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Re: California's Essential Health Benefit Base Benchmark Options Effective January 1, 2017

Dear John,

The California Health Benefits Review Program (CHBRP) asked Milliman to analyze and compare the health services covered by the ten plans available to California as options for California's Essential Health Benefit (EHB) benchmark effective January 1, 2017. Milliman completed a similar analysis for Covered California in early 2012, which was used by stakeholders in the decision making process for selecting the EHB base benchmark plan effective January 1, 2014 through December 31, 2016.

We presented our preliminary findings in a report dated April 22, 2015, with revisions provided in a report dated May 14, 2015. This final report reflects several refinements based on further analysis and additions requested by legislative staff, including discussion about additional regulations related to state-required benefits, an analysis of the pediatric vision and pediatric dental options available for California's EHBs effective January 1, 2017, and an estimate for the potential change in costs associated with a change in the pediatric age limit.

EXECUTIVE SUMMARY

We identified the differences in covered services and benefit limits among the available benchmark plans. Because these differences have a direct effect on the expected healthcare costs, and hence premiums, for plans required to cover EHBs, we also estimated differences in expected average healthcare costs.

All of the available benchmark plans have comprehensive coverage of hospital services, physician services, and prescription drugs. The services that have differing coverage among the plans include, but are not limited to, abortion, applied behavior analysis (ABA) therapy for autism, infertility treatment, acupuncture, chiropractic care, and hearing aids. Most of the plans have service limits for home health visits, skilled nursing facility days, and physical/occupational/speech therapy, with some variation in the number of allowed services.

These coverage and limit differences produce relatively small differences in average healthcare costs. Selecting one of the three California small group plans would result in average EHB costs that are approximately 0.2% lower to essentially the same average cost as the current California EHBs. Selecting the California large group and CalPERS plans would result in average EHB costs that are approximately 0.2% lower to 0.4% higher than the current EHBs.

Selecting one of the three FEHBP options would result in average EHB costs that are approximately 0.2% lower to 0.3% higher than the current California EHBs.

CURRENT ESSENTIAL HEALTH BENEFIT

The current EHBs in California are defined in SB 951 and AB 1453.¹ The EHBs are based on the Kaiser Foundation Health Plan Small Group HMO 30 (federal health product identification number 40513CA035), with the following additional services:

- Mandates enacted prior to December 31, 2011
- Habilitative services
- Pediatric vision care based on FEDVIP vision plan
- Pediatric dental care based on federal CHIP benefits (consistent with Healthy Families dental benefits)

The Center for Consumer Information & Insurance Oversight (CCIIO) released information about the benefits covered by each state's current EHB benchmark plan. We used this structure for our analysis. More detailed information about California's EHBs in CCIIO's standardized structure is available online at: <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/CA.pdf>.

A given EHB defines whether benefits are covered or excluded, but does not specify what types of providers can provide the services² or what constitutes medical necessity for a given benefit. Benefit limits are considered part of the EHB definition.³

MEDICAL BENEFITS

BASE BENCHMARK PLAN OPTIONS

The U.S. Department of Health and Human Services (HHS) released final rules in February 2015 that allow states to select a new base benchmark plan effective plan year 2017 based on health plans available in 2014.⁴ These regulations allow California to select a new base benchmark from the following ten plans:

- Three largest Federal Employees Health Benefits Program (FEHBP) plans
- Three largest CalPERS State Employee Plans
- Largest plan in each of the three largest products in California's small group market
- Largest California commercial group HMO

This is the same structure that HHS used for the 2014 EHB benchmark plans. As discussed later in this report, the largest California commercial group HMO is the CalPERS Kaiser HMO, which is also one of the three largest CalPERS State Employee Plans. As a result, we analyzed only nine potential benchmark plans.

¹ SB 951 is available online at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB951

AB 1453 is available online at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB1453

² Additional Information on Proposed State Essential Health Benefits Benchmark Plans. (n.d.). Retrieved May 14, 2015, from <http://www.cms.gov/cciio/resources/data-resources/ehb.html>.

³ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule. (2015, February 27). Retrieved May 8, 2015, from <http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf> (page 10812).

⁴ Available online at: <http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf>

PLAN COMPARISON

All of the potential EHB base benchmark options are comprehensive. They all cover standard facility and professional services and prescription drugs. We estimate that more than 99% of the underlying benefit costs were consistent among the base benchmark options. The following benefits are covered by all of the base benchmark options:

Allergy Testing	Organ Transplants
Chemotherapy	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
Clinical Trials	Outpatient Rehabilitation Services
Delivery and All Inpatient Services for Maternity Care	Outpatient Surgery Physician/Surgical Services
Dental Anesthesia	Preferred Brand Drugs
Diabetes Education	Prenatal and Postnatal Care
Dialysis	Preventive Care/Screening/Immunization
Durable Medical Equipment	Primary Care Visit to Treat an Injury or Illness
Emergency Room Services	Prosthetic Devices
Emergency Transportation/Ambulance	Radiation
Generic Drugs	Reconstructive Surgery
Home Health Care Services	Rehabilitative Occupational and Rehabilitative Physical Therapy
Hospice Services	Rehabilitative Speech Therapy
Imaging (CT/PET Scans, MRIs)	Skilled Nursing Facility
Infusion Therapy	Specialist Visit
Inpatient Hospital Services (e.g., Hospital Stay)	Substance Abuse Disorder Inpatient Services
Inpatient Physician and Surgical Services	Substance Abuse Disorder Outpatient Services
Laboratory Outpatient and Professional Services	Transplant
Mastectomy-Related Coverage	Urgent Care Centers or Facilities
Mental/Behavioral Health Inpatient Services	Well Baby Visits and Care
Mental/Behavioral Health Outpatient Services	X-rays and Diagnostic Imaging
Non-Preferred Brand Drugs	

The following is a partial list of benefits that were excluded by all of the base benchmark options:

- Cosmetic Surgery
- Long-Term/Custodial Nursing Home Care
- Private-Duty Nursing
- Weight Loss Programs

In addition to these benefits listed, there is a provision of the EHB regulation that states that “an issuer of a plan offering EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB.”⁵ As such, we have excluded these benefits from our comparison of the base benchmark options.

There were some benefits that were not specifically mentioned as covered or excluded by a given plan. Examples of these benefits include treatment for temporomandibular joint disorders (TMJ) and second opinions. We have not included these benefits in our summary of differences as these benefits are not specifically excluded from coverage and are likely to have very small average cost differences among plans.

⁵ Available online at: http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=e5f664054d022da8a14bf5c94315e686&ty=HTML&h=L&mc=true&r=PART&n=pt45.1.156#se45.1.156_1115.

The following are the material benefit differences among the base benchmark options for California's EHB effective January 1, 2017. We also show a comparison to the current essential health benefit. Note that, in general, the FEHBP and CalPERS plans cover more benefits than the small group plans.⁶

Table 1: Coverage Differences Among Base Benchmark Options for January 1, 2017⁷

Coverage of Benefit	Current Essential Health Benefit	FEHBP – GEHA	FEHBP – BCBS Basic	FEHBP – BCBS Standard	CalPERS – Kaiser	CalPERS – Blue Shield Basic	CalPERS – PERS Choice	Small Group – Kaiser HMO 30	Small Group – Kaiser HMO 50	Small Group – Kaiser DHMO 1500
Abortion	X				X	X	X	X	X	X
ABA Therapy for Autism	X				X	X	X	X	X	X
Nutritional Counseling		X	X	X						
Routine Foot Care		X	X	X						
Accidental Dental		X	X	X		X				
Infertility Treatment		X	X	X	X	X				
Acupuncture	X	X	X	X	X		X	X	X	X
Chiropractic Care		X	X	X			X			
Hearing Aids		X	X	X	X	X	X			

There are a few benefits that are covered by most or all of the base benchmark options, but have some quantitative limits associated with the benefit. Quantitative limits are considered part of EHBs, so that the limits in the chosen benchmark plans would become minimum limits in the EHB. We show a comparison of these benefits in the table below. In the table below, blank indicates that the plan offers the benefit with no coverage limits and NC indicates that the plan does not cover the benefit.

⁶ The FEHBP plans specifically exclude “procedures, services, drugs related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.”

⁷ Note that state-required benefits enacted on or before December 31, 2011 will become part of the EHB regardless of which base benchmark plan is selected. For example, even though the FEHBP plans exclude coverage for ABA therapy for autism, since this is a state-mandated benefit, it will become part of the EHB even if one of the FEHBP plans is selected as the base benchmark plan. Our understanding from discussions with DMHC is that nutritional counseling and routine foot care would also be considered state-required benefits, and so would be part of California's EHB even if a federal plan is selected. See the “California Mandates” section below for more detail about state-mandated benefits.

Table 2: Quantitative Limits Among Base Benchmark Options for January 1, 2017⁸

Quantitative Limits on Benefits	Current Essential Health Benefit	FEHBP – GEHA			CalPERS – Kaiser			Small Group – Kaiser HMO 30		
		FEHBP – BCBS Basic	FEHBP – BCBS Standard	CalPERS – Blue Shield Basic	CalPERS – PERS Choice	Small Group – Kaiser HMO 50	Small Group – Kaiser DHMO 1500			
Acupuncture (visits per year) NC = Not Covered		20	10	24	NC	15				
Chiropractic (visits per year) NC = Not Covered	NC	12	20	12	NC	NC	15	NC	NC	NC
Hearing Aids NC = Not Covered 1 = one pair every 5 years 2 = \$2,500 per year up to age 22, \$2,500 every 36 months over age 22 3 = \$1,000 every 36 months	NC	1	2	2	3	3	3	NC	NC	NC
Home Health Care (visits per year)	100	50	25	50			45	100	100	100
Skilled Nursing Facility (days per year)	100	14	50	75	100	100	100	100	100	60
Rehabilitative Speech Therapy (visits per year)		60	50	75			24			
Rehabilitative Occupational/Physical Therapy (visits per year) <small>* identifies a limit that is combined with speech therapy limits.</small>		*	*	*			24			

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

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

The EHB regulations state that the cost sharing provisions of the plan are not considered part of EHBs. Thus, for our analysis we ignored factor 1 above, and estimated the total gross healthcare costs for a typical healthcare plan, and for each of the identified individual services. The cost sharing provisions of the benchmark plans would produce different assumed levels of healthcare utilization. Our analysis is based on expected utilization for a plan with a \$500 deductible, 20% member coinsurance, and \$2,000 out-of-pocket maximum. This specific assumption does not have a material effect on the percentage results, but we believe it is reasonable to assume some cost-sharing when estimating healthcare utilization. We would have similar results if we selected cost sharing elements from copay style HMO plans or deductible and coinsurance style PPO plans. With respect to underwriting and demographic assumptions, we assumed utilization consistent with the typical large employer plan in California.

We created an actuarial cost model for California using information from the Milliman Health Cost Guidelines (HCGs). The Milliman HCGs are developed as a result of Milliman's continuing research on healthcare costs, and are used by most large insurers. The base cost models provide detailed information about nationwide utilization and unit cost by benefit category for a loosely managed standard commercial population. We made several adjustments to the base cost models to better fit California's population and expected local utilization and unit cost levels. We estimated the gross healthcare costs for the hypothetical baseline coverage healthcare plan, as described above, to be approximately \$435 per member per month (PMPM) as of January 1, 2015. We compared this to Covered California rate filings for the 2015 plan year and found our estimated costs to be reasonable.

⁸ Dollar limits in the hearing aid benefit would not be permitted under EHB. If a plan with dollar limits is selected as the base benchmark plan, this benefit must be updated to compliance.

We used a variety of techniques and data to develop estimated costs. Many of our estimates were based on utilization and unit costs from the Milliman HCGs. We have not provided estimates for differences in coverage of habilitative services or pediatric vision and dental services among the base benchmark options because these benefits will become part of the EHBs regardless of the base benchmark plan that is selected.

We estimated the following cost differences among plans. All percentages shown are percentage differences from the current EHBs. For example, if California were to move from the current EHBs to EHBs that used the CalPERS – Kaiser plan as the base benchmark plan, we estimate that this would result in an increase of approximately 0.4% in allowed claim costs for plans providing EHBs.

Table 3: Percent Change in Allowed Costs Compared to Current EHB⁹

		FEHBP – GEHA			CalPERS – Kaiser			Small Group – Kaiser HMO		
		FEHBP – GEHA	FEHBP – BCBS Basic	FEHBP – BCBS Standard	CalPERS – Kaiser	CalPERS – Blue Shield Basic	CalPERS – PERS Choice	Small Group – Kaiser HMO 30	Small Group – Kaiser HMO 50	Small Group – Kaiser DHMO 1500
Percent Difference in Allowed Costs from Current EHB										
Coverage Differences	Abortion	-0.04%	-0.04%	-0.04%						
	ABA Therapy for Autism	-0.27%	-0.27%	-0.27%						
	Nutritional Counseling	0.07%	0.07%	0.07%						
	Routine Foot Care	0.02%	0.02%	0.02%						
	Accidental Dental	0.01%	0.01%	0.01%		0.01%				
	Infertility Treatment	0.17%	0.17%	0.17%	0.17%	0.17%				
Coverage and Limit Differences	Acupuncture	-0.14%	-0.23%	-0.11%		-0.40%	-0.18%			
	Chiropractic Care	0.15%	0.20%	0.15%			0.17%			
	Hearing Aids	0.39%	0.39%	0.39%	0.18%	0.18%	0.18%			
Limit Differences	Home Health Care Services	-0.07%	-0.18%	-0.07%	0.02%	0.02%	-0.09%			
	Skilled Nursing Facility	-0.42%	-0.21%	-0.08%						-0.17%
	Rehabilitative ST/OT/PT	-0.07%	-0.14%	-0.00%			-0.29%			
Total		-0.19%	-0.20%	0.25%	0.38%	0.00%	-0.21%	0.00%	0.00%	-0.17%

Selecting an FEHBP plan would result in a change in allowed costs between -0.20% and 0.25% compared to the current EHBs. Note that these cost differences would be higher after state-required benefits are supplemented in the FEHBP plans. Selecting one of the CalPERS plans would have an impact between -0.21% and 0.38%, and selecting one of the small group plans would have a minimal impact. We have not modeled the impact that an increase in average costs of this size would have on the number of individuals who choose to purchase insurance. This could have a small effect on demand, but the impact on consumers would be dampened because federal premium tax credits would cover all or part of the increase for low income consumers in Covered California.

⁹ Note that state-required benefits enacted on or before December 31, 2011 will become part of the EHB regardless of which base benchmark plan is selected. For example, even though the FEHBP plans exclude coverage for ABA therapy for autism, since this is a state-mandated benefit, it will become part of the EHB even if one of the FEHBP plans is selected as the base benchmark plan. Our understanding from discussions with DMHC is that nutritional counseling and routine foot care would also be considered state-required benefits, and so would be part of California's EHB even if a federal plan is selected. See the "California Mandates" section below for more detail about state-mandated benefits.

Dollar limits in the hearing aid benefit would not be permitted under EHB. If a plan with dollar limits is selected as the base benchmark plan, this benefit must be updated to compliance.

ADDITIONAL DEFINITION FOR HABILITATIVE BENEFITS

California's current definition of habilitative services is provided as follows in Health & Safety Code 1367.005 and Insurance Code 10112.27.

"Habilitation services" means medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Examples of health care services that are not habilitation services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training. Habilitation services shall be covered under the same terms and conditions applied to rehabilitative services under the policy."

The February 2015 federal regulations¹⁰ state that the definition for habilitative services will now be made at the state level, and insurers will no longer be allowed to define habilitative services themselves. The regulations include the following proposed uniform definition of habilitative services that states can adopt.

"We believe that adopting a uniform definition of habilitative services would minimize the variability in benefits and lack of coverage for habilitative services versus rehabilitative services. Defining habilitative services clarifies the difference between habilitative and rehabilitative services. Habilitative services, including devices, are provided for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition. Rehabilitative services, including devices, on the other hand, are provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition.

We proposed adopting the definition from the Glossary of Health Coverage and Medical Terms 45: Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

We did not propose any changes to § 156.110(f), which allows States to determine services included in the habilitative services and devices category if the base-benchmark plan does not include coverage. Several States have made such a determination following benchmark selection for the 2014 plan year, and we wish to continue to defer to States on this matter as long as the State definition complies with EHB policies, including nondiscrimination. If the State does not supplement missing habilitative services or does not supplement the services in an EHB-compliant manner, issuers should cover habilitative services and devices as defined in § 156.115(a)(5)(i)."

In addition, the February 2015 federal regulations state that insurers that previously excluded habilitative services, but subsequently added them, must treat habilitative services as a separate service from rehabilitative services. As such, if these issuers have visit limits on rehabilitative services, they must have separate visit limits on habilitative services.

PEDIATRIC VISION AND DENTAL BENEFITS

BASE BENCHMARK PLAN OPTIONS

Federal regulations allow states to supplement their base benchmark plan with additional benchmarks for pediatric vision and dental benefits.¹¹ States are allowed to select their pediatric vision and dental benefits from either of the following plans:

¹⁰ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule. (2015, February 27). Retrieved May 8, 2015, from <http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf> (page 10811).

- Federal Employee Dental and Vision Insurance Program (FEDVIP)
- The State's Children's Health Insurance Program (CHIP) program, if one exists (starting in 2013, California began offering CHIP coverage through Medi-Cal instead of as a stand-alone program)

This is the same structure that HHS used for the 2014 EHB benchmark plans, when California selected the FEDVIP plan as the benchmark for pediatric vision benefits and the CHIP plan as the benchmark for pediatric dental benefits.

PLAN COMPARISON

California's current EHB for pediatric dental benefits is the CHIP (formerly Healthy Families) plan. CCIIO did not provide a summarized version of the pediatric vision and dental benefits in the same structure as they summarized the medical benefits. For the purpose of our analysis, we assumed that the current EHBs for pediatric dental are substantially similar to the 2014 CHIP/Medi-Cal plan.¹² The two dental plan options for the EHBs effective for plan year 2017 cover substantially all of the same benefits, with similar visit limits. We estimate that the selection of either benchmark would result in similar allowed costs compared to the current EHB.

Table 4: Coverage Differences Among Pediatric Dental Benchmark Options for January 1, 2017

Benefit Class	Benefit	FEDVIP	CHIP/Medi-Cal
Class A – Basic	Oral Exam	1 every 6 months	1 every 6 months
	Preventive – Cleaning	1 every 6 months	1 every 6 months
	Preventive – X-Ray	1 every 6 months	1 every 6 months
	Sealants per Tooth	1 per tooth every 36 months	1 per tooth every 36 months
	Topical Fluoride Application	2 every 12 months	1 every 6 months
	Space Maintainers – Fixed	Medical necessity	1 per quadrant
Class B – Intermediate	Amalgam Fill – One Surface	Medical necessity	Medical necessity
Class C – Major	Root Canal – Molar	Medical necessity	Medical necessity
	Gingivectomy per Quad	1 every 36 months	1 every 36 months
	Extraction – Single Tooth Exposed Root or Erupted	Medical necessity	Medical necessity
	Extraction – Complete Bony	Medical necessity	Medical necessity
	Crown – Porcelain with Metal	1 per tooth every 60 months	1 per tooth every 60 months
Class D – Orthodontic	Medically Necessary Orthodontia	Medical necessity	Medical necessity
	Cosmetic Orthodontia	Not covered	Not covered
Percent Difference in Allowed Costs from Current EHB		0.0%	0.0%

California's current EHBs for pediatric vision benefits are from the FEDVIP vision plan. For the purpose of our analysis, we assumed that the current EHBs for pediatric vision are substantially similar to the 2014 FEDVIP vision plan. The two vision plans differ more than the dental plans. The FEDVIP vision plan, which is part of California's current EHB, offers more comprehensive coverage of benefits than the CHIP/Medi-Cal plan. We estimate that changing to the CHIP/Medi-Cal plan would reduce the total allowed cost of EHBs by about 0.02%.

¹¹ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule. (2015, February 27). Retrieved May 8, 2015, from <http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf> (page 10812).

¹² Healthy Families enrollees transitioned to Medi-Cal beginning in 2013. Their dental coverage was also transitioned to Medi-Cal's dental program, Denti-Cal.

Table 5: Coverage Differences Among Pediatric Vision Benchmark Options for January 1, 2017

Benefit Class	Benefit	FEDVIP	CHIP/Medi-Cal
Diagnostic	Routine ophthalmologic exam with refraction	Medical necessity	1 every 2 years
	Dilation	Medical necessity	Medical necessity
Eyewear	Lenses	1 pair per calendar year	1 pair every 2 years
	Optional Lens Treatment	Ultraviolet Protective Coating Polycarbonate Lenses Blended Segment Lenses Intermediate Vision Lenses Standard Progressives Premium Progressives (Varilux®, etc.) Photochromic Glass Lenses Plastic Photosensitive Lenses (Transitions®) Polarized Lenses Standard Anti-Reflective (AR) Coating Premium AR Coating Ultra AR Coating Hi-Index Lenses	Medical necessity
	Frame	1 pair every year	1 pair every 2 years
Contact Lenses	Contact Lenses	Allowance of \$150 per calendar year in lieu of eyeglasses	Medical necessity
Percent Difference in Allowed Costs from Current EHB		0.00%	-0.02%

Several of the benefits for the FEDVIP plan were expressed in terms of allowances. For example, if a member chooses a "Collection Frame," they pay no cost-sharing and if they choose a "Non-Collection Frame," they pay for the cost in excess of a \$150 allowance. Our cost estimates assumed that eyewear/lenses options are available such that the allowances can cover the entire cost.

ESTIMATED IMPACT OF POTENTIAL CHANGE IN PEDIATRIC DEFINITION

California legislative staff asked Milliman to estimate the cost impact of expanding the definition of "pediatric" coverage from individuals under age 19 to individuals under age 21. Our understanding is that this change would only affect coverage for pediatric vision and dental benefits, and would not refer to limits on any other medical benefit.

Because the premium differences by age for a given plan are fixed by law, the additional cost to provide vision and dental coverage to 19 and 20 year olds cannot be included solely in the premiums for 19 and 20 year olds. Instead, premiums for all members of a plan must be increased by the same percentage determined so that the additional premium collected from all members is sufficient to cover the additional cost of the 19 and 20 year olds in that plan that utilize vision and dental services in the coming year. We started by estimating the additional vision and dental costs for the percentage of members that are 19 and 20. We then spread this cost over the expected costs for all members.

We estimate that allowed costs for EHBs would increase by about 0.17% if the pediatric age limit is changed from 19 to 21.

CALIFORNIA MANDATES

The current EHB includes all Health and Safety code mandates enacted prior to December 31, 2011. The new regulation for the EHB effective January 1, 2017 does not change this effective date for mandates. Most California mandates after December 31, 2011 relate to cost sharing for particular services or requiring carriers to contract with certain providers for certain services.

HHS has provided additional guidance on specific EHB issues since California evaluated their EHB benchmark options in 2012. Of particular interest for this analysis is the change that state-required benefits (mandates) enacted on or before December 31, 2011 are not considered an addition to EHBs (45 C.F.R. 155.170(a)). This means that state-mandated benefits enacted prior to December 31, 2011 will become part of the EHB regardless of which base benchmark plan is selected, even if it is one of the plans offered to federal employees. As a result, all mandates enacted prior to December 31, 2011 that apply to a given market (individual or small group) will be included in the new EHB.

DATA SOURCES

The California Health Benefits Review Program (CHBRP) worked with the two regulators in California, the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) to gather the necessary information about the state-specific plans. In particular, DMHC and CDI provided enrollment estimates that allowed selection of the plans included in this analysis. Milliman obtained the FEHBP and CalPERS EOCs from publicly available sources and CHBRP received the three small group EOCs from DMHC and provided them to Milliman.

This analysis includes the following plans:

1. Three largest Federal Employees Health Benefits Program (FEHBP)
 - a. Government Employees Health Association (GEHA)
 - b. Blue Cross Blue Shield Basic
 - c. Blue Cross Blue Shield Standard
2. Three largest CalPERS State Employee Plans
 - a. CalPERS Kaiser HMO
 - b. CalPERS Blue Shield Basic HMO
 - c. CalPERS PERS Choice
3. Largest plan in each of the three largest products in California's small group market¹³
 - a. Kaiser HMO 30 (DMHC)
 - b. Kaiser HMO 50 (DMHC)
 - c. Kaiser DHMO 1500 (DMHC)
4. Largest California commercial group HMO (same as CalPERS Kaiser HMO)

We relied on the FEDVIP vision and dental coverage documents identified in CCIIO's April 8, 2015 guidance, and Medi-Cal benefits published on the medical.ca.gov website.

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

¹³ CCIIO released a complete listing of the largest three small group products by state for all 50 states on April 8, 2015. The three products identified for California were 40513CA035 (Kaiser), 53011CA001 (Santa Cruz-Monterey-Merced Managed Care Commission), and 80046CA075 (Blue Shield of CA Life & Health Ins Co). This document from CCIIO is available online at: <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/largest-smgroup-products-4-8-15-508d-pdf-Adobe-Acrobat-Pro.pdf>.

The document from CCIIO indicates that "States may identify products other than the products on this list as their largest small group products." Based on guidance from CHBRP and DMHC, we did not use these three products in our analysis. Instead, we used EOCs for the three small group plans provided by DMHC.

LIMITATIONS

Milliman's work is prepared solely for the internal business use of the California Health Benefits Review Program. Milliman does not intend to benefit any third party recipient of its work product, even if Milliman consents to the release of its work product to such third party. We understand that CHBRP intends to share this analysis with the California Legislature, at a Stakeholder meeting on May 15, 2015, and via CHBRP's public website, and we grant permission for this distribution.

In performing this analysis, we relied on data and other information provided to CHBRP by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI). We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between our cost estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

The U.S. Department of Health and Human Services (HHS), through the Center for Consumer Information and Insurance Oversight (CCIIO), is responsible for promulgating regulations and guidance to assist the states in making these decisions. This report makes extensive use of proposed regulations and guidance published by HHS and CCIIO as of the date of this report. Subsequent regulations and guidance could change our interpretation of the EHB selection options and the conclusions in this report.

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and the California Health Benefits Review Program.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this letter.

Sincerely,



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