August 20, 2021

Lynn Nonnemaker
Vice President
America's Health Insurance Plans
lnonnemaker@ahip.org

via email

RE: ADDING DENTAL, VISION, AND HEARING BENEFITS TO MEDICARE ADVANTAGE

Dear Lynn:

America's Health Insurance Plans (AHIP) has retained Wakely Consulting Group, LLC (Wakely) to provide an analysis of the impact of mandating specified coverage for dental, hearing, and vision services by all Medicare Advantage Organizations (MAOs).

Our analysis is based on the benefits described in Sections 601 through 603 of the December 16, 2019, H.R. 3 bill[1] (HR 3), as well as related costs estimated by the Congressional Budget Office (CBO) in its December 10, 2019, report to the Chairman of the Committee on Energy and Commerce[2].

The analysis in this report is presented with two key assumptions:

1. The percentage of "Major" dental treatments to be covered by MAOs is 50%. We assume this percentage to be effective immediately, rather than according to the phase in schedule in HR 3, which does not reach full phase-in until 2029.

2. Part C benchmarks are not adjusted to account for these additional coverage obligations. Excluding these costs from Part C benchmarks would reduce potential CMS expenditures on these new benefits by shifting liability to MAOs, and in many cases, beneficiaries (for example, member premiums would increase for plans that had insufficient rebate to cover the cost of the new benefits).

We make these assumptions in order to provide additional quantitative perspective should Congress consider earlier phase in or making no adjustment to benchmarks. It is important to note that neither of these provisions have been formalized in any Congressional bill. Should these assumptions not materialize, the results of our analysis would be materially impacted.

The analysis presented here is an estimate under key assumptions. Actual MA financial impacts will certainly vary from estimated amounts. Reliance on this report is at AHIP's discretion. This information has been prepared for the sole use of the management of AHIP. We anticipate that

[1] https://www.congress.gov/bill/116th-congress/house-bill/3/text
[2] https://www.cbo.gov/system/files/2019-12/hr3_complete.pdf

AHIP will distribute to its members and may post on its website. Portions of the report should not be used without the prior written permission of Wakely. This information is confidential and proprietary.

This report represents the analysis of the author only and does not necessarily reflect the opinion of Wakely.

Executive Summary

If the fully phased in dental, vision, and hearing services described in HR 3 had been implemented as of January 1, 2021, with no adjustments to Part C benchmarks, we estimate that MAOs would have about $58 PMPM less “flexible” rebate. This represents about 48% of the current national average rebate. By “flexible” rebate, we mean CMS rebate payments that plans can choose to spend on reducing beneficiary cost sharing, adding coverage for non-Medicare-covered services (e.g., OTC drugs or non-Medicare covered transportation), or reducing Part D premiums.

If the new dental, vision, and hearing benefits were required to be classified as non-Medicare covered services in the bid pricing tool (BPT), then the rebate amount would not change; however, the “flexible” rebate would be reduced by about $88 PMPM, or 73% of the current average. The reason for this difference is that if a benefit is classified as Medicare covered, a plan bidding below the benchmark receives 100% of the projected required revenue related to these services; whereas services classified as non-Medicare covered must be paid for with rebates, which have been reduced by one minus the rebate percentage.

The assumptions underlying these estimates are described in the “Assumptions, and Methodology” section of this report. Table 1 shows the calculations.

Table 1 – Nationwide Average Flexible Rebate, CY2021

Bid Component	Current	Addition of Dental, Vision, Hearing	
		As Medicare Covered	As Non-Medicare Covered
Benchmark PMPM	$1,015	$1,015	$1,015
Bid to benchmark ratio	82.3%	90.9%	82.3%
Bid PMPM	$835	$923	$835
Rebate %	66.8%	66.8%	66.8%
Rebate PMPM	$120	$62	$120
PMPM Obligation for Dental, Vision, Hearing Services	$0	$0	$88
"Flexible" Rebate PMPM	$120	$62	$32
Reduction in "Flexible" Rebate as % of current	0%	48%	73%

The analysis in Table 1 reflects a nationwide average based on January 2021 MA enrollment. At the individual plan level, the impact of mandating dental, vision, and hearing coverage could vary significantly. The impact could range from no impact at all for plans that already cover the mandated benefits equal to or better than the fully phased in definition in HR 3 (see Table 2), to significant increases in member premium or reduction in benefits offered for plans that currently do not cover any dental, vision, or hearing services.

In addition to variation in impact caused by the current coverage levels, there are numerous other factors that will impact the magnitude of the mandate, such as:

- Plan star rating
- Part C benchmark amount
- Geographic area
- The MAO's bid to benchmark ratio

As of February 2021, approximately 57.5% of all MA members (excludes Cost plans, MSAs, and PDPs) nationwide were enrolled in plans with a $0 member premium. It is likely that many of these plans will no longer be able to maintain both the $0 premium and current target gain/loss margin levels if the dental, vision, and hearing benefits are mandated without benchmark adjustment. This situation would occur in cases where a $0 premium is currently achieved, but the rebate available is insufficient to "buy down" the value of the new mandated benefits and the Part D premium (for MA-PD plans).

Assumptions, and Methodology

The analysis in this report reflects current (CY2021) MAO benefit offerings, enrollment, rebate levels, star ratings by contract, and premium levels. We have chosen this period so that the analysis reflects the most current known information. Results may vary as all these elements change in future years.

As noted in the introduction, our analysis is based on the December 16, 2019, HR 3 bill and related CBO cost analysis. For purposes of this report, we assumed that the fully phased in dental, vision, and hearing benefits in HR 3 would be effective in 2021, and that Part C benchmarks would not be adjusted compared with current levels.

The benefit provisions modeled in our analysis are shown in Table 2.

Table 2. Covered Services, Cost Sharing, and Limitations

Benefit Category	Covered Services	Beneficiary Cost Sharing	Limitations
Preventative Dental	Oral Exams, Dental Cleanings, Dental x-rays, fluoride treatments	20%	Exams and Cleanings limited to twice per 12-month period
Basic and Major Dental	Restorations, Periodontic, Extractions, Oral disease management, Bridges, Crowns, Root Canals	50%	Payment for Dentures not more than once for any 5-year period
Hearing	Hearing Aids for those with profound or severe hearing loss	0%	Payment for not more than once for any 5-year period
Vision – Exams and Fittings	Routine Eye Exams and Contact lens fitting	0%	One eye exam and contact lens fitting per 2-year period
Vision – Lenses and Contacts	Conventional Eyeglasses and Contact Lenses, regardless of whether post-cataract surgery	Amounts above $85 allowable benefit (increased by CPI each year)	2-year Supply of Contact Lenses
Vision – Frames	Frames	Amounts above $85 allowable benefit (increased by CPI each year)	One per Two-Year Period of either frames or contact lenses

The estimated cost for the services shown in Table 2 is based on projected costs in the December 10, 2019, CBO letter. We estimate a CY2021 required revenue of about $88 PMPM. This estimate was developed as follows:

- Begin with total dental, vision, and hearing costs for Title VI as of 2029 (the year of full phase-in of all benefits), or $83.8B.
- Divide by the CBO projected 2029 total Part B membership of 71M.

- Discount to 2021 using an assumed annual trend of 3.5%, roughly based on the average annual change in the medical services component of the consumer price index over 2019 through July 2021.
- Include a 15% load for administrative expenses and gain/loss margin.

The average national benchmark calculation is based on a member weighted average of standardized (i.e., 1.00 risk score) benchmarks using payment year 2021 star ratings by contract, published benchmarks by county, and January 2021 enrollment in individual MA only and MA-PD plans. We did not consider employer group waiver plans (EGWPs) or prescription drug plans.

We used bid to benchmark ratios published by CMS to derive CY2022 EGWP benchmarks. These ratios are based on actual bids from 2021 bid filings.

Due to the absence of details in the projection, there are several aspects of the CBO report that are unknown and should be considered when evaluating our analysis. A non-comprehensive list of these items is as follows:

- Potential difference in costs between traditional Medicare and Medicare Advantage (e.g., MAO utilization management).
- Possible pent-up demand for beneficiaries without current coverage for some or all these services.
- Impact of beneficiary out of pocket expense, including changes to Part B premiums.
- Effect of increasing Part C benchmarks on MAO bids and plan offerings to account for the new mandated services.

Limitations

The assumptions and resulting estimates included in this report and produced by the model 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 based this analysis based on projected expenses and revenue as filed in the 2021 BPTs and actual results by plan could vary materially. It is the responsibility of AHIP to review the assumptions carefully and notify Wakely of any potential concerns.

Responsible Actuary

I, Tim Courtney, am the actuary responsible for this communication. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to issue this report.

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, I, Tim Courtney, am financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent to AHIP.

Subsequent Events

There are no known relevant events subsequent to the date of information received that would impact the results of this report.

Contents of Actuarial Report

This document and the supporting exhibits/files constitute the entirety of the actuarial report and supersede any previous communications on the project.

Sincerely,

Tim Courtney, FSA, MAAA
Director & Senior Consulting Actuary
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