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State of Colorado: Division of Insurance

Benchmark Plan Benefit Valuation Report

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Introduction and Background

The Colorado Division of Insurance (Colorado, DOI, or State) retained Wakely Consulting Group, LLC (Wakely) to analyze the estimated cost impact of proposed changes to its state benchmark plan in the individual and small group Affordable Care Act (ACA) markets. Wakely was tasked to analyze the cost impact of a new benchmark and to determine if the new benchmark met the actuarial requirements as stated in 45 CFR 156.111.

Starting in 2020, the federal government allowed the following additional options for defining a state Essential Health Benefit (EHB) benchmark plan, beyond what the states had previously been allowed:

1. Selecting an EHB benchmark plan used by another state in 2017
2. Replacing one or more EHB categories in the current benchmark plan with those categories as defined by another state in 2017
3. Selecting a set of benefits to become the state benchmark plan

Colorado wants to evaluate whether the greater flexibility granted by CMS should be utilized to update their EHB benchmark plans.

This is the actuarial report, which is part of the State of Colorado's application for a change in the Federal CMS Plan Year 2023 Essential Health Benefit Benchmark Plan under Selection Option 3. There are two actuarial requirements in order for a change in the benchmark to be accepted. The first is that the new EHB benchmark plan must be equal to a typical employer plan. The second is that the new EHB benchmark plan does not exceed the generosity of the most generous among a set of comparison plans.

This document has been prepared for the sole use of Colorado. This report documents the results, data, assumptions, and methods used in our analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements. Using the information in this report for other purposes may not be appropriate.

Executive Summary

The Colorado Division of Insurance retained Wakely Consulting Group, LLC ("Wakely"), to analyze the estimated cost impact of proposed changes to its state benchmark plan in the individual and small group ACA markets. While the focus of the changes in the EHB package is to address gaps in current behavioral health and substance use disorder treatment, various benefits were considered as part of the evaluation process. Pursuant to 45 CFR 156.111, Colorado has elected to take public comment on a draft set of benefits to comprise the new EHB benchmark plan. Per Colorado's request, we specifically priced the following changes in benefits offered relative to the current (2017) Colorado Benchmark Plan:

- Adding acupuncture
- Adding gender affirming care
- Adding a mental wellness exam
- Expanding the required number of drugs covered for certain United States Pharmacopeia (USP) classes, also referred to as 'Alternatives to Opioids' or ALTOs.

The above EHB benefits[1] were targeted based on discussions with the Division of Insurance (DOI) and stakeholders including carriers, providers, and consumer advocates, and Wakely's and the DOI's interpretation of the current regulations regarding selection of a new state EHB benchmark plan.

We tested this new benchmark to ensure it met both the generosity test and the typical employer test as defined under 45 CFR 156.111, both of which are discussed in greater detail in a subsequent section of this report. Wakely found that if these benefits were included in the new benchmark the plan would meet both regulatory requirements.

The remainder of this document presents the pricing results and analysis of each of the benefit changes, as well as the associated methodology underlying that analysis.

Proposed Benchmark

The current Colorado benchmark plan is Kaiser LG A230 HMO. This plan was set in 2017, in accordance with the EHB rules, and approved by CMS. Under the current regulations, using Option 3, the State is allowed to develop a new benchmark plan by selecting a set of benefits rather than an existing plan offered in the market. As part of its review process, Wakely discussed

[1] A full list of services is provided in Appendix D

potential changes with Colorado's DOI and a Colorado EHB stakeholder group, which included Colorado's individual and small group issuers as well as providers and consumers advocacy organizations. Wakely also conducted analysis on the potential actuarial impact of the proposed changes. Several of the benefits considered for change were not ultimately recommended as a change. Listed below are the recommended changes and their potential impacts.

Note that no proposed changes to the Colorado EHB benchmark plan relate to pediatric dental or vision benefits. Colorado does not intend to change any of the supplemented benefits.

Recommendation: Acupuncture

Description

The State is considering adding acupuncture to the proposed benchmark plan, covering up to 6 visits per member per benefit year. The goal of offering this benefit is to provide an alternative treatment to pain management, particularly to reduce the use of opioids for pain management.

Methodology and Results

Colorado individual and small group ACA carriers provided estimates of the cost of covering up to 12 acupuncture visits. A range of the cost estimate of the benefit was created after removing the high and low carrier estimates to remove outliers. However, the recommendation is to cover up to 6 visits. Wakely used internal data to adjust the issuer-submitted data to represent 6 visits.

To adjust the carrier-provided cost estimate of 12 visits to 6 visits, Wakely separately pulled member-level claim experience for the West region[2] from Wakely internal databases (WIDs) and used this to create a Claims Probability Distribution (CPD) based on the annual number of acupuncture visits per person reported in a calendar year. Acupuncture visits were identified using a set of CPT codes provided by the Colorado DOI (97810, 97811, 97813, and 97814). Using this CPD, we estimated the allowed cost relativity between covering up to 6 and 12 acupuncture visits. Appendix A provides more detail on Wakely's benefit cost estimation approach employed in this report.

The WID data is not available at a state level. The West region data was pulled since Colorado is included in the region. However, not all states in the West region cover acupuncture. As a result, we reviewed the benefit coverage, where available, for all states in the West region. We then grossed up calculated per member per month (PMPM) amounts for the percentage of members insured in states where acupuncture is currently a covered benefit. This gross up was done to

[2] Defined by US Census Bureau: https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf

ensure our estimated claim cost was not understated due to lack of coverage. Wakely also referenced other internal claim databases to confirm reasonability of the results.

The resulting cost estimate used from the estimated range was 0.08% of the total allowed claims.[3]

Recommendation: Gender Affirming Care

Description

The recommendation is to include gender affirming care services, due to the stakeholder workgroup's interest in ensuring equitable and non-discriminatory access to medically-necessary[4] care, as well as an increased number of complaints to the DOI from individuals experiencing barriers with their insurance coverage for gender dysphoria treatment. Furthermore, the suite of services has been shown to have an association with improved mental health outcomes.[5]Generally, the gender affirming care benefits being recommended include facial feminization surgery and chest reconstruction. A complete list of the services being recommended is in Appendix D. Please note that "facial feminization surgery" is an umbrella term regarding a single or group of procedures a person may undergo to treat gender dysphoria, and that the single or group of procedures vary widely dependent on the treatment plan developed with the patient and providers.

Methodology and Results

Similar to acupuncture, Colorado ACA carriers provided estimates of the cost of the gender affirming services being considered. The carrier cost estimates varied significantly and represented different time periods (e.g. year one costs versus steady state). As a result of the varied and inconsistent cost estimate bases, Wakely used publicly available data, Colorado survey data, and the WID to estimate the average, long-term steady state cost of the services. Note that Wakely recognizes that, due to pent up demand, costs for these benefits may be higher in the first year or two of it being offered. However, our analysis of benefit costs focused on what we expect the ultimate run-rate of the benefit to be on an annual basis.

Wakely pulled member-level claim experience for the West region from Wakely internal databases (WIDs) at the CPT level. Wakely then calculated an average unit cost for all services using the unit cost for each CPT code. Next, Wakely estimated the steady state utilization of the service by

[3] Per CMS requirements, the typicality and generosity tests are calculated using the expected value at 100% actuarial value (i.e., allowed claims). Premiums generally change commensurately with changes in allowed cost, although the actual premium change is a function of cost-sharing and non-benefit expense amounts. Overall, the average premium impact is estimated to be slightly less than the allowed impact.
[4] http://www.imatyfa.org/assets/ama122.pdf
[5] https://jamanetwork.com/journals/jamasurgery/article-abstract/2779429

estimating the percentage of the population suffering from gender dysphoria based on public sources.[6] Survey data[7] provided by the DOI indicated that 80% to 100% of transgender individuals would get these surgeries if all barriers were removed. Wakely used a range of estimates for utilization, with 80% at the high end since it is likely that some barriers, such as premiums and cost sharing for coverage, will still exist. Finally, Wakely assumed that the utilization would be spread over 20 to 40 years, given these are one-time surgeries that adults would likely get between the ages of 20 and 60. Using the estimated unit cost and utilization Wakely then estimated the steady state cost of the services.

The resulting cost estimate was 0.04% of the total allowed claims. As noted, this represents a point estimate of the long-term steady state cost of the gender affirming care services. Actual costs to provide the services may vary by year, especially in the initial years of coverage where pent-up demand could increase utilization in the short-term.

Recommendation: Mental Wellness Exam

Description

The recommendation is to add a mental health wellness examination benefit. The examination would be one 45-60 minute visit per year that can include services such as behavioral health screening, education and consultation on healthy lifestyle change, referrals to ongoing mental health treatment, and discussion of potential options for medication.

Methodology and Results

Similar to other benefits, Colorado ACA carriers provided estimates of the marginal cost of adding the mental wellness exam. These estimates were used to create a range of cost estimates for the added service, with the average calculated by removing the highest and lowest carrier estimates to address outliers. Since the cost estimate of this benefit was provided by carriers on the appropriate basis and coverage amount, no adjustments were made to the carrier-submitted estimates. Mental wellness exams were identified using a set of CPT codes provided by the Colorado DOI (H0031, H0032, H0046, H0047, H0049, 96156).

The resulting cost estimate used from the estimate range was 0.02% of the total allowed claims.

[6] Flores et al. estimated that 0.56% of US adults (560 per 100,000) identify as transgender. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6626314/

[7] 2018 One Colorado LGBTQ Health Assessment Study

Recommendation: Expand Number of Drugs Covered in Certain USP Classes

Description

The recommendation is to expand the number of drugs required to be covered in certain USP Classes to provide alternatives to opioids. There are ten drug classes where the State is proposing to increase the minimum number of drugs covered. Appendix E provides the proposed, additional number of drugs required to be covered for the affected USP Classes.

The number of drugs required to be covered in USP Classes by the benchmark plan and the expanded numbers being recommended in this report do not require carriers to cover specific drugs. There may be USP Classes that do not have any drugs covered under the proposed benchmark plan. Under 45 CFR 156.122 the issuers are required to cover at least the greater of: one drug in every USP Category and Class or the same number of prescription drugs in each category and class as the EHB benchmark.

Methodology and Results

The current Colorado EHB benchmark plan includes drug coverage requirements for certain USP Categories and Classes. The proposed recommendation adds 15 drugs to certain USP Categories and Classes, as summarized in Appendix E.

To perform the analysis, Wakely used WID data - internal ACA data from the West region - to estimate the cost for expanding drug coverage in certain USP classes relative to the current benchmark plan (BMP). First, Wakely determined the unit cost of the current benchmark plan for each USP Category and Class and the total utilization for the entire drug class to estimate an allowed PMPM. To more precisely measure costs and utilization for each of the 15 drugs, Wakely used RXCUIs as the unit of analysis. RXCUIs are the clinical drug component, and a single chemically distinct drug may have multiple associated RXCUIs. Wakely identified 53 RxCUIs that belong to the 15 additional drugs that issuers could potentially select to satisfy the additional drug requirements. Wakely then added these 53 RxCUIs - representing the 15 additional unique drugs - to arrive at the proposed BMP formulary and calculated the new unit cost of the proposed covered drugs. Overall utilization was estimated to not increase due to the addition drug count. Wakely based its estimates on state specific information as well as actuarial considerations. While overall utilization was estimated not to increase, we did estimate that 20% of drug utilization would shift to the new drugs in each class. We then calculated the allowed PMPM of the new formulary using the new average unit cost amounts. Lastly, we calculated the difference in the allowed PMPM as a percent of the total medical and drug allowed PMPM between the current requirements and proposed drug counts to estimate an increase of 0.02% to total allowed claims for the expanded drug coverage.

Additional Clarifications on Certain Benefits

Recommendations

In addition to the benefit changes listed above, Colorado recommends making additional changes to the language in its current benchmark plan with the goal of clarifying the coverage of select existing benefits or to comply with federal requirements. Based on conversations with Colorado and CMS, they do not represent actual changes to any EHB benefit coverages. Therefore, no pricing exercise was performed for any such changes. The specific recommendations pertinent to these EHB benefits are:

- Prior Authorization – The recommendation is to remove any reference to prior authorization language in the benchmark plan for Medication-Assisted Treatment (MAT). Prior authorization is not a benefit in and of itself, but rather a way to ensure the appropriateness of the services provided under covered benefits. As such, this is not an actual benefit change and issuers would have the ability to include prior authorization in their benefit and plan designs, subject to state and federal law.
- Mental Health Parity – The recommendation is to remove any language that does not comply with state and federal mental health parity language. For example, the current benchmark plan summary document currently has an exclusion for mental health services that are custodial or residential in nature. This exclusion will be removed.

Summary

After performing the above pricing exercises for the listed benefit changes, the projected total increase of the recommended benefits is 0.16% as a percent of total allowed claims relative to the current benchmark. This is shown in Table 1 below.

Table 1: Impact of Added Benefits – Proposed Benchmark

Benefit Difference	Allowed Cost Impact[8]
Acupuncture	0.08%
Gender Affirming Care	0.04%
Mental Wellness Exam	0.02%
Expanded USP Drug Classes	0.02%
Total	**0.16%**

There are two separate tests that a new benchmark must meet in order for it to be approved. The first test that needs to be met is the typical employer plan test. In particular, a new benchmark must provide a scope of benefits that is equal to a typical employer plan. The second test for a new benchmark is the generosity test. In particular, a state's EHB-benchmark plan must not exceed the generosity of the most generous among plans listed at 45 CRR 156.111(b)(2)(ii)(A) and (B).

For the typicality test, Wakely selected the Anthem Lumenos HSA-Compatible 5000D/100% plan supplemented with the Federal VIP plan for pediatric dental and vision (herein collectively referred to as Anthem Lumenos). The Anthem Lumenos plan was a base-benchmark plan option for the 2017 plan year and therefore can be used for the typicality test under 45 CFR 156.111(b)(2)(i).[9] The Anthem Lumenos plan does not sufficiently cover the pediatric oral and vision EHB category under 45 CFR 156.110(a). As a result, the pediatric oral EHB category from the Federal VIP plan and the FEP BlueVision plan were used to supplement the plan as allowed and required under 45 CFR 156.110(b).

For the generosity test, Wakely selected the Federal Employee Health Benefit (FEHB) GEHA plan supplemented with the FEP BlueVision High plan for vision. Since the FEHB GEHA plan does not sufficiently cover the vision EHB category under 45 CFR 156.110(a), the vision EHB category

[8] Figures were rounded to the first decimal place to align with the generosity standard in which the proposed benchmark cannot exceed the most generous plan by 0.0%. Consequently, figures may not sum to total.

[9] The Anthem Lumenos plan was one of the base-benchmark plan options for the 2017 plan year, specifically a small group plan as defined under 45 CFR 156.100(a)(1).

from the FEDVIP BlueVision High plan was supplemented as allowed and required under 45 CFR 156.110(b).

The primary differences between the current benchmark (Kaiser), Anthem Lumenos, and the FEHB GEHA plan (the current benchmark, typicality comparison plan, and generosity comparison plan respectively) are as follows:

Table 2: Benefit Comparison – Current Benchmark and Comparison Plans

Benefit Category	Kaiser Plan	Anthem Plan	FEHBP GEHA Plan
	Current Benchmark	Typicality Comparison	Generosity Comparison
Chiropractic	Covers up to 20 visits/year	Chiropractic, acupuncture, and massage therapy cover up to 20 visits/year combined	Covers up to 12 visits/year
Acupuncture	No coverage	Chiropractic, acupuncture, and massage therapy cover up to 20 visits/year combined	Covers up to 20 visits/year
Massage therapy	No coverage	Chiropractic, acupuncture, and massage therapy cover up to 20 visits/year combined	No coverage
Home health care	Covers up to 28 hrs/week, must be <8 hrs/day	Covers 100 visits/year	Covers up to 50 visits/year, not to exceed 1 visit up to 2 hrs/day
Infertility services	Covers diagnostic testing and artificial insemination	Covers diagnostic testing only	Covers diagnostic testing only
TMJ services	Covers diagnostic and testing	No coverage	Covers surgery only
Bariatric surgery	Covered	No coverage	Covered
Outpatient physical, speech & occupational therapy	Covers 20 visits/year for each therapy.	Covers 20 visits/year for each therapy	Covers up to 60 visits combined
Pediatric Dental (differences relative to Anthem Plan)[10]	Not covered: periodontics and prosthodontics	N/A	Not covered: sealants, endodontics, periodontics, and prosthodontics
Pediatric Vision	Covers lenses/frames every 2 years	Covers lenses/frames every year	Covers lenses/frames every year

[10] Differences relative to the Anthem Plan (supplemented with FEDVIP) are listed. For example, the current benchmark plan (CHIP) does not cover periodontics and prosthodontics while the Anthem Plan does.

Typicality Test

In order for the proposed benchmark plan to pass the typicality test, the value of the proposed benchmark plan needs to equal the scope of a typical employer plan.[11]

Wakely analyzed the expected relative cost difference of the benefits of the proposed benchmark plan and the Anthem Lumenos plan, which is an option for the typicality test, under CFR 156.111(b)(2)(i). As demonstrated in the previous analysis, the difference in the new benefits in the proposed benchmark plan, relative to the current benchmark plan is 0.16% (see Table 1). Other benefit differences, specifically benefit differences between the Anthem Lumenos and the current benchmark plan, were also estimated[12] and determined to be 0.16% as shown in Table 3. The methodology used to determine these estimates are explained in Appendix A.

As seen in Table 3, the benefit differences between the proposed benchmark and the typical employer plan (as defined by the Anthem Lumenos plan) result in the proposed benchmark having the same level of coverage as a typical employer plan. Given that the proposed benchmark is equal to a typical employer plan, the new benchmark meets the typical employer test.

[11] https://www.regtap.info/uploads/library/PMSC_Slides_022421_5CR_022421.pdf

[12] Only benefit differences estimated to have a value greater than 0.00% are shown.

Table 3: Comparison of Proposed Benchmark to Typical Employer Plan

Benefits	Proposed Benchmark	Anthem Lumenos
Starting Value - Current Benchmark	100.00%	100.00%
Benefit Differences		
New Benefits in Proposed Benchmark (See Table 1)	0.16%	
Bariatric Surgery		-0.02%
Infertility		-0.01%
TMJ Services		-0.01%
Chiropractic, Acupuncture, and Massage Therapy		0.15%
Pediatric Dental		0.02%
Pediatric Vision		0.03%
Total Value of Plan	**100.16%**	**100.16%**

Generosity Test

The second requirement for a new benchmark is the generosity test. In particular, a state's EHB-benchmark plan must not exceed the generosity of the most generous among the set of comparison plans.

Wakely analyzed the generosity among the comparison plans and identified the Federal Employee Health Benefit (FEHB) GEHA[13] plan as the most generous among the set of comparison plans.[14] Wakely has supported over twelve states with EHB analyses over the years and leveraged some of that prior work in identifying the plans most likely to be the most generous. In particular, Wakely has a strong sense of which benefits are significant in value and which have minimal impact on the overall generosity of the plan. Wakely identified the FEHB GEHA plan as likely the most generous using the following process:

1. The current benchmark is the Large Group Kaiser plan.

[13] GEHA (Government Employee Health Association) is an association that offers plans through the FEHB program.

[14] https://www.regtap.info/uploads/library/PMSC_Slides_022421_5CR_022421.pdf

2. Based on prior Wakely analysis and a review of the plan comparison[15], Wakely determined that the GEHA plan was the most generous of the three FEHB plan offerings. This is primarily driven by richer acupuncture, PT/OT/ST, and pediatric dental benefits.
3. Based on a review of the three small group plans, Wakely identified the Anthem Small Group plan as the richest of the three small group plans. The primary driver of generosity for the Anthem plan is chiropractic/acupuncture/massage therapy coverage.
4. Of the two state employee plans, one is identical to the benchmark plan and the other, the United plan, is similar in coverage to the FEHB GEHA plan.[16]
5. Based on the assessment that the Small Group Anthem plan and the Federal GEHA plan were likely among the most generous, these two plans were priced compared to the benchmark plan to determine which was the most generous.
6. The Small Group Anthem plan required supplementation for both pediatric dental and vision. Based on a comparison of the FEDVIP and CHIP plans, the FEDVIP plans were deemed most generous and used for supplementation. The FEHB GEHA plan did not need supplementation for pediatric dental, but was supplemented with the FEP BlueVision High plan for vision.
7. The result of the analysis, details which follow, is that the FEHB GEHA plan is the most generous of the options.

Table 2 above shows the benefit differences between the proposed benchmark and the FEHB GEHA plan.

As seen in Table 4, this results in the proposed benchmark being less generous than the FEHB GEHA plan. Therefore, the proposed benchmark plan meets the requirements of the generosity test.

[15] https://drive.google.com/file/d/0BwguXutc4vbpTlZYRlhKZmFFZWM/view

[16] While the United State Employee Plan was not specifically priced compared to the other potential most generous plans, the proposed benchmark plan was found to be less generous than the GEHA plan (i.e. passed the generosity testing). Even if the United plan was more generous than the GEHA plan, the new benchmark plan would still be less generous than the United and the test would still be passed since the proposed benchmark is less generous than the GEHA plan.

Table 4: Comparison of Proposed Benchmark to Generosity Comparison Plan

Benefits	Proposed Benchmark	FEHBP GEHA
Starting Value - Current Benchmark	100.00%	100.00%
Benefit Differences		
New Benefits in Proposed Benchmark (See Table 1)	0.16%	
Chiropractic		-0.04%
Acupuncture		0.14%
Home Health Care		-0.01%
Infertility		-0.01%
Physical, Speech, and Occupational Therapy		0.24%
Pediatric Dental		-0.09%
Pediatric Vision		0.03%
Total Value of Plan	**100.16%**	**100.26%**

Appendix A: Data and Methodology

Colorado ACA carriers[17] submitted estimated allowed costs for select benefits being considered for the 2023 proposed benchmark plan. These allowed cost estimates were inclusive of any expected savings in other benefit categories. For example, if a carrier believed adding an acupuncture benefit (one of the recommended additions) would decrease opioid utilization, the associated savings would be represented in the estimated cost to add acupuncture. However, issuers did not provide any estimates as a result of the recommended benefits citing, in some cases, data was not available to provide savings estimates. If savings are realized the actual costs may be lower than estimated in this report. The estimates were used to establish a range of the benefit cost by removing the highest and lowest cost estimate for each benefit. Generally, carrier data was used when possible and appropriate.

Although carrier cost estimates were provided for select benefits, there were some cases where the carrier failed to price the ultimate benefit recommended and in other cases carrier cost estimates were not available for all benefits. In these instances, Wakely Internal Databases (WIDs) and other internal databases were used to make appropriate adjustments to the base information in order to isolate the projected costs pursuant to the specific benefit recommendations outlined in prior sections of this document. Specific adjustments by EHB benefit may have included:

- Apply cost relativities between benefits and visit limits
- Coverage utilization adjustments to account for specific benefits not being included in all state benchmarks within the region being analyzed

  Wakely pulled 2017 allowed information by service line from its 2017 (WIDs) and used this data to assess utilization and unit cost data for select benefits. The WID data repository is comprised of issuer EDGE server data and includes over 7 million member lives in 2017. The data itself is available at the Regional level; for this analysis we used the West US region. We used information in the data including (but not limited to) CPT / HCPCS codes, Revenue Codes, Inpatient DRGs, and NDCs to estimate cost impacts and relativities. Wakely assumed the distribution of benefits and services is the same over time. Wakely focused on the percent of allowed cost impact to account for cost estimates being at different points in time.

For the pediatric dental and vision benefit differences, Wakely relied on additional data resources. For the dental benefits, Wakely relied on a proprietary dental model to value the difference in benefits. The model was set to the same year as the WID data to align the percent of allowed

[17] Eight of the eleven carriers in the CO ACA market provided data.

cost estimates. The data was also calibrated to the western region similar to the medical benefit analysis. Finally, based on estimates that the Colorado on-Exchange enrollment is around 17% children, the value of the benefit was reduced to spread the costs over the entire ACA population.

For the vision benefit, Wakely utilized its proprietary vision experience and public information to estimate the utilization and unit cost of vision hardware for children. Wakely assumed that not all children would get new hardware annually, even if the benefit allowed and a range of reasonable assumptions and range of costs were developed. Similar to the dental analysis, the percent of allowed was normalized to the medical experience and the cost spread across the entire ACA population.

Appendix B: Reliances and Caveats

The following is a list of the data Wakely relied on for the analysis:

- List of proposed benefit changes, with corresponding CPT codes, from the DOI and stakeholders
- Carrier-submitted benefit cost estimates for certain services including:
    - Acupuncture
    - Mental Wellness Exam
    - Gender Affirming Care
    - Expanding Chiropractic Services
    - Expanding Physical Therapy Services
    - Expanding Occupational Therapy Services
    - USP Class
    - Expanding the required number of drugs covered for certain United States Pharmacopeia (USP) classes
- 2017 Wakely Internal Databases (WIDs)
- 2018 One Colorado LGBTQ Health Assessment Study
- Colorado 2017 Benchmark Plan Benefit Comparison[18]
- 2017 Colorado benchmark plan information
- The benefits and formulary for select plans including:
    - Kaiser LG A230 HMO & Kaiser State Employee Plan
    - The three largest small group plans
        - Anthem Lumenos HSA-Compatible 5000D/100%
        - Kaiser KP 500/40/Rx

[18] https://drive.google.com/file/d/0BwguXutc4vbpTlZYRlhKZmFFZWM/view

        - United 30/2000/80% CF6
    - Child Health Plan Plus (CHP+) Dental Plan
    - MetLife Federal Dental Plan
    - FEP BlueVision

The following caveats in the analysis should be considered when relying on the results.

- **Data Limitations.** As discussed in the body of this report, the WID database is comprised of issuer-submitted data from CMS's EDGE servers. There are some variances in the EDGE data compared to other data sources that may be used to check the reasonability of the EDGE data; however, the variances were reasonable and not expected to impact the results. Additionally, it is possible that some portion of the data used may have been truncated due to state-specific EHB limits that are stricter than Colorado's current limits. Our analysis indicated any potential impact of such truncation to be low, if not negligible. Where truncation appeared possible, adjustments to the data were made.
- **Enrollment Uncertainty.** This report was produced based on two main data sources – carrier submitted data provided on a 2019 basis and 2017 WIDs. To the extent that the risk profile, mix of services utilized, size, or any other significant characteristic or combination of characteristics of the insured population changes significantly between the data used in this report and any year for which these projections are being used, the data on which this report is based may no longer be applicable.
- **Mental Health Parity.** Any testing for compliance with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was outside the scope of this project, and therefore was not performed. Changes in benefit coverage may affect such compliance; as such, DOI should be aware of any potential effects and take appropriate measures and / or precautions in order to ensure no issues arise. Please note that carriers have attested compliance with MHPAEA since its passage in 2008.
- **Issuer Conformity.** The estimated impacts of removing coverage for specific benefits assumes that any changes to the proposed Benchmark plan will be adopted by all issuers present in the state, with respect to their covered benefits offered to members. All estimates are Wakely's estimate of the change in allowed costs. Actual paid cost and premium impacts may vary by issuer, based on their internal data, models and drugs that they choose to include in their formulary, etc.

Appendix C: Disclosures and Limitations

Responsible Actuaries. Julie Peper and Matt Sauter are the actuaries responsible for this communication. They are Members of the American Academy of Actuaries and Julie is a Fellow while Matt is an Associate of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report. Abby Wolpern and Michael Cohen contributed to this report.

Intended Users. This information has been prepared for the sole use of Colorado Division of Insurance (DOI). Distribution to parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their own actuarial experts in interpreting results.

Risks and Uncertainties. The assumptions and resulting estimates included in this report 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 Colorado or its issuers will attain the estimated values included in the report. 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 cost estimates rely on data provided by issuers in the ACA market in Colorado. 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. The information included in the 'Data and Methodology' and 'Reliances and Caveats' sections identifies the key data and reliances.

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 (the report, including appendices) constitutes the entirety of actuarial report and supersede any previous communications on the project.

Deviations from ASOPs. Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses are in compliance with the appropriate ASOPs with no known deviations. A summary of ASOP compliance is listed below:

ASOP No. 23, Data Quality

ASOP No. 25, Credibility Procedures

ASOP No. 41, Actuarial Communication

Appendix D: Benefit Detail

Benefit Name	Benefit Description	CPT Codes (if available)
Acupuncture	Minimum 6 sessions	97810, 97811, 97813, 97814
Mental wellness exam	One 45-60 minute visit a year that can include services such as behavioral health screening, education and consultation on healthy lifestyle change, referrals to ongoing mental health treatment, and discussion of potential options for medication	H0031, H0032, H0046, H0047, H0049, 96156
Expanded Drug Coverage	Expanded number of drugs required to be covered in 14 USP Classes	See Appendix E for more details
Gender Affirming Care	Blepharoplasty (eye and lid modification)	15820; 15821; 15822; 15823
Gender Affirming Care	Face/forehead and/or neck tightening	21137, 21138, 21139, 21208, 21209
Gender Affirming Care	Facial bone remodeling for facial feminization	21141, 21142, 21153, 21145, 21146, 21147, 21150, 21151, 21154, 21155, 21159, 21160, 21172, 21175, 21179, 21180, 21188
Gender Affirming Care	Genioplasty (chin width reduction)	76.67, 76.68, 21120, 21121, 21122, 211123
Gender Affirming Care	Rhytidectomy (cheek, chin, and neck)	15828; 15824; 15826; 15825;
Gender Affirming Care	Cheek, chin, and nose implants	No CPT codes provided
Gender Affirming Care	Lip lift/augmentation	No CPT codes provided
Gender Affirming Care	Mandibular angle augmentation/creation/reduction (jaw)	21125, 21127, 21244, 0RNC0ZZ, 0RNC3ZZ, 0RNC4ZZ, 0RND0ZZ, 0RND3ZZ, 0RND4ZZ
Gender Affirming Care	Orbital recontouring	21172, 21175, 21179, 21180,
Gender Affirming Care	Rhinoplasty (nose reshaping)	30400, 30410, 30420, 30430, 30435, 30450,
Gender Affirming Care	Laser or electrolysis hair removal	No CPT codes provided
Gender Affirming Care	Breast/Chest Augmentation, Reduction, Construction	19182; 19304; 19325; 19180; 19160; 19301; 19302; 19240; 19200; 19220; 19306; 19307; 85.52; 85.54;

Appendix E: Expanded USP Classes

USP Category	USP Class	Additional Drugs Required by Proposed Benchmark Plan	Cost Impact of Additional Drugs as % of Total Allowed
Analgesics	Nonsteroidal Anti-inflammatory Drugs	2	0.00%
Anticonvulsants	Gamma-aminobutyric Acid (GABA) Augmenting Agents	1	0.03%
Antidepressants	Monoamine Oxidase Inhibitors	1	0.01%
Antidepressants	SSRIs/SNRIs	2	0.00%
Antidepressants	Tricyclics	2	0.01%
Antispasticity Agents	No USP Class	1	0.00%
Cardiovascular Agents	Alpha-adrenergic Agonists	1	0.00%
Central Nervous System Agents	Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines	2	-0.04%
Skeletal Muscle Relaxants	No USP Class	2	0.00%
Sleep Disorder Agents	Sleep Promoting Agents	1	0.00%
Total	**All**	**15**	**0.02%**