



Essential Health Benefits / An Actuarial Assessment of Health Insurance Coverage

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The ACA Requires Plans to Cover Minimum Essential Benefits and Places Limits on Cost Sharing

- The ACA creates 10 categories of essential benefits that plans must cover beginning in 2014:
 - » Ambulatory patient services
 - » Emergency services
 - » Hospitalization
 - » Mental health and substance abuse services
 - » Rehabilitative and habilitative services and devices
 - » Prescription drugs
 - » Laboratory services
 - » Preventive and wellness services and chronic disease management
 - » Maternity and newborn care
 - » Pediatric services

- The essential benefits requirements also places limits on patient costs
 - » Limits out-of-pocket costs to Health Savings Account (HSA) levels (in 2011, \$5,950 for individuals)
 - » Limits deductibles for small group plans to \$2,000 for individuals and \$4,000 for families

Initial Engagement with NHC Resulted in Development of Value Statements on EHB

Goal: Ensure that people with chronic conditions have access to affordable and high-quality services and treatments necessary for prevention, diagnosis and management of their health condition

Domain	Value
Process Transparency	<ul style="list-style-type: none"> ▪ Create processes for meaningful patient input at all stages of defining essential health benefits ▪ Put safeguards in place to protect patients from discriminatory practices ▪ Develop periodic evaluation processes to review the adequacy of the essential health benefits package ▪ Define the interaction of federal essential health benefits with existing state mandates
Criteria to Define “Essential” Benefits	<ul style="list-style-type: none"> ▪ Ensure that access to essential health benefits by individual patients is not impeded by financial barriers ▪ Promote flexibility to accommodate technological advances and evolving evidence ▪ Include benefits from a variety of care settings and providers to meet all patient needs
Recourse in Decision-making	<ul style="list-style-type: none"> ▪ Permit the public to request reconsiderations of the essential health benefits package by the Secretary of HHS ▪ Allow enrollees to challenge a health plan’s interpretation of essential health benefits and rationale for the inclusion or exclusion of individual services

NHC Commissioned an Actuarial Analysis to Estimate Costs of an EHB Package

Create a baseline benefit package

- Use FEHBP BCBS Standard Option as a foundation
- Exclude dental and vision benefits, even though these are covered under the BCBS Standard Option

Price the baseline benefit package

- Calculate covered charges and estimated premium for selected benefit package

Calculate actuarial value

- Adjust premiums and cost-sharing for all four levels of benefit packages established by the ACA
 - » Platinum (90% of covered charges are paid by the plan)
 - » Gold (80% of covered charges are paid by the plan)
 - » Silver (70% of covered charges are paid by the plan)
 - » Bronze (60% of covered charges are paid by the plan)

Analysis Established Potential Premiums and Benefit Design for Plans

Estimated spending using 2011 National Health Accounts projections

- Calculated the cost to pay for covered expenses following FEHBP BCBS Standard Option as a model
- Covered charges for average person would equal \$4,659 per year

Predicted premiums for model plan

- Using standard administrative expenses and other assumptions, annual premium is estimated to be \$5,032 for an individual or \$12,418 for a family

Calculated actuarial value of model plan

- The model plan, as is, has an actuarial value of 0.87 in-network, which is near the platinum level of coverage

Adjusted actuarial value to equal levels defined by the ACA

- Created different benefit design structures to accommodate established actuarial levels (90%/80%/70%/60%)
- Modified deductibles, coinsurance, out-of-pocket maximums, and set copayments to illustrate how benefits may differ within same actuarial value

Analysis Uncovers Importance of Patient Cost Protections

- Affordability is a key protection for patients who will rely on EHB as a standard for coverage
 - » Analysis resulted in an average monthly premium of **\$337 individual/\$833 family** for a benefit plan that would approximate a silver plan using the EHB model
 - » Under the ACA, individuals/families up to 400% FPL would receive a premium tax credit on a sliding income scale basis linked to the silver plan
 - » At 400% FPL, premiums as a percent of income would be capped at 9.5% (\$345 individual/\$708 family per month)
 - » **Above 400% FPL, there is no premium tax credit**
- The results of the analysis also show that benefit design, even within an actuarial value category, can vary substantially
 - » For this reason, it will be critical for patients to enroll in a plan that works with their health care usage patterns
 - » For example, a person with a chronic condition who has high healthcare expenses may consider a plan with a lower out-of-pocket limit, even if the deductible or other early out-of-pocket spending is higher than other plans

At 250% FPL, a Family of Four with One Person with Kidney Disease

Annual Income (Gross)	\$55,875	
Median Necessities* (at 71%)	– \$39,671	← Subtract the cost of taxes, child care, food, housing, transportation, and miscellaneous expenses of 10%
	\$16,204	
Maximum Premiums**	– \$4,500	← Subtract the ACA-defined maximum premium a family at 250% FPL can pay (compared to ~ \$8,000 for a silver plan with no subsidy)
	\$11,704	
OOP Maximum***	– \$5,950	← Subtract the reduced out-of-pocket maximum due to 250% FPL (compared to \$11,900 with no subsidy)
	\$5,754	
Per Month	12	← Divide by 12 for a estimate of remaining funds in monthly budget
	~ \$480	

* The median percentage of a budget assigned to necessities was estimated by Gruber and Perry, April 2011.

** The ACA sets threshold levels for maximum premiums, above which people will receive subsidies. At 250% FPL, the maximum premium is 8.1% of income.

*** The ACA sets reduced out-of-pocket maximums for people with limited income. A Rand study estimated total out-of-pocket spending related to kidney disease was nearly \$9,000 in 2004.

At 450% FPL, an Individual with Rheumatoid Arthritis

Annual Income (Gross)	\$49,005	
Median Necessities* (at 63%)	– \$30,873	← Subtract the cost of taxes, child care, food, housing, transportation, and miscellaneous expenses
	\$18,132	
Platinum Premiums**	– \$5,205	← Subtract the cost of the premium for a platinum plan
	\$12,927	
OOP Maximum***	– \$5,950	← Subtract the out-of-pocket maximum set by the ACA
	\$6,977	
Per Month	12	← Divide by 12 for a estimate of remaining funds in monthly budget
	~ \$580	

* The median percentage of a budget assigned to necessities was estimated by Gruber and Perry, April 2011.

** The actuarial analysis estimated an annual premium of approximately \$5,205 for a platinum plan for an individual. At this level of income, there is no premium subsidy.

*** The ACA sets the standard OOP Maximum at \$11,900. At this level of income, there is no subsidy for the OOP Maximum. A Rand study estimated total out-of-pocket spending related to rheumatoid arthritis was around \$4,800 in 2004.