Public Meeting on California's Essential Health Benefits and Updating the Benchmark Plan

June 27, 2024

Welcome & Introductions

Mary Watanabe, Director, DMHC

Agenda

1. Welcome and Introductions
2. Overview of Essential Health Benefits
3. Process for Establishing a New Benchmark Plan
4. Public Comment
5. Closing Remarks

Overview of Essential Health Benefits

Sarah Ream, Chief Counsel, DMHC

Essential Health Benefits (EHBs)

- EHBs are the benefits that all non-grandfathered health plan contracts in the small group and individual market must cover under federal law and through requirements set forth in state statute.
- Must include benefits from all 10 categories of benefits.

EHB Categories

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Essential Health Benefits

- Per federal requirements, states choose a “benchmark plan,” to establish the EHB benefits in that state.
- States could not select benefits ala carte—had to chose an existing plan product.
- California selected the 2014 Kaiser Foundation Health Plan Small Group HMO 30 plan to be California’s benchmark plan.
- Historically, a state must defray the costs of mandated benefits that “exceed EHB.”

Timeline

- June 27, 2024: Public Meeting
- June – July 2024: Analysis of current benchmark plan and determine benefit allowance for proposed benchmark plan
- July – August 2024: Identify potential options and price
- August 2024: Legislative hearing
- May 2025: Notify HHS of selection of new EHB benchmark plan
- January 1, 2027: Effective date of new benchmark plan

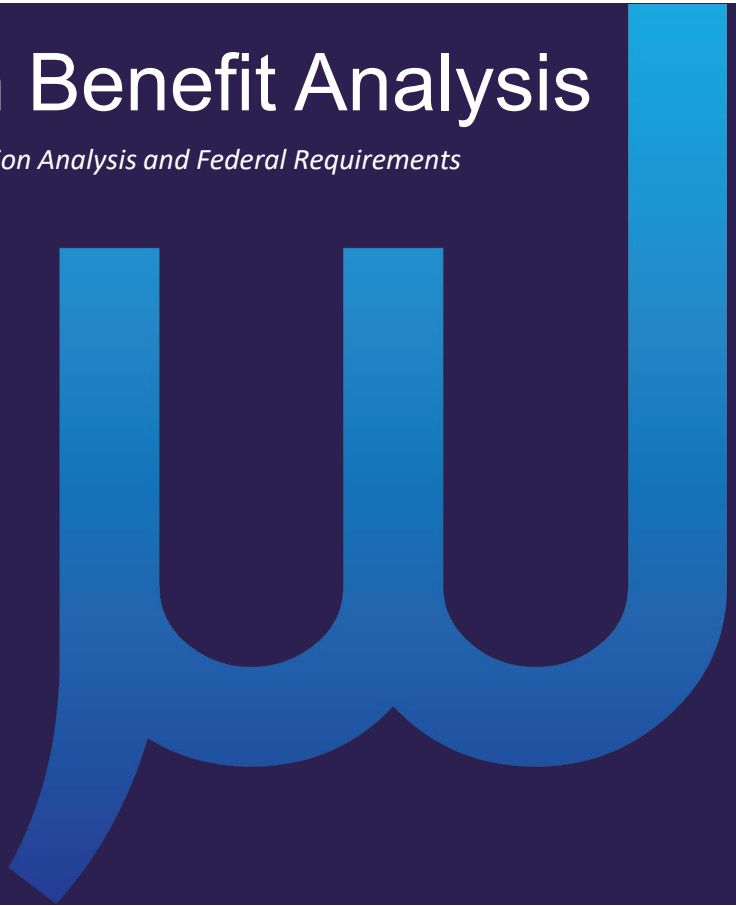
Process for Establishing a New Benchmark Plan

Matt Sauter, Senior Consulting Actuary, Wakely

Wakely
BEYOND THE NUMBERS

Essential Health Benefit Analysis

Plan Year 2027 EHB Benchmark Plan Application Analysis and Federal Requirements



Presented by
Matt Sauter, ASA, MAAA
Jenna Stefan, ASA, MAAA

June 2024

Agenda and Table of Contents

Discussion Topic
Federal Regulations
Typicality Test
Benefit Pricing & EHB Pathways
Disclosures and Limitations

Federal Regulations

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. **To date, states have only used this option.**
- Applications for EHB BMP changes effective BY 2027 are due May 2025. States must:
  - Provide reasonable public comment period (2 weeks minimum).
  - Submit supporting documentation.
  - Fulfill typicality test standard (more on next slide).
- BMP cannot contain any:
  - Lifetime or annual limits or maximum dollars.
  - Discriminatory benefits. E.g., foot care for diabetics revises to foot care as medically necessary.
- CMS must approve any changes to the EHB BMP.

Typicality Test Standard

- New EHB-benchmark plan must provide a scope of benefits that is as or more generous than the scope of benefits in the state's least generous typical employer plan, and as or less generous than the scope of benefits in the state's most generous typical employer plan.
- **Step 1 – Plan Comparisons**
  - Identify and gather plan documents for eligible comparison plans for use in CMS testing. These options include:
    - One of the state's 10 base-benchmark plan options established at 156.100 from which the state was able to select for the 2017 plan year; or
    - One of the five largest group plans provided the plans meet certain requirements like benefits in the plan are from a plan year beginning after December 31, 2013
  - Determine the least and most generous plans among that group.
- **Step 2 – Determine the "Room" to Add/Remove Benefits**
  - Calculate the expected value of covering all of the benefits at 100 percent actuarial value in the proposed EHB-benchmark plan and the two comparison plans.
  - Where the current benchmark falls in that range determines the room to add or remove benefits from the BMP.
- **Step 3 – Compare the Comparison Plans to the Proposed Benchmark**
  - Determine the expected value of the new benchmark plan and confirm it falls in the typicality range.

Benefit Pricing & EHB Pathways

Benefit Pricing & Selection

Changes to EHB

- Wakely will evaluate the value of each benefit being considered for inclusion in the 2027 benchmark (using ACA data, publicly available data, CA health care service plan and insurer input, and actuarial judgement).
- Compare newly proposed benchmark plan against typicality test such that benefit changes do not result in the new EHB plan being richer than the most generous or less rich than the least generous plans for typicality testing.
- Benefit pricing estimates are based on our best understanding of the benefit and the current coverage. In all cases, a range will be provided.

Benefit Pricing & Selection

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.
- Key considerations for the allowed cost included in the analysis
  - The estimates are based on ongoing 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.
- Ultimately, the premium impact of the changes will vary based on health care service plan or insurer pricing, cost sharing of the benefits, and changes, if any, to administrative costs due to the changes.

Benefit Pricing & Selection

Discriminatory Considerations

- Per CMS guidance, the state is required to address discriminatory benefit design in the current EHB BMP.
- Any changes to discriminatory language are not considered changes to the EHB BMP and do not need to be factored into the typicality test.
- Examples of discriminatory language in other states:
  - Covering services for members with particular conditions only. Example: routine foot care for diabetics. Could revise language to specify coverage as medically necessary.
  - Having different benefit limits for different conditions. Example: having a higher acupuncture visit limit for chemical dependency.
  - Covering services for members of a particular age only (e.g., under 21).
  - Lifetime maximums on all benefits must be removed if still prevalent.

Potential Benefit Additions to BMP

Description of Benefits

Benefit*	Notes
Adult dental	Can determine price separately for periodontics, prosthetics, endodontics, orthodontics, endodontics.
Hearing aids	Common offering is annual hearing aid exam and one set of hearing aids every 3 years.
Durable medical equipment	e.g., Wheelchairs, oxygen tanks, wigs.
Services to treat infertility	Can determine price separately for artificial insemination, IVF, fertility medications, and preservation.
Chiropractic services	Current benchmark does not offer chiropractic services. Can determine cost of offering and setting limit at different benefit levels (8, 12, 20, etc.).

*Benefit list shown is not exhaustive. More benefits may be explored following stakeholder feedback.

Recently Approved and Proposed EHB BMP Changes

Summary Table – Medical Only

Themes	# of States*	Relative Cost
Opioid reversal agent (naloxone)	6	Low to Medium
Hearing Exams and Hearing Aids Every 3 Years	4	High
Mental wellness, psychiatric	3	Low
Expanded coverage of prosthetics	2	Low to Medium
Chiropractic	2	High
Acupuncture	2	Medium to High
Nutritional counseling	2	Medium to High
Artery Calcification Testing	1	Low
Weight Loss Treatment for Obese Members	1	Low

Themes	# of States*	Relative Cost
Gender Affirming Care	1	Low
Expanded Coverage for Diagnosis and Treatment of Periodontal Disease to All Ages	1	Low to Medium
Expanded prostate cancer screening access	1	Low to Medium
Expanded Coverage of Medical Formula for Those with Inherited Metabolic Disorders	1	Low
Human Donor Milk	1	Low
Artificial Insemination in Vivo	1	Low
Massage Therapy	1	Low
TMJ Diagnosis, Therapy, and Treatment	1	Low
Expanded Coverage for Insulin/Insulin Supplies	1	High

- "Relative Cost" represents rough, illustrative estimate of average cost impact of adding the benefit
- Some of these benefits are already covered in CA

*Count of states includes both approved and proposed changes effective BY2026
https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb

Disclosures and Limitations

Disclosures and Limitations

- **Responsible Actuaries.** Matt Sauter and Jenna Stefan are the actuaries responsible for this document. Matt and Jenna are Associates of the Society of Actuaries and 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 California stakeholders. 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.
- **Risks and Uncertainties**. The assumptions and resulting estimates included in this document and produced by the modeling are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that California and/or the issuers will attain the estimated values included in the document. It is the responsibility of those receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.
- **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 summaries rely on plan documents for CA and other target states available on CMS's website. 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.

Public Comment

Public comments may be submitted until 5 p.m. on July 11, 2024 to publiccomments@dmhc.ca.gov

Timeline

- June 27, 2024: Public Meeting
- June – July 2024: Analysis of current benchmark plan and determine benefit allowance for proposed benchmark plan
- July – August 2024: Identify potential options and price
- August 2024: Legislative hearing
- May 2025: Notify HHS of selection of new EHB benchmark plan
- January 1, 2027: Effective date of new benchmark plan

Closing Remarks

Mary Watanabe, Director, DMHC