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MEMO

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To: Garen L Corbett
Director, California Health Benefits Review Program

From: Susan Pantely, FSA, MAAA
Barb Dewey, FSA, MAAA
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Re: Independent assessment of premium impact of benefits being considered for California's new Essential Health Benefit effective January 1, 2027

The California Health Benefits Review Program (CHBRP) retained Milliman, Inc. to perform an independent assessment of the premium impact of a short list of benefits being considered for California's new Essential Health Benefit (EHB) effective January 1, 2027. This is additional information for the Legislature to consider in addition to the analysis that the California Department of Managed Health Care (DMHC) retained Wakely to perform.

Most CHBRP reports are written by a multidisciplinary team of subject matter experts, academics, and actuaries to provide a comprehensive discussion of the medical effectiveness, policy impact, and cost analysis of proposed benefit mandates. Given the short turnaround time requested for this analysis, this memo only includes an abbreviated cost analysis.

RESULTS

The following table shows the expected plan paid per member per month (PMPM) impact of the proposed EHB expansion. The plan paid PMPM column reflects the total cost of the benefit less cost sharing using the copays and coinsurance from the proposed 2026 Covered California Silver plan designs. We have used these as a proxy for the 2027 Silver plan designs as it is common for Covered California to try to maintain consistent copays and coinsurance from one year to the next. The estimated premium increase includes the estimated increase in plan paid for the benefit as well as an increase in non-benefit expenses.

PROPOSED ESSENTIAL HEALTH BENEFIT EXPANSION	ESTIMATED PLAN PAID PMPM INCREASE FOR SILVER PLANS	ESTIMATED PREMIUM INCREASE FOR SILVER PLANS
Hearing aids	$1.52	0.21%
Wigs	$0.31	0.04%
Chiropractic care	$0.78	0.11%
Durable medical equipment (DME) - General	$1.64	0.23%
DME - Augmented communication devices	$0.03	0.00%
DME - Neuromodulators	$0.01	0.00%
Infertility	$5.36	0.76%

DATA SOURCES AND METHODOLOGY

An actuarial analysis estimating the impacts of expanding California's EHB is similar to the analyses we perform for coverage mandates. We generally estimate these using Milliman's Consolidated Health Sources Database (CHSD). For the more comprehensive CHBRP analyses, we also supplement this data with a limited survey of California health plans, administered through CHBRP.

Milliman's CHSD is a large database of medical and pharmacy claims and enrollment data submitted by national and regional health plans. The database includes detail on over 75 million commercially insured lives and almost 90 million total insured lives going back more than 10 years. It includes commercial, individual, Medicaid, Medicare Advantage, and Medicare Supplement members' claims and enrollment with nearly national coverage.

We use this data to look at the utilization rates and unit costs for existing coverage in California and other similar states. If the coverage mandate exists in another state or is in another state's EHB, we would consider the utilization rates of the service in that other state. Alternatively, we often use literature sources to estimate the post-mandate utilization rates of the service.

We used three approaches for analyzing the cost impact of the proposed expanded benefits. Wherever possible, we relied on prior work completed for the California Health Benefits Review Program. These reports can be found online at: https://www.chbrp.org/analysis/completed-analyses. For benefits that are already in other states' EHB plans, we looked at utilization levels from that state and unit costs from California. For newer benefits that are still emerging in California and other states, we used estimates for unit cost and utilization to develop potential impacts.

We provide a description of the data source used for each of the benefits below.

Hearing aids

Our understanding is that California is considering adding coverage of one hearing aid per ear every three years, without an age restriction.

CHBRP previously estimated the impact of mandating hearing aid coverage for children.[1] This analysis had information about prevalence for children and the mix of monaural (one hearing aid) vs. binaural (two hearing aids) coverage for hearing aid users. It also had an estimated average annual cost per hearing aid user.

We used prevalence rates from the prior CHBRP analysis (for kids) and a CDC data brief (for adults) and applied these rates to Covered California's enrollment by age band to estimate the overall prevalence for the Covered California market.

The CDC data brief reported on the number of people with no difficulty hearing, some difficulty hearing, and a lot of difficulty hearing or cannot hear. We assumed that 0% of the people with no difficulty hearing, 25% of the people with some difficulty hearing, and 90% of the people with a lot of difficulty hearing would purchase hearing aids. The CDC data brief was based on the 2019 National Health Interview Survey.[2]

We assumed that the mix of monaural and binaural coverage for kids would be 77% monaural and 23% binaural based on data sources cited in the prior CHBRP report. We assumed that the mix for adults would shift to be 25% monaural and 75% binaural.

We adjusted the cost per user from the prior CHBRP report using the ratio of the mix of monaural and binaural coverage for children to the mix of coverage for the full Covered California population. We trended the data to calendar year 2027 using an annual allowed cost trend of 4%.

Hearing aids are typically replaced every 3-5 years. We assumed that 25% of hearing aid users would purchase hearing aids in any given year.

Wigs

California is considering adding coverage of one wig per year without restrictions to condition. CHBRP previously estimated the impact of mandating coverage of medical wigs for enrollees with alopecia areata, scarring alopecia,

[1] https://www.chbrp.org/sites/default/files/bill-documents/SB0/Abbreviated%20Analysis%20of%20SB%20635%20Hearing%20Aids%20FINAL%20060923.pdf
[2] https://www.cdc.gov/nchs/products/databriefs/db414.htm

and alopecia caused by drug treatment such as chemotherapy in the AB 2668 analysis.[3] For this analysis we additionally assumed enrollees with androgenic alopecia (male or female pattern baldness) would also be eligible for wig coverage.

Based on the prior bill analysis, we assumed medical wigs to be $1,530 for enrollees with alopecia areata, scarring alopecia, and alopecia caused by drug treatment such as chemotherapy. Noted in the AB 2668 analysis, surveys report median costs of $450 to $1,500. We assumed the low end of the range, $450, for enrollees with androgenic alopecia. We trended the cost of wigs to calendar year 2027 using an allowed trend of 0.5% based on the December 2024 12-month change in Medical Care Commodity CPI.

We also relied on the prior analysis for an estimated utilization of medical wigs for enrollees with alopecia areata, scarring alopecia, and alopecia caused by drug treatment such as chemotherapy. For enrollees with androgenic alopecia, we used a study of men with moderate to extensive hair loss[4] and a study of female pattern hair loss[5]. Based on the studies, we estimate approximately 26.4% of enrollees have hair loss that can be addressed with a wig.

Other states, such as New York, have wigs included in their EHBs. We used CHSD data in the New York individual market to measure the usage of wigs for patients and found no utilization directly attributable to androgenic alopecia. Therefore, we assumed only 1% of enrollees with hair loss that can be addressed with a wig will use a wig through their healthcare coverage.

Chiropractic care

There are currently 45 states with some amount of chiropractic coverage as part of their EHBs. Most of these states place a cap on the amount reimbursed or the number of visits per year (most commonly, 20 or 30) and may place exclusions or limitations on the visits. It is our understanding that California is considering a 10 visit limit.

We estimated prevalence for this service using survey data reported by the National Center for Complementary and Integrative Health.[6]

We estimated utilization for this benefit using data from other states that mandated coverage for a limited number of chiropractic visits and expanded Medicaid. We chose to use data from New Jersey, Virginia, and West Virginia as the basis for our estimated utilization. These three states had 2.6 million member months of data in 2022 in Milliman's CHSD data. There were similar utilization rates for other states that limited the number of chiropractic visits covered.

We used an average unit cost for chiropractic services using commercial data from California. We trended the data to calendar year 2027 using an annual allowed cost trend of 4%.

Durable medical equipment (DME) - General

At present, all 50 states offer coverage for at least some, but not necessarily all of the equipment included in this category (wheelchairs, walkers, scooters, CPAP machines, portable oxygen, and hospital beds) as part of their EHBs. A noticeable shortfall in this coverage is regarding scooters, with fewer than 20 states covering them.

For our analysis, we used CHSD data to pull claims information from states that offer coverage for these medical devices but benefit limits may vary. With this data, we were able to calculate average utilization per 1,000 members as well as the unit cost for these services. We trended the data to calendar year 2027 using an annual unit cost trend of 5%.

Utilization of these services is expected to increase. We trended the utilization data to calendar year 2027 using an annual utilization trend of 5%.

The utilization of scooters was very low in the claims experience. Scooters have a much higher unit cost than wheelchairs. It is likely that the utilization for this equipment is lower because patients are required to try lower cost options first. We have not made any adjustments to the observed claims data to account for this "step-therapy" phenomenon. If the California legislature intends for this benefit to be covered without step-therapy requirements for lower cost options first, we recommend increasing the cost estimate for this particular service.

[3] https://www.chbrp.org/sites/default/files/bill-documents/AB2668/AB%202668%20Cranial%20Prostheses-%20FINAL.pdf
[4] https://pubmed.ncbi.nlm.nih.gov/9865198/
[5] https://pubmed.ncbi.nlm.nih.gov/11251562/
[6] https://www.nccih.nih.gov/health/chiropractic-in-depth

Durable medical equipment (DME) - Augmented communication devices

California is considering adding coverage for high-tech and low-tech augmented communication devices. High-tech augmented communication devices would include computers and tablets that produce synthesized speech (HCPCS code E2510) and low-tech augmented communication devices include non-electronic communication boards (HCPCS code E1902).

The prevalence number we show in the table is based on a paper about assistive technology published by the National Library of Medicine.[7]

We used CHSD data from 2022 and 2023 to calculate observed average utilization per 1,000 members and unit costs for these two categories of communication devices. For our analysis, we pulled CHSD data from the six states that currently cover augmented communication devices. Based on the EHB Benchmark Plan information from CMS.gov,[2] the following states currently cover augmented communication devices: Ohio, Massachusetts, Maryland, New York, and Wisconsin.

There was not a credible amount of claims experience for low-tech augmented communication devices. We assumed these devices would have the same utilization as high-tech augmented communication devices. As a proxy for a commercial reimbursement rate for these devices, we used the 2020 reasonable charge schedule for these HCPCS codes published by the U.S. Department of Veteran Affairs[3] and adjusted based on the assumption that these rates are intended to be a reasonable proxy for commercial reimbursement.

We trended unit costs to calendar year 2027 using an annual allowed cost trend of 4%.

Durable medical equipment (DME) - Neuromodulators

California is considering adding coverage for neuromodulators such as transcranial direct current stimulation (tDCS), pulsed electromagnetic field therapy (tPEMF), and transcutaneous electrical nerve stimulation (TENS). There is limited coverage for these devices in other state EHBs. The first two devices, tDCS and tPEMF are not currently covered by any state's EHB. Based on the EHB Benchmark Plan information from CMS.gov,[2] TENS is covered in the EHB for Oregon, Vermont, and West Virginia.

We used data for electro-convulsive therapy (ECT) as the basis for our tDCS estimate. ECT is covered in Illinois, Idaho, Delaware, Texas, Pennsylvania, Rhode Island, Tennessee, Vermont, and West Virginia. We selected ECT as the basis for tDCS because both services treat depression through electrical stimulation to the brain. We assumed that tDCS utilization would be 10% of the observed ECT utilization and that the tDCS unit cost would be 10% of the observed ECT unit cost. If California is considering including this in its EHB, we think it is worth gathering more information to make a more informed estimate for this service.

We used data for TENS to estimate utilization and claims for tPEMF. TENS was selected as a proxy for tPEMF because both services are used to treat pain via electrical stimulation. Our analysis assumes that tPEMF will have 50% of the observed TENS utilization and a similar unit cost.

We relied on CHSD data from 2022 and 2023, which represent the most recent full years of data. We trended the data to calendar year 2027 using an annual allowed cost trend of 4%.

Infertility

California is considering adding coverage for infertility diagnosis, artificial insemination, and in vitro fertilization (IVF). CHBRP previously estimated the impact of mandating coverage for these fertility treatment services for scenario 1 of SB 729, and as part of that analysis, CHBRP also modeled the impact of mandating coverage for the Covered California market.[8] We assumed coverage and scope were the same between the prior bill and this current analysis. The prior analysis did not split pharmacy drug by fertility treatment category and we have included all fertility treatment drug costs from that analysis in our estimate. For prescription drugs, we assumed the majority of costs come from enrollees undergoing IVF treatment, who would otherwise meet their out-of-pocket maximum, and did not apply separate cost sharing for prescription drugs.

We trended the fertility treatment services using an allowed trend of 7% and a utilization trend of 2.5% to calendar year 2027. Prescription drugs were trended using a 11.35% to calendar year 2027.

[7] https://www.ncbi.nlm.nih.gov/books/NBK453289/
[8] https://www.chbrp.org/sites/default/files/bill-documents/SB729/SB%20729%20Infertility%20Abbreviated%20Analysis%20Final.pdf

Total premium and silver plan designs

We used average observed 2023 premiums and projected 2025 premiums from the URRT for the five largest Covered California carriers to calculate the average premium for Covered California Silver plans. URRT data is published on the DMHC website.

CAVEATS

We understand that CHBRP intends to provide this memo to the California State Legislature. To the extent that the information contained in this memo is provided to any third parties, the memo should be distributed in its entirety. We do not intend this information to benefit, or create a legal liability to, any third party, even if Milliman consents to the release of its work product to such third party. Similarly, third parties are instructed to place no reliance upon this memo prepared by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. It is the responsibility of any recipient of this memo to make an independent determination as to the adequacy of the proposed results for their organization.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. Actual experience is unlikely to conform exactly to the assumptions used in this analysis. Therefore, actual amounts will almost certainly differ from projected amounts. Milliman has developed certain models to estimate the values included in this memo. The intent of the models was to estimate the premium impacts of expanded EHB benefits. We have reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We have relied upon certain data and information provided discussed above for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this memo may likewise be inaccurate or incomplete. Milliman's data and information reliance includes:

- Enrollment data from Covered California
- Silver premium data from DMHC
- Medical claims data from Milliman's CHSD
- All references listed in the body of this memo

The models, including all input, calculations, and output, may not be appropriate for any other purpose.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

These estimates were put together on a two week timeline. Where possible, we relied on prior work for CHBRP or similar coverage in other states. We assumed no coverage of any benefits at baseline. We have not performed a detailed comparison of Wakely's definition of these benefits to ours.

The authors of this memo are not health insurance compliance experts and are not qualified to give legal opinions. It is strongly recommended that readers seek advice from qualified legal counsel and compliance experts.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this memo are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this memo.