New York's Essential Health Benefit Base Benchmark Options Effective January 1, 2017

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New York State Department of Health

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EXECUTIVE SUMMARY

The U.S. Department of Health and Human Services (HHS) released final rules in February 2015[1] that allow states to select a new base benchmark plan for the 2017 plan year based on health plans available in 2014, using the same process used to select the benchmark plan for 2014. New York can select from the largest three plans offered to federal employees, the largest three plans offered to New York State employees though the New York State Health Insurance Program (NYSHIP), the largest three plans from New York's small group market, and New York's largest non-Medicaid commercial group HMO plan.

The New York State Department of Health asked Milliman to analyze and compare the health services covered by the ten plans that are options for New York's Essential Health Benefit (EHB) benchmark effective January 1, 2017. Milliman completed a similar analysis in early 2012 which informed the decision making process for selecting the EHB base benchmark plan effective January 1, 2014 through December 31, 2016.

This report summarizes the rules and options regarding the selection of a 2017 base benchmark plan, compares the benefits and coverage limits of each of the base benchmark plan options, identifies the benefit supplementation needed for each of the base benchmark plan options, and assesses cost differences between the base benchmark plan options.

We identified the differences in covered services and benefit limits among the available benchmark plans. Because these differences have a direct effect on expected healthcare costs, and hence premiums, for plans required to cover EHB, we also estimated differences in expected average healthcare costs.

All of the available New York State benchmark plans have comprehensive coverage. Only one of the 10 plans does not cover prescription drugs, but as this is a required EHB, this benefit would need to be supplemented. The services with differing coverage among the plans include private duty nursing and hearing aids. Most of the plans have service limits for home health visits, skilled nursing facility days, and rehabilitative physical therapy, occupational therapy, and speech therapy, with some variation in the number of allowed services. These service limits would carry over to the EHB with the benchmark plan selected. However, certain benefit exclusions would not carry over to the EHB with the benchmark plan selected. Per federal rules, federally required benefits (e.g., prescription drugs) and state-mandated benefits enacted before December 31, 2011 (e.g., autism spectrum disorder) would be required to be included in the state's EHB regardless of the benchmark plan selected.

These coverage and limit differences produce relatively small changes in average gross medical costs compared to New York's current EHB. Gross medical costs are defined as the total costs paid for each service, and include the portion paid by the insurance company and the portion paid by the member through member cost sharing. Selecting one of the three small group plans as the new base benchmark plan would result in gross medical costs that are only 0.08% higher than the current EHB. Selecting the large group plan would result in gross medical costs that are approximately 0.06% lower than the current EHB. Selecting one of the NYSHIP plans would result in gross medical costs that are approximately 1.27% lower to 1.49% higher than the current EHB. Selecting one of the federal employee plans would result in gross medical costs that are approximately 0.32% lower to 0.41% higher than the current EHB. It is important to note that those benchmark plans resulting in lower costs would include a reduced level of benefits – either through a reduction in covered benefits or a more limited number of visits – than the state's current EHB.

BACKGROUND

In 2012, federal regulations[2] established a process allowing each state to define their own EHB by first selecting a base benchmark plan from 10 options, including plans offered to federal employees, plans offered to each state's employees, the State's largest small group plans, and the State's largest non-Medicaid HMO plan. Then each state could supplement the base benchmark plan as needed to comply with EHB requirements. The most commonly supplemented benefits were habilitative services and pediatric vision and dental benefits. The federal regulations allowed states to supplement

[1] Available online at: http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf

[2] Available online at: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf

pediatric vision and dental benefits from either the Federal Employee Dental and Vision Insurance Program (FEDVIP) or the State Children's Health Insurance Program (CHIP) plans. Recent federal regulations allow states to select new EHBs effective January 1, 2017 using the same process that was outlined in the 2012 regulations.

Regardless of the base benchmark plan selected, each state's EHB must cover the following categories of benefits:

- Ambulatory patient services
- Emergency room services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorders
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

The EHB includes information about what services are covered and if there are any quantitative limits associated with that coverage. The EHB does not specify what the cost sharing has to be for covered services, what providers are able to provide each service, or what constitutes medical necessity for a covered benefit.

HHS has provided additional guidance on specific EHB issues since New York evaluated their EHB benchmark options in 2012. Of particular interest for this analysis is the change that state-required benefits (mandates) enacted on or before December 31, 2011 are not considered an addition to EHBs (45 C.F.R. 155.170(a)). This means that state-mandated benefits enacted prior to December 31, 2011 will become part of the EHB regardless of which base benchmark plan is selected, even if it is one of the plans offered to federal employees. States are required to defray the costs of state-mandated benefits in Qualified Health Plans (QHPs) that are in excess of the EHB. Based on this guidance, this requirement to defray costs pertains to mandates enacted on or after January 1, 2012. In New York, as of the date of this report, there were no benefit mandates enacted after January 1, 2012. Another regulatory change since the previous analysis is that adult vision and dental benefits are explicitly excluded from being part of EHB regardless of which benchmark plan is chosen (45 C.F.R. 156.115(d)).

Recent federal regulations state that the definition for habilitative services will now be made at the state level, and insurers will no longer be allowed to define habilitative services themselves. While this will result in a change in some states, New York already has a statewide definition for habilitative services. The recent regulations include a proposed uniform definition of habilitative services that states can adopt, which includes devices and clarifies that coverage of devices is required for both rehabilitative and habilitative services.

CURRENT ESSENTIAL HEALTH BENEFIT

New York's current EHB was submitted on October 1, 2012.[3] The EHB is based on the Oxford EPO plan (federal health product identification number 85629NY001), with the following additional services:

- Habilitative services
- Pediatric vision care based on New York CHIP benefits
- Pediatric dental care based on New York CHIP benefits

The Center for Consumer Information & Insurance Oversight (CCIIO) released information about the benefits covered by each state's current EHB benchmark plan. We used this structure for our analysis. More detailed information about New

[3] Available online at: http://info.nystateofhealth.ny.gov/news/essential-health-benefits-ehb-benchmark-plan-selection

York's EHB in CCIIO's standardized structure is available online at: http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html.

MEDICAL BENEFITS

Base Benchmark Plan Options

Recent federal regulations allow states to select a new base benchmark plan for the 2017 plan year based on health plans available in 2014. These regulations allow New York to select a new base benchmark from the following ten plans:

- Three largest Federal Employees Health Benefits Program (FEHBP) plans
- Three largest State Employee Plans
- Largest plan in each of the three largest products in New York's small group market
- Largest New York commercial group HMO

This is the same structure that HHS used for the selection of the 2014 EHB benchmark plans.

Plan Comparison

All of the potential EHB base benchmark options are comprehensive. They all cover standard facility and professional services. Only one of the 10 plans does not cover prescription drugs, but as this is a required EHB, this benefit would need to be supplemented from one of the other nine benchmark plans that include this benefit. With the assumption that the prescription drug benefit would be supplemented, we estimate that more than 98% of the underlying benefit costs were consistent among the base benchmark options. The following benefits are covered by all of the base benchmark options:

Accidental Dental	Other Practitioner Office Visit (Nurse, Physician Assistant)
Allergy Testing	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
Bariatric Surgery	Outpatient Rehabilitation Services)
Breast Reconstructive Surgery	Outpatient Surgery Physician/Surgical Services
Chemotherapy	Post-Mastectomy Care
Chiropractic Care	Prenatal and Postnatal Care
Delivery and All Inpatient Services for Maternity Ca	Preventive Care/Screening/Immunization
Diabetes Care Management	Primary Care Visit to Treat an Injury or Illness
Diabetes Education	Radiation
Dialysis	Reconstructive Surgery
Emergency Room Services	Rehabilitative Occupational and Rehabilitative Phys Therapy
Emergency Transportation/Ambulance	Rehabilitative Speech Therapy
Family Planning Services	Skilled Nursing Facility
Home Health Care Services	Specialist Visit
Hospice Services	Substance Abuse Disorder Inpatient Services
Imaging (CT/PET Scans, MRIs)	Substance Abuse Disorder Outpatient Services
Basic Infertility Treatment	Transplant
Infusion Therapy	Treatment for Temporomandibular Joint Disorders
Enteral Formulas	Urgent Care Centers or Facilities
Inpatient Hospital Services (e.g., Hospital Stay)	Well Baby Visits and Care
Inpatient Physician and Surgical Services	X-rays and Diagnostic Imaging
Laboratory Outpatient and Professional Services	
Mental/Behavioral Health Inpatient Services	
Mental/Behavioral Health Outpatient Services	

The following is a list of benefits that were not covered by any of the base benchmark options:

Cosmetic Surgery
Long-Term/Custodial Nursing Home Care
Weight Loss Programs (e.g. Jenny Craig)

In addition to these benefits listed, there is a provision of the EHB regulation that states that "an issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB."[4] As such, we have excluded these benefits from our comparison of the base benchmark options.

Benefit differences between plans can be categorized as two types. First, there are benefit differences associated with coverage differences. If one plan covers Assisted Reproductive Technology (ART) but another plan does not cover ART, this would be considered a coverage difference. There are also benefit differences associated with quantitative limit differences. If two plans both cover acupuncture, but one plan covers up to 12 visits per year while another plan covers up to 24 visits per year, this would be considered a quantitative limit difference. We have separated our comparisons into these two types of benefit differences.

The table below contains the material coverage differences among the ten base benchmark options for New York's EHB effective January 1, 2017. We also show a comparison to New York's current EHB.

Table 1: Coverage Differences Among Base Benchmark Options for January 1, 2017

Benefit	2014 EHB	FEHBP Plan 1 - BCBS Standard	FEHBP Plan 2 - BCBS Basic	FEHBP Plan 3 - GEHA Standard	NYSHIP Plan 1 – Empire Plan	NYSHIP Plan 2 - CDPHP	NYSHIP Plan 3 - Independent	SG Plan 1 – Freedom EPO	SG Plan 2 – Gold HMO	SG Plan 3 – Freedom PPO	HIP Prime HMO
Autism Spectrum Disorders	X				X	X	X	X	X	X	X
Durable Medical Equipment	X	X	X	X	X	X	X	X	X	X	
Hearing Aids	X	X	X	X	X			X	X	X	
Nutritional Counseling	X	X	X	X	X	X	X	X	X	X	
Prosthetic Devices	X	X	X	X	X	X	X	X	X	X	
Prescription Drugs	X	X	X	X	X	X	X	X	X	X	
Acupuncture		X	X	X	X	X					
Assisted Reproductive Technology (ART)					X						
Non-Emergency Care When Traveling Outside the U.S.		X	X	X	X						
Foot Orthotics - Shoe Inserts					X						
Private Duty Nursing (Skilled Nursing in the Home)					X						

There are a few benefits that are covered by most or all of the base benchmark options, but have some quantitative limits associated with the benefit. Quantitative limits are considered part of EHB, so that the limits in the chosen benchmark plans would become the quantitative limits in the EHB. We show a comparison of these benefits in the table below.

[4] Available online at: http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=e5f664054d022da8a14bf5c94315e686&ty=HTML&h=L&mc=true&r=PART&n=pt45.1.156#se45.1.156_1115.

Table 2: Quantitative Limits Among Base Benchmark Options for January 1, 2017

Quantitative Limits on Benefits	2014 EHB	FEHBP Plan 1 - BCBS Standard	FEHBP Plan 2 - BCBS Basic	FEHBP Plan 3 - GEHA Standard	NYSHIP Plan 1 – Empire Plan	NYSHIP Plan 2 - CDPHP	NYSHIP Plan 3 - Independent	SG Plan 1 – Freedom EPO	SG Plan 2 – Gold HMO	SG Plan 3 – Freedom PPO	HIP Prime HMO
Acupuncture (visits per year)	NC	24	10	20	¥	┼	NC	NC	NC	NC	NC
Chiropractic (visits per year)	¥	12	20	12	¥	¥	¥	¥	¥	¥	¥
Hearing Aids 1 = one pair every 5 years 2 = $2,500 per year up to age 22, $2,500 every 3 years over age 22 3 = $1,500 per aid, per ear, every 4 years, children every 2 years 4 = one purchase every 3 years per impaired ear	4	2^	2^	1	3^	NC	NC	4	4	4	NC
Home Health Care Services (visits per year)	40	50	25	50	¥	45	40	40	40	40	200
Hospice Services (days per year)	210	¥	¥	¥	¥	210	¥	210	210	210	210
Inpatient Rehabilitative Physical/Occupational/Speech Therapy (visits per year or visits per lifetime; visits per lifetime are identified as ~)	60~	¥	¥	¥	¥	60	45	60~	60~	60~	90
Outpatient Rehabilitative Physical/Occupational/Speech Therapy (visits per year or visits per lifetime; visits per lifetime are identified with ~; CDPHP plan has separate visit limits for PT/OT/ST)	60~	75	50	60	¥	30/30/20	20	60	60	60	¥
Skilled Nursing Facility (days per year)	200	75	50	14	¥	45	45	200	200	200	¥

Key

NC	Not Covered
┼	Benefit covered for specific medical conditions
¥	Covered with No Limit
^	Dollar limits in benefit would not be permitted per the EHB and must be updated to compliance if this plan is selected as the base benchmark plan
~	Per Condition Per Lifetime

Methodology

Each of the benchmark plans has plan-paid healthcare costs that differ due to covered services and benefit limitations. In addition, the portion of healthcare costs paid by the plan for each of the 10 benchmark options will differ due to the following factors:

1. Cost sharing provisions create different allocations of total health costs between the plan and the member.
2. Cost sharing provisions affect the utilization of healthcare services.
3. Underwriting provisions affect the average health status of the covered population. This is primarily a difference between the small group benchmark plans and the other benchmark plans.
4. Age, gender, and family size affect the utilization of healthcare services.

The EHB regulations state that the cost sharing provisions of the plan are not considered part of EHBs. Thus, for our analysis we ignored factor 1 above, and estimated the total gross healthcare costs for a typical healthcare plan, and for each of the identified individual services. The cost sharing provisions of the benchmark plans would produce different assumed levels of healthcare utilization. Our analysis is based on expected utilization for a plan with a $500 deductible, 20% member coinsurance, and $2,000 out-of-pocket maximum. This specific assumption does not have a material effect on the percentage results, but we believe it is reasonable to assume some cost-sharing when estimating healthcare utilization. We would have similar results if we selected cost sharing elements from copay style HMO plans or deductible and coinsurance style PPO plans. With respect to underwriting and demographic assumptions, we assumed utilization consistent with a typical large employer plan in New York.

We created an actuarial cost model for New York using information from the Milliman Health Cost Guidelines (HCGs). The Milliman HCGs are developed as a result of Milliman's continuing research on healthcare costs and are used by most large insurers. The base cost models provide detailed information about nationwide utilization and unit cost by benefit category for a loosely managed standard commercial population. We made several adjustments to the base cost models to better fit New York's population and expected local utilization and unit cost levels. We estimated the gross healthcare costs for the hypothetical baseline coverage healthcare plan, as described above, to be approximately $515 per member per month (PMPM) as of January 1, 2015. We compared this to rate filings for carriers participating in the New York State of Health in the 2015 plan year and found our estimated costs to be reasonable.

We used a variety of techniques and data to develop estimated costs for specific covered services. Many of our estimates were based on utilization and unit costs from the Milliman HCGs. We have not provided estimates for habilitative services or pediatric vision and dental services because these benefits will become part of the EHB regardless of the base benchmark plan that is selected. Our estimate for the cost associated with the private duty nursing benefit covered by the NYSHIP Empire Plan was based on the cost incurred by NYSHIP for this benefit in 2014.

Results

We estimated the following cost differences among plans. All percentages shown are percentage changes from the current EHB. For example, if New York were to move from the current EHB to the NYSHIP Empire plan, we estimate that this would result in an increase of approximately 1.49% in gross medical costs for plans providing EHBs.

Table 3: Percent Change in Gross Medical Costs Compared to Current EHB

Percent Change in Gross Medical Costs from Current EHB		FEHBP Plan 1 - BCBS Standard	FEHBP Plan 2 - BCBS Basic	FEHBP Plan 3 - GEHA Standard	NYSHIP Plan 1 – Empire Plan	NYSHIP Plan 2 - CDPHP	NYSHIP Plan 3 - Independent	SG Plan 1 – Freedom EPO	SG Plan 2 – Gold HMO	SG Plan 3 – Freedom PPO	HIP Prime HMO
Coverage Differences	Autism Spectrum Disorders	X[2]	X[2]	X[2]							
	Assisted Reproductive Technology (ART)				0.02%						
	Durable Medical Equipment										-0.78%
	Non-Emergency Care Outside the U.S.	0.00%	0.00%	0.00%	0.00%						
	Nutritional Counseling										-0.06%
	Foot Orthotics – Shoe Inserts				0.00%						
	Private Duty Nursing				0.34%						
	Prosthetic Devices										-0.05%
Coverage and Limit Differences	Acupuncture	0.09%	0.05%	0.08%	0.13%	0.05%					
	Hearing Aids	-0.03%	-0.03%	-0.03%	-0.13%	-0.30%	-0.30%				-0.30%
Limit Differences	Chiropractic Care	X[2]	X[2]	X[2]							
	Home Health Care Services	0.02%	X[2]	0.02%	0.08%	0.01%					0.08%
	Hospice Services	0.00%	0.00%	0.00%	0.00%		0.00%				
	Inpatient Rehabilitative ST/OT/PT	0.04%	0.04%	0.04%	0.04%	0.02%	0.00%				0.04%
	Outpatient Rehabilitative ST/OT/PT	0.31%	-0.32%	0.08%	1.01%	0.24%	-0.91%	0.08%	0.08%	0.08%	1.01%
	Skilled Nursing Facility	-0.02%	-0.06%	-0.11%	0.00%	-0.06%	-0.06%				0.00%
Total		**0.41%**	**-0.32%**	**0.08%**	**1.49%**	**-0.04%**	**-1.27%**	**0.08%**	**0.08%**	**0.08%**	**-0.06%[1]**

Notes

1 The HIP Prime HMO excludes coverage for Prescription Drugs. However, Prescription Drugs are required to be part of EHB so would need to be supplemented if the HIP Prime HMO plan was selected as the base benchmark plan. The costs of Prescription Drugs are not shown here because this is not a relevant difference if this benchmark plan is selected.

2 X indicates a coverage difference, but these benefits would be supplemented because state mandates enacted on or before December 31, 2011 would become part of the EHB.

3 Blanks indicate no change in gross medical costs. Values of 0.00% indicate that there would be a very small impact that rounds to 0.00%.

4 Note that where there are separate hearing aid frequency limits for children and adults, we have assumed the frequency limits associated with coverage for adults.

If one of the FEHBP plans was selected as New York's new EHB, we estimate that gross medical costs would change somewhere in the range from a 0.32% decrease to a 0.41% increase compared to New York's current EHB. These changes are due mainly to limit differences compared to the current EHB. Note that there are a few benefits that are not covered by the FEHBP plans (autism spectrum disorder and unlimited chiropractic care) that would become part of New York's EHB even if one of the FEHBP plans was selected as the new benchmark because state mandates enacted on or before December 31, 2011 would become part of the EHB.

If one of the NYSHIP plans was selected as New York's new EHB, we estimate that gross medical costs would change somewhere in the range from a 1.27% decrease to a 1.49% increase compared to New York's current EHB. The NYSHIP Empire Plan is the most comprehensive plan of all 10 options compared, and would result in an increase in gross medical costs of 1.49% compared to New York's current EHB because of coverage of private duty nursing and no limit on coverage of outpatient rehabilitative services. Selection of the NYSHIP Independent Health plan would result in a reduction in gross medical costs of 1.27% primarily because of more limited coverage of outpatient rehabilitative services and exclusion of hearing aid benefits.

If one of the three small group plans was selected as New York's new EHB, we estimate that gross medical costs would increase by about 0.08%. This is due to a change in Oxford's benefit limits associated with outpatient rehabilitative services. The Oxford plans included in the 2012 analysis included a 60 visit limit per condition per lifetime, while the Oxford plans included in this current analysis no longer have this lifetime visit limit, and instead cover 60 visits per year for speech, physical, and occupational therapies.

If the HIP Prime HMO plan was selected as New York's new EHB, we estimate that gross medical costs would decrease by about 0.06%. The plan has more generous visit limits for outpatient rehabilitative services than the current EHB, which are offset by the exclusion of DME, nutrition counseling, prosthetics, and hearing aids. Note that if New York selects the HIP Prime HMO as the new EHB, New York will need to supplement this plan with Prescription Drug coverage from one of the remaining 10 benchmark options.

PEDIATRIC VISION AND DENTAL BENEFITS

Base Benchmark Plan Options

Federal regulations allow states to supplement their base benchmark plan with additional coverage for pediatric vision and dental benefits. States are allowed to select their pediatric vision and dental benefits from either of the following plans:

- Federal Employee Dental and Vision Insurance Program (FEDVIP)
- State's CHIP program

This is the same structure that HHS used for the 2014 EHB benchmark plans, when New York selected the CHIP plan as the benchmark for both pediatric dental and vision benefits.

Plan Comparison

New York's current EHB for pediatric dental benefits is the CHIP plan. The two dental plan options for the 2017 EHB cover substantially all of the same benefits, with similar visit limits, as shown in Table 4. We estimate that the selection of either benchmark would result in similar gross medical costs compared to the current EHB.

Table 4: Coverage Differences Between Pediatric Dental Benchmark Options for January 1, 2017

Benefit Class	Benefit	FEDVIP	CHIP
Preventive Dental Care	Prophylaxis (Scaling and Polishing)	1 every 6 months	1 every 6 months
	Topical Fluoride Application	2 every 12 months	1 every 6 months
	Sealants	1 per tooth every 36 months	Medical Necessity
Routine Dental Care	Oral Exam	1 every 6 months	1 every 6 months
	Full-Mouth X-Rays	1 every 60 months	1 every 36 months
	Bitewing X-Rays	1 every 6 months	1 every 6 to 12 months
	Non-Surgery Extractions	Medical Necessity	Medical Necessity
	Amalgam - Composite Restorations	Medical Necessity	Medical Necessity
	Stainless Steel Crowns	1 per tooth every 60 months	Medical Necessity
Prosthodontics	Space Maintainers	Medical Necessity	Medical Necessity
Orthodontic	Medically Necessary Orthodontia	Medical Necessity	Medical Necessity
	Cosmetic Orthodontia	Not Covered	Not Covered
Percent Difference in Gross Medical Costs from Current EHB		**0.0%**	**0.0%**

Sources:
(1) https://www.benefeds.com/Education_Support/dental_brochures/MetLife/MetLife2014.pdf
(2) NYS Child Health Plus Benefit Description: Dental and Vision

New York's current EHB for pediatric vision benefits is also the CHIP plan. We estimate that changing to the FEDVIP plan would increase the total gross medical cost of EHB by about 0.01%, primarily due to coverage of contact lenses.

Table 5: Coverage Differences Between Pediatric Vision Benchmark Options for January 1, 2017

Benefit Class	Benefit	FEDVIP	CHIP
Diagnostic	Routine ophthalmologic exam with refraction	Medical necessity	1 every 12 months
Eyewear	Prescribed Lenses	1 set per calendar year	1 set every 12 months
	Frame	1 set every year	1 set every 12 months
Contact Lenses	Contact Lenses	Allowance of $150 per calendar year in lieu of eyeglasses	Medical necessity
Percent Difference in Gross Medical Costs from Current EHB		**0.01%**	**0.00%**

Sources:
(1) http://cvw1.davisvision.com/forms/StaticFiles/English/FEP2014BenefitBooklet.pdf
(2) NYS Child Health Plus Benefit Description: Dental and Vision

DATA SOURCES

HHS regulations include guidance on the categories from which the state will select a benchmark plan to establish the EHB. The benchmark plans and plan categories used in this analysis are as follows:

1. Any of the largest three national FEHBP plan options by enrollment that are open to federal employees
    a. Government Employees Health Association (GEHA)
    b. Blue Cross Blue Shield Basic
    c. Blue Cross Blue Shield Standard
2. Any of the largest three state employee health benefit plans by enrollment
    a. NYSHIP Empire Plan
    b. NYSHIP CDPHP
    c. NYSHIP Independent Health
3. The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market[5]
    a. Oxford Non-Gated Platinum EPO
    b. Oxford Gated Gold HMO
    c. Oxford Non-Gated Platinum PPO
4. The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state
    a. HIP Prime HMO

Milliman obtained the FEHBP and Empire Plan Evidence of Coverage (EOC) documents from publicly available sources while the other documents were provided by the New York State Department of Health.

A plan's coverage of a certain service may be influenced by many factors besides the language in the EOC, including the definition and application of medical necessity, evolving clinical practice, agreements between a carrier and its respective regulating agency, and overriding decisions made by the regulating agencies. The focus of this analysis was to identify and compare services described in the EOC documents for the 10 benchmark plans. To the extent that we were not aware of other factors that may modify the language in the EOC documents, the results of our analysis may likewise be inaccurate or incomplete.

Largest Federal Employee Plans

The plan documents provided for the largest federal employee plans are publicly available and are in an EOC format. While these plans are provided in a full EOC format, they might not capture specific language regarding New York specific mandates due to their nationwide application.

Largest State Employee Plans

The Empire Plan EOC used for this analysis is publicly available. The NYSHIP CDPHP and Independent Health plan documents were provided by the State in an EOC format.

The CDPHP EOC contains several attached riders. For purposes of this analysis, we assume these are all mandatory riders. The following is a list of the riders included in the EOC:

- Eligibility Rider
- Autism Mandate Amendment
- Amendment to HMO Contract
- Patient Protection and Affordable Care Act Amendment
- Rider for Prescription Drugs
- Rider for Contraceptive Drugs and Devices
- Prescription Drug Amendment

[5] CCIIO released a complete listing of the largest three small group products by state for all 50 states on April 8, 2015. The three products identified for New York were 85629NY001 (Oxford EPO), 26420NY002 (Oxford HMO), and 85629NY005 (Oxford PPO). This document from CCIIO is available online at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/largest-smgroup-products-4-8-15-508d-pdf-Adobe-Acrobat-Pro.pdf.

For Independent Health, we relied on a combination of documents received from the State. First, we were provided with a "choices guide" highlighting the plans available to the employees of the State and showing a summary of benefits for each plan. We were also provided an EOC for Independent Health that was used to identify any unique provisions, exclusions, or riders that are attached to the plan. The EOC for Independent Health has two riders attached. For the purpose of this analysis, we assume these were both mandatory riders. The following is a list of the riders included in the EOC:

- Patient Protection and Affordable Care Act Amendment
- Autism Spectrum Disorder Benefits Amendment

Largest Small Group Plans

We were provided a schedule of benefits and a corresponding EOC for each of the small group plans. Two EOC documents were provided, one for the HMO plan and one for both the PPO and EPO plans. Each plan had a unique schedule of benefits.

The schedule of benefits and EOC documents for the small group plans provided to Milliman include blue text and a statement of variability attached to each document. For purposes of this project, we treated these documents as needing to be finalized for distribution depending on the group and plan type. Wording may be included or excluded based on the group and plan type. There are several benefits or benefit limits in the EOC documents in blue text, which we determined are optional riders such as acupuncture and visit limits for home health care services.

The specific notes in the statement of variability for the Oxford PPO and EPO include the following:

- *"If acupuncture services are covered this language will be included. If acupuncture services are excluded this language will be removed."* We assumed acupuncture services are "not covered" in our analysis. The current EHB does not include coverage for acupuncture. Because the current EHB is based on the 2012 Oxford EPO plan, we assumed that this benefit is "not covered" for our analysis of the 2014 Oxford EPO and PPO plans as well.
- "*If a limit applies to SNF services, it will be at least 200 days. The limit may be increased and such increased limit will be reflected here. If SNF is unlimited, this language will be removed."* We included the 200 day limit in our analysis of the PPO and EPO plans.
- *"If a limit applies to home health care services, it will be at least 40 visits. The limit may be increased and such increased limit will be reflected here. If home health care is unlimited, this language will be removed."* We included the 40 visit limit in our analysis of the PPO and EPO plans.
- *"If a limit applies to hospice services, it will be at least 210 days. The limit may be increased and such increased limit will be reflected here. If SNF is unlimited, this language will be removed."* We included the 210 day limit in our analysis of the PPO and EPO plans.

The Oxford HMO EOC for 2014 does not contain a statement of variability. The note below is from a similar statement of variability contained in an Oxford HMO EOC for 2015 that was provided to us. After review of the 2014 EOC, we concluded only the following rider required consideration for this analysis.

- *"If acupuncture services are covered this language will be included. If acupuncture services are excluded this language will be removed."* We assumed acupuncture services are "not covered" in our analysis.

Largest Commercial Group HMO

The HIP Prime HMO plan was provided to us as an EOC. Several riders were attached to the EOC. For the purposes of this analysis, we treated these as mandatory riders. The following is a list of the riders included in the EOC:

- Clinical Trial Rider
- Domestic Partner Coverage
- Federal and New York State Continuation of Coverage Rider
- Federal Mental Illness Parity Rider
- Federal Women's Health Contraceptive Drugs and Devices Rider

- Federal Women's Preventive Services Rider
- Infertility Diagnosis and Treatment Services Amendment
- Maximum Out-of-Pocket Rider
- Mental Illness Rider
- New York State Autism Spectrum Disorder Rider
- Optical Benefits
- Out of Network Dialysis Rider
- Patient Protection and Affordable Care Act Rider
- Prime HMO Amendment Rider
- Prior Approval Requirements
- Prostate Cancer Screening Amendment
- Source of Injury Rider
- Suicide Exclusion Rider
- Utilization Management/Utilization Review Rider
- Value Added Preventative Health Rider
- Value Added Wellness Programs
- Women's Health & Wellness Amendment

Pediatric Vision and Dental Benefits

We relied on publicly available FEDVIP coverage documents identified in CCIIO's April 8, 2015 guidance.[6] For the CHIP benefits, we relied on a published Child Health Plus program document provided by the State.

LIMITATIONS

Milliman's work is prepared solely for the internal business use of the New York State Department of Health. Milliman's work may not be provided to third parties without Milliman's prior written consent. Milliman does not intend to benefit any third party recipient of its work product, even if Milliman consents to the release of its work product to such third party. We understand that the New York State Department of Health intends to share this analysis with stakeholders and on their public website, and we grant permission for this distribution.

In performing this analysis, we relied on data and other information provided by the New York State Department of Health, Department of Civil Service, and Department of Financial Services. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between our cost estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

The U.S. Department of Health and Human Services (HHS), through the Center for Consumer Information and Insurance Oversight (CCIIO), is responsible for promulgating regulations and guidance to assist the states in making these decisions. This report makes extensive use of regulations and guidance published by HHS and CCIIO as of the date of this report. Subsequent regulations and guidance could change our interpretation of the EHB selection options and the conclusions in this report.

[6] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/largest-smgroup-products-4-8-15-508d-pdf-Adobe-Acrobat-Pro.pdf

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and the New York State Department of Health.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Barbara Abbott is a member of the American Academy of Actuaries, and meets the qualification standards for performing the analyses in this report.