

Pennsylvania Insurance Department
Essential Health Benefits Study Summary

Deloitte Consulting LLP
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Note this Essential Health Benefits Study Summary is an excerpt from the August 29, 2012 Essential Health Benefits Study report prepared for the Pennsylvania Insurance Department by Deloitte Consulting LLP.

Issue

Under the Affordable Care Act (“ACA”)¹ the federal Department of Health and Human Services (“HHS”) contemplates that the Commonwealth of Pennsylvania (“Commonwealth”) is permitted to define the minimum required health care services covered by new comprehensive health insurance plans sold in the individual and small group markets, both outside and inside the Health Insurance Exchange (“Exchange”) in 2014 and later years. This minimum set of covered health care services is referred to as the essential health benefits (“EHB”).

The selection of the EHB package would allow the Commonwealth to define the minimum services that will be covered by health insurance policies for approximately 1.6 million² Pennsylvania consumers in 2014. HHS has determined a default EHB package for each state, and this selection will serve as the EHB package absent a state identifying a different benchmark health plan other than the default.

A state identifying an EHB package (other than the default) to be effective in 2014 and 2015 must report this to the federal government during the third quarter of 2012. The federal guidance is incomplete and in some cases ambiguous regarding the specific requirements for EHB, so interpretations and assumptions must be made in any effort to comply with this deadline. Deloitte Consulting LLP (“Deloitte Consulting”) has prepared this summary report exploring various issues to assist the Commonwealth in making its decisions regarding EHB.

Options

Proposed guidance from HHS provides that the Commonwealth may choose an EHB “benchmark” plan from among the ten options listed below. Pennsylvania’s EHB would then be defined by reference to the scope and limitations of covered services under that benchmark plan. The four benchmark plan types (1st column) identified in the guidance provide for ten benchmark plan options for the Commonwealth to consider (2nd column). All of these options need to be supplemented because they do not cover the ACA’s ten required benefit categories. If a state does not make a selection, the proposed guidance from HHS indicates the default EHB package would be the largest plan (according to enrollment) among the three largest small group products in the state.

¹ Patient Protection and Affordable Care Act (Public Law 111-148) and Healthcare and Education Reconciliation Act of 2010 (Public Law 111-152).

² Estimates provided by Deloitte Consulting’s proprietary model; this number represents estimated enrollment for the non-grandfathered plans sold through the individual and small group markets, both on and off the Health Insurance Exchange.

| Benchmark Plan Types | Benchmark Plan Options |
|---|---|
| The largest plan by enrollment in any of the three largest small group insurance products in the State's small group market | 1. Highmark PPO Blue - PPO \$10 Copay |
| | 2. Aetna HMO (POS Plan) |
| | 3. Health Assurance PA Group PPO - Plan 91234 - \$2,500 Deductible 100% Coinsurance |
| One of the three largest State employee health benefit plans by enrollment | 4. Highmark Health Insurance Company PPO |
| | 5. Keystone Health Plan Central HMO |
| | 6. UnitedHealthcare CDHP |
| One of the three largest federal employee insurer options | 7. BlueCross BlueShield Standard Option |
| | 8. BlueCross BlueShield Basic Option |
| | 9. Government Employees Health Association (GEHA) Standard Option |
| The largest HMO plan offered in the State's commercial market | 10. Keystone Health Plan East - Blue Solutions (Small Group) HMO 5/5.1 |

Findings

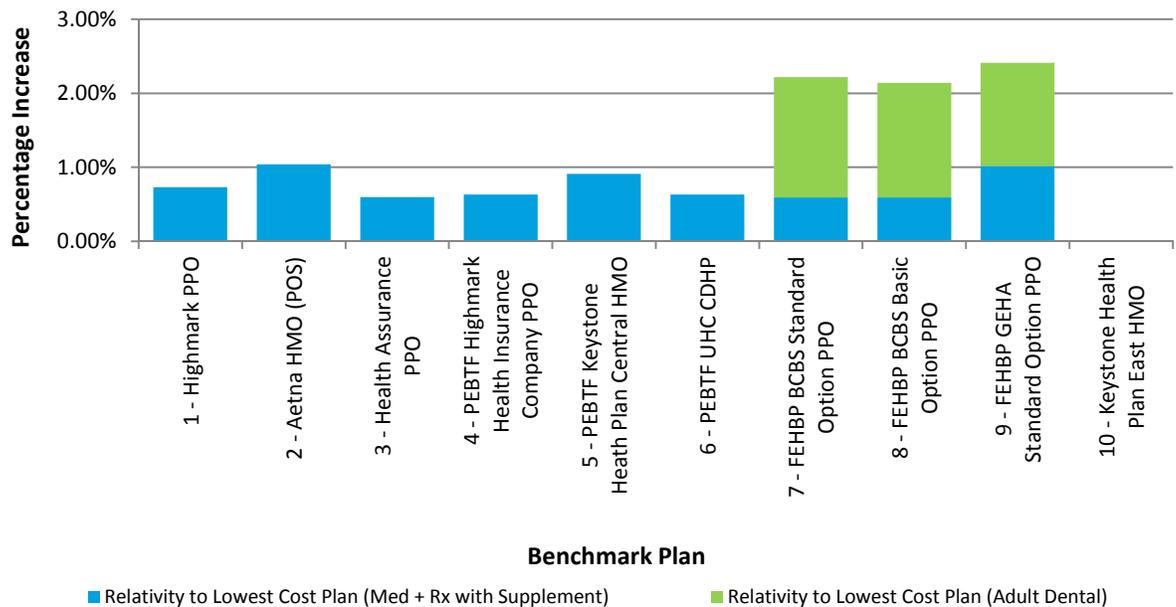
Following are key findings resulting from the analysis of the Commonwealth's available EHB options.

1. **The benchmark plan option selected will have only a small financial impact on the total level of Pennsylvania's EHB** – the difference in total value or cost between the highest and lowest of the ten options is approximately 1% (as shown by the blue bars in the chart below). Because significant adult dental services are covered by some of the benchmark option plans, these plans have higher values and costs (with the adult dental services reflected in the green bars below).

The ACA requires that the EHB reflect a scope of services “equal to the scope of benefits provided under a typical employer plan”, and the ten benchmark plan options proposed by HHS are therefore intended to reflect a typical employer plan. The employer health benefits market is mature, and covered services are often quite similar among plans with large enrollment, so the narrow range of observed variation in the benchmark options is not unreasonable.

Illustrative premium rates were developed for each benchmark option and the percentage increase over the lowest cost plan (the Keystone Health Plan East HMO) are presented in the graph below. Note that each of the ten benchmark plan options include estimated costs associated with supplementing benefits in order to be compliant with the ACA.

Value in Excess of Lowest-Cost Option



Note that the 1% variation in cost level reflects only the difference in value among the various EHB options. It does not include the general increase over today's premium cost rates expected to result from cost inflation and other ACA provisions such as guaranteed issue requirements, adjusted community rating, rating factor restrictions, etc.

2. **The benchmark options are also substantially consistent with respect to the details of coverage of specific items and services** – As would be expected, the benchmark plan options do not differ materially with respect to their scope of coverage of inpatient hospital and surgical services, major categories of prescription drugs, diagnostic testing, emergency services, etc.
3. **Some coverage differences do exist among the options** – The most significant differences among the options with respect to scope of covered services are dental, specialized services (e.g., chiropractic care, private duty nursing), long term care, skilled nursing facility, hospice, mental health, and substance abuse.
4. **All benchmark options will need to be supplemented** – All ten benchmarks need to be supplemented because they do not generally cover habilitative services and some do not cover pediatric oral and pediatric vision services. ACA requires supplementation of the current benefits in these cases.
5. **The highest-value benchmark options are the Federal employees' plans** – due to coverage of dental benefits for adults as well as children.
6. **The lowest-value benchmark option is the Keystone Health Plan East HMO in Pennsylvania's small group market** – due to limited benefit coverage in services such as inpatient hospital, mental health, and substance abuse.

Considerations

Following are considerations that should be taken into account when reviewing the identified benchmark plan options for an EHB package and to gather an understanding of potential impacts and related decisions regarding insurance regulation in Pennsylvania.

1. **Advantages and disadvantages of higher-value EHB options** - A relatively higher-value EHB package will ensure that Pennsylvanians insured under new individual and small group policies beginning in 2014 are covered for a larger scope of medical services, such as full coverage of mental health and substance abuse. Higher-value EHB options tend to have fewer qualitative limits on coverage, and may be simpler to communicate and comprehend. A relatively higher-value EHB package would result in less affordable options on the Exchange and in the individual and small group markets outside the Exchange. Decreased affordability would tend to increase the number of uninsured Pennsylvanians, and would offer insurers less latitude for flexibility and innovation in plan design.
2. **Advantages and disadvantages of lower-value EHB options** – A relatively lower-value EHB package would allow for more affordable options on the Exchange and in the individual and small group markets outside the Exchange. Increased affordability would tend to reduce the number of uninsured Pennsylvanians, and would offer insurers greater latitude for flexibility and innovation in plan design. A relatively lower-value EHB package may expose covered Pennsylvanians, including vulnerable populations, to greater costs at point of service by more narrowly defining the scope of covered items and services.
3. **Impact on vulnerable populations** – The Commonwealth’s most vulnerable populations, like other Pennsylvanians, will experience trade-offs. For example, there is a balance to be achieved between scope of coverage and affordability as EHB options are reviewed. Some specific benefits (e.g., mental health, substance abuse, children’s preventative services) will be of particular importance to some vulnerable (and less vulnerable) individuals, but it is not possible to identify any option that produces an ‘optimal’ result for all vulnerable populations or for the people of the Commonwealth in general. All options will involve trade-offs of the kinds listed above.
4. **It is important to reiterate that all of the Commonwealth’s benchmark options are similar in overall value and scope of covered services, other than adult dental services** – The considerations listed above should be evaluated accordingly. That is, any impact of the decision on benefit levels, affordability, consumer understanding, and vulnerable populations is likely to be small.
5. **Dental benefits** – Private sector employee medical benefit plans typically do not include substantial dental services (routine check-ups and preventive services are sometimes included). If the Commonwealth chooses a benchmark plan option including dental services, it could extend basic dental coverage to Pennsylvanians who otherwise would not purchase it. The disadvantages of such a choice would include a decrease in affordability and a disruption of current typical benefit designs.
6. **Supplementation** - Federal guidance is not clear on the process to determine whether a particular plan adequately covers each of the ten ACA required benefit categories. The approach followed for this analysis is to determine whether some coverage is provided for each of the ten EHB service areas listed in the ACA. Benefits are assumed to require supplementation in any case in which a

benchmark option plan provides no coverage for a specified service area (e.g. hospitalization, pediatric oral services).

7. **State-mandated benefits** – ACA requires that states defray the additional federal cost associated with any additional state-mandated benefits (beyond the EHB) or state-mandated benefits enacted after 12/31/11 for individuals receiving federal subsidies on the Exchange. However,
 - a. Nine of the ten benchmark options include all relevant state-mandated benefits, so additional costs would be incurred only if the Commonwealth selected the Government Employees Health Association Standard Option (i.e., one of the federal employee plans) as the EHB and continued to mandate the medical foods benefit. Costs of approximately \$430,080 for 2014 would be incurred by the Commonwealth for an estimated 224,000 average monthly subsidized members. These costs will increase over time, as more people are anticipated to purchase subsidized insurance on the Exchange. The costs are estimated to grow to approximately \$1 million in 2016 based on 467,000 average monthly subsidized members.
 - b. Costs associated with the “Dental Care for Special Needs and Young Children” mandate enacted after 12/31/11 have been determined to be nil for 2014 since these services were covered by all of the ten benchmark option plans prior to the mandate.

EHB rules regarding state benefit mandates for 2016 and later years are not yet defined, but could result in additional Commonwealth costs or decisions. Federal guidance indicates that while state-mandated benefits currently included in a benchmark plan will not have to be defrayed by the state in 2014 – 2015, HHS intends to develop an approach that may exclude some state-mandated benefits from inclusion in the EHB package for 2016 and beyond. The Commonwealth may also take the opportunity to evaluate current state benefit requirements and consider revisions to manage the transition to EHB smoothly or minimize costs, disruptions, and regulatory inconsistencies across insurance market segments as EHB takes effect.