State of South Dakota

Essential Health Benefits

Analysis of 2021 Benchmark Plan Options

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Prepared By

Nicholas Ramey, ASA, MAAA

Leif Associates, Inc.
1331 Seventeenth Street, Suite 350
Denver, CO 80202
303-294-0994

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Executive Summary

Leif Associates was engaged by the South Dakota Division of Insurance (DOI) in December 2018 to perform an actuarial analysis of the State's 2021 Essential Health Benefit (EHB) benchmark plan options. The scope of our work was as follows:

- To identify gaps in coverage in the current EHB benchmark plan relative to the ten Essential Health Benefit categories as defined by the Affordable Care Act (ACA);
- To develop options for covering any identified gaps in the current EHB benchmark plan; and
- To make recommendations for the selection of the South Dakota 2021 Essential Health Benefits benchmark plan.

Although the plan underlying the 2017 EHB benchmark was the then current version, the plan was originally introduced in 2012. As such there was potential that gaps in coverage beyond those identified during the 2017 EHB benchmark analysis process could have since formed. Because of this, the DOI gathered information from stakeholders, including carriers operating in the State, to assist them in identifying possible gaps in the current EHB benchmark.

The regulatory approach provided for under 45 CFR §156.111 allows the following three options for changing the EHB benchmark for plan years beginning 2020 and later:

1. Selecting the EHB benchmark plan that another State used for the 2017 plan year under 45 CFR §§156.100 and 156.110;
2. Replacing one or more categories of EHBs established at 45 CFR §156.110(a) in the State's EHB benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB benchmark plan that another State used for the 2017 plan year under 45 CFR §§156.100 and 156.110; or
3. Otherwise selecting a set of benefits that would become the State's EHB benchmark plan.

These options are constrained on the lower bound by the typical employer plan, and on the upper by the most generous plan among a set of comparison plans. Both boundaries are discussed in detail below. This analysis relates only to covered services, not to cost-sharing.

Key Findings and Recommendations

ACA-compliant non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces must cover EHB. EHB must include items and services within ten benefit categories and must equal the scope of benefits provided under a typical employer plan constrained as noted above.

As noted above, part of our project is to identify gaps in coverage in the current EHB benchmark, and that since the underlying plan was originally filed in 2012, it is likely that some have formed since the 2017 analysis. Also noted above is that the DOI launched a stakeholder input process to assist them in identifying any potential gaps.

Few gaps were identified through the process and Applied Behavioral Analysis (ABA) therapy for treatment of Autism Spectrum Disorder (ASD) was found to be the one with the most stakeholder interest. As part of the stakeholder input process it was found that 32 states currently include ABA in their EHB benchmark plans. In addition, during the 2019 State legislative session ABA therapy and coverage were discussed at length. Finally, both stakeholder and legislative interest were likely impacted in part by the limited ABA mandate passed by the State in 2015 that applied only to non-ACA grandfathered and transitional business since it spurred discussion and generated useful data.

Executive Summary

We reviewed the benefits under the 2017 benchmark options and the choices for changing the EHB benchmark as provided for in regulation, both in light of the identified shortcoming of the 2017 EHB benchmark, and found the following:

- There were only minor benefit differences between the 2017 benchmark plan options, with the expected cost differences from the Wellmark Blue Select PPO Primary plan being in the range of plus or minus 1%. The one exception was the FEHBP plans which covered dental benefits for adults and as a result had a considerably higher value.
- As a result of this analysis, we recommend modifying the 2017 EHB benchmark through the addition of ABA coverage to habilitative services by utilizing the third option provided for in regulation.

Statutory and Regulatory Requirements

Section 1302(b) of the Affordable Care Act states the requirements for defining EHB. Non-grandfathered plans in the individual and small group markets must cover EHB both inside and outside of the Marketplaces. Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to cover the EHB.

Section 1302(b)(1) provides that EHB include items and services within the following ten benefit 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; and
10. Pediatric services, including oral and vision care.

Section 1302(b)(2) of the Affordable Care Act states that the scope of EHB shall equal the scope of benefits provided under a typical employer plan. In defining EHB, section 1302(b)(4) directs that benefits must not be designed in ways that discriminate based on age, disability, or expected length of life, but must consider the health care needs of diverse segments of the population.

In addition, Section 1311(d)(3) of the Affordable Care Act requires States to defray the cost of any benefits required by State law to be covered by qualified health plans beyond the EHB. If a State adds mandated benefits after December 31, 2011, or chooses a benchmark plan that does not include all State-mandated benefits, the State would be required to defray the cost of those mandated benefits in excess of EHB as defined by the selected benchmark. Note, however, that benefits added to the State EHB through the EHB-benchmark plan selection process required under 45 CFR §156.111 meeting the generosity limitation described in 45 CFR §156.111(b)(2)(ii), meet the definition of EHB and therefore are exempt from the defrayment requirement.

The statute distinguishes between a plan's covered services and the plan's cost-sharing features, such as deductibles, copayments, and coinsurance. The cost-sharing features will determine the level of actuarial value of the plan, expressed as a "metal level" as specified in statute: Bronze at 60% actuarial value; Silver at 70% actuarial value; Gold at 80% actuarial value; and Platinum at 90% actuarial value.

States had the flexibility to choose a benchmark plan from among the following health insurance plans:

- The largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;
- Any of the largest three State employee health benefit plans by enrollment;
- Any of the largest three national FEHBP plan options by enrollment; or
- The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

CMS clarified that the enrollment numbers used to determine the 2017 benchmark plan options would be as of the first quarter of 2014 and the products must have been approved for sale for the first quarter of

2014. The largest small group market plan in the State would be the default benchmark plan for each State. If a State failed to designate a benchmark plan, this plan would have by default become the benchmark plan.

If the benchmark plan chosen by a State is missing coverage in one or more of the ten statutory categories, the State must supplement the benchmark by reference to another benchmark plan that includes coverage of services in the missing category. The default benchmark plan would be supplemented by looking first to the second largest small group market benchmark plan, then to the third, and then, if neither of those alternative small group market benchmark plans offers benefits in a missing category, to the FEHBP benchmark plan with the highest enrollment. Special rules apply to pediatric oral and vision services and habilitative services, which are not included in many health insurance plans.

The EHB plan can include scope and duration limits, although annual and lifetime dollar limits are prohibited. If a benefit, including a State-mandated benefit which has a dollar limit, is included within a State-selected EHB benchmark plan, it must be incorporated into the EHB definition without the dollar limit. However, actuarially equivalent substitutions within statutory categories are allowed, such as replacing dollar limits with visit limits.

A special rule applies to habilitative services. HHS has adopted a uniform definition of habilitative services and for plan years beginning 2017 and later is requiring separate limits on rehabilitative and habilitative services.

As noted above, and briefly summarized below, there are three options for changing the EHB benchmark for plan years beginning 2020 and later:

1. Selecting another State's 2017 EHB benchmark plan;
2. Replacing one or more categories of EHBs in the State's 2017 EHB benchmark plan with the same category or categories of EHB from another State's 2017 EHB benchmark plan; or
3. Otherwise selecting a set of benefits that would become the State's EHB benchmark plan.

Also as noted above, these options are constrained on the lower bound by the typical employer plan, and on the upper by the most generous plan among a set of comparison plans. Both boundaries are discussed in detail below.

As required under 45 CFR §156.111(b)(2)(i), a State's EHB benchmark plan must provide a scope of benefits equal to, or greater than, the scope of benefits provided under a typical employer plan, defined as either:

1. One of the State's 10 base-benchmark plan options used in selecting the State's 2017 EHB benchmark plan; or
2. The largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in the State.

In addition, it is required under 45 CFR §156.111(b)(2)(ii) that a State's EHB benchmark plan must not exceed the generosity of the most generous among a set of comparison plans, including:

1. The State's EHB benchmark plan used for the 2017 plan year; and
2. Any of the State's base-benchmark plan options for the 2017 plan year described in 45 CFR §156.100(a)(1), supplemented as necessary under 45 CFR §156.110.

South Dakota's 2017 Benchmark Plan Options

Summary of 2017 Plan Options

The options used to develop South Dakota's 2017 EHB benchmark plan were identified by the DOI with survey assistance from Leif Associates. The plan recommended and approved as the benchmark was the Wellmark of South Dakota Blue Select PPO Primary. During the 2017 analysis, four coverage gaps were identified. Briefly, these were: 1) substance abuse inpatient services at MHPAEA parity; 2) habilitative services on par with rehabilitative; 3) ACA-level preventive care; and, 4) ACA pediatric vision and dental services. The full set of options was as follows:

Category	Plans
The largest plan by enrollment in any of the three largest small group insurance products in the State's small group market	• Wellmark of South Dakota Blue Select PPO Primary (default plan) • Sanford Health Plan Signature Series (second largest) • DAKOTACARE Choice Group (third largest)
Any of the largest three State employee health benefit plans by enrollment. Note, all three plans have the same benefits and member share has no impact.	• $500 Deductible • $1,000 Deductible • $1,800 Deductible HSA
Any of the largest three national FEHBP plan options by enrollment	• BCBS High Plan • BCBS Standard Plan • GEHA Standard Plan
The largest insured commercial non-Medicaid HMO operating in the State	• Sanford Health Plan Signature Series

Summary of 2017 Benefit Cost Differences

The table below shows a summary of the expected relative benefit cost differences between the benchmark options used to develop the 2017 EHB benchmark plan. All the plans were close in value (± 1.0%) except for the FEHBP plans, which included dental benefits for adults and therefore had a value that was 8% to 10% higher. For details of how these values were derived and how the benefit coverage gaps identified above were addressed through the supplementation methodology required under 45 CFR §156.110, please see the 2017 EHB analysis report.

Category	Plan	Relative Benefit Value
Small Group	Wellmark Blue Select PPO Primary (Default)	0.0%
	Sanford Signature Series	-1.0%
	DAKOTACARE Choice Group	0.1%
State Employee	$500 Deductible	0.3%
	$1,000 Deductible	0.3%
	$1,800 Deductible HSA	0.3%
FEHBP	BCBS Standard	9.1%
	BCBS Basic	8.6%
	GEHA Standard	10.1%
HMO	Sanford Signature Series	-1.0%

Summary

Recommendation

Based on our analysis and the coverage shortcoming identified by the stakeholder process, we recommend continuing the 2017 South Dakota EHB benchmark plan, but with the addition of coverage for ABA therapy subject to the following minimum coverage limits:

- Through age 6 – 1,300 hours per year;
- Age 7 through age 13 – 900 hours per year; and
- Age 14 through age 18 – 450 hours per year.

Methodology

Since our recommendation is to retain the 2017 South Dakota EHB benchmark plan for 2021 augmented with the coverage of ABA therapy for ASD treatment, we simply needed to add the value of that benefit to the value previously determined for the 2017 EHB plan. As such, we were able to leverage the calculation of values and cost differences performed for the 2017 analysis as listed above.

The typical employer plan is therefore the 2017 South Dakota EHB benchmark plan which, as noted above, was based upon the Wellmark of South Dakota Blue Select PPO Primary, supplemented as necessary under 45 CFR §156.110, and as documented in our analysis of South Dakota's 2017 EHB benchmark plan options.

Thus, the test that the proposed plan provide a scope of benefits equal to, or greater than, the scope of benefits provided under a typical employer plan as required under 45 CFR §156.111(2)(i) is automatically met.

The value of the added ABA therapy benefit was developed based on data on ABA therapy claims collected by the DOI from all carriers in the state for both ACA and non-ACA grandfathered and transitional plans.

South Dakota mandated coverage of ABA therapy for non-ACA grandfathered and transitional plans effective beginning 2016. Simultaneously one of the carriers made the benefit available on all their individual and small employer ACA plans as well. The combined data from these sources provided a wealth of information for assessing the impact of adding ABA coverage to South Dakota's EHB benchmark.

Since non-ACA grandfathered and transitional plans are generally closed to voluntary new sales, not surprisingly, no new ASD-diagnosed / ABA-eligible members were added to the enrollment in non-ACA grandfathered and transitional plans and no ABA claims were incurred. The same is approximately also true for ACA-compliant small group plans, and only a small impact was observed. However, ACA-compliant individual plans were open to accept new members, and as expected, the impact to ASD-diagnosed / ABA-eligible members was substantial.

Although it is likely that the impact to ACA-compliant plans reflected the majority of ABA-eligible children in the state, the estimated market-wide claim impact was developed using only the ACA-compliant plans as the base population. This method was chosen for two reasons: 1) it is more conservative, resulting in the greatest estimated relative impact; and, 2) it is unclear how long the non-ACA grandfathered and transitional plans will remain active and their enrollment insulated from an influx of ABA-eligible members.

The 2016 enrollment and total allowed claims for both the ACA and transitional plans were obtained from the 2018 ACA rate filing URRTs. The data regarding ASD-diagnosed / ABA-eligible members and their associated ABA claims were obtained directly from the carriers by the State. The use of allowed claims, rather than paid claims, is to be consistent with the approach required for this analysis that considers underlying benefit costs unimpacted by member share differences.

The estimated impact of the inclusion of ABA coverage in the ACA market was developed by determining the proportion of total allowed claim dollars attributable to ABA claims. Based on our analysis, the value of the addition of ABA therapy to the covered services of ACA-compliant plans is estimated to be 0.3% of allowed claim dollars. In addition, for perspective, we also estimated the impact to the combined ACA and transitional market to be 0.2% by including the transitional claims and enrollment in the total market values. However, as noted above, it is currently uncertain when transitional options will be closed, forcing migration to the ACA-compliant plans, so it is more conservative to assume they continue to be isolated from changes to the EHBs.

The recommended treatment limit for children through age six was developed from this data and provides a level of coverage that would address the needs of a majority of the children represented in the data. Available literature agrees that early intervention is better and therefore should be encouraged. In addition, for school-age children, South Dakota public schools provide services for the treatment of ASD, and this therefore lessens the need for treatment coverage through private insurance. Both circumstances motivate minimum treatment limits that reduce with age. The treatment limits for the older ages were developed based on the limit for the first age band reduced to reflect this decreasing need pattern and to be in proportion to the age-banded limits mandated for non-ACA grandfathered and transitional plans in existing State law.

The second test that must be met is that the proposed plan not exceed the generosity of the most generous among a set of comparison plans including the State's 2017 EHB benchmark plan and any of the State's base-benchmark plan options for the 2017 plan year described in 45 CFR §156.100(a)(1), supplemented as necessary under 45 CFR §156.110.

From the table above of the benefit cost differences of South Dakota's 2017 EHB benchmark plan options, supplemented as necessary, it can be seen that the FEHBP GEHA Standard plan is the most generous of the 2017 options, with a value 10.1% greater than the plan chosen to be the 2017 benchmark, Wellmark of South Dakota Blue Select PPO Primary.

Although our initial review of this regulatory requirement would indicate that the FEHBP GEHA Standard plan is the most generous of the 2017 options allowed under the benchmark determination regulation applicable at the time, all three FEHBP plans contain benefits beyond the ten EHBs (adult dental and/or adult routine eye exam). If the FEHBP plans were to be adjusted to remove these benefits, they would no longer be the most generous among the 2017 options.

As such, the three State employee plans meet the criteria of maximum generosity and are therefore the applicable standard of generosity under 45 CFR §156.111(b)(2)(ii). From the table above of the benefit cost differences of South Dakota's 2017 EHB benchmark plan options, supplemented as necessary, it can be seen that the three State employee plans are the most generous of the 2017 options (under the noted CMS constraint), with a value 0.3% greater than the plan chosen to be the 2017 benchmark, Wellmark of South Dakota Blue Select PPO Primary.

Since the value of the proposed 2021 EHB benchmark plan mirrors the 2017 EHB benchmark plan, but with the coverage addition of ABA therapy valued at an increase of 0.3%, the test is met since the allowable increase in generosity would be the 0.3% noted above.

Appendix B – State Essential Health Benefits-benchmark Plan Actuarial Certification

OMB No. 0938-1174
Expires: XX/XX/2021

APPENDIX B: ESSENTIAL HEALTH BENEFITS (EHB)-BENCHMARK PLAN ACTUARIAL CERTIFICATE TEMPLATE

Instructions for Completing Appendix B:

Under §156.111(e)(2), States must submit an actuarial certification as part of the EHB-benchmark selection process affirming that the State's EHB-benchmark plan:

- provides a scope of benefits that is equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.111(a), the scope of benefits provided under a typical employer plan as defined at §156.111(b)(2)(i); and
- does not exceed the generosity of the most generous among plans listed at §156.111(b)(2)(ii)(A) and (B).

States must complete all fields of this actuarial certification. CMS will consider any partial or blank fields as incomplete. The actuarial report associated with this certification must be submitted as an attachment. Actuarial reports should be uploaded in a format that prevents further editing after submission. For example, States can scan copies of the Actuarial Report or convert documents into a PDF format to upload

SECTION 1: BACKGROUND INFORMATION

State

South Dakota

1. Which EHB-benchmark plan option (at 45 CFR §156.111(a)) is the State using to make changes to its EHB-benchmark plan? *(Only provide one selection)*

- ○ (a)(1) - Selecting the EHB-benchmark plan that another State used for the 2017 plan year under §156.100 and §156.110
- ○ (a)(2) - Replacing one or more categories of EHBs under §156.110(a) under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another State used for the 2017 plan year under §156.100 and §156.110.
- ◉ (a)(3) - Otherwise selecting a set of benefits that would become the State's EHB-benchmark plan.

SECTION 2: TYPICAL EMPLOYER PLANS DETERMINATION FOR §156.111(b)(2)(i)

2. Which definition of a typical employer plan at §156.111(b)(2)(i) was used for the determination under this actuarial certification and associated report? *(Only provide one selection)*

- ◉ One of the selecting State's 10 benchmark plan options established at §156.100 of this subpart, and available for the selecting State's selection for the 2017 plan year.
- ○ The largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in the State, as product and plan are defined at §144.103, provided that: (1) The product has at least ten percent of the enrollment among the five largest large group health insurance products in the State; (2) The plan provides minimum value, as defined under §156.145; (3) The benefits are not excepted benefits, as established under §146.145(b), and §148.220; and the benefits in the plan are from a plan year beginning after December 31, 2013.

3. In accordance with §156.111(b)(2)(i), does the State's proposed EHB-benchmark plan provide a scope of benefits that are equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), the scope of benefits provided under a typical employer plan?

◉ Yes ○ No

4. What plan was the basis for determining that the State's proposed EHB-benchmark plan's scope of benefits are equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), the scope of benefits provided under a typical employer plan?

Wellmark of South Dakota Blue Select PPO Primary

5. Briefly describe the methods, assumptions, and data used to determine that the State's proposed EHB-benchmark plan provides a scope of benefits that are equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), the scope of benefits provided under a typical employer plan.[1]

- Compare the benefits being offered, and
- Compare the costs of the level of those benefits.

The text boxes for questions 5 and 8 are linked so that it is not possible to input distinct responses, as such, we are providing the following response to both questions -

Please see our report, "State of South Dakota • Essential Health Benefits • Analysis of 2021 Benchmark Plan Options".

SECTION 3: LIMITATION ON EXCEEDING GENEROSITY FOR §156.111(b)(2)(i)

6. In accordance with §156.111(b)(2)(ii), does the State's proposed EHB-benchmark plan definition exceed the generosity of the most generous among a set of comparison plans, including 1) the State's EHB-benchmark plan used for the 2017 plan year, and 2) any of the State's base-benchmark plan options for the 2017 plan year described in §156.100(a)(1), supplemented as necessary under§156.110?[2]

○ Yes ◉ No

7. Which plan or plans were used as the basis to determine the most generous plan for this comparison?

Any of the three indicated South Dakota state employee plans

8. Briefly describe the methods, assumptions and data used to determine whether the State's EHB-benchmark plan does not exceed the generosity of the most generous among a set of comparison plans:

- Compare the benefits being offered, and
- Compare the costs of the level of those benefits.

The text boxes for questions 5 and 8 are linked so that it is not possible to input distinct responses, as such, we are providing the following response to both questions -

Please see our report, "State of South Dakota • Essential Health Benefits • Analysis of 2021 Benchmark Plan Options".

[1] A copy of the *Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii)* is available on CCIIO's Regulation and Guidance webpage at: https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html. The actuary's response to Questions 4 and 8 may be the same or different.

[2] The Essential Health Benefits: List of the Largest Three Small Group Products by State for 2017 is available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Top3ListFinal-5-19-2015.pdf. States' EHB-benchmark plans used for the 2017 plan year are available at https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Final-List-of-BMPs_4816.pdf.

SECTION 4: CERTIFICATION LANGUAGE

45 CFR §156.111(e)(2) requires that a State selecting its EHB-benchmark plan must submit an actuarial certification and an associated actuarial report from an actuary, who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies that affirms:

(i) That the State's EHB-benchmark plan provides a scope of benefits equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), the scope of benefits provided under a typical employer plan as defined at §156.111(b)(2)(i); and

(ii) That the State's EHB-benchmark plan does not exceed the generosity of the most generous among the plans listed in §156.111(b)(2)(ii)(A) and (B).

The analysis described in this document and supported in the actuarial report attached to this document was:

(i) conducted by a member of the American Academy of Actuaries, and

(ii) performed in accordance with generally accepted actuarial principles and methods, including complying with all applicable Actuarial Standards of Practice (ASOP).

Name of Actuary Completing Form

Nicholas A. Ramey

Actuary Signature	Date
Digitally signed by Nicholas A Ramey DN: cn=Nicholas A Ramey Date: 2019.06.25 13:44:46 -06'00'	June 25, 2019

PRA Disclosure: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1174. The time required to complete this information collection is estimated to average 47 hours or 2,820 minutes per response for States and .5 hours or 30 minutes per response for Stand Alone Dental Plans. This time includes preparing, reviewing and submitting required documents. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.