs like Medicare prescribe general benefit categories in legislation, but specific determinations on whether and when specific items and services are covered are a matter of administrative law. The Department of Health and Human Services, Centers for Medicare and Medicaid, (CMS) issue regulations and guidance interpreting the statute and describing what will and will not be paid for. However, the federal agency CMS does not make decisions about individual patient care. Instead, CMS contracts with private contractors to do so on behalf of the federal government.

Typically, these contractors are insurance companies, which have experience handling claims, usually because they have a separate private insurance business of their own. Different contractors handle claims in different regions of the country, so it is possible to have inconsistency in claims determination. In the case of disputes, patients have a statutory right to appeal the denial of payment to Medicare's administrative appeals process, which is a unified federal system with greater consistency in results.

Medicaid benefit determinations are more complicated. Although Medicaid is a federal program with legislatively prescribed benefit categories, the states administer the program and can voluntarily cover some additional benefits. Most state Medicaid programs make individual patient care determinations directly through a state Medicaid administrative agency. However, most states also contract with private insurers to enroll some Medicaid beneficiaries in a managed care plan. The insurer makes the initial benefit coverage determination for beneficiaries enrolled in its Medicaid plan. Disputes, however, are subject to a state's administrative agency review, often with a dedicated appeals board.

Contract law governs individual benefit determinations for patients who are enrolled in private insurance plans. There are no uniform national rules, because contract law is within state common law jurisdiction, but state laws tend to be similar. Claims determination often depends on specific contract provisions, especially those that exclude experimental procedures and those that limit coverage to treatments that are medically necessary for the individual patient.<sup>29,36</sup>

Most private insurers provide internal review (conducted by the insurer itself) of enrollee complaints, including disputes over benefit denials, and the ACA requires almost all insurers to offer a more transparent internal review process covering more categories of complaints. Enrollees who are dissatisfied with the internal review decision have very different options, depending upon their particular insurer and plan.

In theory, patients can sue a private insurer under state law for claims denials and other causes of action. However, the role of courts in determining claims has diminished somewhat in the past decade, for several reasons. Perhaps the most important has been the growing use of mandatory arbitration clauses in private insurance contracts, which preclude an enrollee from bringing a lawsuit to require payment for treatment or to recover damages for negligence or other violations of law.<sup>37</sup> The U.S. Supreme Court has also limited the causes of action available to patients who are enrolled in an employer's group health plan.<sup>38,39</sup> Patients in such plans who claim wrongful denial of benefits must sue the employer's plan under federal law, not state contract law.<sup>40</sup> If successful, the patients are entitled to recover only the cost of the treatment denied and not any damages for personal injury.

A third reason for fewer court actions is the growth of external review systems. Almost all states now require insurers to submit certain disputes to a review panel that is entirely independent of the insurer. Having one's claim reviewed by an unbiased expert or group of experts often satisfies patients that their claims have been evaluated fairly, regardless of the outcome. The ACA greatly expands the use of external review panels, requiring their use for almost all insurers, except certain employer-sponsored group health plans.<sup>41</sup>

The ACA leaves in place a multiplicity of processes and decision-makers for determining individual claims, including public administrative procedures, private review procedures, private arbitration, and judicial process. The legislation does not specify how decisions are made in individual cases. With rising health care costs, both public and private insurers are likely to face pressure to make sure that they pay only for care that offers value for money.<sup>42,43</sup> Thus, different decision makers may continue to produce different interpretations of what individual patients are entitled to under their different health plans. Even where courts issue opinions, their decisions often focus on the specific circumstances of an individual patient and therefore create little precedent for other individual decisions.

## Conclusion

The ACA is intended to provide near-universal health insurance coverage for the purpose of enabling Americans to obtain needed medical care. It is also intended to bring greater consistency to health insurance coverage by regulating the terms of most insurance plans. The requirement that private health insurance plans sold on the new health insurance exchanges cover essential health benefits is a major step toward greater consistency in coverage across the population. However, that requirement does not apply to all health plans, and the current definition of essential health benefits lacks specification.

As a result, decisions about covered care at the patient level will continue to be made by many different decision makers, just as they are now. Each decision maker, whether public or private, will continue to interpret – according to different rules – whether the general categories of benefits include something that a provider recommends or a patient seeks. The ACA has begun to face, but has not solved, the very difficult question of the limits of care.

## Conflicts of interest

The author has no conflicts of interest to declare.

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