Comments on the Selection of the Benchmark Plan for Illinois' Essential Health Benefits Package

September 19, 2012

On behalf of the thousands of employer, insurer, and agent and broker members our organizations represent, we appreciate the opportunity to comment on the impending selection of the state's Essential Health Benefits benchmark plan.

As members of the Health Reform Implementation Council's (HRIC) Workgroup on the Essential Health Benefits (EHB) deliberate the selection of the EHB package, we want to underscore the importance of affordability of coverage for individual consumers and small employers. In less than 18 months, the Affordable Care Act will significantly alter the coverage landscape in Illinois and throughout the nation. While the changes in medical underwriting practices and guarantee issue will go a long way towards improving access to coverage and reducing the ranks of the uninsured, the price points for health insurance that will be influenced in large part by the determination of the EHB is another critical component to improving access.

Health insurance that is unaffordable is in and of itself a barrier to coverage.

The Institute of Medicine (IOM) stressed this very point in their recommendations to HHS on defining essential health benefits last fall.[1] The IOM report stated that "unless we are able to balance the cost with breadth of benefits, we may never be able to achieve the healthcare coverage envisioned by the Affordable Care Act."

The task ahead of the HRIC's workgroup is daunting, especially given the compressed timeline in which the state must select its benchmark plan. In addition to affordability, the EHB should provide issuers with the flexibility to design plans that respond to the different needs of the individual and small group markets while utilizing mechanisms that assure quality and cost-effective benefits. We also believe the EHB selection process for 2014-2015 affords us the opportunity to prepare for transition into 2016 by assessing the cost and medical effectiveness of Illinois' health insurance mandates.

We have provided more detailed comments and recommendations in the following pages that expound upon these sentiments and ask for consideration of these comments as the state moves forward in its selection of the EHB.

Sincerely,

Illinois Chamber of Commerce
National Federation of Independent Business/IL
Independent Insurance Agents of Illinois
IL State Association of Health Underwriters
Illinois Life Insurance Council
Aetna
National Association of Insurance & Financial Advisors
Illinois Manufacturers' Association
Illinois Retail Merchants Association
Health Alliance Medical Plans
Meridian Health Plan
Flexible Benefit Service Corporation (Flex)
Cigna

[1] Institute of Medicine of the National Academies. *Essential Health Benefits: Balancing Coverage and Costs.* Washington, DC: The National Academies Press, 2011. http://www.nap.edu/catalog.php?record_id=13234

- **Affordability must be a key point of consideration in the determination of the EHB.**

As stated in our introductory comments, the cost of coverage is an important factor to consider in the decision-making process. Balancing the comprehensiveness of the coverage with the overall cost of that coverage is a delicate one, but the affordability of coverage holds great sway over the benefit purchasing decisions of small employers and their employees and families. The cost of coverage has been a significant contributing factor, if not the only factor, in the erosion of employer-sponsored health insurance amongst small employers with less than 50 employees over the past decade.

We note that at the time of these comments, we have not yet seen the complete analysis by Wakely Consulting with regards to the potential premium impact of the state's 10 benchmark plan options, but Wakely's analysis performed in other states has demonstrated significant variations in the potential premium impact between benchmark plan options.

In the premium impact analysis of Michigan's 10 benchmark plan options, variations in premium impact on a Per Member Per Month (PMPM) basis varied from the baseline plan (or the leanest plan option) as little as $2.00 PMPM to as much as $18.25 PMPM.[2] Wakely's analysis of Oregon's benchmark plan options also yielded similar variations, albeit on a smaller scale ranging between $0.25 PMPM to $12.75 PMPM.[3] In both of these cases, Wakely's estimates did not consider the impact of supplemental benefit options, like habilitative care and pediatric dental, which will also inflate the premium impact of these benchmark options. As members of the HRIC workgroup deliberate the EHB package in its entirety, we would ask that the leanest benefit in any of the remaining benchmark plans be used to supplement the selected benchmark plan if it does not include one of the 10 required categories of essential health benefits. We also ask that habilitative services be offered in parity with rehabilitative services and that these benefits apply cumulatively to support the underlying goal of affordability.

The selection of an EHB that puts costs considerations at the forefront is one of but a few ways states can impact premium prices available in its health insurance market post-2014. It is important to note that there are other pressures on the cost of health insurance, particularly in the individual and small group market, that will come into play in 2014, not least of which is the Health Insurance Tax (HIT) imposed on fully-insured plans. This tax, while not directly imposed on consumers and small employers, will have an indirect impact by way of higher prices for fully-insured plans. Furthermore, since the benchmark options are based on small group and state and federal employee group plans- plans that are typically richer than most individual health insurance plans – the "sticker shock" for many individuals, including the employees of small employers that do not offer coverage, could be especially severe. Although premium subsidies will be available for these individuals, the price inflation on coverage could be such that the subsidy won't make coverage any less costly than it currently is; a prospect that does not bode well for attracting younger, healthier individuals into the risk pool.

While the IOM report stressed the importance of affordability, HHS "Essential Health Benefits Bulletin" issued on December 16, 2011 failed to consider affordability in its proposed transitional approach to the definition of essential

---

[2] Wakely Consulting. *State of Michigan: Essential Health Benefits Analysis and Results – Updated.* August 16, 2012. MI Office of Financial and Insurance Regulation EHB Benchmark Plan Executive Report – 9-5-12.
http://www.michigan.gov/documents/lara/EHB_Report_09_05_12-Final_397063_7.pdf

[3] Wakely Consulting. *State of Maryland Essential Health Benefits Premium Impact of Benchmark Options.* July 18, 2012.
http://www.statereforum.org/sites/default/files/md-ehb-premium-impact-of-benchmark-options-hcrcc-meeting-draft1.pdf

health benefits.[4] Since HHS has given Illinois and other states the opportunity to identify its own benchmark plan for 2014 and 2015, we urge members of the HRIC workgroup to look closely at the IOM recommendations on defining the EHB, which emphasized inclusion of benefit mandates that are evidence-based and utilizing a premium target mechanism for determining what benefits will be included in the EHB.

- **The EHB and any accompanying Department regulations should allow benefit design flexibility.**

HHS' Bulletin on the EHB published last December allows actuarially equivalent substitutions within each of the 10 essential health benefit categories, which provides for flexibility in how carriers design their plans in a cost-effective way.[5] The priorities of the individual market and the small group market are not identical. Employers approach their benefit selection process very differently than that of the individual consumer. Therefore, it is important to allow issuers the flexibility to respond appropriately to the needs of those two markets. The ACA already makes it difficult on many levels for this to occur – especially in the small group market – by limiting deductibles to $2,000 and $4,000 for single and family coverage respectively; limits that are already below that of many plans offered on the market today and could eliminate viable plan options like consumer-directed plan options that include Health Savings Accounts (HSAs).

Flexibility in how benefits are designed is also needed to allow issuers to more effectively manage costs. We ask that consideration be given during the implementation of the EHB to the following points:

  - Allow for the continued use of value-based insurance designs;
  - Allow consumer-directed plans, more specifically High Deducible Health Plans (HDHP) with Health Savings Accounts (HSAs), to remain an option for coverage post-2014;
  - Allow for use of non-dollar benefit limits on non-emergency services;
  - Clarify application of the EHB to in-network providers only and if EHB is applied to out-of-network providers, allow for the imposition of cost-sharing;
  - Allow for commercial market benefits and practices in establishing prescription drug benefits as opposed to deferring to Medicare as the standard for prescription drug coverage in commercial health plans, as was referenced in the HHS' EHB Bulletin; and
  - Allow for utilization and medical management tools to assure quality and cost control.

We also note that the EHB package is intended only to define services that must be covered and not the way those services must be covered. Therefore, the EHB must not dictate specific cost-sharing requirements. This cost-sharing should be determined by the issuer as they design their plans along the actuarial value requirement set forth in the EHB.

- **Evaluate cost and medical effectiveness of state coverage mandates.**

HHS has already put states in the unfortunate position of absorbing the costs of any and all state mandates that were enacted prior to December 31, 2011 either by way of the selection of a benchmark plan that includes all state coverage mandates or by requiring the state to defray the costs of mandated benefits in QHPs that exceed the EHB. As noted by

[4] Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin*. December 16, 2011. http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

[5] Ibid.

the EHB Coalition in their response to HHS' EHB Bulletin, "the transitional approach taken by HHS contradicts the ACA statute by, in some cases, incorporating costly state benefit mandates into the EHB package with little basis in medical evidence."[6] For states like Illinois that do not have a process in place to examine each proposed state coverage mandate with respect to cost and medical effectiveness, we are forced to absorb these costs in some form in 2014 and 2015. This should not, however, preclude the state from implementing a review process moving forward. While HHS has clarified that any new state mandate added post-December 31, 2011 cannot be added to the EHB for 2014 and 2015, it does not guarantee the expansion of a state's EHB to include any new state mandates post-2015. It is also worth noting that HHS has not guaranteed that a state's mandates will be included in the EHB post-2015 further underscoring the need to implement a rigorous evidence-based mandate review process.

Our organizations have previously advocated for the establishment of a panel or process by which every newly proposed state health insurance mandate is subject to an evidence-based review or cost analysis. We continue to advocate for such a process, particularly in light of the potential cost pressures that could continue to put health insurance beyond the reach of small employers and their employees and families.

While we note that state health insurance mandates, when considered by themselves, rarely have a tremendous impact on premiums, the state's coverage mandates, when considered in their entirety, can have a significant impact. In a Commission on Forecasting and Accountability (COGFA) report released earlier this year, the total cost escalation of the state's coverage mandates could account for 5% to as much as 17% or more of total health insurance costs in Illinois.[7] Although this report was based on limited data and performed along a brief timeline, it lays a foundation for a deeper exploration of how Illinois' coverage mandates influence cost and if the medical effectiveness of that mandate on the back-end negates or surpasses the front-end coverage costs.

- **Allow for expedited certification of Qualified Health Plans and plan compliance with the EHB.**

The process by which the definition of the EHB is to occur has changed from that which was initially envisioned by the ACA, creating both opportunity and frustration. The state's selection of the EHB not only provides for a constricted timeline by which issuers have to develop and offer a QHP both inside and outside the exchange, it also affords employers little time to appropriately plan for their 2014 benefit decisions.

While many employers are currently in the process of determining their benefit options for 2013, the EHB selection will inevitably impact premium costs for 2014, which means employers must start planning as early as possible – not only to appropriately prepare for the impact this will have on bottom line costs, but also for the impact this will have on employees and their families. Employers and their employees that are selecting their coverage plans today may find that coverage unaffordable tomorrow.

Employers must be able to effectively communicate employee benefit options and decisions; communication that cannot occur until employers know what health insurance options will exist and what the cost of those options will be in 2014. Furthermore, it is important to note that even though plan compliance with the EHB is not technically effective

[6] Neil Trautwein, Chairman of Essential Health Benefits Coalition, *Response to HHS Request for Information on the Essential Health Benefits Bulletin.* http://ehbcoalition.org/wp-content/uploads/2012/02/EHBC-Comments.pdf

[7] Commission on Government Forecasting and Accountability, *Report: Illinois Health Insurance Mandates, House Resolution 332 and 406*. February, 6, 2012. http://www.ilga.gov/commission/cgfa2006/Upload/022012APPENDIXILHealthInsuranceMandatesReport.pdf

until 2014, issuers, employers, consumers and other stakeholders only have a year to prepare before open enrollment begins in October 2013.

The state has received federal funds for exchange planning and implementation purposes and we urge the Department of Insurance to use these funds to put into place resources that can provide for expedited certification of QHPs in 2013. We believe this is necessary to give consumers and employers time to effectively prepare for the significant changes that will occur in the very near future.

- **Develop process for re-evaluating EHB for plan years 2016 and beyond.**

The compressed timeline by which the state is selecting its EHB is not ideal, but given that HHS has indicated this selection will only effect plan years 2014 and 2015, we hope considerations will be given to how the EHB will be defined in plans years 2016 and beyond very soon. While we recognize that this process will be determined in large part by HHS guidance and rules, we also believe state experience should be an influencing factor in how HHS dictates this process beyond the transitional approach.

Evaluation of state health insurance mandates – both proposed and enacted – mark an opportunity moving forward, but we hope the goal and directive of the HRIC workgroup is to re-evaluate the current selection process to incorporate "lessons learned" in 2016. This should include evaluation of how the EHB impacts the pricing of coverage, as well as its impact on consumer behaviors in both the individual and small group markets. Since HHS has made states the test case in their transitional approach, we believe Illinois is in a position to articulate experiences that can shape EHB selection in 2016, regardless of whether it is retained at the state level or shifted to the federal level.