

Vermont Health Insurance Benefits: Essential Health Benefits Analysis

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What are Essential Health Benefits?

- The “Essential Health Benefits” (EHB) plan is a “reference plan” that the state will use to determine the required benefits and limitations on any small group or individual plan sold in the state starting in 2014.
- We are NOT talking about the Green Mountain Care Plan today.

EHB Applies to All Small Group and Individual Plans Sold in Vermont

- The Essential Health Benefits package will apply to all small group and individual plans offered in the state
- Does not matter whether the plans are sold in the Exchange or outside of the Exchange

Agenda

Review of ACA Requirements

HHS Process/ Proposed Approach

Analysis of Potential Benchmark
Plans

Framework for Selecting a
Benchmark Plan

Discussion/ Feedback

Review of ACA Requirements (Section 1302)

- Affordable Care Act (ACA) requires the Secretary of HHS to define “Essential Health Benefits” (EHB)
- The EHB Definition must:
 - Equal the scope of benefits in a typical employer plan
 - Not be designed in ways to discriminate based on age, disability or expected length of life
 - Must consider health care needs of diverse population

Review of ACA Requirements

EHB Must Include Services Within 10 Categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and chronic disease management
- Laboratory services
- Preventive and wellness services
- Pediatric services, including oral and vision care

Review of ACA Requirements

- EHB considers the benefits covered and excluded as well as restrictions to coverage such as preferred networks and prior authorization
- EHB does not take cost-sharing into consideration

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HHS Solicited Public Advice

- Department of Labor reviewed benefits in variety of employer plans
- Institute of Medicine developed consensus recommendations
- Received comments from a range of national stakeholders

HHS Provides Guidance on EHB

- HHS released a Bulletin in December 2011
 - Provides intended regulatory approach
 - Not binding
 - Public comment was accepted through January 31, 2012.
- The HHS Bulletin:
 - Provides states a role in defining EHB
 - Requires mental health parity
 - Signals that HHS will revisit EHB for 2016 and beyond

Proposed Approach: Use of a Benchmark Plan

- EHB will be defined by a benchmark plan selected by each state
- The benchmark plan will serve as a reference plan reflecting the scope of services and any limits offered by a “typical employer plan”
- The plans offered in the state must be “substantially equal” to this benchmark plan
 - Process used nationally in CHIP and Medicaid expansions
 - Insurers may adjust the specific services covered and any quantitative limits provided
 - Still considering whether to allow actuarially equivalent substitution

Proposed Approach: Use of a Benchmark Plan

- If benchmark plan does not include coverage for all 10 categories, state must supplement the missing categories with the benefits from another benchmark option
 - pediatric oral & vision
 - prescription drugs
 - habilitative services
- Our interpretation of the HHS bulletin is that if a plan offers coverage through a rider, then the state can consider that part of the plan.

Proposed Approach: State Options

- Four Benchmark Plan Options:
 1. Any of three largest products from the small group market
 2. The largest HMO operating in the state
 3. The state employee health benefits plan
 4. The Federal employee health benefits plan

- Default plan (if state doesn't select) is the largest plan by enrollment in the small group market

Proposed Approach: State Mandates

- Per the HHS Bulletin, state mandates are included in EHB for 2014-15 if state selects a benchmark plan that includes the mandates.
- Provides flexibility to states to keep mandated benefits without concern for added state costs (at least for first two years)
- If state mandates are not included in the EHB, then states are required to defray the costs.

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Process for Determining Vermont's Benchmark Plan

- Compare similarities and differences of potential benchmark plans
- Consider impact of different selections based on criteria
- Obtain feedback from Exchange Advisory Committee
- Make recommendation to the Green Mountain Care Board

Potential Vermont Benchmark Plans

- Largest small group plans
 - MVP – Preferred exclusive provider plan
 - BCBSVT – BlueCare
- Largest HMO
 - BCBSVT (benefits are generally the same as in small group)
- State employee plan (administered by Cigna)
- Did not consider the federal employee health benefits plan

Comparison of Potential Vermont Benchmark Plans

- Plans offer similar benefits under the 10 categories
- The differences are primarily in the details and any limitations on coverage (prior authorization, preferred provider requirements)
- Vermont plans already provide mental health parity (per more stringent state law)
- State employee plan provides most comprehensive pediatric vision and oral care

Plans Offer Benefits Across Most of the 10 Categories

Required Category	MVP EPO	BlueCare HMO*	State Plan
Ambulatory patient services	✓	✓	✓
Emergency services	✓	✓	✓
Hospitalization	✓	✓	✓
Laboratory services	✓	✓	✓
Maternity and newborn care	✓	✓	✓
Mental health and substance use disorder services, including behavioral health treatment	✓	✓	✓
Preventive and wellness services	✓	✓	✓

✓ Covers Benefits in Core Plan	(✓) Covers Benefits Through a Rider	✗ Does Not Cover Benefits
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Some Differences Across the ACA Categories

Required Category	MVP EPO	BlueCare HMO*	State Plan
Rehabilitative Services	✓	✓	✓
Habilitative services	?	?	?
Prescription drugs	(✓)	(✓)	✓
Most Pediatric services	✓	✓	✓
Pediatric Oral	(✓)	✗	(✓)
Pediatric Vision	(✓)	(✓)	(✓)

✓ Covers Benefits in Core Plan	(✓) Covers Benefits Through a Rider	✗ Does Not Cover Benefits
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Examples of Similarities Across the Plans

(In-Network Services)

Benefit	MVP EPO	BlueCare HMO*	State Plan
Emergency Services	●	●	●
Mental Health/ Substance Use Disorder Services (outpatient)	●	●	●
Office Visits for diagnosis & treatment of disease	●	●	●
Preventive Care (immunizations, annual routine physical exams, routine mammograms)	●	●	●
Treatment for patients with autism (18 months to 6 years of age)	●	●	●
Outpatient Surgeries (most elective)	●	●	●
Physical, Occupational, Speech Therapy	○	○	○
Hearing Aids	✘	✘	✘

●	●	○	○	✘
Without Restrictions No Prior Approval	Without Restrictions Prior Approval	With Restrictions No Prior Approval	With Restrictions Prior Approval	Excluded



* The BCBSVT small group plan benefits are the same as the large group BCBSVT HMO without riders.

Benefit Differences

(In-Network Services)

Benefit	MVP EPO	BlueCare HMO*	State Plan
Alternative or Complementary (most standard services)	✗	✗	○
Dental Work (with an accident or deformity)	✗	○	●
Fertility Treatments (i.e., medications to promote fertility, artificial insemination, IVP, GIFT, ZIFT)	✗	✗	○
Orthotics	✗	○	●
Private Duty Nursing	✗	○	✗
Vision Care (routine eye exams separate from primary care vision screening)	✗	✗	○

				
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Benefit Differences

(In-Network Services)

Benefit	MVP EPO	BlueCare HMO*	State Plan
Family and Marital Counseling	✗	○	●
Medical food supplements	●	○	○
Organ Transplants: Associated travel	✗	✗	○
Skilled Nursing Facility	○	✗	○
Wig, toupee or hairpiece (for hair loss due to Chemotherapy or alopecia)	✗	○	○

				
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Differences In Limitations for Covered Services (In-Network Services)

Benefit	MVP EPO	BlueCare HMO*	State Plan
Contraceptive Services (including counseling)			
Durable Medical Equipment (Most DME)			
Home Health Services (skilled nursing)			
Home Infusion Therapy			
Hospice			
Inpatient Care (most non-emergency services)			
Intensive Outpatient Mental Health Programs			
Prosthetic Devices			
CT scans			
Transportation (non-emergency ambulance)			

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Out-of-Network Benefit Differences

Benefit	MVP EPO	BlueCare HMO	State Plan
Out-of-Network Non-Emergency Services	○	○	●
Cardiac Rehabilitation	✕	✕	●
Home Infusion Therapy	✕	✕	●
Mental Health/ Substance Use Disorder Services	✕	✕	●
Rehabilitation Facilities	✕	✕	●
Skilled Nursing Facilities	✕	✕	○

				
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**Framework for Selecting a
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Framework for Selecting a Benchmark Plan

- Plan comparison:
 - What benefits are included/excluded from particular plans?
 - Do plans include all categories within the ACA?
 - What are the differences in prior authorization and other restrictions and requirements?

 - What are the implications of out-of-network limitations now, or in the future?
 - If anticipate differences in provider networks, how does that impact the benefit comparison with regard to out-of-network limitations?

Framework for Selecting a Benchmark Plan

- Impact on overall insurance market
 - What does VT want its health insurance market to look like?
 - Large group market?
 - Small group market?
 - State employee's plan?
 - Hybrid of these models?

Framework for Selection of a Benchmark Plan

- Impact on cost:
 - To individuals*
 - that purchase with a subsidy?
 - that purchase without a subsidy?
 - To small employers
 - that purchase with a tax credit?
 - that purchase without a tax credit?
 - To large employers?

*if plans are allowed to be sold outside of the exchange, benefits would be the same but consider the loss of tax credits and increases in broker's fees

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Discussion and Feedback

- Are these the right criteria?
 - What other criteria would you want to include?
- How would you prioritize among the criteria?
- Is there a specific plan that you would advocate for as the benchmark plan?