State of New Mexico

Essential Health Benefits

Actuarial Analysis of Benchmark Plan Options

September 2012

Prepared By

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Executive Summary

Leif Associates was engaged by the New Mexico Health Insurance Alliance to assist the New Mexico Division of Insurance with an actuarial analysis of the State's Essential Health Benefit benchmark plan options. The scope of our work was as follows:

- To identify differences in benefits and gaps in coverage relative to the ten Essential Health Benefit categories as defined by the Affordable Care Act
- To develop options for covering any identified gaps in the benchmark plans
- To compare the plans to each other from the perspective of potential cost differences
- To make recommendations for the selection of the New Mexico Essential Health benefits benchmark plan.

The regulatory approach for defining Essential Health Benefits (EHB) utilizes a reference plan based on employer-sponsored coverage in the marketplace today, supplemented as necessary to ensure that plans cover each of the 10 statutory categories of EHB. This analysis relates only to covered services, not to cost-sharing.

Key Findings and Recommendations

- The Affordable Care Act (ACA) includes requirements for defining the Essential Health Benefits that will be required in non-grandfathered plans in the individual and small group markets both inside and outside of the Exchange beginning in 2014.
- Essential Health Benefits must include items and services within ten benefit categories and should equal the scope of benefits provided under a typical employer plan.
- States have the flexibility to select an existing health plan to set the benchmark for the items and services included in the UHB package, but must include all ten statutory categories. Four types of health insurance plans are identified as the plans a State may choose between, including the largest small employer plan, state employee plans, federal employee plans, and the largest HMO plan. The default plan if the State does not select a plan is the largest small group plan, which in New Mexico is the Lovelace Classic PPO plan.
- We found that there were only minor benefit differences between the benchmark plan options, with the expected cost differences from the Lovelace Classic PPO plan being in the range of plus or minus 1.5%. The one exception was the FEBHP plans which covered dental benefits for adults and as a result are considerably more valuable.
- As a result of this analysis, we recommend adopting the Lovelace Classic PPO plan as New Mexico's Essential Health Benefit benchmark plan, supplemented by:
  - Habilitative services at parity with rehabilitative services. Services for rehabilitation and habilitation will have similar scope, amount, and duration.
  - Pediatric dental and vision benefits at the same benefit level as those provided by the New Mexico S-CHIP plan.

  A list of the various components of the recommended plan can be found in Appendix A.

Statutory Requirements

Section 1302(b) of the Affordable Care Act states the requirements for defining Essential Health Benefits (EHB). Non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent, and Basic Health Programs must cover the EHB beginning in 2014. Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to cover the Essential Health Benefits.

Section 1302(b)(1) provides that EHB include items and services within the following ten benefit categories:

1. Ambulatory patient services,
2. Emergency services,
3. Hospitalization,
4. Maternity and newborn care,
5. Mental health and substance use disorder services, including behavioral health treatment,
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.

Section 1302(b)(2) of the Affordable Care Act states that the scope of EHB shall equal the scope of benefits provided under a typical employer plan. In defining EHB, section 1302(b)(4) directs that benefits must not be designed in ways that discriminate based on age, disability, or expected length of life, but must consider the health care needs of diverse segments of the population.

In addition, Section 1311(d)(3) of the Affordable Care Act requires States to defray the cost of any benefits required by State law to be covered by qualified health plans beyond the EHB. If a State chooses a benchmark plan that does not include all State-mandated benefits, the State would be required to defray the cost of those mandated benefits in excess of EHB as defined by the selected benchmark.

The statute distinguishes between a plan's covered services and the plan's cost-sharing features, such as deductibles, copayments, and coinsurance. The cost-sharing features will determine the level of actuarial value of the plan, expressed as a "metal level" as specified in statute: Bronze at 60% actuarial value, Silver at 70% actuarial value, Gold at 80% actuarial value, and Platinum at 90% actuarial value.

States have the flexibility to select an existing health plan to set the benchmark for the items and services included in the EHB package. All ten statutory categories in section 1302(b)(1) of the Affordable Care Act must be included as a part of EHB. If the benchmark plan does not initially cover a category, the benchmark must be supplemented. States can choose a benchmark from among the following health insurance plans:

- The largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;
- Any of the largest three State employee health benefit plans by enrollment;
- Any of the largest three national FEHBP plan options by enrollment; or
- The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

The largest small group market plan in the State is the default benchmark plan for each State. If a State fails to designate a benchmark plan, this plan will by default become the benchmark plan.

Statutory Requirements

If the benchmark plan chosen by a State is missing coverage in one or more of the ten statutory categories, the State must supplement the benchmark by reference to another benchmark plan that includes coverage of services in the missing category. The default benchmark plan would be supplemented by looking first to the second largest small group market benchmark plan, then to the third, and then, if neither of those alternative small group market benchmark plans offers benefits in a missing category, to the FEHBP benchmark plan with the highest enrollment. Special rules apply to pediatric oral and vision services and habilitative services, which are not included in many health insurance plans.

The Essential Health Benefits plan can include scope and duration limits, although annual and lifetime dollar limits are prohibited. If a benefit, including a State-mandated benefit which has a dollar limit, is included within a State-selected EHB benchmark plan, it must be incorporated into the EHB definition without the dollar limit. However, actuarially equivalent substitutions within statutory categories are allowed, such as replacing dollar limits with visit limits.

New Mexico's Benchmark Plan Options

New Mexico's Essential Health Benefits benchmark plan options were identified by the New Mexico Health Insurance Exchange Advisory Task Force. They are as follows:

Category	Plans
The largest plan by enrollment in any of the three largest small group insurance products in the State's small-group market (default plan)	• Lovelace Classic PPO (largest) • BCBS BlueNet EPO (second largest) • United HealthCare Choice Plus (third largest)
Any of the largest three State employee health benefit plans by enrollment	• BCBS State of NM PPO • Presbyterian
Any of the largest three national FEHBP plan options by enrollment	• BCBS High Plan • BCBS Standard Plan • GEHA Standard Plan
The largest insured commercial non-Medicaid HMO operating in the State	• Lovelace Premier 2500

The Task Force created a spreadsheet of the detailed plan benefits of each of the plans listed above. We relied on this spreadsheet in our analysis. The spreadsheet is attached to this report as Appendix B.

Our approach to the analysis was as follows:

1. Identify all benefit variations across the benchmark plan options as identified in the Task Force spreadsheet.
2. For each of the ten Essential Benefit categories, summarize and evaluate the significant benefit differences, in terms of potential cost as well as compliance with the prohibition on dollar maximums. Where dollar limits were found, we substituted actuarially equivalent visit limits.
3. Set the value of the default plan (Lovelace Classic PPO) to 1.00 and estimate the benefit cost of the other plans relative to the default plan.
4. Summarize the relative value of all of the benchmark plans.

While we feel our review was thorough, we did not have access to all of the detailed plan language for the various plans we reviewed. As such, there may be additional limitations on the benefits of which we were unaware at the time of this study.