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BEYOND THE NUMBERS

VT EHB Benchmark Plan

EHB Overview & Potential 2024 Changes

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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 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 6th

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

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 - IVF	Covers diagnostic testing only	Includes IVF, drugs, AI, and egg preservation with medical and drug lifetime limits (excludes surrogates)	1.31% to 1.71%
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
Total			**1.58% to 2.29%**

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.

Wakely

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 against the typicality test to ensure both tests pass

Benefit Pricing & Selection

Benefit Changes Considered

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

- Nutritional Counseling
  - Current benefit states the benefit is unlimited for diabetics but limited to 3 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
- 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 5 but age limit would be removed

Benefit Pricing & Selection

Benefit Changes Considered Based on Stakeholder Feedback

Benefit	Notes
Hearing Aids	Hearing exam and hearing aids each ear every 3 years
Infertility Services	Goal is to match the State of Vermont 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 3 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 0.22% to 0.49% remaining for additional benefits (e.g., medically tailored meals) or to save 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 $8.30 to $12.00 per member per month (PMPM)

Benefits - Changes Considered	Benefits to Add	Range of Impact to Allowed Costs
Infertility Treatment - IVF	Includes IVF, drugs, AI, and egg preservation; 3 cycle limit	1.31% to 1.71%
Hearing Aids	Propose limit of one per ear every 3 years	0.05% to 0.09%
Medically Tailored Meals	Varies	Varies
Total		**1.35% to 1.79%**
Generosity Testing “Room”		**1.58% to 2.29%**

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
Connecticut	Diagnoses and treatment of infertility IVF – two cycles	N/A
Maine	None	N/A
Massachusetts	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 6 months.
New Hampshire	Diagnoses and treatment of infertility	Artificial Insemination IVF procedures
New Jersey	Diagnoses and treatment of infertility Artificial Insemination	IVF procedures Preservation
New York	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
Pennsylvania	Diagnoses and treatment of infertility Artificial insemination	IVF procedures
Rhode Island	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. 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

- 1.31% to 1.71% increase to allowed costs
- Around an $8.00 to $11.40 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 3 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. 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

Non-EHB Considerations

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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 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 qualified health plans

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.

	Increase in Actuarial Value*			
Benefit	**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.
- **Intended Users.** This information has been prepared for the sole use of the State of Vermont's Department of Financial Regulations. Distribution to parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this document should retain their own actuarial experts in interpreting results.
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- **Conflict of Interest.** Wakely provides actuarial services to a variety of clients throughout the health industry. Our clients include commercial, Medicare, and Medicaid health plans, the federal government and state governments, medical providers, and other entities that operate in the domestic and international health insurance markets. Wakely has implemented various internal practices to reduce or eliminate conflict of interest risk in serving our various clients. Except as noted here, the responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis.
- **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

- CO Benchmark Plan Comparison Chart
  https://drive.google.com/file/d/0BwguXutc4vbpTlZYRlhKZmFFZWM/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