

# **Vermont Essential Health Benefit Benchmark Plan Review**

**A presentation to the Green Mountain Care Board by:**

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# EHB Benchmark Plan Change Process Overview

Essential health benefits are defined through a state-selected, federally-approved benchmark plan.

The federal government allows States three options to update their benchmark plans :

- Select a benchmark plan used by another state during the 2017 plan year;
- Replace one or more categories of essential health benefits (EHBs) with the same category or categories of EHB used in another state's benchmark plan for the 2017 plan year; or
- Otherwise select a set of benefits to constitute the State's benchmark plan.

The Green Mountain Care Board (GMCB) has jurisdiction to review and approve, with recommendations from the Department of Vermont Health Access (DVHA), the benefit packages for qualified health plans. DFR has regulatory responsibility for the provision of the benefit packages. AHS Office of Health Reform coordinates the state agencies.

# GMCB Authority

- Under 18 V.S.A. § 9375(b)(9), the Green Mountain Care Board (GMCB) has authority to review and approve, with recommendations from the Department of Vermont Health Access (DVHA), Vermont's EHB-benchmark plan.
  - DFR has regulatory responsibility for the provision of the benefit packages.
  - AHS Office of Health Reform coordinates the state agencies.
- GMCB first approved a benchmark plan on September 20, 2012;
- GMCB last approved a benchmark plan on July 16, 2015;
- Both times, the Board accepted DVHA's recommendation to select the Vermont Health Plan's (TVHP) CDHP-HMO to serve as Vermont's EHB benchmark plan.

# EHB Benchmark Plan Change Process Overview

Under the Affordable Care Act, essential health benefits (EHBs) are defined by reference to State-specific EHB-benchmark plans. 45 C.F.R. § 156.100, et seq.

The federal government, in 45 C.F.R. § 156.111, allows states three options to update their benchmark plans :

- Select a benchmark plan used by another state during the 2017 plan year;
- Replace one or more categories of essential health benefits (EHBs) with the same category or categories of EHB used in another state's benchmark plan for the 2017 plan year; or
- Otherwise select a set of benefits to constitute the State's benchmark plan.

If a state selects a new EHB-benchmark plan under any of the options allowed under §156.111, the included benefits will not be treated as state mandates for purposes of defrayal under 45 C.F.R. § 155.170.

# The State Flexibility to Stabilize the Market Grant Program

- **Project Scope:** *Assess EHB-Benchmark plan to inform whether issuers offering EHB in the State are meeting the needs of their respective individual and small group markets and are affordable for consumers.*
- **Primary Goal:** determine whether modification of the plan will increase affordability for consumers and provide an EHB-Benchmark plan that best reflects the needs of the State's health insurance market and population, in accordance with applicable EHB-Benchmark plan selection criteria.
- **Secondary Goals:** The assessment will also be used to:
  - Assess whether potential modifications to the set of benefits included in the State's EHB-Benchmark plan or modification of specific categories of benefits will increase affordability for consumers;
  - Analyze benefits to reflect medical advances and address gaps in services; and
  - Defray costs associated with providing public notice and opportunity for public comment on a State's selection of an EHB-benchmark plan;

# Legislative Mandate (Act 74)

- Analyze current and proposed Essential Health Benefits (EHB) to address unforeseen health needs and improve benefit design. Specifically:
  - hearing aids,
  - dentures,
  - vision care,
  - durable medical equipment,
  - infertility services, and
  - two primary care visits with no cost-share
- Assess whether the benchmark plan is appropriately aligned with Vermont's health care reform goals regarding population health and prevention, as set forth in the Vermont All-Payer Accountable Care Organization (ACO) Model agreement and the Department of Health's State Health Improvement Plan; and
- Determine whether to recommend requesting approval from the Centers for Medicare and Medicaid Services to modify the benchmark plan

# Additional Benefit Considerations

- Mental Health and Substance Use Disorder Benefits
- Preventive Dental
- Tobacco Treatment
- Lactation Consultations
- Medically Tailored Meals
- Gym Membership
- Nutritional Counseling
- Pre-Diabetes Self-Management Tools

# Working Group Members

Organization	Name
Department of Financial Regulation	Sebastian Arduengo, Emily Brown, Anna Van Fleet
Department of Vermont Health Access	Adaline Strumolo, Dana Houlihan, Sean Sheehan
GMCB	Michael Barber
Office of the Director of Health Care Reform	Ena Backus, Wendy Trafton
BCBSVT	Sara Teachout
MVP	Jordan Estey
Northeast Delta Dental	Brian Duffy
Vermont Hospital Association	Devon Green
Vermont Medical Society	Jill Sudhoff-Guerin
Vermont Legal Aid	Mike Fisher



# EHB Benchmark Plan Analysis Timeline

Task	Date	Detail
Legislative Report with Findings	January 2022	Summary of work to date and benefit proposal
Presentation to GMCB	February 2022	Presentation to Board for Qualified Health Plan (QHP) approval
GMCB Public Comment Period	February - March 2022	
CMS Update	March 2022	Prior to CMS-required public comment period
Public Comment Period	March/April 2022	30-day public comment period
Official CMS Submission	April 2022	
CMS Review and Finalization	May-August 2022	
New Plan Review	March 2023	DFR to review new contract language. GMCB to review premium impact.
Implementation of New Plans	January 2024	Plans with new benefits effective for plan year 2024

# VT EHB Benchmark Plan

*EHB Overview & Potential 2024 Changes*

January 2022

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# Estimates are for Illustrative, Discussion Purposes

The current estimates are still being refined and peer reviewed. Estimates shown today should be considered for illustrative and discussion purposes only.

**DRAFT**

# Overview of Federal Regulations on EHB

# Federal Regulations

## Typicality and Generosity Tests

- There are two actuarial requirements a proposed benchmark plan must meet, the typicality test and generosity test
- Typicality Test - Provide a scope of benefits in the new EHB-benchmark plan that are equal to the scope of benefits provided under a typical employer plan selected by the state
- Generosity Test - Ensure the new EHB-benchmark plan does not exceed the generosity of the most generous among a set of comparison plans
  - Exceeding the most generous plan is defined as anything above 0.0% beyond most generous plan

# Wakely Process

# Wakely Process

## Overview

1. Review State & Stakeholder Information & Input
2. Plan Comparisons (CMS Tests)
3. Price Benefits
- 4. Benefit Discussion and Decisions**
5. Submission
  1. Public comment estimated to begin by April 1st
  2. Submission to CMS by May 6<sup>th</sup>



# Benefit Comparisons

## Generosity Test

# Plan Comparisons

## Generosity Test

### Comparison of Benefits

1. Identify and gather plan documents for eligible comparison plans for use in CMS testing
2. Compare benefits between current benchmark plan and plans used for generosity testing
3. Determine total benefit difference; this dictates the “room” available to modify benefits (Generosity test)

# Plan Comparisons

## Generosity Test

1. Among all benchmark options, two richest plans were identified to be the Federal GEHA and the State Plan
2. Based on analysis, the State Plan was identified as the richest of all options for the generosity test
3. As a result, the State Plan effectively places a ceiling on how rich total EHB BMP benefits can be under current Federal regulations

# Plan Comparisons

## Claim and Premium Impact Considerations

- EHB regulations focus on the change in allowed costs (insurer paid plus member cost share) but the impact to premium is also important for consumers.
- Wakely estimated the impacts using VHCURES data, primarily using data from the state employee plans. Other data, such as Wakely's ACA database, was used to validate estimates or in cases in which the benefits are not currently covered in Vermont.
- Key considerations for the allowed cost and premium impacts included in the analysis
  - The estimates are based on ongoing estimated costs. Any pent up demand that may occur in the initial years of coverage is not incorporated.
  - The estimates only include the cost of the specific benefits being considered, and downstream impacts (e.g., maternity costs for infertility, potential savings from increased well-being from having hearing aids) are not included.
- **Actual impacts included in the 2024 premium by the issuers may vary, potentially significantly, based on the above considerations, as well as each issuer's underlying data, assumptions, and fixed administrative costs.**

# Generosity Test

## Key Benefit Differences with State Plan

Benefit	Current Benchmark Plan (BMP)	State Employer Plan (Most Generous)	Range of Allowed Cost Compared to Current BMP
Infertility Treatment	Covers diagnostic testing only	Includes IVF, drugs, AI, and egg preservation with medical and drug lifetime limits (excludes surrogates)	0.61% to 1.01%
Acupuncture	Not covered	Covered	0.23% to 0.43%
Chiropractic Care	12 visits per year	60 visits per yr combined with PT, OT, ST	0.05% to 0.10%
Rehabilitation - PT/OT/ST	30 visits per year combined	60 visits per yr combined with Chiro	0.00% to 0.02%
Habilitative Services	30 visits per year combined	60 visits per yr combined	0.00% to 0.01%
Massage Therapy	Not covered	Covered	0.00% to 0.02%
All Others	N/A	N/A (assumes the same supplementation as current BMP for pediatric benefits)	Negligible
<b>Total</b>			<b>0.89% to 1.59%</b>

All pricing estimates in the analysis are based on the ongoing cost of the services. Neither downstream costs (e.g. maternity costs for infertility) nor pent up demand costs are included. Totals may not add due to rounding.

# Benefit Pricing

Changes to EHB

# Benefit Pricing & Selection

## Changes to EHB

### Benefit Selection Process

1. Evaluation of the value of each benefit being considered for inclusion in 2024 benchmark (using VHCURES data, Wakely data and insight)
2. Comparison of newly proposed benchmark plan against generosity test such that benefit changes do not result in the new EHB plan being richer than the most generous plan included in the generosity testing
  - a. EHB focuses on the allowed cost of services, which is the overall cost of the benefit (combined cost of the insurer paid amount and member cost sharing)
  - b. Ultimately, the premium impact of the changes will vary based on insurer pricing, cost sharing of the benefits, and changes, if any, to administrative costs due to the changes
3. Ultimately, will also need to compare proposed benchmark against the typicality test to ensure benchmark passes both tests

# Benefit Pricing & Selection

## Discriminatory Considerations

Potential changes to address discriminatory benefit design; these changes are likely not considered changes to the EHB Benchmark plan

- Nutritional Counseling
  - Current benefit states the benefit is unlimited for diabetics but limited to three for all others; could remove the limit for all conditions (based on medical necessity)
- Habilitative
  - Current benefit states that the limit does not apply to under 21 treatment of Autism; could remove the age limit if no medical reason for the limit
- Foot Care
  - Current benefit excludes foot care except for diabetics; could state that covered for all conditions, if medically necessary
- Prescribed Food and Nutritional Formulae
  - The current benefit excludes coverage except for inherited metabolic disease; could exclude unless medically necessary for any condition and regardless of age
  - This includes formulas or supplements administered through a feeding tube
  - Also includes 100% amino acid formula, which is currently limited to children under age five
  - Age limit would be removed to address discriminatory benefit design issues if no medical reason for the age limit



# Benefit Pricing & Selection

## Benefit Changes Considered Based on Stakeholder Feedback

Benefit	Notes
Hearing Coverage	Hearing exam and hearing aids each ear every three years
Infertility Services	Goal is to match the State of Vermont's employee health plan benefit
Medically Tailored Meals	Benefit can vary significantly in terms of who qualifies, frequency, and amount of benefit provided
Nutritional Counseling	Not priced - the goal was to increase from a limit of three to "unlimited". Currently unlimited for diabetics; changing due to discrimination rules rather than an EHB change is a possibility
Wellness/Gym Benefit	Not priced as current offerings exist in market and difficult to offer equitably across the state

# Benefit Pricing & Selection

## Cost of Additional Benefits

- If infertility and hearing benefits are added, there is still around 0.23% to 0.49% remaining for additional benefits (e.g., medically tailored meals) or saving for potential future benefit changes
- The average market premium impact, based on 2021 premiums and a range of fixed administrative cost assumptions, would be an average increase of around \$4.20 to \$7.00 per member per month (PMPM)

Benefits - Changes Considered	Benefits to Add	Range of Impact to Allowed Costs
Infertility Treatment	Includes IVF, drugs, AI, and egg preservation; three cycle limit	0.61% to 1.01%
Hearing Coverage	Propose limit of one per ear every 3 years	0.05% to 0.09%
Medically Tailored Meals	Varies	Varies
<b>Total</b>		<b>0.65% to 1.09%</b>
<b>Generosity Testing “Room”</b>		<b>0.89% to 1.59%</b>

All pricing estimates in the analysis are based on the ongoing cost of the services. Neither downstream costs (e.g. maternity costs for infertility) nor pent up demand costs are included. Totals may not add due to rounding.

# Infertility Services

## Benefit Pricing

### Benefit Definition

- Coverage for three cycles of in-vitro fertilization, including evaluation, counseling, egg preservation and other related services
- Benefit intended to reflect current State employer plan benefit (that is, equivalent to the medical and drug lifetime limits)
- How a “cycle” is defined may alter the comparison - need to define exactly what constitutes a cycle

### Background

- Some of the comparable Northeastern states currently have some infertility coverage beyond diagnostics and testing
- Three states cover artificial insemination and three cover in-vitro fertilization

# Infertility Services

## Benefit Pricing

### Background – Northeast State Coverage

State	Infertility Coverage*	Exclusions and Limits
<b>Connecticut</b>	Diagnoses and treatment of infertility IVF – two cycles	N/A
<b>Maine</b>	None	N/A
<b>Massachusetts</b>	Diagnoses and treatment of infertility Artificial insemination IVF – unlimited cycles	Only covered if unable to conceive during one year, or has been diagnosed with cancer and is expected to become infertile after treatment, or is age 35 or older and has not been able to conceive for six months.
<b>New Hampshire</b>	Diagnoses and treatment of infertility	Artificial Insemination IVF procedures
<b>New Jersey</b>	Diagnoses and treatment of infertility Artificial Insemination	IVF procedures Preservation
<b>New York</b>	Diagnoses and treatment of infertility	Members must be between the ages of 21 and 44 Infertility must be due to malformation, disease, or dysfunction IVF procedures
<b>Pennsylvania</b>	Diagnoses and treatment of infertility Artificial insemination	IVF procedures
<b>Rhode Island</b>	Diagnoses and treatment of infertility IVF – three cycles	N/A

\* Discriminatory requirements do not allow the benefit to be limited to certain ages or conditions, absent medical evidence. The provided coverage is based on the original EHB documents.

# Infertility Services

## Benefit Pricing

### **Benefit Considerations**

- Increased claim cost related to additional maternity cycles
- Improved mental wellbeing for affected members
- Improved support for organic state population growth
- Egg preservation could be carved out to reduce costs but cost is minimal

### **Cost and Utilization**

- 0.61% to 1.01% increase to allowed costs
- Around an \$3.90 to \$6.50 PMPM increase in the average market premiums (there will be further variation based on metal level as well)
- Approximately 0.5% to 1.0% of members may utilize these services

# Hearing Aids & Exams

## Benefit Pricing

### Benefit Definition

- Hearing exams and hearing aids for adults and children
- Hearing aids are limited to one per ear every three years

### Background

- Adult hearing benefits for adults are not prevalent in the ACA markets, with only 11 states explicitly requiring adult hearing aids to be offered. However, more than half of states require coverage for children. Given discriminatory requirements, many states who only covered child hearing aids, are now also covering adults under the benefit (not a change to EHB when done for discriminatory design purposes).
- Vermont and Pennsylvania are the only two Northeast states with no hearing aid coverage in their commercial EHBs
- While significant variation exists in services covered, limits, and cost-sharing, the most common offering is covering hearing aids every 36 months with coinsurance between 0% to 50%

# Hearing Aids & Exams

## Benefit Pricing

### Background – Northeast State Coverage

State	Hearing Aid Coverage*	Coverage Period
Connecticut	Requires individual and group health insurance policies to provide coverage for hearing aids for children and adults and classifies hearing aids as durable medical equipment	24 Months
Maine	Requires health insurance policies to provide coverage for hearing aids for children and adults	36 Months
Massachusetts	Requires certain health plans to provide to any minor 21 years of age or younger coverage for hearing aids	36 Months
New Hampshire	Requires health insurance policies to provide coverage for hearing aids for children and adults	60 Months or when prescription changes (sources vary)
New Jersey	Requires coverage for children 15 years of age or younger	24 Months
New York	Requires health insurance policies to provide coverage for hearing aids for children and adults	36 or 48 Months (sources vary)
Pennsylvania	Not an EHB	N/A
Rhode Island	Requires coverage for children and adults	36 Months

\* Discriminatory requirements do not allow the benefit to be limited to certain ages, absent medical evidence. The provided coverage is based on the original EHBs.

# Hearing Aids & Exams

## Benefit Pricing

### **Benefit Considerations**

- Potential for pent up demand in early years
- Improved mental wellbeing for affected members
- Limit may not be too impactful due to medical necessity
- Pre-authorization and other utilization management can be used by the issuers to manage coverage

### **Cost and Utilization**

- 0.05% to 0.09% increase to allowed costs
- Around a \$0.30 to \$0.60 PMPM increase in the average market premiums (there will be further variation based on metal level)
- Approximately 0.1% to 0.2% of members may utilize the benefit



# Medically Tailored Meals

## Benefit Pricing

### Benefit Definition

- Provide nutritious groceries or meals to beneficiaries where proven to improve health outcomes
- This benefit could be configured to consider a wide range of which members are eligible, how generous the benefit is, and how often it is provided

### Background

- While several studies exist and certain Medicare Advantage plans offer a similar benefit, ACA coverage is minimal

### Benefit Considerations

- Pilot program may be best way to introduce benefit
- Significant thought around discrimination and CMS push back is needed
- Challenges in determining meaningful benefit amount, covered population (conditions, income), and premium impact
- What benefit can be offered under the remaining allowed amounts under the generosity test

# Wakely Process

## Medically Tailored Meal Pricing Grid

Grid is for illustrative, discussion, and relativity purposes.

### Cost and Utilization

Multiple considerations for the medically tailored meal benefit:

- Balancing a non-discriminatory benefit with higher costs
- Based on the innovative nature of the benefit, should a pilot program be done first
- Significant uncertainty on the use of the benefit, which could be determined based on member cost sharing for the benefit
- Multiple different vendors and approaches; below structure and cost are just one example
- Current assumptions are 20% of the ACA market would be eligible based on health care conditions and 10% on food insecurity (combination of the two needed for eligibility)

	Benefit Unit Cost					
	1 Box	1 Bundle	2 Boxes	3 Boxes or 2 Bundles	3 Bundles	Full Coverage
Engagement	\$40	\$60	\$80	\$120	\$180	\$275
20%	0.03%	0.04%	0.06%	0.09%	0.13%	0.20%
40%	0.06%	0.09%	0.12%	0.17%	0.26%	0.40%
60%	0.09%	0.13%	0.17%	0.26%	0.39%	0.60%
80%	0.12%	0.17%	0.23%	0.35%	0.52%	0.80%
100%	0.15%	0.22%	0.29%	0.44%	0.65%	1.00%

Benefit Packages	Description
Produce Box	Assortment of healthy produce
Grocery Bundle	Mixed assortment of healthy groceries
Comprehensive	Comprehensive monthly groceries

# EHB Changes

## Potential Options

- The two most likely benefits to add are infertility treatment and hearing coverage
- The table below shows the impact if either or both of those benefits are covered
- The premium impact below is the average market premium. The actual premium impact could vary based on issuer pricing and metal level.

<b>Benefit Change Options</b>	<b>Additional Allowed Cost Impact</b>	<b>Estimated Average Market Premium Impact PMPM</b>	<b>Remaining Room - Generosity Test</b>
<b>Infertility Treatment Only</b>	0.61% to 1.01%	\$3.90 to \$6.50	0.28% to 0.58%
<b>Hearing Coverage Only</b>	0.05% to 0.09%	\$0.30 to \$0.60	0.84% to 1.50%
<b>Both Infertility Treatment and Hearing Coverage</b>	0.65% to 1.09%	\$4.20 to \$7.00	0.23% to 0.49%

All pricing estimates in the analysis are based on the ongoing cost of the services. Neither downstream costs (e.g. maternity costs for infertility) nor pent up demand costs are included. Totals may not add due to rounding.

# Non-EHB Considerations

# Non-EHBs

## Benefits Considered

Stakeholders mentioned a few additional benefits to consider for changes in the Essential Health Benefits benchmark plan. These benefits are not eligible to be EHB, but for comprehensiveness, the cost of each is included.

- Adult Dental
  - Not permitted to be an EHB
  - The cost of preventive and dentures was priced
- Adult Vision
  - Not permitted to be an EHB
  - The cost of vision exams and eyewear every two years was priced
- Free Primary Care office visits
  - This is not a benefit, but rather a cost sharing consideration
  - A high level impact of offering free PCP visits has been included
  - The Standard Plan Design stakeholder group is also considering this request

# Non-EHBs

## Cost Defrayal

- If the state mandates new benefits outside of Essential Health Benefits, the state must defray the cost of those benefits for certain consumers
- Specifically, the cost to the state would be for all qualified health plans (QHPs) as follows:
  - Each QHP issuer in the state shall quantify the cost attributable to each additional benefit
  - A QHP's calculation is based on analysis performed in accordance with generally accepted actuarial principles and methodologies and by a member of the American Academy of Actuaries
  - The calculation should be conducted prospectively to allow for the offset of an enrollee's share of premium and for purposes of calculating the PTC and reduce cost-sharing
  - The actual payment by the state can either be based on the state wide average cost of additional state-required benefits or based on each QHP issuer's actual cost
- Should the state mandate adult dental and/or vision, the state would be required to defray the cost of these benefits for QHPs

# Adult Dental

## Benefit Summary

### **Benefit Definition**

- Priced two different potential benefits
  - Adult preventive, including an exam and cleaning every 6 months
  - Adult dentures
- Both currently priced with no cost sharing and assuming it would be a mandatory benefit (that is, no selection)

### **Background**

- Essential Health Benefits do not allow for inclusion of any adult dental benefits
- The state could mandate that the benefit be covered in the ACA or for all fully insured commercial plans, but would need to defray the costs for any QHP

# Adult Dental

## Benefit Summary

### **Benefit Considerations**

- Dental health is often related to physical health
- Preventive coverage could ensure getting the proper cleaning, but benefit would not cover any restorative needs
- Denture coverage is difficult to cover without office visits and preventive care (member would likely have some out of pocket costs)

### **Cost**

- Preventive: Estimated increase in allowed costs would be between 1.3% and 1.7% for adult coverage only (child dental plans are covered separately under the ACA). The impact would be less if cost sharing were applied to the benefit.
- Dentures: Estimated increase in allowed costs would be between 0.0% and 0.2%. The impact would be less if cost sharing were applied to the benefit.



# Adult Vision

## Benefit Summary

### Benefit Definition

- Eye exam and eyeglasses or contacts every two years. Includes the assumption that reasonable cost sharing or other cost containment measures would be incorporated in the benefit.
- Currently priced assuming it would be a mandatory benefit (i.e., no selection).

### Background

- CMS regulations do not allow for the classification of any adult vision benefits as a EHB.
- The state could mandate that the benefit be covered in the ACA or for all fully insured commercial plans, but would need to defray the costs for any qualified health plans.
- In commercial markets, adult vision benefits are not prevalent in the ACA markets, with only 6% of plans offering coverage from 2020 to 2022. The large group market has higher prevalence (35%).
- Significant variation in services covered, spending allowance, and cost-sharing.
- The most common offering is routine eye exams at no cost; hardware every 12 months with various copays or spending allowance.

# Adult Vision

## Benefit Summary

### **Benefit Considerations**

- Improved quality of life
- Dilated eye exams are important to ensure early detection of ocular diseases. These exams can also detect serious health diseases.

### **Cost**

- Limits and cost sharing will drive the overall cost significantly. Ultimately, actual costs could be outside the range based on the final plan structure but the below costs are illustrative based on a moderate vision plan.
- Estimated increase in paid costs would be between 0.6% and 1.0% for adult coverage only (child vision is already covered as part of the medical plan).

# PCP and MHSA Visits

## Benefit Summary

### **Benefit Definition**

- Provide two PCP and/or MHSA visits with no cost-share on the standard plan designs

### **Background (based on 2022 plan designs)**

- Vermont's standard plan designs waive the deductible for office visits on most plans. The exceptions are HDHPs (not allowed) and the bronze plan with the lower drug maximum out of pocket. Where the deductible is waived, the copays for office visits are \$20 for gold, \$35 for silver, and \$40 for bronze.
- Both BCBSVT and MVP offer a non-standard bronze plan where up to 3 office visits have no cost sharing before the deductible/copays start. BCBSVT offers this on their nonstandard silver and gold plans as well, while MVP waives the deductible (there is a \$30 copay) for the first 3 office visits for their non-standard silver plan.

### **PCP and MHSA Utilization (based on the draft 2023 Federal Actuarial Value Calculator)**

- The 2023 federal actuarial value calculator's (AVC) continuance tables for PCP visits (excludes MHSA) for silver plans implies that roughly 86% of members have two or fewer office visits in a year (including some who have none) and almost 80% of PCP office visits would be "free" if up to two PCP office visits were covered.
- The Federal AVC does not have a continuance table for MHSA office visits but the overall utilization of MHSA visits is roughly 60% to 80% (varies by metal level) of the PCP utilization per member per year, on average.

# PCP and MHSA Visits

## Benefit Summary

### Benefit Considerations and Cost

- First dollar coverage of PCP visits will require MH/SUD coverage in parity.
- Changing this benefit will require the premiums or cost sharing for other services to be increased to offset the impact to actuarial value.
- The impact is smaller for richer plans (e.g. gold) since the copay is less. It is most expensive for bronze plans in which the deductible currently applies to PCP and MHSA office visits, where the change in benefit would also be most beneficial to members.
- The following table shows the change in actuarial value by metal level for both 2 free visits and 1 free visit. Platinum was not reviewed given how rich the plan already is.
- There were significant changes to the federal AVC for 2023, which is significantly increasing actuarial values for the silver plans, without any cost sharing changes.
- The Standard Plan Design workgroup is considering these changes for the silver and bronze standard plans.

Benefit	Increase in Actuarial Value*			
	Gold (OV Copay of \$20)	Silver (OV Copay of \$35)	Bronze (OV Copay of \$40)	Bronze (Deductible applies to OVs)
2 Free PCP/MHSA Office Visit	0.3% to 0.4%	0.7% to 0.9%	0.8% to 1.0%	4.1% to 4.8%
1 Free PCP/MHSA Office Visit	0.2% to 0.3%	0.4% to 0.6%	0.5% to 0.7%	2.7% to 3.3%

- These estimates are draft and would need to be refined if this benefit change is pursued. Specifically, a distribution of member office visits would need to be created that combines both PCP and MHSA visits.
- The actuarial value increase is roughly similar to the increase in premiums, assuming cost sharing for other services are not increased to offset.

# Questions?

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# Appendices

# Disclosures and Limitations

# Disclosures and Limitations

- **Responsible Actuaries.** Julie Peper and Matt Sauter are the actuaries responsible for this document. Julie is a Fellow of the Society of Actuaries and Matt is an Associate of the Society of Actuaries. Both Julie and Matt are Members of the American Academy of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this document.
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- **Data and Reliance.** The current cost estimates rely on data provided obtained in the VHCURES data set, online publications, and third party subject matter experts. As such, we have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly.
- **Subsequent Events.** These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this report. Material changes as a result of Federal or state regulations may also have a material impact on the results. There are no specifically known relevant events subsequent to the date of engagement that would impact the results of this document.
- **Contents of Actuarial Report.** This document is not an actuarial report and does not comply with Actuarial Standards of Practice on communication. Once the analysis is complete, a full report will be provided the lists all data and assumptions used in the comparison of benefits for purposes of supporting EHB changes to CMS.



# Additional EHB Regulations and Information

# Links & Resources

- CMS EHB Reference Page  
<https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb>
- CMS' EHB Process Overview (February 2021)  
[https://www.regtap.info/uploads/library/PMSC\\_Slides\\_022421\\_5CR\\_022421.pdf](https://www.regtap.info/uploads/library/PMSC_Slides_022421_5CR_022421.pdf)
- CO Benchmark Plan Comparison Chart  
<https://drive.google.com/file/d/0BwguXutc4vbpTIZYRIhKZmFFZWWM/view>

# Federal Regulations

- Under 45 CFR 156.111 states may select a new EHB-benchmark plan (BMP) for 2020 BY or later (finalized in 2019 NBPP) using one of 3 options
  - Select an EHB-benchmark that another plan used for the 2017 BY
  - Replace one or more categories of EHB with another 2017 BY BMP
  - Select a new set of benefits to become the state's EHB-benchmark plan, provided certain conditions are met
- May 7, 2021 application deadline for BY 2023
  - Provide reasonable public comment period
  - Submit supporting documentation
  - Fulfill typicality and generosity standards

# Federal Regulations

## Typicality and Generosity Tests

- Generally, there are two actuarial requirements the proposed benchmark plan must meet – the typicality and generosity test
- Typicality Test - Provide a scope of benefits in the new EHB-benchmark plan that are equal to the scope of benefits provided under a typical employer plan selected by the state
- Generosity Test - Ensure the new EHB-benchmark plan does not exceed the generosity of the most generous among a set of comparison plans by 0.0 percentage point actuarial increase

# Federal Regulations

## Typicality Test

- Step 1 – Select a typical employer plan among the options at §156.111(b)(2)(i): One of the state’s 10 base-benchmark plans or one of the five largest group plans
- Step 2 – Calculate the expected value of covering all of the benefits at 100 percent actuarial value in the proposed EHB-benchmark plan and in the typical employer plan, including any necessary supplementation
- Step 3 – Compare the expected value of covering all of the benefits (at 100 percent actuarial value) in the typical employer plan to that of the state’s proposed EHB-benchmark plan

# Federal Regulations

## Generosity Test

- Step 1 – Determine the most generous plan among this set of comparison plans
- Step 2 – Calculate the expected value of covering all of the benefits at 100 percent actuarial value in the proposed EHB-benchmark plan and in the most generous plan among the set of comparison plans, including any necessary supplementation
- Step 3 – Compare the expected value of covering all of the benefits (at 100 percent actuarial value) in the most generous plan among the set of comparison plans to that of the proposed state's EHB-benchmark plan