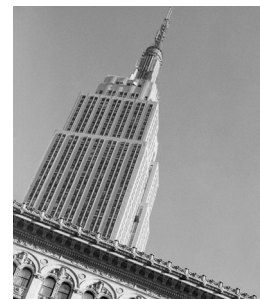
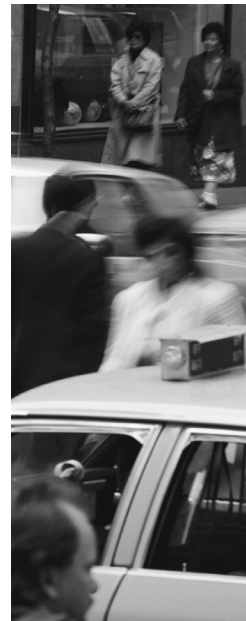
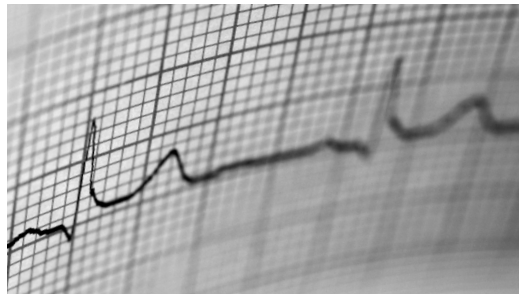


Defining Essential Health Benefits: Federal Guidance and New York Options



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Defining Essential Health Benefits: Federal Guidance and New York Options

Peter Newell

DIRECTOR, HEALTH INSURANCE PROJECT
UNITED HOSPITAL FUND



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Foreword

Given the legal and political uncertainties surrounding the full implementation of the Affordable Care Act (ACA), many states have adopted a wait-and-see approach. Under the leadership of the Cuomo Administration, however, New York has pressed ahead; in recent months, the state has chosen a major information technology vendor for work on the enrollment and income verification infrastructure, promulgated an executive order creating the health insurance exchange, and held public events on wide variety of the ACA topics. Here at the Fund, we're moving ahead as well.

Defining Essential Health Benefits: Federal Guidance and New York Options, the fifth in a series of ACA-related publications undertaken with the support of the New York State Health Foundation, examines options for New York policymakers in determining the “essential health benefits” that will be required for all individual and small group policies beginning in 2014. Under the ACA, that definition was to be supplied by the Secretary of the U.S. Department of Health and Human Services (HHS), within general categories of benefits

established in the legislation. In December of 2011, however, HHS expanded the role that states would play in deciding on the benefit package during a two-year transition period, requiring states to pick from a menu of “benchmark options” based on popular plans.

HHS's decision presents a difficult challenge for New York, and an opportunity for the Fund to undertake work that it does well: analyzing complex federal guidance and applying it to New York's unique insurance regulatory framework and markets. Inextricably linked to affordability, the adequacy of subsidies, and larger goals of health reform—such as improving quality, engaging patients, and containing costs—benefit design is the most elemental of health care reform tasks. *Defining Essential Health Benefits* highlights the choices policymakers face and important areas where greater clarity in federal rules would be helpful.

JAMES R. TALLON, JR.

President

United Hospital Fund

Executive Summary

Benefit design is among the most elemental of implementation issues in health care reform, but the Affordable Care Act (ACA) left the definition of the “essential health benefits” (EHBs) required in all individual and small group policies to the discretion of the Secretary of the U.S. Department of Health and Human Services (HHS), so long as ten statutory categories of benefits are represented. With the health care world expecting a detailed list of benefits, HHS issued a bulletin in December 2011 signaling its intention to share benefit design decisions with states, by giving them a menu of “benchmark options” based on popular state insurance products in four categories and requiring them to choose one; the categories include popular state small group plans, coverage for state and federal public employees, and coverage from the state’s largest HMO. Under the proposed guidance, still subject to change, these benchmark plans would in turn be upgraded as necessary to supplement any benefits lacking in the ten statutory ACA categories, and health plans would be allowed some discretion to substitute or modify benefits, as long as the overall value of the benefit package did not decline, and ACA anti-discrimination and other standards were met. Benefit categories likely to need supplements include prescription drugs; rehabilitative and habilitative services and devices; mental health and substance abuse disorders; and pediatric services, including oral and vision services.

Importantly, the proposed guidance leaves untouched the ACA requirement that states must defray the cost of mandated individual and group benefits not included in the benchmark option chosen by the state. It also sets the groundwork for some highly technical definitions important for state decision-making. Among the most nettlesome is the distinction between a health insurance “product” and a health insurance “plan,” with a product representing a general platform for coverage, such as an HMO or PPO, and a plan describing the actual

benefits enrollees receive, except for those benefits delivered through riders to the main policy.

Analyzing the various benchmark options first requires a detailed understanding of the health benefits required in New York by statute and regulation. New York’s benefit requirements are complicated and have evolved over the past 40 years: different requirements are in place for individual and small groups; some benefits are contingent on other types of benefits being offered; benefits are organized according to the type of licensee offering the products; and New York law requires policies to include provisions that could be described as a benefit, a contractual right, a service delivery feature, or a consumer protection. New York’s 1995 Point of Service Law introduced a new set of mandated benefits for standardized individual products required to be offered by all state HMOs; in many areas, the law requires coverage that exceeds standards for typical small group plans.

A second key component of the analysis is identifying the potential benchmark options and the benefits they provide. We chose ten potential options, based on HHS guidance and enrollment data, including small group plans offered by two Oxford licensees and a third by Empire BCBS; the New York State Health Insurance Program’s Empire Plan for state public employees and HMO plans offered by Independent Health Association and Capital District Physicians Health Plan under the program; two Blue Cross Blue Shield Association of America plans offered to federal employees, and a third federal plan offered by the Government Employees Health Association; and an HMO plan offered mainly to New York City public employees by HIP, part of the EmblemHealth companies.

We compared the benchmark options in each category to each other, and the benefits they provide to the universe of mandated benefits required of individual and small coverage in New York, in order to highlight selected differences

between these options and typical plans in New York, and to determine those benefits for which New York could be obligated to defray the cost. We also identified some additional areas where more complete federal guidance would be necessary for a complete understanding of New York options. These include the role of out-of-network benefits provided by some of the benchmark options; a clearer definition of what constitutes a plan and the treatment of riders; the ability of plans to substitute benefits; more recent enrollment data; the federal and state roles in determining supplements to benefits; standards for mental health and substance abuse disorder services; and guidance on whether New York requirements and policy provisions in such areas as out-of-network access, coverage of dependents, domestic partners and same-sex spouses, and various other consumer protections and rights would prevail under the new system.

The HHS guidance shifts some responsibility to states for difficult decisions on balancing benefits and costs, and on setting benefits that make sense for both individuals and small employers. It requires a difficult but long-overdue focus on the benefits New York needs, and a decision in a few short months on a benchmark option. Generally, all of the plans provide comprehensive benefits that, despite their differences, fall within a fairly narrow range in terms of their actuarial value. Although federal guidance is incomplete and there are limitations to a plan-by-plan analysis under the current means of describing benefits, some useful observations can be made.

The Federal Employee Health Benefits Program (FEHBP) options have many attractive features, including superior wellness benefits. But these options do not cover the universe of New York mandated benefits, they cover some benefits typically not provided in New York to individuals or groups, and they restrict coverage of pregnancy terminations to cases of rape, incest, and threat to the life of the mother. This exclusion is particularly problematic in New

York, with its long tradition of providing access to a full range of reproductive health services to women.

The New York small group plans are very similar, and the choice of any of these options, which represent almost a third of total small group enrollment, would limit the disruption in this market and avert premium increases due to enhanced benefits. But these plans do not fully cover all mandated benefits for individuals, although New York would appear to have the option of aligning individual and small group benefits more closely. Another important concern with this benchmark category is that, since outpatient drug benefits are delivered through riders, it is difficult to describe all of the benefits in this group with certainty. The choice of any of the small group plans would seem to require supplementing this option with the drug benefit from another benchmark plan, which would require a more detailed analysis.

In terms of the New York State Health Insurance Program (NYSHIP) plans, choosing either of the two HMO plans (or the HIP option from the fourth category) would provide a close facsimile to typical small group coverage, with added mental health and substance abuse coverage, but would involve many of the same limitations as choosing the small group plans. The NYSHIP HMOs offer more complete coverage for New York individual benefit mandates than the small group plans, but not complete coverage. And their reliance on riders to deliver drug benefits means some uncertainty on what is actually covered, and a supplement from another benchmark plan drug benefit.

The NYSHIP Empire Plan has a structure that would be difficult to duplicate, and a richer benefit package than a typical small group plan, though some of the differences might be smoothed out if health plans are ultimately granted some discretion to vary benefits. But it has some advantages over the other benchmark options. With over one million enrollees, the Empire Plan alone among the benchmark

options meets all the benefit requirements for individual and small group coverage. And because prescription drug benefits are included in the plan, it is the most certain option in terms of benefits. As New York grapples with important discretionary decisions on the future of existing public programs and commercial market subsidies, the types of plans that will be available

in the exchange, and a host of other issues regarding ACA implementation, the choice of the Empire Plan as New York's benchmark option during a two-year transition period offers less uncertainty and could be a useful bridge to a 2016 benefit environment that may be characterized by a more evidence-based structure and greater sensitivity to costs.

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Introduction

The year 2011 was a tumultuous one for the implementation of the Affordable Care Act (ACA). As the U.S. Department of Health and Human Services (HHS) rolled out major regulations and funding initiatives at a steady clip, opponents sought the law's repeal in Congress, and cases challenging the constitutionality of the measure worked their way through federal courts. As the year drew to a close, few developments were as eagerly awaited as a decision by the Secretary of HHS on just what health services would make up the "essential health benefits" package required to be included in all individual and small business policies beginning in 2014.

A number of events helped set the stage for and inform the Secretary's decision. The U.S. Department of Labor (DOL) published a required advisory report in April 2011, analyzing past reports and plan documents describing benefits.¹ Tellingly, the design for the benefit study evaluated employer groups' benefits based on three categories: "with coverage," "without coverage," and "not mentioned," the last category a harbinger of the difficulty of pinning down the details of benefit offerings. A more ambitious consensus report issued by the Institute of Medicine (IOM) in October 2011 fully engaged on the many complex issues, recommending that a small group plan, upgraded to meet statutory requirements included in the ACA, be the basis for the new standard, with costs restrained through the use of a national premium threshold.² Recognizing the tremendous variability in benefits among states and a gap between benefits and an evidence base for many services, the report suggested the possibility that states might use waiver provisions in the ACA to

establish their own version of essential benefits and participate in a national effort to reshape a high-value benefit package.

With the publication of the IOM report, the expectation was that the Secretary would publish a detailed schedule of benefits based on the ten categories of services outlined in the ACA, and then consumers, businesses, health plans, and providers would sort through the implications on the cost and quality of coverage, weighing in via the federal rulemaking process to seek adjustments. State policymakers, mindful of a provision requiring states to defray the cost of mandated benefits not included on the federal list,³ waited with special interest: the Secretary's definition of EHBs would require some states either to find resources during lean times to offset the costs of state-mandated benefits not included in the essential health benefits package, or to repeal the conflicting requirements, alienating supporters who had fought to enact the laws in the first place, often after long and emotional campaigns. But on December 16, 2011, the HHS Secretary threw the health care world a curveball, signaling the department's intention to push the decision back on to states for a two-year transition period. Taking a leaf out of its own book, HHS issued a bulletin announcing its intention to pursue regulations under which states themselves would establish the bulk of their essential benefits by selecting from a designated menu of popular benefit packages covering federal and state public employees and small groups.⁴ This "reference plan" approach, used to guide state benefit decisions for the State Children's Health Insurance Program (CHIP) in 1997⁵ would establish the core of each state's essential

¹ U.S. Department of Labor. April 15, 2011. *Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services*. Available at <http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf> (accessed May 8, 2012).

² Ulmer C, J Ball, E McGlynn, and S Bel Hamdaunia, Editors; Committee on Defining and Revising an Essential Health Benefits Package for Qualified Health Plans; Institute of Medicine. October 2011. *Essential Health Benefits: Balancing Coverage and Cost*. Washington, D.C.: National Academies Press. Available at <http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx> (accessed May 8, 2012).

³ Affordable Care Act, Section 1311(d)(3).

⁴ Center for Consumer Information and Insurance Oversight, U.S. Department of Health and Human Services. December 16, 2011. *Essential Health Benefits Bulletin*. Available at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf (accessed May 8, 2012).

⁵ U.S. Code Section 42 CFR 457.410 and 457.420.

benefit package, which would be fine-tuned in several ways. The approach described in the bulletin, for example, would then require states to supplement benefits in areas that do not measure up to coverage required in the ten ACA categories, and also give health plans some flexibility to craft benefit packages which vary from the benchmark standards and supplements as long as certain tests are met.

While HHS is careful to describe its new course on essential health benefits as a work in progress, it has indicated its intention to issue a formal regulation. Preliminary guidance indicates that states opting to select a benchmark plan (states that do not will be assigned one by HHS, likely the largest small group plan) will be required to do so by September 2012.⁶ Still-evolving federal guidance, incomplete enrollment data, and questions of scope and interpretation all hamper a detailed analysis of the options available at this point for New York. In this report we examine health benefit plans that are the likely options, or at least proxies, for a New York benchmark, discuss the potential policy implications of the various choices based on a review of the benefits in these plans and current New York mandates, and highlight areas requiring further study and interpretation. Developing this analysis requires keeping a number of balls in the air at once: ACA requirements and subsequent regulatory guidance; consideration of the federal benchmark options based on New York enrollment; analysis of the benefits provided under the various benchmark options; and a review of New York's statutory and regulatory requirements related to benefits, as well as consumer protection rules. We begin with the federal standards.

The ACA and Federal Guidance

The ACA requires the Secretary to define the essential benefits⁷ to be offered in fully insured individual and small group coverage both within and outside the Exchange (except for “grandfathered” and self-funded plans) beginning in 2014, and mandates that ten general categories be included, along with “the items and services covered within the categories.”⁸ Additional guidance, reflecting the unresolved tensions in the ACA, requires the Secretary to “ensure that the scope of the essential health benefits is equal to the scope of benefits under a typical employer plan,”⁹ but also lists several other “required elements for consideration,” including “the health care needs of diverse segments of the population, including women, children, persons with disabilities and other groups,” and avoiding benefit designs that “discriminate against individuals because of their age, disability or expected length of life.” Taken together, this guidance presents the Secretary with a formidable task: defining a benefit package that meets the needs of children, women, both small and large employers, both healthy and gravely ill individuals, and disabled individuals. But at the core of EHBs are the ten required categories of coverage:¹⁰

- (A) Ambulatory patient services.
- (B) Emergency services.
- (C) Hospitalization.
- (D) Maternity and newborn care.
- (E) Mental health and substance use disorders services, including behavioral health treatment.
- (F) Prescription drugs.
- (G) Rehabilitative and habilitative services and devices.
- (H) Laboratory services.
- (I) Preventive and wellness services and chronic disease management.
- (J) Pediatric services, including oral and vision care.

⁶ *Bulletin* [see note 4], p. 9.

⁷ Affordable Care Act, Section 1302(b).

⁸ Affordable Care Act, Section 1302(b)(1).

⁹ Affordable Care Act, Section 1301(b)(2)(A).

¹⁰ Affordable Care Act, Section 1302(b)(1).

The HHS Approach to Essential Health Benefits

Four Benchmark Plan Types

In its December 2011 bulletin, HHS proposed a multifaceted approach beginning with “a benchmark plan selected by each State ... [which] would serve as a reference plan, reflecting both the scope of services and any limits offered by a ‘typical employer plan’ in that State.”¹¹ In choosing their benchmark plan, states must pick one benchmark from among four categories of plans, which HHS considers to “best reflect the statutory standards for EHB” in the ACA:

- “(1) The largest *plan* [emphasis added] by enrollment in any of the three largest small group insurance products in the State’s small group market;
- (2) Any of the largest three State employee health benefit plans by enrollment;
- (3) Any of the largest three national FEHBP plan options by enrollment; or
- (4) The largest insured, commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state.”¹²

Under the proposal, enrollment data for the first quarter of the year two years prior to the coverage year will determine the specific benchmark options. In other words, the essential health benefits for coverage beginning January 1, 2014 will be based on enrollment reported to HHS at the end of March 2012, and HHS states its intent to “assess the benchmark process for the year 2016 and beyond based on evaluation and feedback.”¹³

HHS supplemented the bulletin in January 2012 by releasing an “illustrative list” of the

three largest national FEHBP options by enrollment as well as the three largest small group “products” in each state, according to data it collects at HealthCare.gov, based on enrollment as of June 30, 2011.¹⁴ The agency notes that it is “still collecting and reviewing public comment on the EHB bulletin and will subsequently release regulations,” and, importantly, will also release enrollment information on “each specific combination of benefits and cost sharing that make up a *plan*” [emphasis added], information that it does not currently collect.¹⁵

Products and Plans

Improved data collection will be critical to solidifying state choices for homegrown benchmark options, given the important distinction that HHS makes regarding the difference between “products” and “plans” and its ongoing efforts to define the terms. The December 2011 bulletin cites the following distinction from HealthCare.gov: “products’ [are] the services covered as a package by an issuer, which may have several cost-sharing options and riders as options. A ‘plan’ refers to the specific benefits and cost sharing provisions available to an enrolled consumer. For example, multiple plans with different cost-sharing structures and rider options may derive from a single product.”¹⁶ The January *Illustrative List* notes that “while product information is collected, enrollment information on each specific combination of benefits and cost sharing that make up a plan is not collected for display on HealthCare.gov. In the future, HHS intends to provide this additional information on actual

¹¹ *Bulletin* [see note 4], p. 8.

¹² *Bulletin* [see note 4], p. 9.

¹³ *Bulletin* [see note 4], p. 9.

¹⁴ Center for Consumer Information and Insurance Oversight, U.S. Department of Health and Human Services. January 25, 2012. *Essential Health Benefits: Illustrative List of the Largest Three Small Group Products by State*. Available at http://ccio.cms.gov/resources/files/Files2/01272012/top_three_plans_by_enrollment_508_20120125.pdf (accessed May 8, 2012).

¹⁵ *Illustrative List* [see note 14], p. 2.

¹⁶ *Bulletin* [see note 4], p. 9, note 26.

benchmark options.”¹⁷ But in a Frequently Asked Questions (FAQ) document released February 2012,¹⁸ the agency refines the distinction, describing a product as “a package of benefits an issuer offers that is reported to State regulators in an insurance filing. Generally, this filing describes a set of benefits and often a provider network, but does not describe the manner in which benefits may be tailored, such as through the addition of riders. For the purposes of identifying the benchmark plan, we identify the plan as the benefits covered by the product *excluding all riders*” [emphasis added].

The fundamental question of just what constitutes a plan for the purposes of a benchmark rule is a particularly important factor to New York—where, for example, a prescription drug benefit is not mandated for groups, and is nearly always arranged by selecting from a number of possible drug benefits and purchasing the corresponding rider. Visit limitations for various services are also often selected through riders.

State Supplements and Defaults

Once a benchmark option is selected, the second key step for states in building an essential health benefit package under the HHS proposal is to supplement the plan so all the requirements of the ACA categories are satisfied. The services in the categories are not defined and depart at times from how commercial health coverage is described, organized, and delivered today. While five of the categories are relatively straightforward—ambulatory services, emergency services, hospitalization, maternity and newborn care, and laboratory services—we have noted potential interpretive issues with a sixth, prescription drugs. The four remaining

categories will likely require supplementing or more complete guidance.

Mental Health and Substance Abuse Disorders. Differences in requirements applying to small group and large group plans with respect to mental health and substance abuse disorders, discussed below, lend some uncertainty to the benefits that will be required, as does the use of the term “behavioral health treatment,” which could be considered either a general term describing the mental health services or one describing particular modes of treatment.

Rehabilitative and Habilitative Services and Devices. Rehabilitative services such as physical and occupational therapy and speech language pathology are common in both public and commercial coverage, and occur in a range of settings. Under typical contract terms, these services are aimed at helping patients restore or maintain skills impaired through an accident or illness. Habilitative services, often specifically excluded from commercial health coverage but required as essential health benefits, are aimed at helping people with disabilities, often children, acquire or improve skills. Despite this different goal, the therapeutic services patients receive through habilitative and rehabilitative care are often very similar, though habilitative care might also cover speech-generating devices, for example.

Preventive and Wellness Services and Chronic Disease Management. ACA provisions applying to individual and group plans¹⁹ set a new floor for preventive services, tied to periodic updates of evidence-based lists

¹⁷ *Illustrative List* [see note 14], p. 2.

¹⁸ Center for Consumer Information and Insurance Oversight, U.S. Department of Health and Human Services. February 17, 2012. *Frequently Asked Questions on Essential Health Bulletin*. Available at <http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf> (accessed May 8, 2012).

¹⁹ Affordable Care Act, Section 2713.

promulgated by the U.S. Preventive Services Task Force.²⁰ New York mandated the provision of these services in all policies in legislation adopted in 2011.²¹ Beyond these preventive health measures, it is not clear what wellness and chronic disease management services will be expected. Health plans often provide all members with access to wellness services such as classes, nurse hotlines, web-based literature, discounts, and health evaluation tools, but not necessarily as specific benefits covered under individual policies. Diabetes care management is a required benefit under New York law, and some plans manage services for other treatments and diseases, direct patients to specific providers, or employ a higher level of utilization management. We note some of the different ways the benchmark plans cover benefits below.

Pediatric Services, Including Oral and Vision Care. New York health plans cover a full range of pediatric services under the state's longstanding "well-baby" mandate, but coverage of other than routine preventive oral and vision care coverage is not required, and it is comparatively rare for adults and children unless it is linked to a disease or accident requiring medical attention covered under the policy. When dental and vision services are provided, they are typically offered in separate coverage by an employer group, with the employee paying a portion of or even the full cost of the coverage. ACA provisions requiring stand-alone dental policies to be offered through the exchange and coordinated with EHB coverage add another layer of complexity to how this category will be administered.²²

Fully aware of the inconsistencies between ACA statutory requirements and the state benchmarks, HHS highlighted benefit categories likely in need of attention—pediatric oral and vision services, mental health benefits, and habilitative services—and proposed a process for states to supplement these categories, establishing hierarchical "defaults" to guide those decisions.²³ In short, the process involves "cutting and pasting" the coverage from a category of benefits from a benchmark plan that was not selected into the one that was, in order to shore up inadequate coverage in that category.

For most benefit categories, states may simply choose the missing benefits from another benchmark plan, although special rules apply to states that opt not to select their own benchmark option. Some categories of benefits, those likely to be lacking because of the structure of commercial benefits, have special rules; for habilitative care, the proposed default is either the health plan benefit for rehabilitation services, or the coverage determined by the health plan and reviewed by HHS. For pediatric oral services, the default is either the largest Federal Employee Dental and Vision Insurance Program (FEDVIP) benefitor the state's CHIP benefit. For pediatric vision services, the default is the FEDVIP benefit. Compared to other elements of the bulletin, the supplementing process seems the area most likely to be revised in future guidance, as HHS indicates its ongoing consideration of other options.

Health Plan Flexibility

After the choice of a single benchmark option and determining necessary supplements, a third

²⁰ Available at <http://www.uspreventiveservicestaskforce.org/uspstf/uspabrecs.htm>; *Women's Preventive Services: Required Health Plan Coverage Guidelines Supported by the Health Resources and Services Administration*. Available at <http://www.hrsa.gov/womensguidelines/> (both accessed May 8, 2012).

²¹ Chapter 219 of the Laws of New York, 2011.

²² Affordable Care Act, Section 1311(d)(2).

²³ *Bulletin* [see note 4], p. 10.

component in the shaping of essential health benefits is HHS's proposal to allow health plans to provide coverage that is "substantially equal" to the benchmark plan selected and modified to comply with the ACA categories.²⁴ In its bulletin, HHS noted that a similar standard is in effect for health plans offering CHIP, and that it was considering allowing health plans to make adjustments both to specific services covered and to quantitative limits, and that these substitutions might be permitted to occur both within a particular category of service and across categories. If it establishes such flexibility, HHS intends to require that any substitutions are "actuarially equivalent," a standard also in place for CHIP,²⁵ which means generally that the value to the consumer of the original EHB package will be the same as under an alternative plan, whether measured by the dollars each plan would pay out, or the consumer's share of costs. One example cited by HHS involves substituting a benefit plan with 20 physical therapy visits and 10 occupational therapy visits, for a plan

allowing the reverse—20 occupational therapy visits and 10 physical therapy visits, so long as the plans are actuarially equivalent.

If the proposed process for the substitution of benefits seems discordant with the overall effort to create a uniform benefit package mirroring the ACA's ten-category plan, another factor could also lead to more uncertainties in state planning and essential health benefits. The HHS FAQ discusses the ACA's prohibitions on annual and lifetime limits on essential health benefits and their relation to defining EHBs.²⁶ Generally, ACA requirements eliminate annual or lifetime dollar limits on EHBs over a phased-in period. HHS interprets this requirement to mean that all benchmark plans with benefits tied to dollar limits would need to be revamped to eliminate the dollar caps, but health plans could achieve a similar purpose by "scope and duration limitations" or other "non-dollar" limits, so long as they do not violate antidiscrimination provisions and meet actuarial equivalence tests (and, perhaps, other criteria to be determined).

Potential Benchmark Plans for New York

Applying the benchmark options contained in the HHS bulletin to New York involves some uncertainty, both because data for the first quarter of 2012 are not yet available, and because it is not yet clear how the preliminary federal rules will ultimately play out. Based on the federal guidance and 2011 enrollment reported to the New York State Department of Financial Services (DFS),²⁷ however, we reviewed ten possible benchmark options for New York. Table 1 shows the options for New York, at this stage, and includes enrollment and premium figures for each possibility, based on recent data. The data available was insufficient to provide perfect "apples to apples" comparisons, but it gives a fair idea of the

prevalence of various benchmarks and premium costs.

Largest Small Group Plans

New York's largest three small group plans are offered by Oxford Health Plans (OHP) and Oxford Health Insurance Company (OHIC), both UnitedHealthcare subsidiaries, and by Empire BCBS, a subsidiary of Indianapolis-based Anthem Blue Cross Blue Shield; Oxford is by far the largest small group insurer in New York, with its enrollment concentrated in New York City and the lower Hudson Valley. Oxford's Exclusive Plan EPO is written through this accident and health insurer license, and the Liberty HMO through its Article 44 HMO. The

²⁴ *Bulletin* [see note 4], p. 2.

²⁵ U.S. Code 42 CFR 457.431.

²⁶ *HHS FAQ* [see note 18], questions 8 and 9.

²⁷ Health Insurance Data Exhibit (HIDE) for third quarter 2011, personal communication with New York State Department of Financial Services.

Table 1. New York Benchmark Options

Plan	New York Enrollment	Monthly Premium	Tier
Empire BCBS EPO	141,679 ^A	\$579.22 ^B \$1,157.28 \$1,041.67 \$1,735.34	Single Couple Parent/children Family
Oxford Health Insurance Company Metro EPO	164,829 ^A	\$613.98 ^C \$1,350.76 \$1,139.72 \$1,909.12	Single Couple Parent/children Family
Oxford Health Plans HMO	125,527 ^A	\$468.11 ^D \$1,029.85 \$869.57 \$1,457.13	Single Couple Parent/children Family
NYSHIP Empire Plan	662,172 ^E	\$597.55 ^F \$1,400.42	Single Family
NYSHIP CDPHP HMO	38,967 ^E	\$515.04 ^F \$1,263.84	Single Family
NYSHIP IHA HMO	23,139 ^E	\$592.21 ^F \$1,244.46	Single Family
FEHBP BCBSA Basic	52,034 ^G	\$487.54 ^H \$1,141.70	Single Family
FEHBP BCBSA Standard	81,826 ^G	\$587.88 ^H \$1,327.80	Single Family
FEHBP GEHA Standard	4,467 ^G	\$370.89 ^I \$843.46	Single Family
HIP Prime HMO	225,900 ^J	\$522.99 ^K \$1,288.08 \$647.34 ^L \$1,586.73	Single Family Single, w/rider Family, w/rider

Note: As is customary for public employee plans, premiums for state and federal public employees represent only two rating tiers, individual and family coverage. Commercial insurers typically offer coverage in two-, three-, and four-tier options; the last is shown here.

^A New York State DFS response to United Hospital Fund FOIL Request. January 10, 2012. Health insurance data exhibit, 3Q11.

^B Personal communication, Empire BCBS representative. March 4, 2012. Rates for Manhattan, Queens, Nassau, and Suffolk as of December 2011. Includes drug coverage.

^C Personal communication with OHP of NY representative. February 1, 2012. Rate based on effective date of March 1, 2012, business located in ZIP code 10016. Includes drug coverage.

^D Personal communication with OHIC of NY representative. February 1, 2012. Rate based on effective date of March 1, 2012, business located in ZIP code 10016. Includes drug coverage.

^E New York State Department of Civil Service response to United Hospital Fund FOIL Request. February 16, 2012. Active employees, dependent survivors, retirees, and vestees as of December 2, 2011 in all benefit programs, for state agencies and participating employees; participating agencies (local governments) not included.

^F New York State Department of Civil Service response to United Hospital Fund FOIL Request. February 16, 2012. Monthly COBRA premium, less 2% allowable administrative charge.

^G Personal communication with U.S. Office of Personnel Management. January 23, 2012.

^H U.S. Office of Personnel Management, Non-Postal Monthly Rates, 2012. Available at <http://www.opm.gov/insure/health/planinfo/2012/brochures/71-005.pdf#page=159>.

^I U.S. Office of Personnel Management. Non-Postal Monthly Rates, 2012. Available at <http://www.opm.gov/insure/health/planinfo/2012/brochures/71-006.pdf#page=123>.

^J Personal Communication with NYC Office of Labor Relations. April 18, 2012.

^K NYC Office of Labor Relations, 2012 monthly COBRA premium, less 2% allowable administrative charge. Available online at <http://www.nyc.gov/html/olr/downloads/pdf/healthb/cobra.pdf>.

^L Premium rate includes cost of optional rider for prescription drugs and appliances.

two plans have only minor differences in benefits: the OHIC EPO plan uses Oxford's somewhat broader Freedom network while its Liberty network serves HMO enrollees; there are also slightly different enrollee access provisions between the two plans because of New York consumer protections that apply differently to network-based products issued by commercial insurers and HMOs, an issue discussed below. Rounding out the small group options is Empire's Prism EPO plan, which, ironically, the company announced it would phase out beginning on April 1, 2012.

New York State Public Employee Plans

The New York State Health Insurance Program (NYSHIP), administered by the Department of Civil Service, counts more than 1.1 million enrollees, with about two-thirds of that total representing active and retired employees of state agencies and public authorities and their dependents, and the remainder active and retired employees of local governments that can opt to join the program. State employees can choose from the statewide Empire Plan or several HMOs offering coverage in specified regions. While HMOs are a popular choice upstate, the Empire Plan accounts for more than 80 percent of the total contracts covering state workers. The NYSHIP HMO options are very similar to a typical HMO policy offered to a large group in New York, but the Empire Plan also offers a number of unique features.

First, two insurers—Empire BCBS and UnitedHealthcare—deliver benefits to enrollees, with Empire administering hospital-related benefits, and United underwriting outpatient care, prescription drugs, and mental health and substance abuse services. Second, Empire Plan benefits are subject to collective bargaining agreements the state negotiates with a number of bargaining units, and there are minor benefit

differences between these bargaining units; lower-salaried workers within bargaining units are often subject to reduced cost-sharing. Third, through a change in its enabling statute in 2010,²⁸ Empire Plan administrators can opt to self-fund the program, but they are still subject to all state benefit mandates and consumer protections that apply to fully insured plans. Fourth, the Empire Plan's Participating Provider Organization (PPO) structure means enrollees can choose either in-network or out-of-network providers for covered services. In-network providers, who are part of the Empire Plan network, accept the fee schedule, and members who choose out-of-network care receive reimbursement up to an amount deemed usual, customary, and reasonable (UCR). Members choosing to receive services from non-participating providers who do participate in a second Empire Plan network organized by MultiPlan are also eligible for a discounted out-of-network rate; this "double out-of-network" benefit is very unusual.

Because of variances among benefits of the various bargaining groups covered under the Empire Plan, there are two alternatives for this State public employee benchmark option. If the 32 separate "benefit programs" covering the different collective bargaining units are viewed as separate plans, then the three most popular of these programs—Civil Service Employee Association (87,219 covered lives), Public Employee Federation (83,727 covered lives), and New York State Corrections Officers and Police Benevolent Association (49,831 covered lives)—would represent the three possible benchmarks. If the Empire Plan is viewed as a single plan despite the benefit differences, then it and the two largest HMOs in terms of enrollment—Capital District Physicians Health Plan (CDPHP) and Buffalo-based Independent Health Association (IHA)—would represent the three options. We have assumed the latter

²⁸ Chapter 56 of the Laws of New York, 2010.

interpretation, following the common view and statutory description of the Empire Plan as a single plan, its joint administration by the two insurers, and the minor differences in benefits, some due only to cost-sharing features.²⁹

Federal Employee Health Benefits Program Options

Managed by the federal Office of Personnel Management (OPM), the FEHBP was created in 1960 and covers over 8 million federal workers, including over 300,000 New Yorkers. HHS guidance simplified the choices of benchmark options available under FEHB by limiting the menu to the three largest national plans, rather than regional coverage offered in states by many plans, which is popular in New York. Of these three, two with nearly identical benefits—the BCBSA Standard and Basic options—are administered by the Blue Cross and Blue Shield Association, the national trade association for 38 Blue Cross Blue Shield plans. While covered services are “identical” according to HHS, the Standard plan provides out-of-network reimbursement. In New York, the plans are managed by Empire BCBS, Excellus BCBS, and HealthNow BCBS within their respective service areas, though two of the three plans also offer HMO coverage to federal employees.

The third federal option is the Government Employees Health Association (GEHA) Standard plan. GEHA, the second largest national plan and the administrator of the federal high-risk pools for states, describes the plan in its member handbook as a “fee-for-service ... health plan with a preferred provider organization.” In New York, members access services through a network of providers arranged by benefits consultant MagnaCare.

Like NYSHIP, the FEHBP has some unique

features because of its status as an insurer of public employees across the U.S. and around the world. Most federal employees do not have collective bargaining rights over wages and benefits, and, of particular note, the program is exempt from all state benefit mandates.³⁰ Instead, benefits are established year to year, in response to requests for proposals or “call letters” promulgated by the Office of Personnel Management.

Largest New York State HMO

The fourth benchmark category is the least defined, and the only one not to explicitly mention either “products” or “plans.” Though the selection is more open to interpretation, the most likely candidate for this option is the Health Insurance Plan of Greater New York (HIP), affiliated with GHI to form EmblemHealth. HIP is the largest non-Medicaid HMO in New York, with nearly 540,000 enrollees in 2010, excluding Medicaid enrollment.³¹ A product known as HIP Prime accounts for the bulk of HIP’s commercial membership, most of it representing workers, retirees, and dependents covered under the New York City Health Benefit Program, and administered by the city’s Office of Labor Relations (OLR). As in the FEHBP and NYSHIP programs, city workers can choose from a number of plans, and the HIP Prime product was the second largest, accounting for over 225,000 employees, retirees, and dependents in 2011.³² A rider must be purchased, however, to obtain drug and other benefits, and overall, the HIP Prime plan is governed by New York’s rules for large-group, community-rated HMO coverage, the same as the HMO products offered to state public employees through NYSHIP.

²⁹ Empire Plan and NYSHIP HMO enrollment data obtained through Freedom of Information Law Requests to the Department of Civil Service, and received on February 3, and February 16, 2012, and represent enrollment as of December 2, 2011.

³⁰ United States Code, Title 5, Chapter 89, section 8902(m).

³¹ UHF analysis of NAIC Annual Statement for the calendar year 2010, Health Insurance Plan of Greater New York.

³² Personal communication with New York City Office of Labor Relations, April 17, 2012.

Comparing the Benefits of the Benchmark Options

Before turning to an analysis of how each of these plans stacks up as a potential benchmark option for New York, it is important to discuss two key elements: New York’s statutory and regulatory provisions regarding mandated benefits, and the sources and methodology we used to evaluate the benefits covered in the various benchmark offerings.

Navigating state and federal mandated benefit requirements (See Appendix for details) is complex. New York State statutory benefit requirements go back decades and are imprinted with the benefit designs prevalent in the early 1970s: basic hospital coverage offered by Blue Cross plans; basic medical (outpatient) coverage offered by Blue Shield plans; and “major medical” coverage offered by the Blues and life insurers combining coverage for both types of services. New York’s benefit mandates for individuals and groups are contained in separate parts of the Insurance Law according to the type of the insurer offering the benefits—commercial insurers in one part, nonprofit plans and HMOs in another—and they often apply on the basis of other underlying benefits in place. If hospital coverage is offered, for example (it is not required under New York law), the plan must provide home care and inpatient prescription drugs. If outpatient prescription drug coverage is offered (also not required), it triggers a number of other benefit requirements, including off-label cancer drugs, bone mineral density tests for osteoporosis, contraceptive drugs and devices, enhanced infertility service coverage, and special dietary supplements for individuals with metabolic disorders.

A second and more recent set of mandates established benefit requirements for individuals enrolled in HMOs. New York’s 1995 Point of Service Law³³ mandated that all HMOs licensed in the state offer two standardized HMO products to individuals, and that these two

products contain a list of mandated benefits—a modernization of benefit requirements, if you will, but one based on a comprehensive Empire BCBS indemnity product that was being discontinued at the time. Benefits required for these products at times exceed requirements for individual and group coverage in the core statutory provisions, and the core requirements include some mandates not required in the standardized direct pay products. While it might be considered a case of the tail wagging the dog—fewer than 20,000 people are enrolled in the standardized HMO products, compared to more than 1.6 million small group members³⁴—we assumed that the universe of New York mandated benefits includes all required coverage provisions from both categories.

To identify the benefits provided through the benchmark options, we reviewed a wide variety of documents associated with each option, including detailed certificates of coverage. First, the certificates are not organized uniformly, and do not track the ten categories of benefits in the ACA, or even include benefits in each category, as we noted earlier. Second, the certificates prepared by different health plans use different terms to describe benefits. For example, one health plan might provide an aggregate limit on “short-term rehabilitation” that includes a number of covered services; a second plan might list limitations on physical therapy, occupational therapy, and speech therapy, with a separate limitation on home care visits; and a third might specify coverage for “respiratory therapy” or “cardiac therapy.”

Benefits are also described in certificates both in terms of what is covered and what is excluded. One health plan might list services covered *if* certain conditions are met, and later on exclude the same services *unless* the conditions are met. Above all, as the federal DOL report notes, just because a certain service

³³ Chapter 504 of the Laws of New York, 1995.

³⁴ Individual enrollment estimated based on personal communication with the New York State Department of Financial Service on January 4, 2012, representing enrollment on June 30, 2011; small group enrollment from HIDE Exhibit, as of third quarter of 2011.

is not described in plan documents, it does not mean it is not covered under a policy. For example, some plan documents specified coverage for allergy testing and treatment, and some did not, but these services might well be covered under general descriptions for outpatient care, laboratory tests, and prescription drugs. While some health plans include provisos in their certificates stating that unless services are specifically enumerated, they are not covered, it is also possible to view the exclusions as more important to coverage, taking the view that all services not excluded are covered if they meet medical necessity criteria and other conditions for coverage. Despite these difficulties, the certificates were the primary source for this benefit analysis.

In order to get a handle on the bottom-line policy options for New York, we first compared each of the benchmark options within each of the four categories to a baseline representing the universe of New York benefit requirements, a step that is important in gauging the exposure to New York in terms of defraying the cost of mandated benefits not included in the reference plan. Next, we compared each of the benchmark options in a category to the others in that category, highlighting benefits that are atypical in terms of New York requirements. This analysis was somewhat selective, and it does not represent an exhaustive comparison of all benefits of all benchmarks and all state benefit mandates. We then reviewed the options in light of the implications of federal guidance, and highlighted miscellaneous but relevant issues, some of which depend on additional federal guidance or are related to unique components of New York's regulatory framework.

Largest Small Group Plans

Selecting a benchmark from among a series of high-enrollment New York small group plans is

an attractive option, because the choice locks in the benefits that cover more than 1.6 million small group plan members, minimizing the disruption in the market and the potential for premium increases due to additional benefits present in other benchmark options. But the choice is not as straightforward as it might seem. First, none of the small group benchmark options covers all required individual *and* small group mandated benefits, raising the possibility of state defrayal costs. Second, though Empire and Oxford offer prescription drug coverage for the three plans (in 2010, the companies paid out more than \$650 million in pharmacy claims for their small group customers in all products³⁵), the coverage is provided through a rider that, under the preliminary HHS guidance, would not be included in the benchmark. Under HHS proposed rules, a drug benefit from another benchmark plan would have to be selected. Because the drug benefit is purchased through a rider and so many New York benefit mandates are contingent on underlying prescription drug coverage, an important question arises: would those benefits be included in the benchmark package despite the absence of prescription drug coverage?

Additional complexity arises from the mental health and substance abuse service benefits provided by these small group plans. The federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prohibits health plans that offer these benefits from limiting them through financial requirements or visit limitations that differ from limits applied to benefits for enrollees' physical ailments, but it exempts companies with 50 or fewer employees.³⁶ New York requirements, modified by "Timothy's Law," require similar coverage of mental health and substance abuse services, but exempt employer groups of 50 and fewer from broader coverage requirements for biologically-based mental illness and for children with serious emotional

³⁵ UHF analysis of NAIC Supplemental Health Care Exhibit—Part I, submitted by Oxford and Empire companies as an exhibit to their 2010 Annual Statements.

³⁶ Public Law 110-343, Title V, Subtitle B, section 512.

Table 2. New York Mandated Benefits and New York Small Group Benchmark Options

New York Benefit Mandate	OHP HMO	OHIC Metro EPO	Empire BCBS Prism EPO
Prescription Drugs: In Policy	Rider available	Rider available	Rider available
Private Duty Nursing: \$5,000 Annual/\$10,000 Lifetime	No coverage	No coverage	No coverage
Skilled Nursing Facility: Unlimited	200 days	200 days	60 days
Inpatient Rehabilitation: Unlimited	60 consecutive days per condition/lifetime	60 consecutive days per condition/lifetime	30 days
Outpatient Rehabilitation: 90 Visits per Condition per Year	60 visits per condition/lifetime	60 visits per condition/lifetime	30 visits cardiac rehab 30 visits PT 30 visits OT/ST/VT combined
Home Health Care: 200 visits	40 visits	40 visits	60 visits
Durable Medical Equipment: Unlimited	\$1,500 annual limit combined with supplies	\$1,500 annual limit combined with supplies	Covered 50% coinsurance
Medical Supplies: Unlimited	See above	See above	Covered
Prosthetics: Unlimited	Covered One per lifetime for adults	Covered One per lifetime for adults	Covered 50% coinsurance
Orthotics: Unlimited	No coverage	No coverage	Covered 50% coinsurance

OT: Occupational therapy. PT: Physical therapy. ST: Speech therapy. VT: Vision therapy.

Table 3. New York Small Group Benchmark Plan Benefit Differences

Benefit	OHP HMO	OHIC Metro EPO	Empire BCBS Prism EPO
Hearing Aid	One per 3 years; \$1,500 max	One per 3 years; \$1,500 max	No coverage
Wellness/Care Management	Gym rebate \$200/six months Utilization management program ^A	Gym rebate \$200/six months Utilization management program ^A	Gym rebate \$400 annual Medical case management program ^B Case management ^C

^A Utilization management programs include disease management and complex case management services for HIV, transplants, asthma, diabetes, heart disease, and rare chronic conditions.

^B Program includes benefit reductions for failure to preauthorize services when required.

^C Case management is available for members with chronic, debilitating, or catastrophic illness or injury.

disorders.³⁷ These more expansive mental health benefits are available to small groups through a rider.

The practical effect of these laws is that three categories of benchmark options—FEHBP, NYSHIP, and largest HMO—feature essentially unlimited inpatient and outpatient mental health and substance abuse benefits, while the New York small group options offer more limited coverage. It is not clear what impact the ACA and proposed EHB guidelines will have. While HHS states in its recent FAQ that “consistent with Congressional intent, we intend to propose that the parity requirements apply in the context of EHB,”³⁸ that statement may mean full parity for all individual and small group coverage, or it may mean maintaining the current exemption under the MHPAEA for small group members.

Guidance from the U.S. Department of Labor’s Employee Benefits Security Administration in December 2010 indicates that “small employers are still exempt” from parity requirements, despite the changes in the ACA,³⁹ and a Congressional Research Service analysis⁴⁰ that also predates the EHB bulletin concluded that the specific language changes to the MHPAEA in the ACA preserve the small group exemption but extend parity requirements to individual coverage. It may be that, in selecting its benchmark option, New York will determine the level of mental health coverage small groups will receive by picking either the small group option, with the more limited benefits, or one of the three large group options, which are governed by parity requirements. But federal rulemaking, either through the EHB process or final rules for parity standards, could also resolve the issue.

Table 2 highlights some key considerations for this category of benchmark options in terms of New York’s mandated benefits. As noted earlier, none of the small-group benchmarks meets the benefit standards for prescription drugs, private duty nursing, outpatient rehabilitation, home health care, skilled nursing, durable medical equipment, orthotics, medical supplies, home care, and skilled nursing facilities, though partial coverage is offered in many instances.

In comparing these options outside the context of state-mandated benefits (see Table 3), covered services are similar, as one would expect; in the case of the two Oxford products, they are nearly identical. While the Oxford and Empire BCBS plans show some differences in rehabilitative services, it is not clear how much this reflects semantic differences, and how much would be obviated under HHS’s proposal to allow health plans to substitute benefits. The Oxford products also provide an allowance of up to \$1,500 every three years for hearing aids.

New York State Public Employee Plans

As noted earlier, this category of benchmark options includes the NYSHIP Empire Plan option, administered by Empire BCBS and UnitedHealthcare, and two popular regional HMOs, IHA and CDPHP. In terms of New York benefit mandates (Table 4), the NYSHIP HMOs exhibit the same shortcomings as New York small group benchmark plans: drug coverage is obtained through a rider (though it is a required offering under Department of Civil Service specifications), and the plans only partially cover a range of rehabilitative, home care, and other

³⁷ Chapter 748 of the Laws of New York, 2006.

³⁸ HHS FAQ [see note 18], question 13.

³⁹ U.S. Department of Labor, Employee Benefits Security Administration. December 22, 2010. *FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation*. Question 8. Available at <http://www.dol.gov/ebsa/faqs/faq-aca5.html> (accessed May 8, 2012).

⁴⁰ Sarata AK. December 28, 2011. *Mental Health Parity and the Patient Protection and Affordable Care Act of 2010*. Congressional Research Service No. R41249. Available online at <http://www.ncsl.org/documents/health/MHparity&mandates.pdf> (accessed May 8, 2012).

Table 4. New York Mandated Benefits and New York State Public Employee Benchmark Options

New York Benefit Mandate	Empire Plan	CDPHP HMO	IHA HMO
Prescription Drugs: In Policy	Covered	Rider	Rider
Private Duty Nursing: \$5,000 Annual/\$10,000 Lifetime	Covered ^A	No coverage	No coverage
Skilled Nursing Facility: Unlimited	Covered	45 days per year	45 days per year
Inpatient Rehabilitation: Unlimited	Covered	60 days per condition	45 days per year
Outpatient Rehabilitation: 90 Visits per Condition per Year	Unlimited	30 visits PT 30 visits OT 20 visits ST	20 visits PT/OT/ST combined 36 visits cardiac rehab 24 visits pulmonary rehab
Home Health Care: 200 Visits	Unlimited	Unlimited	40 visits per year
Durable Medical Equipment: Unlimited	Covered	Covered 50% coinsurance	Covered 50% coinsurance
Medical Supplies: Unlimited	Covered	Covered Home care/hospice only	Covered Home care/hospice only
Prosthetics: Unlimited	Covered	Covered 50% coinsurance	Covered 50% coinsurance
Orthotics: Unlimited	Covered	Covered 50% coinsurance	Covered 50% coinsurance

^A The Empire Plan benefit is called “skilled nursing in the home.”

OT: Occupational therapy. PT: Physical therapy. ST: Speech therapy.

Table 5. New York State Public Employee Benchmark Plan Benefit Differences

Benefit	Empire Plan	CDPHP HMO	IHA HMO
In Vitro Fertilization and Similar Reproductive Treatments	\$50,000 lifetime max	No coverage	No coverage
Diabetic Shoes	\$500 per year max	One pair per year	Covered
Prosthetic Wigs	\$1,500 lifetime max	\$400 lifetime max	No coverage
Hearing Aids	\$1,500 per aid per ear, every 4 years for adults & every 2 years for children	No coverage	Exam only
Eye Exam/Glasses	No coverage	No coverage	Covered
Wellness/Care Management	Benefits management program ^A	Voluntary case management program ^C	\$250 allowance for gym and wellness services ^E
	Centers of excellence ^B	Specialty networks ^D	Voluntary case management program ^F

^A Program includes medical case management and high-risk pregnancy program.

^B Centers of excellence benefit (including travel allowance) available for transplant and cancer patients on an optional basis, and required for infertility services.

^C Program available for members with chronic debilitating or catastrophic injury and can result in “alternative or additional care” to inpatient or surgical services.

^D Specialty networks established for some services, including bariatric surgery and organ transplantation.

^E Allowance for health and fitness club memberships at registered organizations; sport and recreational family activities; and health services, including dietary counseling, vitamins and herbs, yoga, tai chi, pilates, acupuncture, and massage therapy.

^F Voluntary case management program can result in “alternative services” furnished under an alternative treatment plan.

services required under individual coverage. In contrast, prescription drug coverage is embedded in the Empire Plan, and it arguably meets or exceeds all New York benefit mandates.

Under the Home Care Advocacy Plan, managed by UnitedHealthcare's Optum subsidiary, skilled nursing facility services, home care, skilled nursing care in the home, physical therapy, occupational therapy, and other services are based on determinations of medical necessity rather than limitations on visits. But these benefits are not the only ones that set the Empire Plan apart. Table 5 highlights differences between it and the two NYSHIP HMO options, with an eye on benefits that are not typical of small group plans. The Empire Plan offers, for example, a limited benefit for in vitro fertilization, and an optional "centers of excellence" program, at the option of the policyholder, under which covered benefits can also include travel expenses and treatment at designated specialty centers. The IHA HMO plan is the only one of the three NYSHIP options that offers coverage for eye exams and glasses.

Federal Employee Health Benefits Program Options

In a preface to the illustrative list designating the FEHBP plans, HHS notes that "covered services are the same" for the Basic and Standard BCBSA plans,⁴¹ though there are a few minor differences in benefits in addition to the richer out-of-network benefits for the Standard plan. As one would expect from coverage exempt from all state-mandated benefits, selection of one of these options as a benchmark would involve the potential for the highest amount of state defrayal costs. Table 6 highlights some of the more important differences between the FEHBP plans and New York benefits, many related to home care and rehabilitative services. The most important service excluded from coverage from

the FEHBP plans, however, is elective abortion coverage.

Under restrictions imposed by federal appropriation language for the FEHBP, abortions are excluded from coverage, except in the case where the life of the mother would be in danger, or if the pregnancy is the result of rape or incest. In contrast, no such exclusion is included in the NYSHIP plans, and the HIP Prime certificate explicitly defines family planning services as including elective abortion coverage. New York law for individual and small group commercial coverage neither mandates nor excludes coverage of abortion services, but it is typically included in individual coverage and group coverage, unless an employer group requests a rider excluding coverage. Riders with this exclusion rarely if ever limit therapeutic pregnancy terminations, and exclusions of elective pregnancy terminations in group coverage are relatively infrequent.

ACA provisions do not preempt state laws regarding abortion,⁴² but they do require issuers of Qualified Health Plans available in the Exchange and covering these services to establish separate allocation accounts.⁴³ It is important to remember that EHBs govern both Exchange plans for small groups and individuals and non-Exchange plans for small groups and individuals.

Table 7 highlights some of the differences between the BCBSA and GEHA plans. The Blues offer a generally richer benefit package, and they have distinctive benefits compared to common New York market offerings. The most notable of these are the FEHBP wellness provisions, which are the most extensive of all the benchmark options, and coverage for surgical treatment of sexual dysfunction.

Largest New York State HMO

The HIP Prime benchmark option reflects its regulation as a New York State large group HMO, and the unique role it plays in the New

⁴¹ *Illustrative List* [see note 14], p. 3.

⁴² Affordable Care Act, Section 1303(c).

⁴³ Affordable Care Act, Section 1303(b)(2).

Table 6. New York Mandated Benefits and FEHBP Benchmark Options

New York Benefit Mandate	BCBS Standard and Basic	GEHA Standard
Prescription Drugs: In Policy -Enteral Formulas -Infertility Drugs	Covered Covered Covered	Covered No coverage No coverage
Private Duty Nursing: \$5,000 Annual/\$10,000 Lifetime	No coverage	No coverage
Skilled Nursing Facility: Unlimited	Limited secondary benefits (Standard) No coverage (Basic)	14 days, \$700 per day max
Inpatient Physical Rehabilitation: Unlimited	75 days PT/OT/ST combined with outpatient (Standard) 50 days PT/OT/ST combined with outpatient (Basic)	Unlimited
Outpatient Physical Rehabilitation: 90 visits per Condition per Year	See “inpatient,” above	60 visits PT/OT combined 30 visits ST
Home Health Care: 200 visits	25 visits (RN only, no coverage of home health aide services)	50 visits (RN only, no coverage of home health aide services)
Hospice Care: 210 Days	7 consecutive days max	\$15,000 per year max
Autism Treatment ^A	No coverage	Partial coverage ^B
Chiropractic Care: Unlimited	12 manipulations per year (Standard) 20 manipulations per year (Basic)	12 manipulations per year

OT: Occupational therapy. PT: Physical therapy. ST: Speech therapy.

^A New York’s treatment benefit for autism spectrum disorder includes coverage for applied behavioral analysis of up to \$45,000/yr; behavioral health treatment, psychiatric, psychological, and pharmacy care, nonrestorative therapeutic care, and assistive communication devices (New York Insurance Law, section 4303, subsection (ee)).

^B Based on personal communication with GEHA representatives on March 21, 2012, GEHA provides coverage for therapeutic behavioral services for children with autism, but overall does not meet the service requirements of the New York mandated benefit.

Table 7. Federal Employee Health Benefits Program Benchmark Plan Benefit Differences

Benefit	BCBS Standard and Basic	GEHA Standard
Basic and Preventive Dental	Covered	Covered
Mail-Order Prescription Drugs	Covered (Standard) No coverage (Basic)	Covered
Surgery for Erectile Dysfunction	Covered	No coverage
Elective Pregnancy Termination	No coverage	No coverage
Prosthetic Wigs	Up to \$350 per lifetime	No coverage
Christian Science Practitioners and Christian Science Facilities	No coverage	Covered
Acupuncture	Covered	Covered
Wellness/Care Management	Care management program ^A Health risk assessment program with incentives	Flexible benefits option ^B Maternity management program ^C Online rewards program for healthy behavior

^A The care management program includes a disease management program, case management program, and diabetes management incentive program; it is available for members with complex health care needs and provides the services of a professional case manager. The disease management program is available to help members improve self-management of diabetes, asthma, chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure and certain other rare conditions.

^B Under the flexible benefits option, GEHA may identify medically appropriate alternatives to contract benefits as a less costly alternative.

^C Program participation guarantees ongoing communication with a registered nurse throughout a pregnancy as well as complimentary educational materials.

York City Employee Health Benefits program. Next to NYSHIP's Empire Plan, HIP Prime provides the most complete coverage for mandated individual and small group health benefits (Table 8), but it delivers coverage for most prescription drugs, appliances, and equipment through a rider, a feature of the unique structure of the New York City Employee Health Benefit program.

Table 9 shows some of the differences between HIP coverage and typical individual and group coverage, including a benefit for refractive eye exams and eyeglasses, wellness programs providing a smoking cessation benefit, discounts for hearing aids, weight loss programs, and a special program for pregnant mothers.

Other Issues for Consideration

Out-of-Network Benefits. One major issue on which more clarity would be helpful is the treatment of out-of-network benefits, which are offered in three of the benchmark options (the FEHBP BCBSA Standard Plan and GEHA plan, and the NYSHIP Empire Plan). The HHS bulletin and the two subsequent pieces of guidance have been silent on this issue, although the ACA clearly contemplates the presence of products with out-of-network benefits, since it requires disclosure on this subject.⁴⁴ If a state selects a benchmark option with an out-of-network benefit, does that benefit become a part of the EHB standard that would apply to all individual and small group products? One would assume not; otherwise, in-network-only coverage could not be offered. In this scenario, the availability of plans with out-of-network benefits would depend on health plan business decisions in and out of the Exchange, or New York health insurance exchange requirements for certifying qualified health plans. Yet New York's 1995 Point of Service Law established the HMO Point of Service Plan, creating an "out-of-plan benefit

system" and "in-plan and out-of-plan covered benefits" for the express purpose of preserving provider access during an era when a major fee-for-service option for individuals was being withdrawn.⁴⁵ Certainly, in common parlance, out-of-network coverage is described and viewed as a benefit, obtained through the payment of additional premiums.

Benefits, Rights, and Protections. Just what constitutes a "benefit" is a question that falls into a gray area where ACA provisions and HHS guidance leave off, and New York statutory and regulatory provisions and benchmark option coverage features kick in. Under a more narrow view, benefits would consist only of those clinical, covered services that health plans provide. Under a broader view, benefits might be viewed as including a variety of New York consumer protections, access provisions, family coverage rules, and rights. In addition to the question of out-of-network "benefits," there are a number of other areas where clearer regulatory guidance would be useful.

New Yorkers covered under HMOs and other kinds of managed care products have a number of special protections. Enrollees can seek reimbursement for out-of-network visits if their plan's network lacks a "health care provider with appropriate training and experience" to meet their health care needs.⁴⁶ A second layer of protection is in place for new enrollees or enrollees with diseases or conditions that are life-threatening or degenerative and disabling. These provisions require managed care organizations to have procedures in place allowing enrollees to designate their specialist as their primary care physician, to easily access care through a center of excellence experienced in the treatment of the disease, to seek care or continue a course of treatment with a provider terminated from a health plan's network, and (for

⁴⁴ Affordable Care Act, Section 1311(e)(3)(A).

⁴⁵ New York Insurance Law, Section 4322(a).

⁴⁶ New York Public Health Law, Sections 4403, 6 (a) and following; see also New York Insurance Law, Section 3217-A (a)(11) and following.

Table 8. New York Mandated Benefits and HIP Prime Benchmark Option

New York Benefit Mandate	HIP Prime HMO
Prescription Drugs: In Policy	Rider available
Private Duty Nursing: \$5,000 Annual/\$10,000 Lifetime	No coverage
Inpatient Rehabilitation: Unlimited	90 days ST/OT/RT/PT combined
Outpatient Rehabilitation: Unlimited	90 visits ST/OT/PT/VT combined 32 days cardiac therapy
Durable Medical Equipment: Unlimited	Home care only
Medical Supplies: Unlimited	Home care only
Prosthetics: Unlimited	Post-mastectomy only
Orthotics: Unlimited	No coverage

OT: Occupational therapy. PT: Physical therapy. RT: Respiratory therapy. ST: Speech therapy. VT: Vision therapy.

Table 9. HIP Prime Benefit Differences

Benefit	HIP Prime Coverage
Vision	Refractory eye exam and eyeglasses
Wellness/Care Management	Healthy Beginnings prenatal care program Vision, hearing aid, weight loss program discounts

new enrollees) to continue treatment with a non-participating provider under certain circumstances. There are slight differences in these rights when plans are offered by HMOs as opposed to accident and health insurers, though New York policymakers have closed the gap somewhat over the years.

A second area in which specific coverage provisions are important is eligibility for dependents and family members, and rights to extend coverage. New York law permits but does not require health plans to provide domestic

partner coverage,⁴⁷ although the NYSHIP and HIP Prime benchmark options count domestic partners as eligible dependents. Same-sex spouses have the same rights to family coverage under policies as opposite-sex spouses in New York, even if they were married in other states.⁴⁸ COBRA-like coverage is also extended under family policies to children through age 29,⁴⁹ three years more than required under the ACA provision, and to unmarried dependent children of any age who are incapable of gainful employment because of mental illness or

⁴⁷ New York State Department of Financial Services, Office of General Counsel opinion, January 20, 2005.

⁴⁸ New York State Department of Financial Services, Office of General Counsel Opinion No. 08-11-05.

⁴⁹ Chapter 240 of the Laws of New York, 2009.

disability.⁵⁰ New York law also permits enrollees and dependents in group plans who lose eligibility for coverage to continue coverage for periods longer than are required under the federal COBRA law.⁵¹ While the FEHBP options include some similar provisions, neither domestic partners nor same-sex spouses are eligible for coverage, although ongoing litigation has resulted in OPM directing BCBSA to cover the same-sex spouse of a covered employee in California.⁵²

Our assumption is all of these New York statutory provisions applying to policies “issued or issued for delivery in this state” would apply to the EHB package, even if the FEHBP option were selected, but some of these matters have proved contentious in the past, and decisions could have some impact on federal subsidy costs.

Access to Providers. Another area worth examining in terms of potential differences

between the FEHBP options and New York benchmarks is access to providers. So-called “freedom of choice” provisions in New York’s Insurance Law⁵³ require policies covering medically necessary physician services to cover the same services when provided by a specified number of other licensed health care providers when they are practicing within their scope of practice; other provisions tied to particular benefits provide access to categories of providers. Together, these provisions spell out rules for accessing physical therapists, occupational therapists, podiatrists, dentists, speech language pathologists and audiologists, psychiatrists, certified and registered psychologists, chiropractors, clinical social workers, midwives, registered nurses, and certified home health agencies. While FEHBP contracts include similar provisions, this is another area in need of clarification and study.

⁵⁰ New York Insurance Law, Section 4303(d).

⁵¹ Chapter 236 of the Laws of New York, 2009.

⁵² *Karen Golinski v. US. Office of Personnel Management and John Berry, Director*, No. 3:10-cv-00257 JSW (N.D. Ca.), Order dated February 22, 2012; Shirley Patterson [Assistant Director Federal Employee Insurance Operations, Office of Personnel Management], letter to William Breskin [Vice President for Government Programs, BCBSA], March 9, 2012.

⁵³ New York Insurance Law, sections 4235(f), 3216 (i), 4301(b).

Discussion

Before summarizing the analysis of the relative merits of the benchmark options, it is worthwhile to highlight a few important points. First, all of the options are comprehensive, and, despite their differences, fall within a fairly narrow band in terms of their actuarial value. Second, New York does not have the option of approaching this decision from the perspective of an à la carte menu, choosing, for example, a wellness benefit from a FEHBP plan, the hospital benefit from the Empire Plan, and the outpatient benefit from a large group HMO. It must choose one option, and live with whatever supplements or benefit adjustments are required. Third, while a benchmark option decision is due in September 2012, additional regulatory guidance is likely; it may allow health plans to substitute benefits based on actuarial equivalence principles and impose visit limitations.

In tackling this chore, New York would benefit from federal clarification on six key items: sensible guidance on what constitutes a “plan,” for benchmark purposes, particularly the issue of drug coverage through riders; a clear standard on mental health and substance abuse coverage; the role of out-of-network benefits; clarification of the respective state and federal roles in determining supplements to the benchmarks; clarification of health plans’ ability to substitute benefits and use visit limitations; and confirmation that New York laws will govern issues related to who is entitled to family coverage as a spouse or dependent, as well as other issues unique to New York’s regulatory framework, including consumer protections.

Evaluating the relative merits of the benchmark requirements available to New York is hampered by unresolved federal regulatory issues, incomplete enrollment data, and the opacity of plan benefit descriptions, but useful observations can still be made.

Federal Benchmarks. The BCBSA and GEHA options are comprehensive plans covering thousands of New Yorkers, are administered by local BCBS plans, and contain some appealing features, particularly in the area of wellness programs. But these plans also have some shortcomings. First, as we have shown, they do not meet many of New York’s mandated benefit requirements, including both individual and group requirements. Second, choosing a benchmark option that excludes coverage for elective abortions seems unlikely in New York, given the State’s long tradition of making a full range of reproductive services available for women.

New York State Small Group Plans.

Choosing a benchmark from this category would mean choosing from three closely matched benefit plans with significant small group enrollment, minimizing disruption in the small group market, and avoiding some additional costs inherent in other benchmark options—which, if reflected in premiums, could cause some employers to drop coverage. But it would also trigger an obligation for New York to assume some of the costs for uncovered mandates, which, if history is any guide, might be passed back to insurance purchasers through adjustments to New York’s Health Care Reform Act funding system. New York’s lone benefit deferral experience—enacted as part of the Timothy’s Law implementation—was a complex undertaking. Part of the law required New York to assume the cost of the benefit expansion for small groups through the State’s General Fund, but the program was ultimately discontinued.⁵⁴

Current federal guidance may allow New York some room to reduce its exposure. While the HHS framework for benchmark options is based on benefits provided by plans on March 31, 2012, changes to current mandates involving

⁵⁴ Background information available at <http://www.dfs.ny.gov/insurance/timothy.htm> (accessed May 8, 2012).

non-benchmark options such as direct-pay products do not appear to be barred. New York appears to have the option of aligning the standardized HMO product benefits with small group requirements, allowing the State to avoid a financial obligation, which could in turn result in lower premiums for individuals and small groups. But the flip side of the coin would surely be higher out-of-pocket costs for individuals currently enrolled in the standardized plans (many of whom have chronic illnesses), gaps or reductions in needed benefits, and interruption of longstanding provider relationships. The missing components needed for a thorough review of this option are an understanding of the reach of the subsidies and employer tax credits available through the ACA to individuals and employer groups, and details of the plans that would be offered through the Exchange. The inclusion of a platinum-level actuarial value option that more closely approximates the high value of the standardized HMO plans, for example, and the availability of plans with out-of-network benefits, would assuage some of the hardships these individual enrollees would face. But this is a complex undertaking given the looming deadline for selecting a benchmark option.

The second problem with the small group benchmark option is HHS's product/plan distinction, and the resulting disqualification of benefits provided through riders. Choosing any of the small group benchmark plans would mean choosing another benchmark plan drug benefit. Given the complexity of drug benefits—including such issues as formularies, exclusions, cost-sharing, prior authorization for specialty pharmacy products, and mail-order provisions—this decision requires specialized analysis. Finally, there is some uncertainty over just what a small group benchmark option actually represents, given the number of New York mandates that only become effective when a drug benefit is in place, which is unsettling.

State Public Employee Benchmark

Options. This category really represents two sub-options: the Empire Plan, and the IHA and CDPHP HMO options. Although there are some minor differences between the IHA and CDPHP plans, they cover a closer share of New York mandated benefits than small group plans and offer full mental health and substance abuse parity, but deliver a drug benefit through a rider, which creates the same “virtual benchmark option” problem, and would involve the substitution of another benchmark plan drug benefit.

The HIP Prime HMO option is best viewed in the context of the small group and NYSHIP HMO options. It lacks a drug benefit, which creates the same uncertainty, and would trigger the need for another drug benefit as a supplement.

With drug coverage incorporated into its benefit package, and boasting coverage for over one million active employees and retirees (roughly two-thirds the size of the entire small group market), the Empire Plan is in a class of its own. Its comprehensive benefit package meets or exceeds individual and small group benefit mandates, making it the only benchmark option that does so. Its broader coverage features make it a richer benefit package than a New York small group plan, which could result in higher premiums than other benchmark options, though some of the differences are on the margins. One important consideration would be the success individual health plans have in managing many benefits through medical necessity determinations, as the Empire Plan does, rather than through visit limitations on services such as home care and rehabilitation, without the benefit of the Empire Plan's unique structure.

When one considers that HHS will revisit its EHB approach in 2016, perhaps with an eye on reducing the federal subsidy costs or emphasizing an evidence-based approach,⁵⁵ the

⁵⁵ *Bulletin* [see note 4], p. 13.

Empire Plan's modestly richer benefit package seems less of a concern. Some of the benefits may be altered through state supplement rules, health plans' ability to substitute benefits, or the use of visit limits as opposed to annual dollar maximums. The Empire Plan would bring more certainty as a benchmark in terms of identifiable benefits, would avoid state defrayal costs, and also would have value as a bridge during a transition period when New York will be

implementing the Exchange and federal reforms, reevaluating state public programs for individuals, subsidies for commercial products like the standardized direct pay plans and Healthy New York, and making decisions on whether to enact a Basic Health Program. Its broader benefit package might also ease transitions for those New Yorkers who will turn to Exchange-subsidized coverage upon losing eligibility for New York public programs.

Conclusion

The proposed federal EHB requirements have prompted states to begin a long overdue reevaluation of archaic and confusing benefit requirements. In some ways, the proposed federal standards are like a draft zoning code imposed on diverse residential communities with lots of small homes, renovated haphazardly over the years by different builders to accommodate growing families of benefits: the new outpatient addition is added to the inpatient services area on the ground floor, but the drug benefit room

can only be reached through the stairway from the cellar. Though challenging, the federal EHB process provides important local input during a two-year window. This gives New York policymakers some breathing room to select a benchmark option from a menu of generally comprehensive benefit packages, while building the infrastructure to prepare for more evidence-based decisions on benefits that will lie ahead, along with heightened concerns over the cost of coverage.

Appendix: Methodology and Sources

The two main areas explored in this report are the benefits required under New York laws and regulations, and the health benefits provided under the ten benchmark option plans that were evaluated, based on preliminary HHS guidance.

For the most part, federal benefit standards were established after similar New York reforms, or have already been incorporated into New York law. In terms of New York State requirements, we reviewed Insurance Law sections 3216 and 3221 for individual and group requirements for commercial accident and health insurers; section 4303, which contains individual and group benefit requirements for nonprofit insurers and HMOs; and Article 44 of the Public Health Law, which sets standards for HMOs. These are the core benefit requirements for individual and group coverage that have been developed over decades, and, as a result, are somewhat antiquated. We also reviewed standards established in Insurance Law sections 4321 and 4322 that are the basis for “standardized individual enrollee direct payment contracts” that HMOs have been required to offer since 1996, which represent a significant update of benefit requirements. In addition to these statutory standards, we reviewed a number of New York State Department of Financial Services (DFS) circular letters, Office of General Counsel opinions, and regulations related to benefits and consumer protections, including 11 NYCRR Part 52. Adopted in the early 1970s, and amended over 40 times since then, the so-called “Reg 62” sets out minimum standards for health insurance policies.

In addition to these statutory and regulatory sources, we also considered many DFS publications on health benefits, most designed to assist health plans in their formal product filings with the department. These were very useful, and included:

- Mandated and Make Available Benefits Commercial, HMO & Article 43 Contracts*, available at the Department of Financial Services,
<http://www.dfs.ny.gov/insurance/health/lbenall.htm>;
- Review Standards for Major Medical and Other Similar-Type Comprehensive Health Insurance for Article 43 Corporations Issuing Group Contracts*, as of 9/24/10, available at the Department of Financial Services,
http://www.dfs.ny.gov/insurance/acrobat/ah_majMed43.pdf;
- Review Standards for Major Medical and Other Similar-Type Comprehensive Health Insurance for Group Commercial Insurers Subject to Article 32*, as of 9/24/10, available at the Department of Financial Services,
http://www.dfs.ny.gov/insurance/acrobat/ah_compmedgrp.pdf;
- Review Standards for Standardized Individual Direct Pay Contracts Point of Service*, available at the Department of Financial Services,
<http://www.dfs.ny.gov/insurance/acrobat/hsrfPosc.pdf>; and
- Review Standards for Standardized Individual Direct Pay Contracts (HMO Only) Checklist for SERRFF Filings*, available at the Department of Financial Services,
<http://www.dfs.ny.gov/insurance/acrobat/hsrfHmoc.pdf>.

Under the DFS's longstanding interpretation, there is a link between the Section 4303 and 4322 benefit standards for coverage of individuals, with the department having taken the position that "Section 4303 defines the parameters of covered services (unless Section 4322(b) expressly changes the requirements) and those parameters must specifically appear in the contract." We did not review statutory or regulatory requirements for individual and small group coverage through Healthy New York, since it does not appear to add to the universe of mandated benefits.

Our primary source for the benefits provided to enrollees by health plans in the four benchmark categories were the certificates of coverage—the legal documents that describe the insurer's obligations under the policy, how enrollees access coverage, federal and state laws on benefits, consumer protections, appeals and other matters, covered services, and exclusions, some of which are required by New York regulations. These documents usually referred to and included a Summary of Coverage or similar section that summarized benefits, and often contained information about visit limits, maximums, and cost-sharing.

For the **largest small group plan** category, we obtained certificates from representatives of Oxford and Empire BCBS, and reviewed additional material summarizing benefits and riders available under the policies provided by representatives of both companies.

For the **state public employee** category, we obtained HMO certificates from Independent Health Association and Capital District Physicians Health Plan and, for the Empire Plan, from the New York State Department of Civil Service. The Empire Plan certificates are available online (<http://www.cs.ny.gov/ebd/ebdonlinecenter/certs/mc/index.cfm>). Since these three plans are among the choices available to state and local government workers and retirees, there is a wealth of information summarizing benefits and comparing options, and we reviewed much of it, including:

NYSHIP General Information Book (Empire Plan), available at New York State Department of Civil Service, <http://www.cs.ny.gov/ebd/ebdonlinecenter/pamarket/gib.cfm>;

Empire Plan at a Glance, available at New York State Department of Civil Service, <http://www.cs.ny.gov/ebd/ebdonlinecenter/pamarket/glance.cfm>;

Empire Plan Preventive Care Coverage January 2011, available at http://www.cs.ny.gov/ebd/ebdonlinecenter/preventive_care_coverage/preventive_care_coverage_Stand_Alone.pdf;

2012 Rates and Information for Active Employees (NY), available at New York State Department of Civil Service, http://www.cs.ny.gov/ebd/ebdonlinecenter/choices12/actives/actives_RATE_flyer12_pef_ucs_rep.pdf;

2011 HMO Specifications, available online at New York State Department of Civil Service, http://www.cs.ny.gov/2011hmospecifications/pdfs/q_n_a.pdf; and

Choices for 2012, available online at New York State Department of Civil Service, http://www.cs.ny.gov/ebd/ebdonlinecenter/choices12/actives/actives_choices12_SET.pdf, which had the most succinct comparison of benefits offered under the different options for state workers.

For the **federal employees** category, we analyzed plan brochures made publicly available by the U.S. Office of Personnel Management, which administers the Federal Employee Health Benefits Program (FEHBP), as well as benefit summaries available at the Government Employees Health Association (GEHA) and Blue Cross Blue Shield Association (BCBSA) Federal Employee Health Benefit Program websites. We analyzed the following:

Blue Cross and Blue Shield Service Benefit Plan, available at <http://www.opm.gov/insure/health/planinfo/2012/brochures/71-005.pdf>;
Government Employees Health Association Benefit Plan brochure, available at <http://www.opm.gov/insure/health/planinfo/2012/brochures/71-006.pdf>;
Blue Cross Blue Shield 2012 Standard & Basic Option Service Benefit Plan Summary, available at BlueCross BlueShield's Federal Employee Program website at <http://www.fepblue.org/benefitplans/2012-sbp/bcbs-2012-RI71-005.pdf>; and
GEHA 2012 Benefits at a Glance, available at http://www.geha.com/GEHA_Health_Plans/2012PlanComparison.pdf.

For the **largest HMO** category, we obtained the HIP Prime HMO certificate that is the basis for coverage under the New York City Health Benefit program through HIP from representatives of EmblemHealth. We also reviewed guides and summaries of coverage for New York City workers provided by the New York City Office of Labor Relations, which administers the program, including:

Summary Program Description, available online at http://www.nyc.gov/html/olr/downloads/pdf/healthb/full_spd.pdf, and
Affordable Coverage, Personal Care, an EmblemHealth enrollment brochure for the City of New York, available online at http://www.emblemhealth.com/pdf/enrollment/city_enrollment_brochure.pdf.

Finally, in terms of the two standardized individual contracts providing HMO only and HMO/Point of Service benefits, we reviewed certificates of coverage supplied by CDPHP, Empire BCBS, and Oxford Health Plans.

As noted in the body of the report, determining health plan benefits to a high degree of specificity is made difficult by the complexity of the documents involved, health plans' use of different terms and formats, the inclusion of broad categories of services, the many amendments to the core documents, and the dynamic between covered services and exclusions. For the most part, we relied on the certificates of coverage and summaries of coverage as the primary source for this analysis, since these documents are the most complete statement of health plans' obligations under the policy, and the contractual basis for legal disputes over covered benefits. In a limited number of instances, we clarified our understanding of benefits by speaking with New York State and New York City public employee program officials, and representatives of the health plans offering benchmark category coverage.

In most instances, we did not evaluate differences in cost-sharing provisions for benefits, as this coverage feature will likely be governed by ACA standards for the platinum, gold, silver, bronze, and catastrophic actuarial value tiers, and on the decisions health plans make based on these rules.

Related Publications

Passive/Active: Defining the Role for a Health Benefit Exchange in the Interests of New Yorkers (2011). The role that New York's health benefit exchange might play ranges from passive marketplace, with the free market alone determining its offerings, to active purchaser, using its leverage to achieve system-wide goals. This report—fourth in a series of health benefit exchange-related research projects—provides context for the debate on those options and lays out policy options under various models. (With support from the New York State Health Foundation)

Two into One: Merging Markets and Exchanges under the Affordable Care Act (2011). Third in the Fund's health benefit exchange series, this report focuses on two discretionary decisions New York must make—merging exchanges for individuals and small businesses, and merging the individual and Small Group markets—with estimates of the premium change that would result from setting rates based on their combined experience. (With support from the New York State Health Foundation)

Health Insurance Coverage in New York, 2009 (2011). This edition of the Fund's annual chartbook quantifies differences in insurance coverage and uninsurance around New York State and within New York City, breaking data down into 14 separate regions across the state, including the five boroughs of New York City. (With the Urban Institute)

Coordinating Medicaid and the Exchange in New York (2011). The second in the Fund's health insurance exchange series describes the steps needed to integrate New York's Medicaid program and exchange, within five key areas: eligibility and enrollment, renewals and transitions, information systems, consumer communications, and challenges associated with aligning plans, networks, and benefits. (With support from the New York State Health Foundation)

The Big Picture III: Private and Public Health Insurance Markets in New York, 2009 (2011). The latest in the Fund's series of yearly reports highlighting enrollment and financial results in New York's insurance markets, including, in this edition, an examination of factors leading to increased profitability and challenges relating to the State's structuring of a health insurance exchange.

Building the Infrastructure for a New York Health Benefit Exchange: Key Decisions for State Policymakers (2011). Examining critical structural decisions facing the State, this first in the Fund's health insurance exchange series provides an analytic framework for policymakers as it discusses the type and scope of possible exchanges and presents a detailed assessment of governance issues. (With support from the New York State Health Foundation)

Cost Sharing in New York's Health Insurance Market (2010). Examining the impact of cost sharing—deductibles, copayments, and coinsurance—on group health insurance premiums, this report examines how the trend toward increased out-of-pocket costs for employees degrades the value of insurance, and discusses better aligning cost-sharing with quality goals. (With support from the New York State Health Foundation and the New York Community Trust)

New York State and the Emerging Federal Health Care Reform Blueprint (2010). Prepared in anticipation of the passage of federal health care reform, this report examines the important new policy considerations for New York of key federal reform issues, including public program expansion, income subsidies, and market reforms. (With support from the New York State Health Foundation)

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