Essential Health Benefits/Standard Plan Rulemaking Advisory Committee

EHB, Standard Plan, & Rulemaking Overview

April 10, 2015

EHB
What are Essential Health Benefits?

Ten categories of benefits that nongrandfathered and non-transitional individual and small group major medical plans must cover.

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care

EHB
What are Essential Health Benefits? (Cont.)

5. Mental health and substance use disorder services, including behavioral health treatment (to comply with federal mental health parity)
6. Prescription drugs
7. Rehabilitative AND habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management and
10. Pediatric services, including oral and vision care

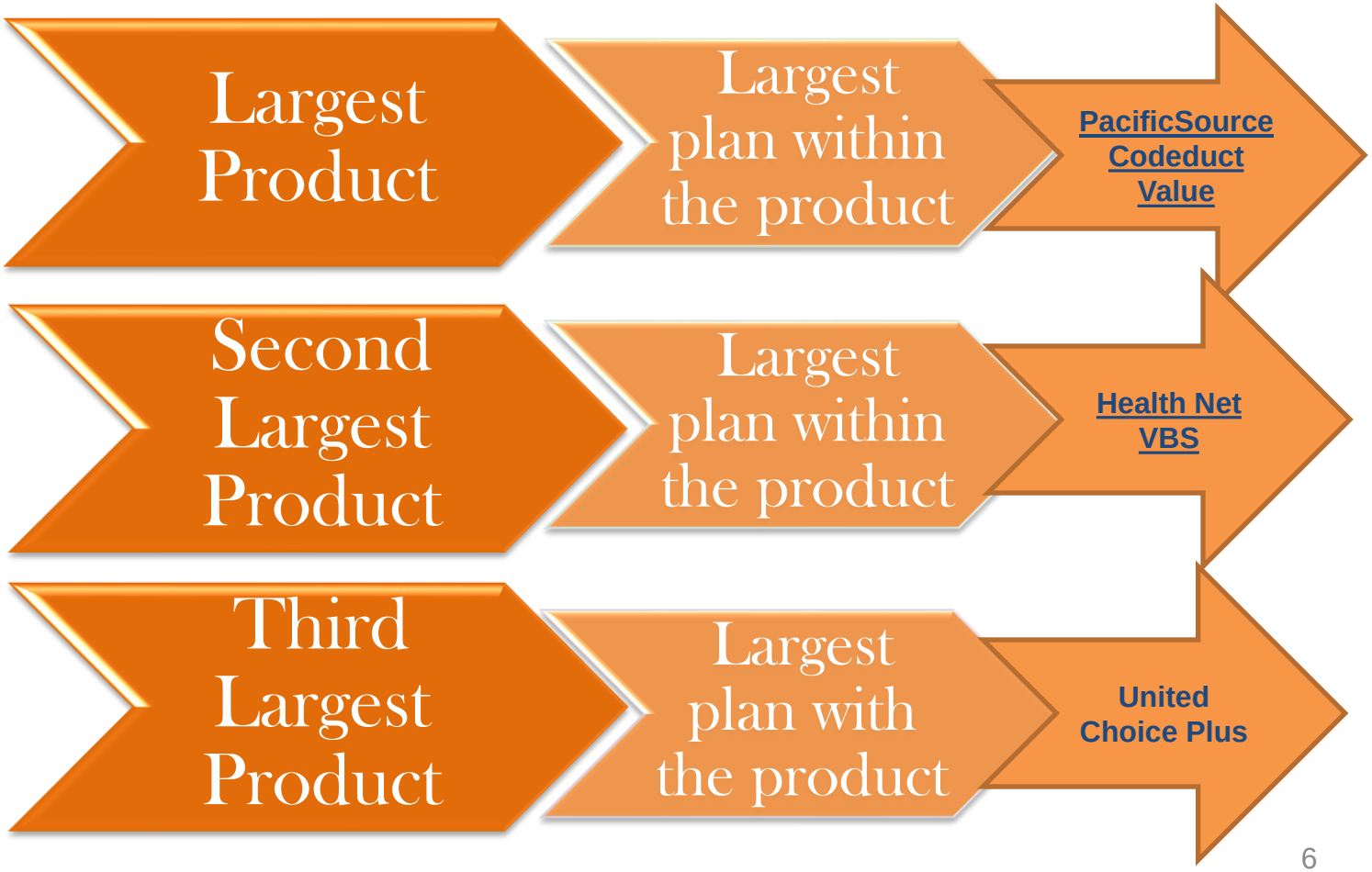
EHB
What is a Benchmark Plan?

- One of 10 plan options that reflects the scope of services offered by a typical employer plan:
  - The largest plan in the three largest small group products (3)
  - The three largest state employee health benefit plans (3)
  - Three federal employee health benefit plans (3) and
  - The largest commercial non-Medicaid HMO (1)

EHB
What is a Benchmark Plan? (Cont.)

- The benefits and services in the plan we select become the state's EHB.
  - At a minimum, individual and small group plans must cover these benefits.
    - Exceptions

EHB
Benchmark Options – Small Group Plans



EHB
Benchmark Options – State Employee Plans

Largest Plan – PEBB Statewide

Second Largest Plan– Providence Choice

Third Largest Plan–Kaiser HMO

EHB
Benchmark Options – Federal Employee Plans

Blue Cross Blue Shield: Standard

Blue Cross Blue Shield: Basic

Government Employees Health Association Standard

EHB
Benchmark Options – Commercial HMO

The Largest Insured Commercial Non-Medicaid HMO

EHB
State Mandates

States must "defray the cost" of any state mandate that exceeds essential health benefit coverage when the coverage is purchased through the exchange.

EHB
Supplementation

- **Supplementation:**
  - If a state selects a benchmark that does not include benefits in all of the essential health benefit categories, the coverage must be "supplemented" with benefits from the missing categories.
    - Habilitative services
    - Pediatric vision/dental

EHB
Scope and Substitution

- **Scope:**
  - Carriers must offer benefits that are "substantially equal" to the benefits offered by the benchmark plan.
- **Substitution:**
  - Carriers would be allowed to make actuarially equivalent substitutions within EHB categories.

Standard Plans
What are Standard Plans?

Standard Plans
Actuarial Value

Actuarial Value: The percentage of an insured's expected medical spending that a health plan is expected to pay. Actuarial value measures health plan generosity.

$$\textbf{ACTUARIAL VALUE} = \frac{\textbf{Medical Spending covered by health plan}}{\textbf{Enrollee's total expected medical spending}}$$

Example: If a health plan has an actuarial value of 88 percent, the plan is expected to pay 88 percent of an enrollee's total medical spending on covered services. The enrollee would pay the remaining 12 percent out of pocket in the form of deductibles, co-pays, & coinsurance.

Standard Plans
Actuarial Value (Cont.)

- AV under the ACA is based on the expected health experience of a "**standard population**" not the actual experience of plan enrollees.
- AV is calculated on the **essential health benefits** only. Any benefits in addition to the required EHB do not affect a plan's Actuarial Value.

Standard Plans
Calculation of Actuarial Value

AV Calculator: The federal government created an actuarial value calculator to estimate a plan's actuarial value. Each plan's cost-sharing is entered into the calculator, and the calculator uses the experience of the standard population to arrive at the AV.

When we decide on cost-sharing for the standard plans, we will use the AV calculator to ensure the plans are within the AV ranges for the metal levels.

Standard Plans
Metal Levels

Metal Levels (+/- 2%):

- Bronze – 60% AV
- Silver – 70% AV
- Gold – 80% AV
- Platinum – 90% AV

Plans that offer identical benefits can have completely different AVs based on the application of cost share (deductibles, copays, coinsurance, OOPM).

Standard Plans

Why Have Standard Plans?

Standard Plans:

- Are a prerequisite for participation in the individual and small group health benefit plan markets– both in and out of the exchange.

- Help consumers make true apples to apples coverage comparisons.

- Help DCBS to determine the reasonableness of rate variations between carriers and better enable DCBS to monitor and understand price and benefit changes in the individual and small group markets.

Standard Plans

Developing Plan Design

- Understand the current market
  - Common/Popular plan designs
- Develop a set of plan designs
  - Start with silver level plan
  - Determine preferred structure (e.g. HDHP, deductible plan with OV copays, etc.)
  - Provide multiple plan design options for the silver level, focusing on both structure and dollar/percent cost share amounts
- Gather feedback on options and make adjustments to design
- Adjust the Silver design to create Bronze and Gold

Wakely Consulting Group

- The Department has contracted with Wakely Consulting Group, an actuarial consulting firm, to conduct an analysis of the 10 benchmark plan options and to design the standard plan.

Rulemaking

Goal of the Advisory Committee

Goal:

To recommend a plan and design that balances affordability and coverage and that is not disruptive to the Oregon health insurance market.

Rulemaking
Decision-Making Criteria

1. The extent to which a benchmark option covers each of the 10 statutory categories of EHB.

2. The extent to which a benchmark option requires supplementation to ensure that the plan provides coverage for all ten categories of EHB.

3. The extent to which a benchmark option includes coverage of Oregon mandates and the cost to the state of selecting an option that fails to cover one or more Oregon mandates.

4. The extent to which a benchmark option contains an appropriate balance of benefits among the 10 EHB categories to ensure that benefits are not unduly weighted toward any category and that the plan design does not discriminate against a protected class.

Rulemaking
Decision-Making Criteria (Cont.)

5. The capacity of both individual and small group health benefit plan issuers to provide the coverage required by a benchmark option and a standard plan design.

6. The prevalence in the Oregon individual and small group markets of a standard plan design and coverage under a benchmark option.

7. The affordability of a benchmark option and a standard plan design.

8. The extent to which a benchmark option or standard plan design will require modification by the Department to comply with the Affordable Care Act (mental health parity, dollar limits, age limits, etc.).

Rulemaking Overview

- Essential Health Benefits (EHB):
  - The Advisory Committee will consider the fiscal impact of the rule and will review EHB benchmark options and, using the decision-making criteria, recommend selection of a benchmark plan.
  - The Department will consider the recommendation and public comment sand make the final decision.

Rulemaking Overview (Cont.)

- Standard Plans:
  - The Advisory Committee will consider the fiscal impact of the rule and will review plan design options (cost-share applied to the benchmark) and, using the decision-making criteria, recommend a standard plan design.
  - The Department will consider the recommendation and public comments and make the final decision.

Rulemaking Overview (Cont.)

- The Department must:
  - Notify the public of the rulemaking by publishing a notice with the Secretary of State prior to the hearing.
  - Notify interested parties – those who have signed up to receive notices of rulemakings.

Rulemaking Overview (Cont.)

- The Department must:
  - Notify legislators
  - Conduct a hearing to give people an opportunity to testify about the rule to inform the Department's decision
  - Allow for additional public comment
  - Publish the final rule and
  - Submit the EHB plan to CMS

Next Steps

Overview of the Next Meeting

Date and Time: April 21 from 9:30 AM to 12:30 PM

Location: Room 260, Labor & Industries Building, 350 Winter St. NE, Salem

Helpful Links

- Meetings are streamed live online at: www.oregon.gov/DCBS/Pages/video_hearing.aspx
- Meeting materials, agendas, and updates are available online at:
- www.oregon.gov/DCBS/insurance/legal/committees-workgroups/Pages/essential-health-benefits/essential-health-benefits.aspx

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