Milliman

4370 La Jolla Village Drive
Suite 700
San Diego, CA 92122

Tel (858) 558-8400
Fax (858) 597-0111
www.milliman.com

February 21, 2012

David Panush
Director, Government Relations
California Health Benefit Exchange
2535 Capitol Oaks Drive, Suite 120
Sacramento, CA 95833

**Re: Summary of cost variations for specific services between the California Essential Health Benefits (EHB) benchmark plans**

Dear David:

The California Health Benefits Exchange (HBEX) asked Milliman, Inc. to compare relative costs of covered services between the California benchmark plans. We looked at plans identified as benchmark plans as described in the "Essential Health Benefits Bulletin, issued December 16, 2011." The plans we analyzed were:

- GEHA Federal plan
- BCBS Basic Federal plan
- BCBS Standard Federal plan
- CalPERS Blue Shield Basic HMO
- CalPERS Choice
- CalPERS Kaiser HMO
- Small Group Anthem – Solution 2500 PPO (CDI regulated)
- Small Group Kaiser HMO (DMHC regulated)
- Small Group Anthem Blue Cross PPO 30 (DMHC regulated)
- Commercial Large Group Kaiser HMO

This analysis only includes services we identified as varying in coverage or benefit limits between the 10 benchmark plans.

## Results

The results of our cost analysis are shown in the attached Table 1. This table lists a subset of services from Table 1, "Services with Coverage or Limit Differences Between Potential California Essential Health Benefit Benchmark Plans," from our letter sent on February 13, 2012 showing only services where variation in coverage would likely result in a significant difference in costs.

Certain services were estimated to have no significant cost to the plan and are not shown in Table 1. These services included Christian Science services, non-cancer clinical trials and prosthetic devices for laryngectomies.

***Costs of a Hypothetical Minimum Coverage***

To provide a context for the variable costs, we have developed a framework for a plan with Hypothetical Minimum coverage. This plan does not represent any one of the 10 possible EHB packages - rather it is a least common denominator plan. For each service, we identified the lowest level of coverage in any of the 10 benchmark plans. This Minimum plan was then supplemented with services that will be required by ACA. We have set this baseline to be equal to 100%, where costs are attributed to the total as shown in Table 1, section (a).

***Costs of Non-Uniformly Covered Services***

Table 1, section (b) estimates the cost of each service by benchmark plan to the extent the coverage is more generous than the Hypothetical Minimum coverage. The first column summarizes the minimum observed coverage for a service among the 10 benchmark plans, as augmented to comply with the minimum ACA coverage. The remaining columns show the additional cost of each plan based on differences in that plan's coverage or benefit limits, and the Hypothetical Minimum plan. For example, if the plan offers the Hypothetical Minimum coverage, then the additional cost shown would be 0%.

Section (c) of Table 1 shows the total estimated costs of Hypothetical Minimum coverage (a) plus the additional non-uniformly covered services (b).

Based on this analysis, we estimate the two most generous plans with respect to covered services are the CalPERS Blue Shield Basic HMO and the Anthem Small Group PPO plans. The leanest plan is estimated to be the CalPERS Choice plan. This illustrates the range in estimated plan costs due to the chosen EHB benchmark is about 2.36% (101.87% to 104.23%). Note that the least expensive Essential Health Benefit plan is estimated to be about 102% of the costs if California could pick and choose the minimum covered service provisions of the 10 benchmark plans.

## Theoretical Basis

Each of the 10 benchmark plans has plan-paid healthcare costs that differ due to covered services and benefit limitations. In addition, the cost of the 10 benchmark plans will differ due to the following factors:

1. Cost sharing provisions create different allocations of total health costs between the plan and the member.
2. Cost sharing provisions affect the utilization of healthcare services.
3. Underwriting provisions affect the average health status of the covered population. This is primarily a difference between the small group benchmark plans and the other benchmark plans.
4. Age, gender, and family size affect the utilization of healthcare services.

The Essential Health Benefits bulletin states that the cost sharing provisions of the plan are not considered part of essential health benefits. Thus, for our analysis we ignored factor 1 above, and estimated the total gross healthcare costs for a typical healthcare plan, and for each of the identified individual services. The cost sharing provisions of the 10 benchmark plans would produce 10 different assumed levels of healthcare utilization. Our analysis is based on expected utilization for a plan with a $500 deductible and 20% member coinsurance. This specific assumption does not have a material effect on the percentage results, but we believe it is reasonable to assume some cost-sharing when estimating healthcare utilization. With respect to underwriting and demographic assumptions, we assumed utilization consistent with the typical large employer plan in California.

We estimated the gross healthcare costs for the hypothetical baseline coverage healthcare plan, as described above, to be approximately $390 per member per month (PMPM) as of January 1, 2012. We compared this with preliminary research by the California Health Benefit Review Program (CHBRP) for its 2012 mandate analysis model, and found our estimated costs to be reasonable.

We used a variety of techniques and data to develop estimated costs, including the Milliman Health Cost Guidelines.

## Adjustments for ACA-Required Services

If the State defines their EHB based on a benchmark plan that excludes one or more of the 10 categories of benefits identified in the ACA, the State must supplement the service based on another benchmark plan.

We estimate that the following services will require supplementation in one or more benchmark plans:

***Habilitative Services.*** Habilitative services, which are required to be covered by ACA, may have a significant cost. However, there is a great deal of uncertainty regarding this service category. The scope of services has not yet been clearly defined within the EHB package, and the plans do not specify how these services are currently defined or covered. Therefore, we have shown the estimated cost of habilitative services as 0% in Table 1.

Once habilitative services are defined more precisely, we can estimate to what extent the 10 benchmark plans cover all or a portion of the services. If the plans all currently cover habilitative services at about the same level, then the required adjustment for ACA required services will be similar for each of the 10 plans, so the relative cost for the 10 benchmark plans will remain similar to the amounts shown in our table. On the other hand, if coverage for habilitative services between the 10 benchmark plans varies significantly, then the required adjustment will lead to differences in relative costs compared to those shown in our table.

***Pediatric Dental and Vision Care.*** Of the 10 benchmark plans, three covered pediatric dental care and eight covered pediatric vision care. We estimated the gross cost for pediatric dental services in California using the Milliman Dental Cost Guidelines. Our estimates assume covered services will include those typically covered by employer sponsored dental plans, including diagnostic and preventive services, basic dental services, and major dental services. We assumed orthodontics would not be covered, however can provide a separate estimate if needed. We estimate that for plans currently not covering pediatric dental and vision services, gross health care costs would increase 1.36% and 0.44%, respectively.

***Mental Health Parity and Addiction Equity Act (MHPAEA).*** According to the ACA, coverage will have to be consistent with the MHPAEA. This Act requires that if certain mental health and substance abuse disorders are covered by a plan, they must have limits in parity with limits for other health disorders. Of the 10 benchmark plans, two have limits for non-Severe Mental Illness (non-SMI) and Substance Abuse but no such limits for SMI or other medical disorders. This is inconsistent with MHPAEA, which would require that these limits be removed. However, there is one plan (CalPERS Choice) that does not appear to cover non-SMI. Our understanding of MHPAEA is that this plan would not need any supplementation to be consistent with this Act, because MHPAEA does not require coverage, just parity for any services that are covered.

## Data Reliance

This report relies on data and projections from a number of sources. We have not audited or independently verified the accuracy of those sources. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

Data sources we used include:

1. **GEHA Federal Plan** (received from HBEX, 1-9-2012)
2. **BCBS Federal Plan - Basic** (received from HBEX, 1-9-2012)
3. **BCBS Federal Plan - Standard** (received from HBEX, 1-9-2012)
4. **CalPERS Kaiser HMO** – Kaiser Permanente Basic Plan (received from Kaiser, 1-12-2012)
5. **CalPERS Blue Shield Basic HMO** – Blue Shield Access+ HMO (www.calpers.ca.gov)
6. **CalPERS Anthem Blue Cross PERS Choice PPO** – PERS Choice Basic Plan (www.calpers.ca.gov)
7. **Small Group Anthem Blue Cross PPO** – Anthem Blue Cross Life and Health Small Group Solution 2500 PPO (Z270, 06Z7) (received from Anthem, 1-13-2012)
8. **Small Group Kaiser HMO** – Kaiser Permanente for Small Businesses Evidence of Coverage for Sample Group Agreement Grp Small Nonm – Plan 1637 Plan 30-N; Opt (received from Kaiser, 1-12-2012)
9. **Small Group Anthem Blue Cross PPO30** – Anthem Blue Cross Small Group PPO $30 Copay (received from Anthem, 2-1-2012)
10. **Commercial Large Group Kaiser HMO** – Kaiser Permanente Traditional Plan - (received from Kaiser, 1-12-2012)
11. "Essential Health Benefits Bulletin", Center for Consumer Information and Insurance Oversight, December 16, 2011
12. "Essential Health Benefits: Comparing Benefits in Small Group Products and State and Federal Employee Plans", ASPE Research Brief, December 2011

## Additional Comments

The costs in this letter are estimates for a typical large employer plan in California. Actual premiums and costs for specific services within the Exchange will vary from the amounts shown here for many reasons, including, but not limited to, provider reimbursement, cost-sharing provisions, demographics, health status, and medical inflation. With respect to health status, we assume the Exchange will enroll a large cross section of the population. To the extent that the Exchange enrolls a disproportionate percentage of individuals who need a service on this list, the percentage impact of a particular service may be higher than our estimate.

The costs in this letter do not include the indirect cost impact of adding services. For example, our estimate for Assisted Reproductive Technology does not include additional delivery and neonatal medical costs that may be associated with coverage of this service.

The costs in this letter are not intended to serve as a price list for services covered or not covered. Moreover, they are not meant to suggest the amount the State would be responsible to pay if a state-mandated benefit were not considered an EHB.

This report is not meant to represent a comprehensive list of all services covered, nor to be a substitute for the Evidence of Coverage of each plan.

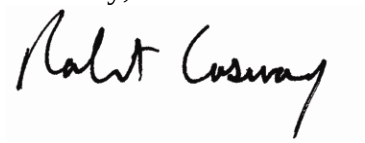
Whether a plan covers a certain service may be influenced by many factors besides the language in the Evidence of Coverage, including the definition and application of medical necessity, evolving clinical practice, agreements between a carrier and its respective regulating agency, and overriding decisions made by the regulating agencies. The focus of this analysis was to compare the costs for services described in the Evidence of Coverage documents for the 10 benchmark plans. To the extent we were not aware of other factors that may modify the language in the Evidence of Coverage documents, the results of our analysis may likewise by inaccurate or incomplete.

This report was produced for the internal use of the California Health Benefits Exchange. No portion of this report may be provided to any other party without Milliman's prior written consent. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

## Qualifications

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

Sincerely,



Robert Cosway, FSA, MAAA
Principal and Consulting Actuary

# California Health Benefit Exchange: Comparison of Potential Essential Health Benefit Benchmarks

## TABLE 1: Estimated Cost of Alternate Essential Health Benefits As a Percent of Costs for a Hypothetical Minimum Essential Health Benefit with the Minimum Coverage for Each Service in Any of the 10 Benchmark Plans (1)

| | Hypothetical Minimum Essential Health Benefits = Minimum Observed Coverage, Supplemented with ACA-Required Services | Federal Plans | | | California State Employee Plans | | | Commercial Small Group Plans | | | Commercial Large Group Plans |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | | FEHBP - GEHA | FEHBP - BCBS Basic | FEHBP - BCBS Standard | CalPERS Blue Shield Basic HMO | CalPERS - Choice | CalPERS - Kaiser HMO | Small Group - Anthem PPO - CDI | Small Group - Kaiser HMO - DMHC | Small Group - Anthem Blue Cross PPO30 - DMHC | Commercial Large Group - Kaiser HMO - DMHC |
| **a) Estimated Costs for Hypothetical Minimum Essential Health Benefits** | | | | | | | | | | | |
| Uniformly Covered Benefits, including the Value of the Least Observed Coverage | 97.94% | | | | | | | | | | |
| ACA-Required Services (3) | | | | | | | | | | | |
| Pediatric Dental | 1.36% | | | | | | | | | | |
| Pediatric Vision | 0.44% | | | | | | | | | | |
| Non-Severe Mental Illness (non-SMI) Services (4) | 0.00% | | | | | | | | | | |
| Substance Abuse (4) | 0.26% | | | | | | | | | | |
| **Hypothetical Minimum Essential Health Benefits** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** |
| **b) Estimated Costs for Non-Uniformly Covered Services, in Excess of the Hypothetical Minimum Essential Health Benefits** | | | | | | | | | | | |
| Acupuncture | Not Covered | 0.24% | 0.27% | 0.27% | 0.00% | 0.21% | 0.37% | 0.37% | 0.37% | 0.27% | 0.37% |
| Assisted Reproductive Technology (ART) | Not Covered | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.03% | 0.00% | 0.02% | 0.00% |
| ABA Therapy for Autism | Not Covered | 0.00% | 0.00% | 0.00% | 0.27% | 0.00% | 0.27% | 0.27% | 0.27% | 0.27% | 0.27% |
| Chiropractic | Not Covered | 0.22% | 0.22% | 0.22% | 0.47% | 0.26% | 0.00% | 0.47% | 0.00% | 0.34% | 0.00% |
| Habilitative **(2), (3)** | ACA-Required | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| Hearing Aids | Not Covered | 0.44% | 0.25% | 0.25% | 0.20% | 0.44% | 0.20% | 0.00% | 0.00% | 0.00% | 0.00% |
| Home Health | Covered - 2 hours per day. 25 days per year | 0.11% | 0.00% | 0.00% | 0.20% | 0.09% | 0.20% | 0.17% | 0.17% | 0.17% | 0.17% |
| Infertility Services (Non-ART) | Not Covered | 0.13% | 0.13% | 0.13% | 0.13% | 0.00% | 0.13% | 0.13% | 0.00% | 0.12% | 0.13% |
| Non-Severe Mental Illness (non-SMI) Services **(4)** | Not Covered | 0.85% | 0.85% | 0.85% | 0.85% | 0.00% | 0.85% | 0.85% | 0.85% | 0.85% | 0.85% |
| Pediatric Dental Care **(3)** | ACA-Required | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| Pediatric Vision Care **(3)** | ACA-Required | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| Physical And Occupational Therapy | Covered - 24 visits per year | 0.84% | 0.71% | 0.98% | 0.98% | 0.00% | 0.98% | 0.98% | 0.98% | 0.00% | 0.98% |
| Skilled Nursing Facility | Not Covered | 0.43% | 0.00% | 0.00% | 0.85% | 0.85% | 0.85% | 0.85% | 0.85% | 0.85% | 0.85% |
| Smoking Cessation Counseling | Covered - Two attempts per year, four counseling sessions per attempt | 0.01% | 0.01% | 0.01% | 0.01% | 0.00% | 0.01% | 0.01% | 0.01% | 0.01% | 0.01% |
| Smoking Cessation Drugs | Covered - $100 per year and excludes OTC | 0.06% | 0.06% | 0.06% | 0.06% | 0.00% | 0.06% | 0.00% | 0.06% | 0.00% | 0.06% |
| Speech Therapy | Covered - 24 visits per year combined with PT, OT, and Chiro | 0.02% | 0.06% | 0.09% | 0.09% | 0.00% | 0.09% | 0.09% | 0.09% | 0.00% | 0.09% |
| Substance Abuse **(4)** | Covered at Parity | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| Surgically implanted Hearing Devices | Not Covered | 0.03% | 0.03% | 0.03% | 0.03% | 0.03% | 0.03% | 0.00% | 0.03% | 0.00% | 0.03% |
| **Total Cost over the Hypothetical Minimum Essential Health Benefits** | | **3.40%** | **2.62%** | **2.90%** | **4.14%** | **1.87%** | **4.05%** | **4.23%** | **3.69%** | **2.90%** | **3.82%** |
| **c) Total Cost of Essential Health Benefits based on each Benchmark Plan (c) = (a) + (b)** | | **103.40%** | **102.62%** | **102.90%** | **104.14%** | **101.87%** | **104.05%** | **104.23%** | **103.69%** | **102.90%** | **103.82%** |

(1) Milliman's review was based on each plan's Evidence of Coverage. These summaries have not been reviewed by the carriers or plan sponsors.
This table only includes services that have been identified as varying significantly in whether or how they are covered by the different Benchmark Plans.
All vallues are expressed as a percent cost of a Hypothtetical Minimum Plan that covers:
- All uniformly covered healthcare services
- For non-uniformly covered services (on this list), the minimum coverage seen in any of the 10 benchmark plans.
- If not included above, additional coverage required by ACA.

(2) We have not yet estimated a PMPM cost for Habilitative Services, since the scope of services for that category has not yet been defined.
(3) If the State defines their EHP based on a benchmark plan that excludes one or more of the 10 categories of benefits identified in the ACA, the State must supplement that service based on another benchmark plan. These are the services we estimate will require supplementation by one or more benchmark plans.

(4) According to the ACA, coverage will have to be consistent with the MHPAEA, which requires that if certain mental health and substance abuse disorders are covered by a plan, they must have limits in parity with limits for other health disorders. MHPAEA does not require coverage, just parity for any disorders that are covered.
**Non-SMI:** There was one plan (CalPERS-Choice) that did not cover any non-SMI, and so the Minimum Coverage would be "no coverage". CalPERS Choice could continue to not offer non-SMI coverage and still be compliant with MHPAEA, and the cost shown in line (c) for that plan does not include non-SMI coverage. However, for all other plans, the variable cost is shown based on coverage without limits to comply with parity.
**Substance Abuse:** All plans had some coverage, so to comply with parity all coverage must be without limits. This cost is shown in the Hypothetical Minimum Coverage, and the variable cost for all plans is 0%.