Vermont Health Benefit Exchange
Essential Health Benefits & Plan Designs

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Exchange Insurance Plan Components

Essential Health Benefits

- Which benchmark plan should be used to establish the EHB?

Plan Design/Cost-Sharing Structure

- What purchasing approach should the Exchange take for Exchange plan design?
- What plan designs should the Exchange offer?

FEDERAL ESSENTIAL HEALTH BENEFITS

EHB: Definitions & Principles

- ACA Definition: The “Essential Health Benefits” (EHB) plan is the “benchmark” that the state will use to determine the required benefits and quantitative limitations of any small group or non-group plan sold in 2014 and 2015
- ACA Principles:
  - Comprehensive benefits across ten statutory categories
  - Scope of benefits under a typical employer plan
  - Coverage consistent with the mental health parity laws
  - State flexibility
- Additional Vermont Principle:
  - All state mandates should be included

EHB: ACA Requirements

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

State Flexibility in EHB Decisions

- **Select a Benchmark Plan**
- **Select a Pediatric Oral Plan, either:**
  - Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the highest national enrollment
  - The state's Children's Health Insurance Program (SCHIP)
- **Select approach to Habilitative Services, either:**
  - Require plans to offer same services for habilitative needs as it offers for rehabilitative needs and offer them at parity. State would ensure compliance.
  - Plans would decide habilitative coverage and report decision to HHS. HHS would evaluate and define future habilitative services.
- **Pediatric Vision requirement**
  - If benchmark plan lacks pediatric vision care, state would include benefits covered in FEDVIP plan with highest enrollment

EHB: Benchmark Plan Options

- HHS approach permits state to select benchmark plan from among four plan types:

  1. Largest plan in any of three largest small group products (MVP, two BCBSVT products)
  2. Largest insured commercial HMO (BCBSVT)
  3. Any of the largest three state employee plans (CIGNA)
  4. Any of the three largest Federal Employee Health Benefits Program (FEHBP) plans

- Vermont analyzed options 1, 2, 3

Premium Impact of Benefit Differences, by %

Comparing the two largest small group plans and the state employee plan:

- The percent differences based on medical costs only (i.e. prescription drugs were not included under prior guidance)
- CIGNA benefits are expected to impact premiums by approximately 1%, driven by four highly significant additional benefits such as infertility treatment.

Estimated Impact of Benefits % of Premium	MVP EPO	BCBS HMO	CIGNA
Low Cost Impact	0.0%	0.1%	0.2%
High Cost Impact	0.0%	0.2%	0.7%
Total Differences	**0.0%**	**0.4%**	**0.9%**
Compared to MVP		**0.3%**	**0.9%**

Premium Impact, By Dollar Amount

- The estimated premium impact of benefit differences assumes a per member per month (PMPM) medical premium of $290
  - If add the BCBSVT benefits to a medical plan with a $290 PMPM that does not already have the benefits, premiums would be expected to increase approximately $1.00 PMPM.

- The actual premium impact will depend on benefit design (i.e. metal tier), health insurer, and demographics of the enrolled population, among other factors.

Estimated Impact of Benefits PMPM	MVP EPO	BCBS HMO	CIGNA
Low Cost Impact	$0.12	$0.53	$0.93
High Cost Impact	$0.00	$0.98	$2.73
Total Differences (100% AV)	**$0.12**	**$1.51**	**$3.66**
Compared to MVP (100% AV)		**$1.39**	**$3.54**
Compared to MVP (70% AV)		**$0.98**	**$2.48**

Premium Impact, High Cost Benefits

- The benefit differences with the most significant impact are highlighted in the table below

Detailed Impact of Benefit Differences PMPM Range of Estimates	MVP EPO	BCBS HMO	CIGNA
High Cost Benefits			
Infertility treatments	n/a	n/a	$1.35-$2.00
Routine vision care and lenses - Adult	n/a	$0.80 - $1.20	$0.85-$1.30
Total High Cost Benefits	**$0.00**	**$0.80 - $1.20**	**$2.10 - $3.30**
All Low Cost Benefits	**$0.10 - $0.25**	**$0.45 - $0.60**	**$0.85 - $1.10**
Total Differences (100% AV)	**$0.10 - $0.25**	**$1.25 - $1.80**	**$2.95 - $4.40**
Total Differences (70% AV)	**$0.05 - $0.20**	**$0.90 - $1.25**	**$2.10 - $3.10**

In addition to the range of estimated impacts, actual premium impacts will vary based on plan design, demographics and other health plan rating factors.

Mental Health /SUD Considerations

- Parity is required by federal law
- VT's laws exceed federal requirements by applying to non-group market, too
- Key considerations: comments by advocates of mental health patients and their families
- Collected information showed minor differences in services covered
  - None weighed in favor of either benchmark option
  - Differences in out-of-network coverage are not limits considered by HHS to carry over to the definition of essential health benefit; reflective of networks

EHB Decisions & Rationales

- **Benchmark plan**: BCBSVT benefit package
  - Minimize market disruption for covered population (individuals and small businesses)
    - 77% of Vermonters in markets expected to enter the Exchange

    have a BCBS product → adopting their benefits allows for consistency and familiarity
  - Balance of cost and comprehensiveness
    - Coverage differences between plans are primarily minor and comprise quantitative limits
    - Middle of the options for cost
  - This is a starting point
    - Decision affects covered benefits for insurance offered in the Exchange in 2014 and 2015

EHB Decisions & Rationales, cont.

- **Pediatric Dental**: SCHIP benefit package
  - Identical to coverage under Medicaid and familiar to more Vermont families than federal benefits

- **Habilitative Services**: Require plans to offer habilitative services at parity with rehabilitative services

- **Pediatric Vision:** Supplement BC/BS benchmark with FEDVIP plan

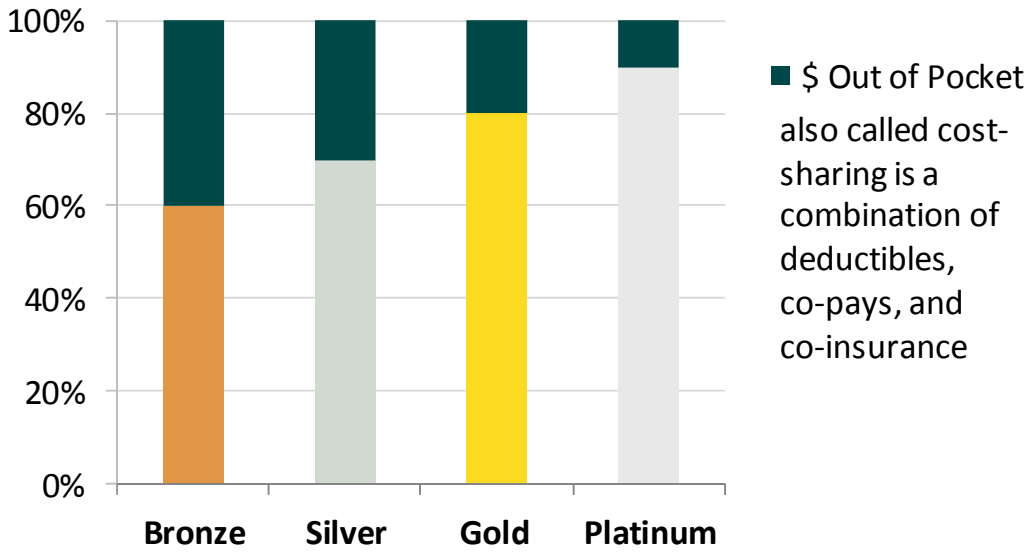
APPROACH FOR PLAN DESIGN

Federal Definitions for Plan Design

All Qualified Health Plans (QHPs) must cover "**essential health benefits**". The total cost of providing these benefits will be split between insurance coverage and what people pay out of pocket for services.

QHPs are grouped into four sets of actuarial value (AV) or "metal level" which is the amount covered by insurance:

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



Factors Driving Plan Designs

- Additional federal regulations
  - Out of pocket maximum limits of $6250 (estimated 2014)
  - Small group plan designs must have deductible no greater than $2000, although HSA and HRA contributions can be considered
- Vermont prescription drug law
  - Limits out of pocket expenditures for Rx to $1250 (2014)
- Current market parameters
  - Existing copay only plans are at gold or platinum-equivalent levels

DVHA Process for Plan Design Recommendations

- Study current market
  - Distribution of members by actuarial value (AV) of plan
  - Common plan design cost-sharing structures
- Develop a set of plan designs at each of the metal levels for GMCB consideration
  - Determine which existing plan designs should be considered
  - Gather input from advisory board
  - Provide multiple options for each metal level, allocating cost-sharing to services categories, setting co-pay and deductible $$, or co-insurance %
  - Get feedback from workgroup on each plan design's benefits, concerns, including member group disruption, and make revisions
  - Make recommendations to the GMCB on the number of plans and cost-sharing structures to offer in the Exchange
  - Once federal model is released adjust the cost-sharing amounts if AVs differ from those developed if necessary (i.e. move deductible from $1,000 to $1,100)

Principles for Decision Making

- Creating meaningful choice for consumers
- Encouraging high value services, like primary care and generic drugs, and innovation – in alignment with State priorities
- Minimizing disruption for small group and individual market
- Maximizing portability of plans, allowing consumers to move between employer and individual coverage while maintaining desired plan
- Affordability
- Administrative simplicity
- Maximizing individual premium tax credits

Approach

- Exchange as "active purchaser"
  - Required by Vermont law 18 V.S.A 1803(b)(1)(A)
  - Solicit insurers to propose plans to be offered on the Exchange
  - Provide guidelines that these plans must meet to ensure consistency with Vermont's health care reform goals
  - Exchange applies guidelines to the plans proposed & selects plans

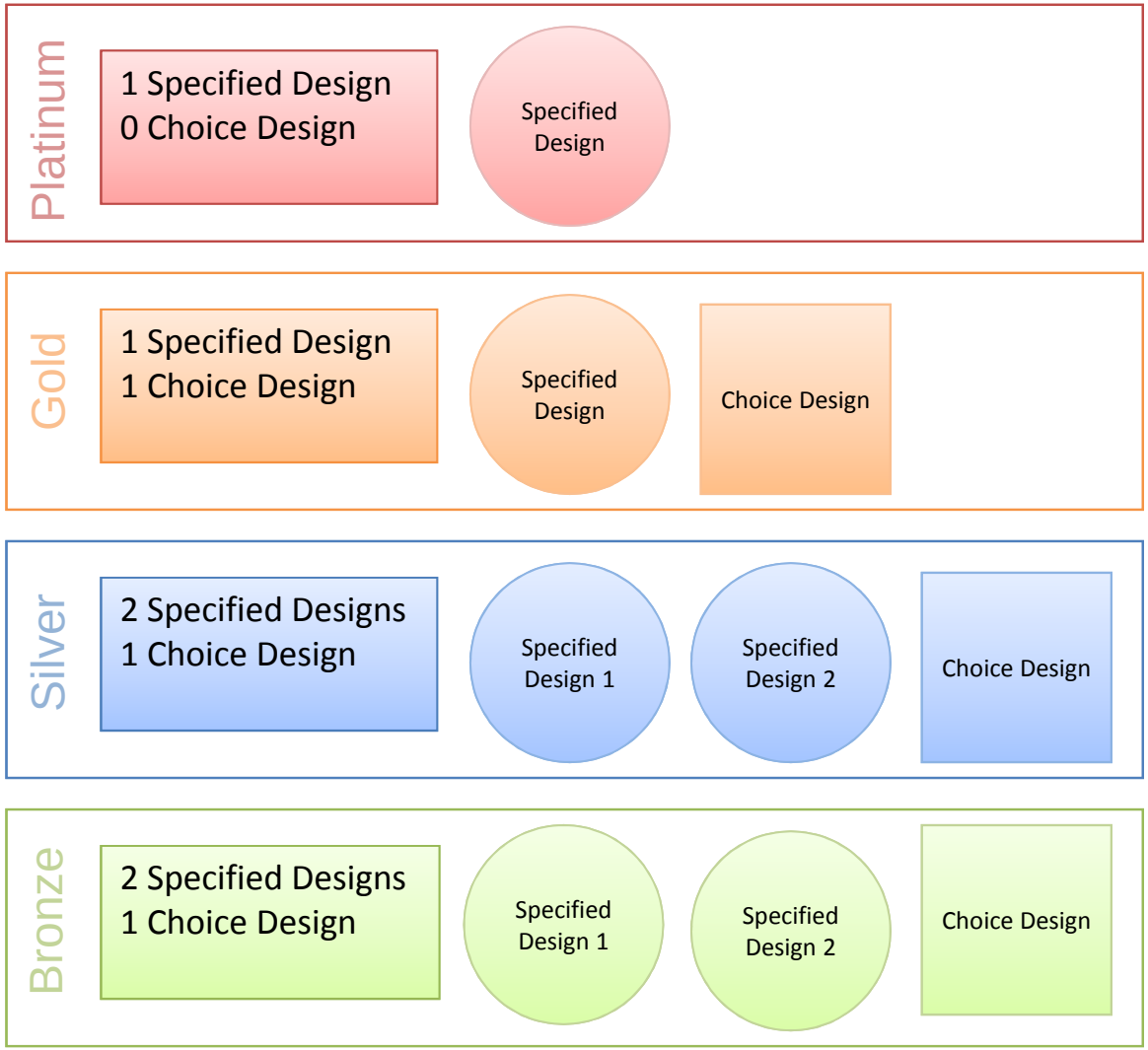
Approach

- A **hybrid approach** of state-specified plan designs and some "choice" plans designed by insurance carriers within set parameters

- **4 specified design options across four actuarial levels:**
  - **At Platinum**: 1 Specified Plan Design
  - **At Gold**: 1 Specified Plan Design
  - **At Silver**: 2 Specified Plan Designs
  - **At Bronze**: 2 Specified Plan Designs

- Additional "Choice" Plan Designs
  - One each at bronze, silver, and gold levels

Proposed Specified Plan Design Options



Total

6 Specified Designs
3 Choice Designs (to be discussed 9/6)

Key:
Circle = State-Specified Design

Square = Insurer Choice Design

Approach Rationale

- **Finding balance with a reasonable range of options**
  - **Consumer research and stakeholder input suggest offering fewer plans**
    - Specificity removes small variations, making plan differences more apparent and easier to compare, giving consumers meaningful choice
    - At platinum and gold levels, little meaningful variation in cost-sharing → one specified design is sufficient. However 2-3 specified designs for the silver and bronze levels is necessary for meaningful choice
  - Administrative simplicity with fewer plans
  - **Including flexibility in plan options has benefits as well**
    - Reduces the small-group market disruption of jumping entirely to state- specified designs
    - Uses insurers' experience in designing plan cost sharing structures, networks and wellness programs
    - Flexibility allows for targeted innovation

STANDARD PLANS

Specified Platinum Plan

Deductible/OOP Max-	Plan Design: Deductible
Medical Ded	$250
Rx Ded	$0
Integrated Ded	No
Medical OOPM	$1,250
Rx OOPM	$1,250
Integrated OOPM	No
Family Deductible / OOP	Stacked, 2x Individual
Medical Deductible waived for:	Prev, OV, UC, Amb, ER
Service Category	**Copay / Coinsurance**
Inpatient/Outpatient/Radiology	10%
ER	$100
Preventive	$0
PCP Office Visit	$10
Specialist Office Visit	$20
Urgent Care	$40
Ambulance	$50
Rx Generic	$5
Rx Preferred Brand	$40
Rx Non-Preferred Brand	50%

Why this plan?

- Moderate deductible
- Comparatively small OOP maximum
- Creates a range of different choices across metal levels
- Similar to most popular state employee plan - familiarity
- Priority for affordable cost-sharing for primary care services and generic drugs
- Portability for individuals – one specified plan design for individuals and small groups

Specified Gold Plan

Deductible/OOP Max	Plan Design: Deductible
Medical Ded	$750
Rx Ded	$50
Integrated Ded	No
Medical OOPM	$4,250
Rx OOPM	$1,250
Integrated OOPM	No
Family Deductible / OOP	Stacked, 2x Individual
Medical Deductible waived for:	Prev, OV, UC, Amb, ER
Drug Deductible waived for:	Generic scripts
Service Category	**Copay / Coinsurance**
Inpatient/Outpatient/Radiology	20%
ER	$150
Preventive	$0
PCP Office Visit	$15
Specialist Office Visit [4]	$25
Urgent Care	$45
Ambulance	$50
Rx Generic	$5
Rx Preferred Brand	$40
Rx Non-Preferred Brand	50%

Why this plan?

- Mid-range deductible – creates a range of options along metal levels
- Close to Catamount Health design – familiarity (though CH is higher metal)
- Priority for affordable cost-sharing for primary care & generic drugs
- Portability for individuals – one specified plan design for individuals and small groups

Specified Silver Plans

Deductible/OOP Max	Plan Design 1: Deductible	Plan Design 2: HDHP
Medical Ded	$1,900	$1,750
Rx Ded	$100	$1,250
Integrated Ded	No	Yes
Medical OOPM	$5,000	$6,250
Rx OOPM	$1,250	$1,250
Integrated OOPM	No	Rx -No, Medical - Yes
Family Deductible / OOP	Stacked, 2x Individual	Aggregate, 2x Individual
Medical Deductible waived for:	Prev, OV, UC, Amb, ER	Preventive
Drug Deductible waived for:	Generic scripts	Wellness scripts
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient/Outpatient	40%	20%
ER	$250	20%
Radiology (MRI, CT, PET)	40%	20%
Preventive	$0	0%
PCP Office Visit	$20	20%
Specialist Office Visit	$30	20%
Urgent Care	$50	20%
Ambulance	$100	20%
Rx Generic	$10	$10
Rx Preferred Brand	$50	$50
Rx Non-Preferred Brand	50%	50%

Why these 2 plans?

- Priority for affordable cost-sharing for primary care & generic drugs
- Portability for individuals – important at silver for federal premium tax credits & cost-sharing subsidies
- Variation in cost-sharing design between two plans (mostly co-pays versus mostly coinsurance)
- HDHP plan design qualifies for health savings accounts & health reimbursement accounts

Specificed Bronze Plans

Deductible/OOP Max	Plan Design 1: Deductible	Plan Design 3: HDHP
Medical Ded	$1,900	$2,000
Rx Ded	$100	$1,250
Integrated Ded	No	Yes
Medical OOPM	$6,250	$6,250
Rx OOPM	$1,250	$1,250
Integrated OOPM	Rx -No, Medical - Yes	Rx -No, Medical - Yes
Family Deductible / OOP	Stacked, 2x Individual	Aggregate, 2x Individual
Medical Deductible waived for:	Preventive	Preventive
Drug Deductible waived for:	Applies to all scripts	Wellness scripts
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient/Outpatient/Radiology	50%	50%
ER [3]	$350	50%
Preventive	$0	0%
PCP Office Visit	$35	50%
Specialist Office Visit	$80	50%
Urgent Care/Ambulance	$100	50%
Rx Generic	$12	$12
Rx Preferred Brand	40%	40%
Rx Non-Preferred Brand	60%	60%

- Specified proposed bronze plans approached the limit of actuarial value level
- Expanding the list of MH/SA treatment codes had modest impact on increasing benefits in the plans
- Prudent to make cost-sharing adjustments for purpose of keeping plans within upper limits of bronze plan actuarial values
- Revisions may be necessary after HHS releases its actuarial value calculator

Future revisions to approved plan designs

DVHA may make minor modifications to approved plan designs under the following conditions:

1. As needed to meet forthcoming federal guidance
2. Modifications restricted to the following:
   - Co-pay changes of *less than or equal to* $15
   - Co-insurance changes of *less than or equal to* 5 percentage points
   - Deductible changes of *less than or equal to* $200

INSURER DESIGNED PLANS

Optional Catastrophic Plans

- At the option of carriers catastrophic plans may be offered on the Exchange
  - ACA requirements: Catastrophic plans may be offered
    - Limited to the non-group market
    - Must provide the Essential Health Benefits
    - Have a minimum deductible which equals amount of HDHP OOPM in the individual market, i.e., approx., $6250 in 2014, except for preventive health services and three primary care visits
    - Under the age of 30, if exempt from the individual mandate because no access to affordable coverage or has an economic hardship

“Choice” Plan Design

GMC Board approved flexibility for DVHA to approve “Choice” plans based on proposed criteria.

Process:

- State would release RFP
- Insurers would submit qualified “choice” plan designs
- DFR would review submissions and certify plans
- DVHA would select plans to offer on the Exchange from certified plans based on specific criteria

“Choice” Plan Design Criteria

DVHA will use following criteria in choosing a “Choice” plan:

- Meaningfully different from standard plans
  - Distinct design structure within same AV level, e.g., difference of $500 in deductible, or an AV that varies by at least 10% for three major service categories
  - Ensures additional plan designs offered will increase the diversity of options for groups/members
  - Both quantitative and non-quantitative differences
- Fosters significant innovations in:
  - Wellness promotion - demonstrated experience and success
  - Promoting individual engagement in prevention
  - MH/SA integration and promotion within the plan design
- Discourages issuers from offering HDHP as choice plans