

# **District of Columbia Plan Year 2026 Benchmark Plan Change Actuarial Report**

PREPARED FOR THE DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE

JUNE 27, 2024

TRACI HUGHES, FSA, MAAA  
DAVE DILLON, FSA, MAAA

## Table of Contents

Introduction and Background .....	3
Proposed Benchmark Plan .....	4
Benchmark Plan Assessment .....	4
Required Testing .....	5
Conclusion .....	6
ASOP 41 Disclosures .....	7

## Introduction and Background

Lewis & Ellis, LLC (L&E) was engaged by the District of Columbia (D.C.) Health Benefit Exchange (DC HBX) to assess and certify a proposed change to D.C.'s Benchmark Plan (BMP) for plan year 2026 Benchmark Plan (BMP).

In 2018, the Centers for Medicare and Medicaid Services (CMS) began allowing states three options in selecting an Essential Health Benefits (EHB)-benchmark plan for 2020 and beyond. The options included<sup>1</sup>:

1. Selecting the EHB-benchmark plan that another state used for the 2017 plan year.
2. Replacing one or more categories of EHBs 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.
3. Otherwise selecting a revised set of benefits for the state's EHB-benchmark plan.

These regulations allow a state to modify its EHB-benchmark plan annually. If a state decides to change its EHB-benchmark plan, it must inform CMS by the first Wednesday in May, two years prior to when the new benchmark plan will take effect.

For plan year 2026, DC is utilizing option 3 to propose a revised set of benefits for the BMP. Based on the regulations 45 CFR §156.111, supplemented by guidance from CMS, Marketplace Oversight division, the Center for Consumer Information and Insurance Oversight (CMS/CCIIO), for plan years beginning on or after January 1, 2026, a State's BMP must:

- Provide a scope of benefits that is equal to the scope benefits of a typical employer plan in the State. The scope of benefits in a typical employer plan in a State is any scope of benefits that is as or more generous than the scope of benefits in the least generous plan, and as or less generous than the scope of benefits in the most generous plan in the State, among the following:
  - One of the selecting State's 10 base-benchmark plan options established at § 156.100, and available for the selecting State's selection for the 2017 plan year, or

---

<sup>1</sup> "Information on Essential Health Benefits (EHB) Benchmark Plans." Centers for Medicare and Medicaid Services, [www.cms.gov/marketplace/resources/data/essential-health-benefits](https://www.cms.gov/marketplace/resources/data/essential-health-benefits).

- 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 of this subchapter, provided that:
  - The product has at least 10 percent of the total enrollment of the five largest large group health insurance products in the State,
  - The plan provides minimum value, as defined under § 156.145,
  - The benefits are not excepted benefits, as established under § 146.145(b), and § 148.220 of this subchapter, and
  - The benefits in the plan are from a plan year beginning after December 31, 2013.

L&E will refer to the requirements described above as the “required testing”.

## Proposed Benchmark Plan

The current BMP is the Small Group Blue Preferred PPO \$1,000 – 100%/80% Plan offered by Group Hospitalization and Medical Services (GHMSI). This BMP was set for plan year 2017 and has remained unchanged through plan year 2025.

The current BMP includes coverage for infertility, limited to diagnosis, testing, and counseling only. For plan year 2026, DC is proposing one change to the infertility benefit.

The proposed BMP would expand coverage for infertility treatment to include all procedures consistent with established medical practices by licensed physicians and surgeons to treat infertility, including diagnosis, testing, counseling, medication, surgery, and gamete intrafallopian transfer, in vitro fertilization, and standard fertility preservation services.

## Benchmark Plan Assessment

Based on guidance issued by CMS/CCIIO<sup>2</sup>, L&E conducted the required testing by comparing the expected value of fully paying (i.e., no member cost-sharing) all of the covered benefits within each of following plans: the proposed benchmark plan, the selected “Least Generous Plan”, and the selected “Most Generous Plan”.

---

<sup>2</sup> Both via internal communication and as published in “Example of an Acceptable Methodology for Comparing Benefits of a State’s EHB-benchmark Plan Selection”, available at the following link: <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/final-example-acceptable-methodology-for-comparing-benefits.pdf>.

---

## REQUIRED TESTING

---

For the required testing, the current benchmark plan was selected to represent the “Least Generous Plan”, or the “floor” of a typical employer plan. This was one of DC’s base-benchmark plan options available for selection for the 2017 plan year.

For the comparison of the expected value of the proposed BMP and the Least Generous Plan, L&E relied on its prior analysis of DC’s state mandate for expanding infertility benefits. Since the only difference between the proposed BMP and the Least Generous Plan is the expansion of infertility benefits, the expected value of the added infertility benefits is equal to the difference in the expected value of the two plans.

L&E’s estimate of the expanded infertility benefit was based on information collected by surveying DC insurers as well as publicly available data, including data from the Centers for Disease Control and Prevention (CDC), the Society for Assisted Reproductive Technology (SART), and Planned Parenthood. The analysis resulted in a best estimate value of \$1.88 per member per month (PMPM)<sup>3</sup>, after adjusting to full coverage (i.e., no cost sharing).

Accordingly, L&E estimates that the proposed BMP has an expected value that is \$1.88 PMPM greater than the Least Generous Plan.

The Cigna Large Group PPO plan was selected to be the “Most Generous Plan”, or the “ceiling” of a typical employer plan. This plan meets the requirements for a selected large group plan per 45 CFR §156.111 supplemented by guidance from CMS/CCIIO.

L&E compared the benefits of the proposed benchmark to the Cigna plan and found benefit differences as shown in the table below. L&E estimated PMPM values for each benefit difference using various sources as cited. Other than the benefits listed below, the two plans cover the same benefits, including infertility treatment.

---

<sup>3</sup> Based on defrayal analysis performed by L&E for the District of Columbia Department of Insurance, Securities, and Banking. Analysis report not publicly available.

Benefit Differences	Proposed Benchmark Plan	Most Generous Plan
<b>Pediatric Dental &amp; Vision</b>	\$1.65 PMPM <sup>4</sup>	Not Covered
<b>Obesity Treatment &amp; Bariatric Surgery</b>	Not Covered	\$1.35 PMPM <sup>5</sup>
<b>Hearing Aids</b>	Not Covered	\$0.19 PMPM <sup>6</sup>
<b>Routine Foot Care</b>	Not Covered	\$0.09 PMPM <sup>7</sup>
<b>Acupuncture</b>	Not Covered	\$1.83 PMPM <sup>8</sup>
<b>Gene &amp; Cellular Therapy</b>	Not Covered	\$5.11 PMPM <sup>9</sup>
<b>Total Benefit Differences</b>	<b>\$1.65</b>	<b>\$8.57</b>

Since the estimated value of the benefit differences for the Most Generous Plan is greater than for the proposed BMP.

Therefore, the proposed BMP passes the required testing.

## Conclusion

DC is proposing a new EHB-benchmark plan for plan year 2026, where the proposed plan expands the current EHB-benchmark plan's infertility benefits. Per federal regulations, a newly proposed EHB-benchmark plan must pass certain required testing. The analysis outlined in this report shows that the proposed EHB-benchmark plan passes the required testing and is therefore compliant with federal regulations.

<sup>4</sup> Based on review analysis performed by L&E for another state. Review report not publicly available.

<sup>5</sup> Based on state health benefit mandate fiscal impact analysis performed by L&E for another state. Analysis report not publicly available.

<sup>6</sup> Based on state health benefit mandate fiscal impact analysis performed by L&E for another state. Analysis report not publicly available.

<sup>7</sup> Based on L&E's internal AV calculator, built using CMS EDGE data.

<sup>8</sup> Based on state health benefit mandate fiscal impact analysis performed by L&E for another state. Analysis report available at this link: <https://apps.legislature.ky.gov/recoreddocuments/note/20RS/hb198/HM.pdf>

<sup>9</sup> Based on study accessed through the National Library of Medicine at this link: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10678302/>

## ASOP 41 Disclosures

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations<sup>10</sup>, promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct<sup>11</sup>, to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

### Identification of the Responsible Actuary

The responsible actuaries are:

- Traci Hughes, FSA, MAAA, Vice President & Principal
- David Dillon, FSA, MAAA, Senior Vice President & Principal

These actuaries are available to provide supplementary information and explanation.

### Identification of Actuarial Documents

The date of this document is June 27, 2024. The date (a.k.a. “latest information date”) through which data or other information has been considered in performing this analysis is March 11, 2024.

### Disclosures in Actuarial Reports

- The contents of this report are intended for the use of the DC Health Benefit Exchange. The authors of this report are aware that it may be distributed to third parties. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring a suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis, LLC is financially and organizationally independent from the health insurers and providers involved in this analysis. There is nothing that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the DC Health Benefit Exchange in assessing and certifying a proposed change to D.C.’s Benchmark Plan.

---

<sup>10</sup> The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.

<sup>11</sup> These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- Lewis & Ellis has reviewed the data provided by the insurers and DC Health Benefit Exchange for reasonableness, but the data has not been audited. L&E nor the responsible actuaries assume responsibility for these items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.
- Several of the assumptions made in this analysis are subject to uncertainty and it is not unexpected that actual results could differ from the calculated estimates.
- L&E is not aware of any subsequent events that may have a material effect on the findings.
- There are no other documents or files that accompany this report.

**Actuarial Findings**

The actuarial findings of the report can be found in the body of this report.