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## HEALTH INSURANCE PLAN REGULATION AFTER THE AFFORDABLE CARE ACT: A COST-BENEFIT ANALYSIS COMPARISON

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### I. Introduction

In a rapidly evolving healthcare landscape, particularly since the enactment of the Patient Protection and Affordable Care Act (ACA) in 2010, regulators have confronted a number of challenges in crafting general rules of prospective applicability for health insurance plans. These challenges include quantifying costs and benefits of regulatory actions that seem difficult to predict, monetizing certain benefits, satisfying the demands of a robust cost-benefit analysis regime, and accounting for heightened uncertainty in the healthcare markets and recently, on Capitol Hill.

I will examine these and other challenges faced by regulators through the lens of two regulations: a 2013 regulation promulgated by the Department of Health and Human Services (HHS) and a 2018 regulation issued by the Department of Labor (DOL)<sup>2</sup>. Part I of this Article examines the cost-benefit analysis conducted by HHS through the rule's Regulatory Impact Analysis (RIA); Part II analyzes the DOL rule on the same grounds; Part III studies the contrasts that emerge between the two regulations; Part IV comments on how differently the two agencies have approached cost-benefit analysis; and in Part V, I examine two case studies drawn from two different agencies, each subject to the Office of Management and Budget's (OMB) regulatory review, to consider how the two regulations can inform cost-benefit analysis.

HHS and DOL must conduct a RIA for all significant rulemakings.<sup>3</sup> Both rules qualified as significant rulemakings under Executive Order 12,866 because of their economic impact.<sup>4</sup>

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<sup>1</sup> Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,833 (Feb. 25, 2013).

<sup>2</sup> Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28,912 (June 21, 2018).

<sup>3</sup> See Exec. Order No. 12,866, 58 Fed. Reg. 51,735, 51,741 (Oct. 4, 1993).

<sup>4</sup> *Id.* at 51,378 (defining "significant regulatory action" subject to OMB review as "any regulatory action that is likely to result in a rule that may (1) have an annual effect on the economy of \$100 million or more in any one year

Significant rules analyzed under this category are defined as actions that would exert an economic impact of \$100 million or more in a single year.<sup>5</sup> As agencies subject to review from OMB, economically significant proposed rulemakings promulgated by HHS and DOL must be reviewed by OMB’s Office of Regulatory and Information Affairs (OIRA). Both the HHS and DOL rules received OMB approval at the proposed and final rulemaking stages. The final DOL rule became effective on August 20, 2018.<sup>6</sup>

Both HHS and DOL examined the impacts of the two regulations under Executive Order 12,866 and Executive Order 13,563.<sup>7</sup> These orders direct all agencies to analyze costs and benefits of the regulation, to maximize net benefits if the agency finds regulation is necessary, and to study alternatives to the proposed regulation, including choosing not to regulate.<sup>8</sup>

## II. Essential Health Benefits and the Actuarial Value Rule

The ACA, as enacted by Congress in 2010, ensures that “non-grandfathered” health insurance policies sold in the individual and small group markets cover a basic package of services. The statute directed the Secretary of HHS to take regulatory action that would determine the standards by which essential health benefits (EHB) would be defined. The statute also stipulated that HHS would devise a formula by which the actuarial value (AV) of individual plans could be uniformly applied to assist consumers when choosing among several health insurance plans.<sup>9</sup>

### A. The Need for Regulatory Action

This rule finalized standards for issuance of health plans, and specifically applied a definition to EHB and calculation of AV under the ACA. HHS justified the need for regulatory action by noting that “[e]stablishing specific approaches for defining EHB and calculating AV will bring needed clarity for states, issuers, and other stakeholders.”<sup>10</sup>

In addition to offering each of the mandated EHB consistent with the ACA, non-grandfathered health insurance plans must satisfy defined AV: 60% for “bronze” plans, 70% for “silver” plans, 80% for “gold” plans, and 90% for “platinum” plans. These AVs, dubbed “metal levels,” were implemented by HHS to help consumers compare health plans and allow potential enrollees to consider “the relative payment generosity of available plans.”<sup>11</sup> The HHS rule predicted that “[t]aken together, EHB and AV will significantly increase consumers’ abilities to

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or more, or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as “economically significant”); (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impacts of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in this Executive order.”).

<sup>5</sup> *See id.*

<sup>6</sup> *See* 83 Fed. Reg. 28,912 (June 21, 2018).

<sup>7</sup> *See* Exec. Order No. 13,563, 76 Fed. Reg. 3,821 (Jan. 18, 2011),

<sup>8</sup> In addition to these executive orders, the Unfunded Mandates Reform Act requires that executive agencies include a written cost-benefit analysis for each economically significant rulemaking they issue. *See* Unfunded Mandates Reform Act, Pub. L. No. § 104-4, 109 Stat. 48 (1995) (codified as amended at 2 U.S.C.).

<sup>9</sup> *See* 78 Fed. Reg. 12,833, 12,835 (Feb. 25, 2013).

<sup>10</sup> *Id.* at 12,857.

<sup>11</sup> *Id.* at 12,834.

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compare and make an informed choice about health plans.”<sup>12</sup>

Under the rule, each state must adopt an EHB benchmark plan for policies sold to consumers in that state. The final rule defined an EHB benchmark plan as one that would reflect both the scope of services and any limits offered by a “typical employer plan” in the given state. The approach HHS adopted to define AV relied on “standard assumptions about utilization and prices, and, for most products, directs issuers to use an AV calculator created by the Department to compute AV.”<sup>13</sup>

## B. Cost-Benefit Methodology

The EHB final rule as promulgated by HHS “present[s] quantitative evidence where it is possible and supplement[s] with qualitative discussion.”<sup>14</sup> HHS concluded that in compliance with Executive Order 12,866, the EHB rule’s benefits justified its costs.

## C. Consideration of Costs

The EHB rule included an accounting statement, pursuant to OMB Circular A-4. HHS analyzed the rule using both a 3% and 7% discount rate. The HHS rule calculated the annual monetized costs of the rule at 3.4 million per year for the period from 2013 to 2016 at a discount rate of 7%, and alternatively at 3.1 million per year for the period from 2013 to 2016 at a discount rate of 3%.<sup>15</sup> These discount rates are consonant with the requirements of OMB Circular A-4, which provide for a real discount rate of 7% to be applied as a base-case for regulatory analysis.<sup>16</sup> OMB Circular A-4 calls for discount rates of 7% and 3%, and generally does not allow OIRA-reviewable regulatory action to depart from those figures.<sup>17</sup>

Costs of the regulatory action were calculated to include administrative costs associated with information collection requirements imposed on health insurance plan issuers. The HHS rule included a detailed, quantified estimate of the number of issuers and licensed entities that would be affected by the EHB and AV requirements. The rule segmented these actors by market participation: individual, small group, and large group markets, and combinations thereof.

HHS disclosed that it expected two new primary costs to result from the rule: 1) administrative costs on insurance plan issuers to comply with reporting requirements established by the regulatory action; and 2) potential new costs resulting from increased utilization of health care services by policyholders who were previously uninsured or underinsured.<sup>18</sup>

With regard to administrative costs, the regulation envisioned that plan issuers that did not previously satisfy EHB standards for prescription drug coverage would incur “one-time

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<sup>12</sup> *Id.*

<sup>13</sup> *Id.* at 12,857.

<sup>14</sup> *Id.* at 12,858.

<sup>15</sup> *Id.*

<sup>16</sup> Office of Management and Budget, *Circular A-4: Regulatory Analysis* 33 (Sept. 17, 2003), <https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf>.

<sup>17</sup> Narrow exceptions to these prescribed discount rates exist for very long time spans, in part because of considerations of intergenerational equity. *See id.* at 35–36.

<sup>18</sup> 78 Fed. Reg. 12,833, 12,861 (Feb. 25, 2013).

administrative costs” related to bringing their pharmaceutical benefits plans into compliance with EHB.<sup>19</sup> The rule also accounted for minor administrative costs related to analyzing AV standards and computing AV. However, the rule concludes that each of these costs would be minimal because EHB would be based on a benchmark plan that largely reflects a typical health insurance plan offered in the market of each state currently. Finally, the rule pointed out that issuers are adept at offering multiple plans with varying cost-sharing designs already, and that the framework envisioned by the rule would not create wholly new resource demands.

The rule also discussed costs of providing newly mandated services pursuant to EHB, which are transferred from plan beneficiaries to insurers. HHS noted that the small group market was unlikely to experience significant changes, as many plans in this market already contained EHB.<sup>20</sup>

This general proposition was qualified by the mention of four exceptions: EHB would require small group plans to provide more robust coverage for mental health and substance use disorder, habilitative services, pediatric dental care, and pediatric vision services. The rule treated these changes as transfers, rather than new costs imposed on the system, because consumers had previously been forced to pay these costs out of pocket.<sup>21</sup> Instead, under EHB, insurers would price coverage of health insurance policies consonant with these new coverage requirements, and individuals would pay premiums that reflected this reality.

The rule also stipulated that if states exercised their option under the ACA to define habilitative services themselves (which had previously rarely been identified by either insurers or regulators as a distinct group of services), the process of insurers bringing their products into compliance with states’ criteria could create new administrative and contracting costs.<sup>22</sup> However, the rule declined to analyze this cost, as it was not clear which states would exercise this option at the time of the final rule’s promulgation, or how those states would define habilitative services even if they chose to act.

The rule also discussed costs to states and state regulators. The final rule concluded that though states may need more resources to enforce compliance with EHB and ensure that plans satisfy the AV prescribed by one of the metal levels, these costs would be minimal. HHS pointed out that, to the extent a state requires insurers to offer benefits packages above and beyond the minimum standards in EHB, the ACA separately requires the state to defray costs of these benefits through a state-run qualified health plan.<sup>23</sup>

#### D. Consideration of Benefits

As a general matter, HHS noted that the benefits of health insurance coverage articulated by the agency in previous RIAs, “including improvement in clinical outcomes and financial security,” applied with equal force to the EHB rule.<sup>24</sup>

HHS did not include annual monetized benefits in the final rule. Instead, the rule justified its costs by reference to qualitative benefits. HHS articulated three specific types of benefits that would result from the rule. First, the rule was designed to improve health insurance coverage by

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<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

<sup>21</sup> *Id.* at 12,860.

<sup>22</sup> *Id.* at 12,861.

<sup>23</sup> *Id.*

<sup>24</sup> *Id.* at 12,859.

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expanding access to coverage of benefits, particularly in the individual market, including maternity and prescription drug coverage.

Second, the rule valued alignment with consumer and employer choices. EHB benchmark plans are defined by what is offered in a typical employer-offered health insurance plan in that state. HHS stated that its chosen approach permitted states to build on health insurance coverage that was already widely available, minimized market disruption, and provided consumers with a benchmark plan similar to existing products. HHS predicted that this would augment consumer understanding of plan options and “may facilitate consumers’ abilities to make choices that better suit their needs.”<sup>25</sup>

Third, the regulatory action increased efficiency due to its greater transparency, a benefit allowing consumers to compare coverage. The rule noted that in the pre-ACA individual market, consumers faced considerable difficulty in making well-informed choices when choosing among competing health insurance plans.

Another benefit arising from the ability of consumers to compare plans was that the rule fostered competition between health insurers on “price, quality, and service—rather than variations in benefit design.”<sup>26</sup> Because the rule’s AV system encouraged people to compare like plans within a single “metal level,” consumers were better positioned to understand relative plan value and make more informed, rational choices about the plan that may better match their health needs.

The HHS rule directly affected all Americans enrolled purchasing health insurance through the federal or individual state health exchanges. The rule also beneficially accrued to enrollees in non-grandfathered individual and small-group health coverage plans purchased outside of the exchanges.

The rule included the U.S. Congressional Budget Office’s (CBO) July 2012 estimate that there would be 24 million enrollees in exchange coverage by 2016.<sup>27</sup> However, by 2016 only 11 million people had enrolled in a health insurance plan on the exchanges.<sup>28</sup> Though the agency did not explicitly ground its cost-benefit analysis in CBO’s projected enrollment through the exchanges, the expected net benefits of the rule have doubtlessly been lower than HHS expected, given that fewer people enrolled than anticipated.

#### E. Distributional Effects

The HHS rule considered distributional effects. The rule states that “[t]he anticipated effects on enrollees in the individual market are expected to be larger than the effects on enrollees in the small group market.”<sup>29</sup> The rule goes on to note that “[c]overage in the small group market is much more likely to include EHB already and, in fact, is included in the choice of benchmark plans.”<sup>30</sup> Finally, the rule observed that “almost all products in the group market have AV above

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<sup>25</sup> *Id.* at 12,860.

<sup>26</sup> *Id.*

<sup>27</sup> *Id.* at 12,859.

<sup>28</sup> *White House Says CBO ‘Cannot Accurately Predict’ Effects of Health Bill*, THE BOSTON GLOBE (June 26, 2017), <https://www.bostonglobe.com/news/politics/2017/06/26/white-house-says-cbo-cannot-accurately-predict-effects-health-bill/EsqkbcwKbUSIod2s4wp911/story.html>.

<sup>29</sup> 78 Fed. Reg. 12,833, 12,860 (Feb. 25, 2013).

<sup>30</sup> *Id.*

60 percent, while there are likely to be changes to products in the individual market due to the provisions of this proposed rule.”<sup>31</sup>

## F. Regulatory Alternatives

The HHS rule discussed several alternative regulatory solutions to the final rule. In response to comments received, the agency considered adopting a national definition of EHB. However, HHS chose to allow each state to adopt an individual EHB because this approach maximized “state flexibility and issuer innovation in benefit design.”<sup>32</sup> The agency also believed that such an approach would have required a significant overhaul by insurers and would have been market disruptive.

The agency also considered leaving the ACA’s ten required benefit categories intact, simply codifying the statute’s language without giving insurers further guidance on EHB, leaving them free to structure their benefits packages. HHS did not adopt this alternative because the agency believed it would have permitted “extremely wide variation across plans in the benefits offered.”<sup>33</sup> This wide variation would have failed to assure consumers that their basic health needs would be consistently covered by insurers and would have failed to improve consumers’ abilities to make informed choices when selecting a health insurance plan.

The agency also considered allowing insurance plan issuers to use their own data in calculating AV in connection with a HHS-defined standard population, as required by the ACA.<sup>34</sup> However, the agency chose to both define the standard demographic population *and* calculate AV, because deferring to issuers would not maximize the benefits of consumer transparency or increased competition.

In response to comments that the RIA was insufficiently quantitative in the proposed EHB and AV rules, HHS stated that the final rule’s RIA builds off the agency’s RIA for its rule finalizing the establishment of health insurance exchanges.<sup>35</sup> Accordingly, the RIA associated with this rule was assessed only with reference to the costs and benefits of applying a specific definition of EHB and calculating AV. The RIA defended its analysis by arguing that “HHS provided quantitative estimates of the costs and benefits associated with the specific provisions of this regulation where possible, and supplemented those estimates with qualitative discussion.”<sup>36</sup>

This regulation, establishing guidelines for EHB, was promulgated to implement the ACA. In issuing the regulation, HHS “explained that it was impossible—both practically and as a matter of principle—to separate the benefits created by the particular regulation at hand from the benefits of the larger statute.”<sup>37</sup> Effectively, the monetizable value of the benefits described in the regulation were incorporated by reference to their locus in the ACA—a statute that lacked a formal cost-benefit analysis. The result was an OIRA-approved regulation asserting that it satisfied Executive Order 12,866, even as benefits remained unquantified.

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<sup>31</sup> *Id.*

<sup>32</sup> *Id.* at 12,861.

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> *Id.* at 12,862.

<sup>36</sup> *Id.*

<sup>37</sup> Jonathan S. Masur & Eric A. Posner, *Unquantified Benefits and Bayesian Cost-Benefit Analysis* (2015), <https://bfi.uchicago.edu/sites/default/files/research/Masur%20%26%20Posner%20Unquantified%20Benefits.pdf>.

### III. Association Health Plan Rule

On October 12, 2017, President Trump issued Executive Order 13,813, titled “Promoting Healthcare Choice and Competition Across the United States.” Focusing its objectives on reinterpreting provisions of the ACA, the order cleared the way for broader issuance of healthcare plans that did not comply with the ACA’s EHB requirements.<sup>38</sup> After noting its purpose “to expand the availability of and access to alternatives to expensive, mandate-laden PPACA insurance,”<sup>39</sup> the order described three objectives to increase consumer choice in healthcare: easing restrictions on association health plans (AHP), promoting short-term, limited-duration insurance plans, and improving health reimbursement arrangements. The order specifically directed the Secretary of Labor to “consider proposing regulations or revising guidance, consistent with law, to expand access to health coverage by allowing more employers to form AHPs.”<sup>40</sup>

#### A. Need for Regulatory Action

While AHPs existed before DOL issued its final rule, “their reach was limited by the Department’s prior interpretation of the conditions when an AHP constitutes an employer-sponsored plan under ERISA.”<sup>41</sup> The AHP rule sought to “broaden the types of employer groups or associations that may sponsor a single group health plan under ERISA for the benefit of the employees of the group or association’s member employers.”<sup>42</sup> The rule asserted that its regulatory action would “provid[e] new, affordable health insurance options for many Americans.”<sup>43</sup>

The regulation included four substantive means by which it pursued its goal to broaden the types of employers who can offer single-payer healthcare. First, the rule “relax[e]d the requirement that group or association members share a common interest, as long as they operate in a common geographic area, in order for the group or association to qualify as bona fide.”<sup>44</sup> Second, the rule clarified that associations whose members operate in the same industry are allowed to sponsor AHPs, regardless of their geographic location.<sup>45</sup> Third, the rule “clarif[i]e[d] the existing requirement that bona fide groups or associations sponsoring AHPs must have at

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<sup>38</sup> Exec. Order No. 13,813 (Oct. 12, 2017).

<sup>39</sup> *Id.*

<sup>40</sup> *Id.* The Department’s proposal for permitting short-term, limited duration health plans has proceeded through a separate rulemaking process.

<sup>41</sup> 83 Fed. Reg. 28,912, 28,940 (June 21, 2018). The final rule stated that “[u]nder the prior interpretation, eligible group or association members had to share a common interest (usually, in practice, operate in the same industry) and genuine organizational relationship, join together for purposes other than providing health coverage, exercise control over the AHP, and have one or more employees in addition to the business owner in order for the group or association to qualify as bona fide.”

<sup>42</sup> *Id.*

<sup>43</sup> *Id.*

<sup>44</sup> *Id.* at 28,940.

<sup>45</sup> *Id.*

least one substantial business purpose unrelated to the provision of benefits.”<sup>46</sup> Fourth, the rule allowed small business owners and their dependents eligibility to participate in AHPs. By way of example, the rule mentioned that local chambers of commerce may offer AHPs to the employees of its member entities.<sup>47</sup>

## B. Cost-Benefit Methodology

The regulation noted that the proposed AHP rule would also affect tax subsidies, federal revenues, and Medicaid. The proposed final rule remarked that its impacts were intended to “be positive on net,”<sup>48</sup> a nod to the requirements of the canonical cost-benefit documents Circular A-4 and Executive Order 12,866. However, the proposed final rule further stated that “the incidence, nature and magnitude of both positive and negative effects are uncertain,” and that “predictions of these impacts are confounded by numerous factors.”<sup>49</sup>

The confounding factors the proposed rule cited are “dynamic” and “unstable” conditions that currently “prevail[] in local individual and small group insurance markets under existing ACA and State rules;”<sup>50</sup> a lack of data on both “risk profiles of existing and potential associations and the individual and small group markets with which they intersect;”<sup>51</sup> a similar lack of data on “on the relative availabilities and sizes of subsidies and tax preferences for prospective AHP enrollees in Exchanges or Small Business Health Options Program (SHOP) Exchanges versus in AHPs;”<sup>52</sup> pending “[l]egislative proposals to amend or repeal and replace the ACA;”<sup>53</sup> “States’ broad discretion to regulate AHPs, and variations in State practices;” as well as “[i]nteractions with related initiatives per Executive Order 13,813<sup>54</sup>, including HRAs [health reimbursement account] and short-term limited duration insurance policies.”<sup>55</sup>

Rather than attempting to quantify the costs and benefits of the rule, DOL instead chose to engage in an almost exclusively qualitative analysis. The rule prefaced its findings with the disclaimer that “what follows is a mostly qualitative assessment of this proposal’s potential impacts, rather than a quantitative prediction.”<sup>56</sup> The rule’s RIA noted that DOL would be accepting comments and data that “[would] allow the impacts of the rule to be quantified,” which would in turn “enable[s] it to more fully assess the proposed rule’s effects.”<sup>57</sup> The final rule referenced publicly available estimates regarding the AHP rule’s effects on the individual and

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<sup>46</sup> *Id.*

<sup>47</sup> *Id.* at 28,940–41. “[T]he final rule would newly allow a local chamber of commerce that meets the other conditions in the rule to offer AHP coverage to all of its members, including self-employed working owners, based on having their principal places of business within a single state or metropolitan area.”

<sup>48</sup> 83 Fed. Reg. 614, 626 (Jan. 5, 2018).

<sup>49</sup> *Id.*

<sup>50</sup> *Id.* at 627.

<sup>51</sup> *Id.*

<sup>52</sup> *Id.*

<sup>53</sup> *Id.*

<sup>54</sup> President Trump issued Exec. Order No. 13,813 in Oct. 2017 to recast several provisions of the ACA following Congress’ unsuccessful efforts over the course of that year to repeal the law in its entirety.

<sup>55</sup> 83 Fed. Reg. 614, 627 (Jan. 5, 2018).

<sup>56</sup> *Id.* The final rule, however, includes an estimate of the number of Americans projected to be newly insured as a result of relaxed AHP regulations. See 83 Fed. Reg. 28,912 (June 21, 2018) (“The Department also notes the U.S. Congressional Budget Office (CBO) predicted that 400,000 people who would have been uninsured will enroll in AHPs.”).

<sup>57</sup> 83 Fed. Reg. 614, 626 (Jan. 5, 2018).

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small group markets, but noted that the agency lacked sufficient data “to assess the accuracy of these estimates.”<sup>58</sup>

### C. Consideration of Costs

The proposed AHP final rule acknowledged that it would likely increase the federal budget deficit. “The proposal is likely to have offsetting effects on the budget, with some increasing the deficit and others reducing the deficit. On balance, deficit-increasing effects are likely to dominate, making the proposal’s net impact on the federal budget negative.”<sup>59</sup>

DOL also noted that operational risks and mismanagement may inflict new costs like the heightened need for federal and state oversight. “The flexibility afforded AHPs under this proposal could introduce more opportunities for mismanagement or abuse, increasing potential oversight demands on the Department and State regulators.”<sup>60</sup>

Perhaps more relevant to note are the considerations *not* considered to be costs in the rule. A number of conceivable costs were excluded from the rule’s cost-benefit analysis: administrative costs borne by people who mistakenly believed they were covered for services their AHP plans do not cover, the new financial costs borne by those who lost access to care after their employer chose to join an AHP that covers fewer services, and the social costs borne by these same people in losing access to care.

### D. Consideration of Benefits

DOL stated in its proposed regulatory action that “[i]nsuring more American workers, and offering premiums and benefits that faithfully match employees’ preferences, are the most important benefits of this rule.”<sup>61</sup>

The proposed rule articulated multiple benefits that would result from DOL’s regulatory action. First, DOL cited efficiency gains through advantages of scale and administrative savings by easing restrictions on the creation of AHPs. Second, the agency cited increased choice as a benefit. Third, the proposed rule noted the benefit of enabling larger, more stable risk pools. Fourth, the rule mentioned increased access to health insurance as a potential benefit.<sup>62</sup>

In terms of defining who the beneficiaries of the regulatory action would be, the rule painted in broad strokes. For example, the proposed final rule included language such as “it is possible that this proposed rule will extend insurance coverage to some otherwise uninsured individual families and small groups.”<sup>63</sup> Though DOL avoided approximating how many Americans might

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<sup>58</sup> *Id.* at 23,948. The final rule noted, but did not adopt as its own analysis, a publicly available report which “estimated that between 2.4 million and 4.3 million individuals would move from the individual and small group markets combined, and enroll in AHPs by 2022 under a moderate enrollment scenario, between 710,000 and 1.1 million of which would move from the individual market . . . This translates into aggregate premium decreases of between \$9.3 billion and \$25.1 billion, with the former corresponding to more generous AHP benefits.” *Id.* at 28,948–49.

<sup>59</sup> *Id.* at 632.

<sup>60</sup> *Id.*

<sup>61</sup> *Id.* at 626.

<sup>62</sup> *Id.* at 626–31.

<sup>63</sup> *Id.* at 631.

be interested in enrolling in an AHP in its RIA, the final rule adopted a CBO-produced estimate that predicted that 400,000 previously uninsured Americans would gain access to health insurance as a result of the new AHP standards.<sup>64</sup>

The proposed AHP rule noted that 61% of individuals under age sixty-five have employer-sponsored coverage, 38% of individuals under age sixty-five obtain coverage from private employers with fifty or more employees, 9% are insured through smaller private employers, and 14% receive insurance from public-sector employers.<sup>65</sup> In addition to the 400,000 Americans that the DOL projected would choose to enroll in a newly offered policy through an AHP, the final rule concluded that about 3.6 million consumers who currently purchase health plans through the individual or group markets will ultimately enroll in health insurance plans authorized under the AHP rule.<sup>66</sup>

The final rule stated that a subset of the following consumer groups represent potential AHP customers: “[s]ome of the 25 million individuals under age 65” currently in individual markets, “including approximately 3 million who are sole proprietors or dependents thereof;” “an additional 6 million who are employees of small businesses or dependents thereof;” “25 million individuals under age 65 who currently are covered in small group markets;” “Some of the 28 million individuals under age 65 who currently lack insurance, including 2 million who are sole proprietors or dependents thereof, and an additional 5 million who are employees of small businesses or dependents thereof;” and “some of the 1.6 million private, small-firm establishments (those with fewer than 50 employees) that currently offer insurance and the 4 million that do not.”<sup>67</sup>

#### E. Distributional Effects

The DOL rule considered distributional effects in keeping with Executive Order 12,866 and Circular A-4. The regulation assessed the effects on small-business owners and their dependents. The rule did not, however, directly assert that the rule’s distributive benefits justify its costs. Instead, generalist rhetoric about the positive effects of the action for small business owners and potential members of newly-authorized AHPs were found throughout the proposed and final versions of the DOL rule.

#### F. Regulatory Alternatives

The final rule discussed several alternative solutions to the AHP rule. The first, retaining the Department’s existing sub-regulatory guidance, did not hold sway because DOL concluded that the current regime “generally block[ed] working owners who lack[ed] employees from joining AHPs.”<sup>68</sup> The rule invoked principles of autonomy to find that existing practices were unacceptable. The DOL stated that the requirement stipulating that members of an AHP share a certain “commonality” often inhibits associations from “achieving sufficient scale in local markets to effectively establish and operate efficient AHPs.”<sup>69</sup> The rule noted that uncertainty

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<sup>64</sup> 83 Fed. Reg. 28,912, 28,951 (June 21, 2018).

<sup>65</sup> *Id.* at 626.

<sup>66</sup> 83 Fed. Reg. 28,912 (June 21, 2018).

<sup>67</sup> *Id.* at 633–34.

<sup>68</sup> *Id.* at 632.

<sup>69</sup> *Id.*

about whether entities within a single industry might satisfy the commonality requirement prevented the formation of nationwide AHPs. The rule also rejected maintaining the requirement that AHPs “exist for purposes other than providing health benefits”<sup>70</sup> on the grounds that this restriction precluded the creation of welfare-enhancing AHPs in cases where there is no other cognizable reason for rejecting their establishment. The final rule retained the existing sub-regulatory guidance for AHPs, while creating “an alternative basis for groups or associations to meet the definition of an ‘employer’ under ERISA section 3(5).”<sup>71</sup>

Another alternative, relaxing the requirement that association members control an AHP, was thought to increase the risk that AHPs would be “vulnerable to mismanagement or abuse.”<sup>72</sup> The proposed rule noted that easing this control requirement would likely spur valuable economic activity by incentivizing rapid establishment of new AHPs, as entrepreneurs and investors could “identify and seize opportunities to reap and share with enrollees the economic benefits AHPs can deliver.”<sup>73</sup> However, the DOL concluded that the possibility of market failures, combined with uncertainty as to whether ERISA would even authorize such a move, counseled against taking this further deregulatory action.<sup>74</sup>

The rule also reveals that DOL considered limiting the rule’s applicability to fully-insured AHPs, rather than permitting self-insured AHPs as the proposed rule does. The rule noted that self-insurance has in the past been utilized “both to evade State oversight and to maximize opportunities for abusive financial self-dealing,”<sup>75</sup> which often exacts high financial and insurance stability costs on enrollees. Despite this recognition, the DOL chose to allow self-insured AHPs to form AHPs because those that are “well-managed” have the potential to realize efficiencies that some insured AHPs cannot.<sup>76</sup>

Finally, the proposed rule stated that the DOL considered but ultimately declined to extend to newly-authorized AHPs the pricing requirements and minimum EHB standards that are binding on other health plans sold in the individual and small group markets.<sup>77</sup> The rule permits small businesses and entities to form AHPs in order to receive benefits that are reserved for insurance plans provided by large employers. Certain product and pricing restrictions do not apply in the large-group health insurance market. Though “[a] number of public comments raised the risk that AHPs would exercise their flexibility in ways that harm local individual and small group markets” and “advocated a level playing field where AHPs compete with issuers under the same

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<sup>70</sup> *Id.*

<sup>71</sup> 83 Fed. Reg. 28,912, 28,955 (June 21, 2018).

<sup>72</sup> 83 Fed. Reg. 614, 632 (Jan. 5, 2018).

<sup>73</sup> *Id.*

<sup>74</sup> In the final rule, the DOL stated that “the Department has determined that the control test is necessary to satisfy the statutory requirement in ERISA section 3(5) that the group or association must act ‘in the interest of’ the employer members in relation to the employee benefit plan in order to qualify as an employer.” 83 Fed. Reg. 28,912, 28,955 (June 21, 2018). The Department also concluded that “[t]he control test is also necessary to prevent formation of commercial enterprises that claim to be AHPs but, in reality, merely operate similar to traditional insurers selling insurance in the group market.” *Id.*

<sup>75</sup> 83 Fed. Reg. 614, 632 (Jan. 5, 2018).

<sup>76</sup> The final rule observed that “[l]arge AHPs sometimes may achieve savings by offering self-insured coverage. Because large group plans in and of themselves constitute large and potentially stable risk pools, it often is feasible for them to self-insure rather than to purchase fully-insured large group insurance policies from licensed health insurance issuers.” *Id.* at 28,943.

<sup>77</sup> *Id.*

rules,”<sup>78</sup> the DOL concluded that such restrictions would inhibit the newly authorized AHPs’ “flexibility to offer products and premiums that more closely align with their members’ preferences.” The DOL cited this flexibility as “a significant benefit for those members.”<sup>79</sup> The final rule stated that this flexibility “also frees AHPs from some regulatory overhead, and may enable some AHPs to achieve the scale necessary for administrative efficiency and market power.”<sup>80</sup>

#### IV. Contrasting Regulatory Impact Analyses

The two rules strongly differ in their implementation. The Obama administration issued the EHB final rule in the months leading up to its rollout of the ACA. The rule was one of the final regulatory actions in one of the administration’s most significant regulatory efforts. In contrast, the Trump administration issued its AHP rule following a torrential legislative battle on Capitol Hill between proponents and opponents of the ACA. This conflict resolved itself, at least for the time-being, with an odd result: the continuing force and effect of a law that the White House and Republican majorities in both houses of Congress vehemently opposed. It was under this shadow that President Trump issued Executive Order 13,813 (instructing federal agencies to reinterpret the ACA) and the DOL issued its proposed AHP rule.

The two rules also might be contrasted by the degree to which they embrace the idea of the administrative state. While the HHS rule is clearly an affirmative rulemaking action, the DOL rule is a deregulatory action in that its essential function is to ease previously prescribed restrictions on how AHPs may be created and maintained. The rule itself states as much: “This proposed rule is expected to be an E.O. 13,771 deregulatory action, because it would expand small businesses’ access to more lightly regulated and more affordable health insurance options, by removing certain restrictions on the establishment and maintenance of AHPs under ERISA.”<sup>81</sup> Yet similar criteria govern both rules; deregulatory actions are also subject to notice-and-comment requirements<sup>82</sup> and are subject to the same standards of judicial review as affirmative rulemaking.<sup>83</sup>

Other differences, however, are also relevant. The institutional relationships of HHS and DOL to cost-benefit analysis diverge to some extent. According to University of Chicago Law School professors Jonathan Masur and Eric Posner, HHS regulators may be especially disinclined to monetize benefits.<sup>84</sup> In a set of selected economically significant regulations promulgated between 2010 and 2013, HHS issued eleven regulations in which benefits were not monetized and five regulations in which neither costs nor benefits were quantified. The DOL did not monetize benefits in four regulations issued during the same period. However, Masur and Posner note that HHS found itself in an especially precarious position when conducting cost-benefit analyses in rulemakings issued between passage and implementation of the ACA. They note that HHS “had to promulgate a number of regulations implementing the Affordable Care Act, and as we noted above, the costs and benefits of such regulations are difficult or impossible

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<sup>78</sup> 83 Fed. Reg. 28,912, 28,955 (June 21, 2018).

<sup>79</sup> *Id.*

<sup>80</sup> *Id.* at 28,959.

<sup>81</sup> 83 Fed. Reg. 28,912, 28,955 (June 21, 2018).

<sup>82</sup> See Administrative Procedure Act §1, 5 U.S.C. § 551(5) (2012).

<sup>83</sup> See *Motor Vehicles Mfr. ’s Ass’n v. State Farm*, 423 U.S. 29 (1983).

<sup>84</sup> See Masur and Posner, *Unquantified Benefits*, *supra* note 37 at 1.

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to calculate separate from the statutes themselves.”<sup>85</sup>

## V. Omitted Values

Perhaps the most striking characteristics of the cost-benefit analysis in both the HHS and the DOL rules are what the regulations excluded from their respective RIAs. Though the decision to refrain from attempting to monetize certain values is still consistent with larger project of cost-benefit analysis, the regulations reflect a certain cost-benefit minimalism on the part of the two executive agencies. The regulatory actions promulgated by HHS and DOL are each products of executive agencies governed by trademark, OMB-guided cost-benefit analysis requirements. Unlike an independent agency such as the Securities and Exchange Commission, which is formally exempt from satisfying most cost-benefit analysis benchmarks,<sup>86</sup> both of these regulations lie within the heartland of cost-benefit analysis subject to OIRA review. This reality makes the agencies’ disinclination to monetize all the more striking.

Though HHS chose not to monetize benefits in issuing its EHB and AV rule, it is not difficult to imagine guideposts for doing so if the agency had been so inclined. The essential goal of the regulation fit squarely within several of the Obama administration’s larger policy priorities in enacting the ACA. First, the agency could have monetized the value of induced market activity. HHS could have projected the efficacy of the EHB standard in measuring how many people purchased insurance as a result of being able to understand what previously indecipherable insurance policies actually covered (and who otherwise might not have entered the market). Similarly, HHS could have also monetized the value of heightened transparency and health insurance policies’ clarified pricing structure through the rule’s AV provision. We can envision at least two monetizable benefits that would fall within this category: both the absolute value to the economy of consumers who entered the market as a result of the AV provision’s newfound price transparency, as well as this benefit’s marginal value to consumers who were already in the individual or small group health market but previously considered health insurance an opaque and confusing product.

The cost-benefit analysis for the proposed DOL rule might have considered monetizing certain costs of the regulatory action. The rule might have anticipated criticisms that loosening requirements for AHP formation would lead to more instability in the health insurance market, and used the transaction costs associated with a policyholder’s change of insurance plans alongside the number of consumers expected to make such a change in a given year to assess an initial cost of the regulatory action. This monetization might have included the costs of consumer confusion when policyholders realize their new AHP-issued health insurance plan does not cover all of the same services as other plans subject to traditional EHB minimum coverage requirements under the ACA cover. The DOL might also have chosen to monetize the cost of decreases to social welfare when newly authorized AHPs fail or become insolvent and participants are left without a viable health insurance coverage option.

Additionally, the DOL might have chosen to monetize its regulation’s benefits. Ostensibly, the regulatory action is designed to shift the individual and small-group market health insurance

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<sup>85</sup> *Id.* at 15.

<sup>86</sup> See John C. Coates IV, *Cost-Benefit Analysis of Financial Regulation: Case Studies and Implications*, 124 YALE L.J. 882, 909 (2015), <https://www.yalelawjournal.org/article/cost-benefit-analysis-of-financial-regulation>.

market demand curves rightward by relaxing regulatory requirements that previously imposed costs on market participants and kept others from entering the market entirely. The net benefits of this action might be comprised of at least three categories the Department could have monetized: the flexibility value to local entities of now being authorized to organize new associations for the sole, express purpose of extending health insurance, the promotion of risk-pooling that might result from striking the heretofore-extant “common interest” requirement, and eliminating adverse selection challenges that would be less severe under the new allowance for intra-industry AHPs.

One final value that both HHS and the DOL might have considered including in a more rigorously monetized cost-benefit analysis is the value of health insurance itself. Studies have demonstrated that health insurance improves financial security,<sup>87</sup> quality of care,<sup>88</sup> patients’ perceptions of their health and thereby well-being,<sup>89</sup> while decreasing mortality.<sup>90</sup> Monetization of either a uniform (or differently weighted, by consumer category) value of health insurance could proceed from the general proposition that purchasing health insurance satisfies individual risk aversion, which itself explains why many consumers’ willingness-to-pay for health insurance exceeds the policy’s expected value.<sup>91</sup> If the agencies were interested in a more ambitious monetization effort, consumers who are statutorily required to purchase health insurance might be considered separate from those who enter the market voluntarily.<sup>92</sup> Once an agreed-upon figure for this value emerged, the agencies could have proceeded to determine how expanded or restricted access to health insurance would affect net social welfare.

Analysts can discern individuals’ expected ex-ante utility from health insurance,<sup>93</sup> which could theoretically provide a starting point for the agencies’ contingent valuation measurements. Furthermore, there are positive externalities the agencies might have considered in assessing costs and benefits. Extensive research suggests that health insurance has a quantifiable social value.<sup>94</sup> Finally, individuals might have moral commitments to provide health insurance to their families or employees (which may be particularly salient in the case of small business owners and AHPs). In a cost-benefit maximalist universe, the value of these commitments can be

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<sup>87</sup> See, e.g., H. Allen, K. Baicker, A. Finkelstein, S. Taubman, B.J. Wright, *What the Oregon Health Study Can Tell Us About Expanding Medicaid*, HEALTH AFF. (Millwood) (2010).

<sup>88</sup> See, e.g., B. Sommers, R.J. Blendon, E.J. Orav, A.M. Epstein, *Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance*, J. OF THE AM. MED. ASSOC.: INTERNAL MED. (2016).

<sup>89</sup> See, e.g., A. Finkelstein, S. Taubman, B. Wright, et al, *The Oregon Health Insurance Experiment: Evidence From the First Year*, THE QUARTERLY J. OF ECON. (2012).

<sup>90</sup> See *Care Without Coverage: Too Little, Too Late*. Washington, DC: Institute of Medicine (2002).

<sup>91</sup> See e.g., B. Sommers, A. Gawande, and K. Baicker, *Health Insurance Coverage and Health—What the Recent Evidence Tells Us*, NEW ENGLAND J. OF MED. (Aug. 10, 2017), <https://nejm.org/doi/full/10.1056/NEJMsb1706645>.

<sup>92</sup> The latter group (of consumers not subject to the individual mandate) has likely expanded significantly in light of Congress’ December 2017 decision in its tax reform bill to vitiate the IRS penalty assessed for consumers who fail to purchase health insurance.

<sup>93</sup> See Nathaniel Hendren, *Measuring Ex-Ante Welfare in Insurance Markets*, HARVARD UNIV. FACULTY OF ARTS & SCI. (March 2018), <https://scholar.harvard.edu/files/hendren/files/exantewtp.pdf>. Hendren’s work posits that “[r]evealed-preference measures of willingness to pay (WTP) capture the value of insurance only against the risk that remains when choosing insurance.” Accordingly, his paper “provides a method to translate observed market WTP and cost curves into an ex-ante value of insurance that can analyze the impact of insurance market policies on ex-ante expected utility.”

<sup>94</sup> C. Green and K. Gerard, *Exploring the Social Value of Health-Care Interventions: a Stated Preference Discrete Choice Experiment*, 18 HEALTH ECON. 951–76 (2009).

monetized.<sup>95</sup>

## VI. Lessons for Cost Benefit Analysis

The reluctance of both HHS and DOL to engage in full-throated quantified cost-benefit analysis in these two rules may reflect some regulators' instinctual beliefs that "[w]hen we try to convert health [or lives] into dollars, much of what is important gets lost in the translation."<sup>96</sup> Even so, the agencies seem intent on carrying out their mandates to engage in cost-benefit analysis in a reasoned way. The product we are left to analyze seems to be somewhat of a middle ground: a general acquiescence with the precepts of cost-benefit analysis and a good-faith effort to fulfill the obligations of Executive Order 12,866 and Circular A-4, combined with a striking lack of quantification on the benefits side (and in the case of the proposed DOL rule, on the cost side as well). John Coates' qualitative-instead-of-quantitative arguments seem to be satisfied here, even as the relevant rules were promulgated by agencies subject to OMB review rather than independent financial regulatory agencies.<sup>97</sup>

Masur and Posner offer another explanation for benefit-quantification reticence that seems plausible here, especially in the case of the EHB rule. "We suspect that it would be embarrassing for a regulator to issue a regulation that fails a cost-benefit analysis by its own admission. Moreover, even if there is a statutory mandate, the regulator may fear that regulation would be vulnerable to attack as arbitrary and capricious. Thus, it will be tempting for regulators to claim unquantifiable benefits even when they can be quantified."<sup>98</sup> On this view, the EHB rule is required by statute and thus is a presumptively legitimate exercise of agency rulemaking authority: Congress has specifically directed the Secretary of HHS to issue the regulation. However, as Masur and Posner noted, "[i]f the statute forces the agency to promulgate a regulation whose costs exceed its benefits, a cost-benefit analysis will reveal to Congress that statute was inefficient and that it should avoid similar statutes in the future."<sup>99</sup> Though it is far from clear that the costs of the EHB rule would have exceeded its benefits, even had HHS quantified benefits, this institutional fear provides a somewhat reasonable explanation of the agency's choice to perform only a qualitative assessment of benefits.

With respect to the AHP rule, institutional fear that a regulation will be challenged as arbitrary and capricious may be even more pronounced.<sup>100</sup> For example, unlike the EHB rule, the regulation has not been directed by statute. Instead, President Trump's "two-for-one" deregulatory executive order is the most readily cognizable justification for the regulation. The

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<sup>95</sup> See generally Eric Posner and Cass Sunstein, *Moral Commitments in Cost-Benefit Analysis*, 103 VIRGINIA L. REV. 8 (2017).

<sup>96</sup> FRANK ACKERMAN & LISA HEINZERLING, PRICELESS: ON KNOWING THE PRICE OF EVERYTHING AND THE VALUE OF NOTHING 143 (2004).

<sup>97</sup> See Coates, *supra* note 86 (discussing the newer obligations for cost-benefit analysis in financial regulation).

<sup>98</sup> Masur and Posner, *Unquantified Benefits*, *supra* note 37 at 2.

<sup>99</sup> *Id.*

<sup>100</sup> These fears appear well-founded in light of a March 2019 federal court ruling in the District of Columbia. In an APA challenge brought by eleven states and the District of Columbia, the court invalidated the AHP rule's interpretation of "employer." The court concluded that the "DOL's Final Rule stretches the definition of 'employer' beyond what ERISA's text and purpose will bear." *New York v. U.S. Dep't of Labor*, No. 18-747 JDB, 2019 WL 1410370 (D.D.C. Mar. 28, 2019). The court remanded the rule to the DOL to study how its severability provision affects remaining portions of the Final Rule.

DOL characterizes the AHP rule as a deregulatory action pursuant to the order. In any litigation over the AHP rule, cost-benefit analysis may take on even more importance than usual in defending against an arbitrary and capricious challenge. If an agency can offer no other basis for rolling back one previously promulgated rule instead of another besides “the President said something must go,” the chances of satisfying judicial review of agency action under the APA appear to be suspect. As one administrative law scholar noted, “[a]n agency decision to repeal a regulation because ‘it had to’ in order to satisfy E.O. 13,771 almost certainly will not satisfy that [arbitrary and capricious] standard.”<sup>101</sup> But a deregulatory action commenced pursuant to Executive Order 13,771 may in fact survive APA arbitrariness review. There is a colorable argument that “Executive Order 13,771, like its predecessors, recognizes that agencies must inherently weigh conflicting goals, priorities, and associated costs as a necessary part of reasoned decision-making under the APA.”<sup>102</sup>

The numerous benefits cited by both HHS and the DOL in the promulgated rules suggests that there may be institutional self-consciousness at play, given that the agencies listed as many qualitative benefits as possible in order to justify their regulatory actions. This is a version of the “kitchen sink” approach, in which agencies might be inclined to document comparatively more qualitative benefits when they are unable to quantify asserted benefits. This thesis, however, is not universally true: one study that performed a series of simple regressions to determine the relationship between benefit counts and the extent to which benefits were quantified yielded no relationship for the full sample.<sup>103</sup>

Though the two selected rules point in different directions in their political postures and assumptions about the appropriate degree of government regulation of private firms, both rules nod to behavioral economics as an animating force. The HHS rule was highly concerned with addressing problems of bounded rationality and irrational decision-making. The rule’s standardization of what would constitute EHB under the statute and its emphasis on the metal ordering system for distinguishing plans by AV reflected these tendencies. The DOL rule also projected the agency’s preoccupation with preventing market failures. The Department considered, but ultimately rejected, an alternative regulatory action that would have let non-AHP members operate AHPs. This insistence on member control—rather than opening operation to any market actor—reveals that behavioral economics recommend at least a small degree of continued regulatory intervention, even in facially “deregulatory” actions like the AHP rule. To be sure, the AHP rule also embodied classical and neoclassical assumptions about consumer sovereignty. Still, the staying power of behavioral considerations in the AHP rule suggests that behavioral law and economics has explanatory authority across regulatory contexts.

It might also be said that the two rules analyzed here provide an affirmation of the Kaldor-Hicks criterion as a defense of agencies’ use of cost-benefit analysis. Among the most commonsensical justifications for cost-benefit analysis, the Kaldor-Hicks criterion (sometimes called potential Pareto superiority) asks “whether the winners win more than the losers lose.”<sup>104</sup>

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<sup>101</sup> “Dean Krent on the ‘Two for One’ Trump Administration Executive Regulatory Order,” Chicago-Kent College of Law, <https://blogs.kentlaw.iit.edu/ck-now/dean-krent-on-two-for-one-trump-executive-regulatory-order/>.

<sup>102</sup> See Reply in Support of Defendant’s Motion to Dismiss at 20, *Pub. Citizen, Inc. v. Trump*, 297 F. Supp. 3d 6 (D.D.C. 2018) (No. 17-253).

<sup>103</sup> H. Jackson and P. Rothstein, *The Analysis of Benefits in Consumer Protection Regulation* (Dec. 2015) (unpublished manuscript), [https://www.law.ox.ac.uk/sites/files/oxlaw/jackson\\_and\\_rothstein\\_article\\_december\\_2015.pdf](https://www.law.ox.ac.uk/sites/files/oxlaw/jackson_and_rothstein_article_december_2015.pdf)

<sup>104</sup> Cass Sunstein, *The Value of a Statistical Life: Some Clarifications and Puzzles*, 4 J. OF BENEFIT-COST ANALYSIS 237, 256 (2013) (citing Matthew D. Adler and Eric A. Posner, *New Foundations of Cost-Benefit Analysis*

Cass Sunstein explains that “[t]he central idea is that if the winners could compensate the losers, and there would be a surplus, satisfaction of the Kaldor-Hicks criterion shows a net welfare gain.”<sup>105</sup> In the case of HHS and OMB’s consideration of the EHB rule, if we assume that the welfare gains that insurance policyholders would enjoy surpass the welfare losses that plan issuers suffer in being required to comply with adjusting their products to comply with EHB standards and AV calculation, then the rule can be characterized as Kaldor-Hicks efficient. For the DOL’s proposed regulatory rollback, if we assume that the welfare gains by would-be AHP members are greater than the potential losses suffered by policyholders previously unable to purchase plans, then the regulation is Kaldor-Hicks efficient.

For the purposes of analyzing these rules, it is relevant to note that health-related benefits and costs present somewhat of a *sui generis* case when it comes to the question of discounting. “When future benefits or costs are health-related, some have questioned whether discounting is appropriate, since the rationale for discounting money may not appear to apply to health.”<sup>106</sup> Though this principle seems facially valid, given the potential dangers posed on dignitarian grounds for discounting future health effects, regulators might consider how broadly this maxim should extend. There seems to be, for example, a meaningful difference between an FDA regulation that authorizes patient access to a certain drug with life-saving or chronic pain-ameliorating effects and the DOL regulation governing the standards by which business entities can join to form an AHP. Though both are “health-related,” it seems uncontroversial to state that the latter is less directly correlated with readily discernible changes in population health than the former. The level of generality regulators adopt in exempting health-related rules from normal OMB-mandated discounting practices is relevant in light of the “professional consensus that future health effects, including both benefits and costs, should be discounted at the same rate.”<sup>107</sup>

In some ways, the conversation about whether the costs calculated in the EHB rule are appropriate, and whether the lack of any discounting in the qualitative AHP rule can be defended, is a condition precedent to a larger issue: the persistent uncertainty of regulating health insurance plans in a rapidly-evolving environment. Agencies subject to OIRA review such as HHS and the DOL rely on estimates and projections to perform *ex-ante* cost-benefit analysis when they consider regulatory action. But the limits of these approximations are clear in the context of health insurance. Even the CBO has faced challenges in its attempts to craft reasonable projections for how many consumers will take advantage of statutory and regulatory changes in health insurance.<sup>108</sup>

This inherent uncertainty may be intractable, particularly in the early years after the implementation of a piece of domestic legislation as sweeping as the ACA. However, the regulatory response to this uncertainty need not be so one-dimensional. The chosen route of both HHS and the DOL appears to be cost-benefit analysis-avoidant; where benefits or costs are difficult to monetize, the agencies’ default approach eschews even attempting to monetize regulatory outcomes. There are, of course, other tacks. The agencies might instead make use of

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(2006)).

<sup>105</sup> *Id.*

<sup>106</sup> W. MILLER, L. ROBINSON, AND R. LAWRENCE, VALUING HEALTH FOR REGULATORY COST-EFFECTIVENESS ANALYSIS 300 (2006).

<sup>107</sup> *Id.*

<sup>108</sup> Consider that the EHB rule referencing CBO’s projection of 24 million enrollees in health insurance exchanges by 2016 badly missed the mark of the actual 2016 enrollment of less than 11 million.

cost and benefit ranges.<sup>109</sup> Under this approach, the agency would not face the potentially unsatisfying result of definitively declaring a specific dollar amount gained or saved. Instead, the agency could define a range of possibilities, bookended by the extreme upper and lower points of likelihood. Individual points within the range could be subjected to probability weighting so as to provide a more accurate depiction of likely outcomes.

Rather than merely asking how the approaches taken by HHS and the DOL might better serve the purposes of cost-benefit analysis, it is relevant to pause and ask whether regulatory rules should instead be considered under a different evaluative framework. Measuring social welfare directly is one alternative. It is at least plausible that health benefits are more readily measured by a “social welfare function” tool like the one proposed by Matthew Adler.<sup>110</sup> Adler’s analysis purports to correct “for the diminishing marginal utility of money by using an appropriately constructed measure of individual well-being as the indicator of how well each person is doing, and how much he or she stands to gain or lose from a given policy.”<sup>111</sup> A utilitarian approach to SWF would determine all changes in individual well-being as a result of the proposed HHS and DOL rules, aggregate those values, and then produce a measurable shift in total social welfare. Adler also describes a prioritarian approach to SWF, which in this context might suggest that the well-being of uninsured or underinsured individuals should be weighted more heavily than already fully-insured consumers.<sup>112</sup>

Happiness research offers another alternative. Rather than determining individuals or firms’ willingness-to-pay when determining the value of the welfare gains realized by a given regulatory intervention, happiness research concerns its inquiry with how individuals rate their own happiness or life satisfaction.<sup>113</sup> This metric can be determined either by experienced happiness,<sup>114</sup> or more commonly, “subjective self-reported well-being.”<sup>115</sup> If willingness-to-pay for social goods like future health benefits is difficult or undesirable to monetize, perhaps these social well-being measures should displace willingness-to-pay in at least some problems that require valuation in cost-benefit analysis. Social well-being measures might be assigned monetary values for incremental increases in happiness, for example. But, a difficult problem often emerges: when an individual’s behavior is subject to bounded rationality, or their preferences are unstable, happiness metrics seem to provide few answers. Even if the use of net social benefits is subject to legitimate criticism for reliance on questionable standards of contingent valuation, they are at least calculable.

In conclusion, CBA as applied to regulation of health insurance plans in the small group and individual markets remains an important tool available to administrative agencies as they evaluate the tradeoffs of policy choices. The conspicuous absence of more monetized benefits, and the heavily reliance on qualitative costs, must be read against the backdrop of the difficulty

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<sup>109</sup> For more on the use of ranges by agencies, see Cass Sunstein, *The Real World of Cost-Benefit Analysis: Thirty-Six Questions (And Almost as Many Answers)*, 114 COLUMBIA L. REV. 167 (2013).

<sup>110</sup> Matthew D. Adler, *A Better Calculus for Regulators: From Cost-Benefit Analysis to the Social Welfare Function*, DUKE L. J. 1, 2 (2017) (unpublished manuscript).

<sup>111</sup> *Id.*

<sup>112</sup> *See id.*

<sup>113</sup> See Lisa Robinson, *Irrationality, Happiness and Benefit-Cost Analysis*, J. OF COST-BENEFIT ANALYSIS (2016).

<sup>114</sup> Paul Dolan is among the most vocal proponents of measuring experienced happiness rather than self-reported levels of life satisfaction. He describes this rationale and the concept of experienced happiness as a legitimate indicator of individual welfare in PAUL DOLAN, *HAPPINESS BY DESIGN: CHANGE WHAT YOU DO, NOT HOW YOU THINK* (2014).

<sup>115</sup> Lisa Robinson, *[Ir]rationality, Happiness and Benefit-Cost Analysis: Introduction to the Special Issue*, 7 J. OF COST-BENEFIT ANALYSIS 1, 3 (2016).

of valuing future health benefits and costs. This posture must also be understood with reference to the institutional tendencies of HHS and the DOL, two OMB agencies with their own distinct relationships to the project of cost-benefit analysis.