

Essential Health Benefits Overview

Presented by
Timothy Harris, FSA, MAAA
Stacey Muller, FSA, MAAA

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Agenda and Purpose

- Agenda
 - Overview of Essential Health Benefits (EHB) rules and options
 - Preliminary results of EHB study
- Purpose of this presentation is to provide common background and the outcomes of Milliman's analysis regarding Essential Health Benefits

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Essential Health Benefits – Development History

- ACA indicated Essential Health Benefits (EHB) to be decided by Secretary of HHS for 2014 and later
- DOL Report – April 15, 2011 surveyed employer plans
- Institute of Medicine – October 17, 2011 Key Recommendations:
 - Should balance cost and comprehensiveness by reflecting small group market, guided by a national premium target
 - Process or framework needed to update EHBs
 - Recommended flexibility across states
- HHS Bulletin – December 16, 2011 States to decide EHB using one of 10 benchmark plans
- HHS Proposed Final Rule – July 20, 2012 Data collection standards

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Essential Health Benefits – Populations Impacted

EHB applies to:

- Non-grandfathered insured plans in the individual and small group markets, both in and out of the Exchange
- Basic Health Plan
- Becomes one option for Medicaid Benchmark and Benchmark Equivalent Populations
 - Medicaid Expansion Population
 - Certain Current Medicaid Populations

EHB does not apply to:

- Grandfathered plans
- Self-insured plans
- Insured Large Group plans

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Essential Health Benefits – Scope of Services

- EHB refers to covered services, not cost sharing
- 10 Categories to be covered by EHB
 - 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

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Essential Health Benefits – Benchmark Plans

- For 2014 and 2015, the State can create an EHB package based on 4 benchmark plan options
 1. The largest plan by enrollment in any of the three largest small group insurance products in the State's small group market.
 2. Any of the largest three State employee health benefit plans by enrollment.
 3. Any of the largest three national FEHBP plan options by enrollment.
 4. The largest insured commercial non-Medicaid HMO operating in the State.

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Essential Health Benefits – Plan Definition

- Definition of Small Group ‘Product’ and ‘Portal Plan’
 - “Product”: Offering by insurance carrier / employer that has a defined set of services covered under the plan
 - Multiple cost sharing provisions may occur between plans that are considered the same product
 - “Portal Plan”: The discrete pairing of a package of benefits with a particular cost sharing option.
 - Multiple plans may be included under the same product
 - Riders may be included if commonly used

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Essential Health Benefits – Outstanding Question

- Annual Benefit Limitation on Essential Health Benefit Service
 - Common for insurance carriers to have annual visit or dollar limitations on services such as physical therapy.
 - EHB Bulletin states, “*Propose that a health insurance issuer have some flexibility to adjust benefits, including both the specific services covered and any quantitative limits.*”
 - Degree of state and insurance carrier flexibility is unclear but dollar limits clearly not allowed.

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Essential Health Benefits – Regulatory Precepts

- Intended by ACA to be broadly representative of a “typical employer plan”
- Encompass 10 categories of care in ACA
- Secretary not to make coverage, reimbursement decisions or establish incentive programs
- Must not discriminate and must meet needs of diverse segments of the population
- States to cover cost of mandated benefits in excess of EHB

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Essential Health Benefits – Benefits Not Commonly Covered by Benchmark Plans

- Habilitative Services
 - Not commonly described in commercial insurance coverage
 - HHS seeking comment
 - Currently proposing two options:
 - Parity with “Rehabilitation” – Same coverage for PT / ST / OT for Habilitation
 - Plans would decide which services to cover, with HHS review
 - HHS guidance indicates states may be responsible for enforcing

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Essential Health Benefits – Benefits Not Commonly Covered by Benchmark Plans

- Pediatric Vision and Dental Services
 - If services are offered, generally provided through a third party benefit manager
 - State can set benchmark to Federal Employees Dental and Vision program or CHIP
 - HHS proposes that *non-medically* necessary orthodontic benefits are not covered

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Essential Health Benefits – Potential New York Benchmark Plans

- Three largest Federal Employees Health Benefits Program (FEHBP)
 - Government Employees Health Association (GEHA)
 - Blue Cross Blue Shield Basic (BCBS Basic)
 - Blue Cross Blue Shield Standard (BCBS Standard)
- Three largest New York State Employee Plans (NYSHIP)
 - Empire Plan
 - Capital District Physicians Health Plan HMO
 - Independent Health HMO
- Three largest New York Commercial Small Group Products
 - Oxford EPO
 - Oxford HMO
 - Oxford Direct
- Largest New York Commercial Group HMO
 - HIP Prime (part of Emblem Health)

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Tasks for EHB Study

- Understanding potential overlap of benchmark plans with current state mandated benefits
- Identifying which services are
 - Consistently covered by all the benchmark plans
 - Covered by all plans but with varying limits, such as annual visit limits
 - Excluded by some plans but covered by others
 - Required by ACA but not covered by any benchmark plans
- Evaluating the expected cost differential between benchmark plans for the above categories

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Analysis of State Mandated Benefits

- Small group benefit mandates
 - Included in small group benchmark plans, New York state employee plans, and the largest commercial HMO plan
 - Not covered fully by Federal employee plans and would result in additional state costs

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Comparison of Potential Benchmark Plans

- Potential benchmark plans were summarized and variation in covered services, due to covered service or benefit limitations, were identified
- Costs for the differences were estimated based on standard demographics and statewide allowed charges and utilization assumptions

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Illustrative Essential Health Benefits

- An illustrative EHB definition was developed based on each of the benchmark options
 - Removed any dollar limits
 - Added benefits needed to conform to ACA requirements
- Noted that some benchmark options included dental coverage which would extend to adults as well as children
 - Federal employee plans include limited coverage for cleanings and simple services
 - New York state employee plans include full dental coverage

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Cost Impact to Small Group Plans Varies with Selected Benchmark

- Estimated costs to the current small group market (as represented by the Oxford covered services)

EHB Benchmark	Impact on Gross Medical Costs for Small Group Insurance
FEHBP - GEHA	2.78%
FEHBP - BCBS Basic	2.24%
FEHBP - BCBS Standard	3.19%
Empire Plan	4.39%
CDPHP	4.35%
Independent Health	4.34%
Oxford (All Plans)	1.17%
Largest Non-Medicaid HMO (HIP Prime)	1.24%

- Individual benefit mandates exceed small group mandates
 - For home health, private duty nursing (PDN), outpatient physical therapy, and orthotics
 - Would result in additional state costs regardless of benchmark (although all but PDN would be covered by the Empire Plan)

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Caveats

These estimates provide comparative information with respect to options for selecting essential health benefits offered in the state of New York. It should be used to understand the options and potential impacts of the essential health benefit benchmark options. The results may not be suitable for other purposes. Further details on the assumptions and methodology will be provided in the final report.

These results have been prepared solely for the internal use of, and is only to be relied upon by, the New York State Department of Health. Although Milliman understands that this information may be distributed to third parties, Milliman does not intend to benefit, or create a legal duty to, any third party recipient of its work.

The results are technical in nature and dependent upon specific assumptions and methods. No party should rely upon these results without a thorough understanding of those assumptions and methods.

Actual experience will deviate from any projected impacts because of a variety of influences, including emerging experience under newly designed plans, changes in insurance pricing and practices, and adjustments to reflect new regulations.

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Questions?

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**Comments can be submitted by August 17,
2012 to Danielle Holahan at
exchange@health.state.ny.us**

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