wakely.com

State of Vermont: Department of Financial Regulation

Benchmark Plan Benefit Valuation Report

July 21, 2022

Prepared by:

Wakely Consulting Group, LLC

Matt Sauter, ASA, MAAA

Senior Consulting Actuary

Julie Peper, FSA, MAAA

Principal and Senior Consulting Actuary

Michael Cohen, Ph.D.

Director and Senior Consultant

Alex Jarocki

Senior Analyst

Table of Contents

Introduction and Background

The Vermont Department of Financial Regulation (Vermont, DFR, or State) retained Wakely Consulting Group, LLC (Wakely), an HMA Company, 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

This is the actuarial report, which is part of the State of Vermont's application for a change in the Federal CMS Plan Year 2024 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 Vermont. 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 change to the EHB that Vermont is proposing is to add a benefit covering an annual hearing exam and a hearing aid for each ear every 3 years for adults and children. Pursuant to 45 CFR 156.111, Vermont has elected to take public comment on a draft set of benefits that comprise the proposed new EHB benchmark plan. Per Vermont's request, we specifically priced the marginal cost of offering a hearing aid benefit relative to the current (2017) Vermont Benchmark Plan.

The hearing benefit[1] was targeted based on discussions with the Department of Financial Regulation (DFR) and stakeholders including carriers, providers, and consumer advocates. 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 the hearing aid benefit is included in the new benchmark the plan it would meet both regulatory requirements.

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

Proposed Benchmark

The current Vermont benchmark plan is the BlueCross BlueShield of Vermont Standard CDHP (CDHP). This plan was the initial benchmark plan for plan year 2014, and was set again 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 potential changes with DFR and a Vermont EHB stakeholder group, which included Vermont's individual and small group issuers as well as providers and consumer advocacy organizations. Wakely also conducted analysis on the potential actuarial impact of the various proposed benefit changes. Several of the benefits considered for change were not ultimately recommended as a change. Listed below is the recommended change and the potential impact.

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

Recommendation: Hearing Aid Coverage

DESCRIPTION

The State is considering adding a hearing aid benefit that includes an annual hearing exam and one hearing aid per year each 3 years to the proposed benchmark plan. Adding the recommended hearing benefit will improve the alignment of the benchmark plan with the State's health care policy goals to create equity among insured populations by implementing benefit designs serving Vermont's whole population, regardless of disability or age. A review of essential health benefits in the Northeast region revealed Vermont and Pennsylvania were the only two Northeast states with no hearing aid coverage in their benchmark plans. Adding the recommended hearing benefit

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

to Vermont's benchmark plan will bring their hearing coverage more in-line with other Northeast states' EHBs and improve the health and quality of life of affected members. Furthermore, industry research suggested the 3-year limit will not prevent members from receiving necessary hearing aids due to the average lifespan of modern hearing aids and the 3-year limit not applying to medical necessity.

Methodology and Results

To perform the analysis, Wakely used Wakely Internal Databases[2] (WID) data – internal ACA data from the Northeast Region – to estimate the cost for adding an annual hearing exam and a hearing aid for each ear every 3 years. Hearing aid exams and hearing aid claims were identified using the most recent Wakely ACA Claims Grouper code set to identify CPT codes assigned to hearing exams and hearing aids alongside CPT codes gathered from industry research and resources. We then determined the associated allowed PMPM claim cost for the set of CPT codes.

Since the WID data is not available at the state level, we used the Northeast region data since Vermont is included in the region. However, not all states in the Northeast region cover hearing exams and hearing aids. As a result, we reviewed the benefit coverage, where available, for all states in the Northeast region. We then adjusted the calculated per member per month (PMPM) amounts to account for the percentage of members insured in states where hearing exams and hearing aids are currently a covered benefit. This adjustment was performed to ensure our estimated claim cost was not understated due to lack of coverage. Furthermore, Wakely made an age adjustment to account for Vermont having an older population, which is more likely to use a hearing aid benefit. Wakely made other adjustments based on other published studies and analyses on hearing aid costs. Wakely also referenced other internal claim databases to confirm the reasonability of the results.

The resulting cost estimate used from the estimated range was 0.10% of the total allowed claims.[3]

[2] Additional details on Wakely's Internal Databases can be found in Appendix A

[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.

Additional Clarifications on Certain Benefits

RECOMMENDATIONS

In addition to the benefit changes listed above, Vermont 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 Vermont and CMS, they do not represent actual changes to any EHB benefit coverages. Therefore, no pricing exercise was performed for any such changes. The recommendation is to remove any reference to an individual's diagnosis (e.g., diabetes) or age (e.g., under 21) in the benchmark plan that is presumed to be discriminatory under 45 CFR 156.125. Examples of benefits with potentially discriminatory language in the current EHB and for which the language was revised in the proposed benchmark plan document include:

- Nutritional Counseling
- Habilitative Services
- Rehabilitative Services
- Foot Care
- Prescribed Food and Nutritional Formulae

Summary of Benefit Additions

After performing the above pricing exercises for the listed benefit changes, the projected total increase of the recommended benefits is 0.10% 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[4]
Annual Hearing Aid Exam & Hearing Aids Every 3 Years	0.10%
Total	**0.10%**

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

[4] 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%.

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 Blue Cross Blue Shield of Vermont Plan J with additional coverage for lifestyle and stomach acid drugs offered in benefit year 2022 (collectively referred to as Plan J). Plan J had the highest enrollment within the large group products in Vermont (estimated to be almost half of the fully-insured large group market). It also met other requirements in 45 CFR 156.111and therefore can be used for the typicality test under 45 CFR 156.111(b)(2)(i). Plan J is identical to the current EHB BMP with the exception of including drug coverage for lifestyle drugs and stomach acid drugs. It does not sufficiently cover the pediatric dental and vision EHB category under 45 CFR 156.110(a). As a result, the pediatric dental and vision EHB categories from the State CHIP plan were used to supplement the plan as allowed and required under 45 CFR 156.110(b).

For the generosity test, Wakely selected a state employee plan that meet the standards under 45 CFR 156.100, or the 2014 Blue Cross Blue Shield of Vermont's TotalChoice plan. Since the TotalChoice plan does not sufficiently cover the dental and vision EHB categories under 45 CFR 156.110(a), the State CHIP and Federal VIP plans, respectively, were used to supplement the plan as allowed and required under 45 CFR 156.110(b). The TotalChoice plan and preceding supplementation as herein collectively referred to as TotalChoice.

Overall, the three plans described above had identical dental and vision benefit offerings except for Plan J where Wakely used the State CHIP plan as supplementation for Pediatric Vision while the other plans had vision offerings equivalent to the Federal VIP plan. Table 2 provides an overview of the above plans and their pediatric dental and vision offerings.

Table 2: Pediatric Dental and Vision Offerings

Plan Name	Description	Dental Offering	Vision Offering
CDHP	Current Benchmark	Equivalent to State CHIP	Equivalent to Federal VIP
Plan J	Typicality Comparison	State CHIP	State CHIP
TotalChoice	Generosity Comparison	State CHIP	Federal VIP

The primary differences between the current benchmark, Plan J, and the TotalChoice plan (the current benchmark, typicality comparison plan, and generosity comparison plan respectively) are as follows:

Table 3: Benefit Comparison – Current Benchmark and Comparison Plans

Plan Name Description	CDHP Current Benchmark	Plan J Typicality Comparison	TotalChoice Generosity Comparison
Acupuncture	No coverage	No coverage	Covers up to 20 visits/year
Chiropractic	Covers up to 12 visits/year	Covers up to 12 visits/year	Covers up to 60 visits/year combined with PT, OT, and ST
Pediatric Eyeglasses (differences relative to current BMP)	Covered	Lenses every 2 years for ages 6 and above (BMP limit is 1 year)	Covered
Pediatric Contacts	Covered	Not Covered	Covered
Infertility Treatment	Covers diagnostic testing only	Covers diagnostic testing only	Covered: diagnostic and treatment, including in-vitro fertilization (IVF) procedures
Lifestyle Drugs and Stomach Acid Drugs[5]	No Coverage	Covered	No Coverage
Massage therapy	No coverage	No coverage	Covered
Physical, Speech, and Occupational Therapy	Covers up to 30 visits per year combined	Covers up to 30 visits per year combined	Covers up to 60 visits per year limit combined with chiropractic

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.[6]

Wakely analyzed the expected relative cost difference of the benefits of the proposed benchmark plan and Plan J, 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

[5] Lifestyle drug coverage includes erectile dysfunctional drugs.

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

benchmark plan, relative to the current benchmark plan is 0.10% (see Table 1). Other benefit differences, specifically benefit differences between Plan J and the current benchmark plan, were also estimated[7] and determined to be 0.10% as shown in Table 4. The methodology used to determine these estimates are explained in Appendix A.

Through review of the plan documents and discussions with the plan sponsors, it was determined the proposed benchmark and Plan J covered the same benefits except the proposed benchmark covered hearing aids and hearing exams, had richer aspects of pediatric vision (see below), and did not cover lifestyle and stomach acid drugs. The below section details the benefit differences of the pediatric vision and lifestyle and stomach acid drug coverage.

For pediatric vision, the proposed EHB BMP plan has coverage equivalent to the Federal VIP plan. Plan J does not have comprehensive pediatric vision coverage so Wakely supplemented with the State CHIP plan. Wakely identified two differences in benefit coverage between the Federal (i.e., benchmark) and CHIP plans. The first difference is that the State CHIP plan does not cover contacts while the proposed benchmark does. The second difference is that the State CHIP plan covers eyeglasses once a year for children under 6, the age where the majority of eye development occurs,[8] and once every two years for children 6 and older. The proposed benchmark plan covers eyeglasses for all children once a year.

Wakely assumed that since the State CHIP plan does not offer contact coverage, overall cost in the eyeglass and contact categories would be lower than in the proposed benchmark plan. This is due to both unit cost differences between the categories and also in the utilization pattern of members who would elect contacts as their first option when given the opportunity to choose between contacts and eyeglasses relative to those would choose eyeglasses. In addition, children with contacts would typically also have glasses so there are additional costs when contacts are covered. Next, a utilization decrease relative to the proposed benchmark plan was applied to members age 6 and older to account for the eyeglass benefit limit being once every two years in the State CHIP plan.

Using Wakely's Internal Databases, the distribution of children less than age 6 and 6 or greater was estimated. This distribution was then applied to estimated pricing differential PMPMs for the two cohorts to arrive at a pricing difference between the two plans. Lastly, the prevalence of children in the market was taken into account to arrive at an ultimate percentage of premium differential of 0.05% as shown in Table 4.

---

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

[8] "Because a child's visual system is growing and developing, especially during the first 5-6 years of life, glasses may play an important role in ensuring normal development of vision." https://aapos.org/glossary/glasses-for-children

The other benefit difference in Plan J is the coverage of lifestyle and stomach acid drugs that are not covered in the proposed benchmark plan. The Vermont DFR provided Wakely medical and pharmacy claims data extracts from Vermont's all-payer claims database (APCD) – Vermont Health Care Uniform Reporting and Evaluation System (VHCURES). Wakely used the VHCURES data as the underyling data to price this benefit difference.

To price the benefit, Wakely pulled utilization and cost information from the VHCURES data for the applicable drugs and benefit coverage. Adjustments to the base data were made to account for utilization and unit cost differences between the base information to isolate the estimated benefit differences relative to the proposed benchmarkFinally, the cost estimate was then put on a percent of allowed basis and estimated to be 0.15%.

As seen in Table 4, the benefit differences between the proposed benchmark and the typical employer plan (as defined by Plan J) 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.

Table 4: Comparison of Proposed Benchmark to Typical Employer Plan

Benefits	Proposed Benchmark	Plan J
Starting Value - Current Benchmark	100.00%	100.00%
Benefit Differences		
Hearing Benefit (See Table 1)	0.10%	
Lifestyle and Stomach Acid Drugs		0.15%
Pediatric Vision		-0.05%
Total Value of Plan	100.10%	100.10%

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 State employee plan as the most generous among the set of comparison plans.[9] 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 State employee plan as likely the most generous using the following process:

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

1. The current benchmark is the BlueCross BlueShield of Vermont Standard CDHP plan.
2. Based on prior Wakely analysis, 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 three plans had nearly identical coverage of benefits.
4. Similarly, the two State Employee plans cover the same benefits but with different cost sharing. Furthermore, the State Employee plans were found to be more generous than the current benchmark driven primarily by richer infertility, acupuncture, chiropractic care, and therapy benefits.
5. Based on the assessment that the State Employee 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 TotalChoice plan required supplementation for both pediatric dental and vision. The State CHIP pediatric dental and the Federal VIP's pediatric vision were 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 TotalChoice plan is the most generous of the options.

Table 3 above shows the benefit differences between the current benchmark and the TotalChoice plan.

As seen in Table 5, this results in the proposed benchmark being less generous than the TotalChoice plan. Therefore, the proposed benchmark plan meets the requirements of the generosity test.

Table 5: Comparison of Proposed Benchmark to Generosity Comparison Plan

Benefits	Proposed Benchmark	TotalChoice
Starting Value - Current Benchmark	100.00%	100.00%
Benefit Differences		
Hearing Aid Coverage	0.10%	
Infertility Treatment		0.81%
Acupuncture		0.33%
Chiropractic Care		0.07%

Benefits	Proposed Benchmark	TotalChoice
Physical, Speech, and Occupational Therapy		0.01%
Massage Therapy		0.01%
All Other Benefit Variances		0.00%
Total Value of Plan	**100.10%**	**101.23%**

Conclusion

The analysis and results presented in this report, particularly Tables 4 and 5, show the proposed benchmark plan satisfies the actuarial requirements as stated in 45 CFR 156.111. Furthermore, the methodology and adjustments used to produce the results are reasonable and are in compliance with Actuarial Standards of Practices (ASOPs). Therefore, we believe the proposed benchmark plan, this report, and associated documents satisfy all requirements for Vermont's 2024 Essential Health Benefit Benchmark Plan pending CMS approval.

Appendix A: Data and Methodology

The Vermont DFR provided Wakely a data extract containing 2017 through 2020 enrollment, medical, and pharmacy detail from Vermont's all-payer claims database (APCD) - Vermont Health Care Uniform Reporting and Evaluation System (VHCURES). The VHCURES extract included data from ACA, state employee, and fully-insured large group lines of business. Wakely used VHCURES as the primarily data source to estimate benefit costs contained in this report.

Although the VHCURES data contained data for most benefits, certain benefits such as hearing aids were either not present in the data or determined to have a more appropriate pricing source. In these instances, Wakely Internal Databases (WIDs) and other internal databases were used to estimate benefit costs and make appropriate adjustments to the base information. The WID data repository is comprised of issuer EDGE server data and includes over 7 million member lives in 2018. The data itself is available at the Regional level; for this analysis we used the Northeast US region.

For both VHCURES and WID data sources, Wakely pulled 2018 allowed information by service line and used this data to assess utilization and unit cost data for select benefits. 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 made at different points in time.

Once CPT-level (in some cases NDC & member-level was also used) data was acquired, we made any 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:

- 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
- Unit Cost adjustments to reflect coverage for only a portion of NDCs within a class or for changes in drug offerings (e.g., more generics available compared to the data period), where appropriate

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 VHCURES and WID data used to align the percent of allowed cost estimates. The data was also calibrated to the northeast region similar to the medical benefit analysis. Finally, based on estimates that children account for approximately 16% of Vermont on-Exchange enrollment, 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 data 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 cost 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:

- A data extract provided by the State from the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), containing enrollment, medical, and pharmacy claims data for all payors in the state of Vermont for the period 2017 – 2020.
- 2018 Wakely Internal Databases (WIDs)
- 2017 Vermont benchmark plan information, sourced from CMS
- The benefits and formulary for select plans including:
    - Blue Cross Blue Shield of Vermont's TotalChoice
    - BlueCross BlueShield of Vermont Standard CDHP
    - Blue Cross Blue Shield of Vermont Plan J with lifestyle and stomach acid drugs
    - Government Employees Health Association Inc. (GEHA) Benefit
    - Child Health Plan Plus (CHP+) Dental
    - MetLife Federal Dental
    - Federal VIP BlueVision
    - Vermont's State CHIP Dental
- Information gained from regular conversations with the State and other market stakeholders, including Blue Cross Blue Shield of Vermont and MVP Healthcare.
    - Plan benefit and cost-sharing summaries
    - Large group membership estimates
- Various internal and external research to supplement the analysis contained within this report

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

- **Data Limitations.** The VHCURES data listed above was provided by the State for the support of this analysis. Wakely was provided with a data dictionary in order to tailor the data to our needs, but no further audit of the data for correctness or completeness was performed. Furthermore, claims and enrollment data from 2018 formed the basis of this analysis due to run-out and data lag in later years of the VHCURES data set. Finally, we

note that the data provided was a subset of the entire VHCURES data set, so it was assumed to be complete for our purposes.

    - The WIDs used in this report include databases comprised of EDGE server data. 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.

- **Enrollment Uncertainty.** This report was produced based on 2018 experience data. To the extent that the risk profile, mix of services utilized, size, or any other significant characteristic of combination of characteristics of the insured population changes significantly between 2018 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, DFR 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. Alex Jarocki and Michael Cohen contributed to this report.

Intended Users. This information has been prepared for the sole use of Vermont Department of Financial Regulation (DFR). 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 Vermont 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 the State of Vermont via their all payer claim database - VHCURES. 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

Category	Code	Description
Hearing Aid Exam	92590	HEARING AID EXAMINATION & SELECTION MONAURAL
Hearing Aid Exam	92591	HEARING AID EXAMINATION & SELECTION BINAURAL
Hearing Aid Exam	92592	HEARING AID CHECK MONAURAL
Hearing Aid Exam	92593	HEARING AID CHECK BINAURAL
Hearing Aid Exam	92594	ELECTROACOUS EVAL HEARING AID MONAURAL
Hearing Aid Exam	92595	ELECTROACOUS EVAL HEARING AID BINAURAL
Hearing Aid Exam	S0618	AUDIOMETRY FOR HEARING AID
Hearing Aid Exam	V5010	ASSESSMENT FOR HEARING AID
Hearing Aid Exam	V5011	HEARING AID FITTING/CHECKING
Hearing Aid	V5014	HEARING AID REPAIR/MODIFYING
Hearing Aid	V5020	CONFORMITY EVALUATION
Hearing Aid	V5030	BODY-WORN HEARING AID AIR
Hearing Aid	V5040	BODY-WORN HEARING AID BONE
Hearing Aid	V5050	HEARING AID MONAURAL IN EAR
Hearing Aid	V5060	BEHIND EAR HEARING AID
Hearing Aid	V5070	GLASSES AIR CONDUCTION
Hearing Aid	V5080	GLASSES BONE CONDUCTION
Hearing Aid	V5090	HEARING AID DISPENSING FEE
Hearing Aid	V5095	IMPLANT MID EAR HEARING PROS
Hearing Aid	V5100	BODY-WORN BILAT HEARING AID
Hearing Aid	V5110	HEARING AID DISPENSING FEE
Hearing Aid	V5120	BODY-WORN BINAUR HEARING AID
Hearing Aid	V5130	IN EAR BINAURAL HEARING AID
Hearing Aid	V5140	BEHIND EAR BINAUR HEARING AI
Hearing Aid	V5150	GLASSES BINAURAL HEARING AID
Hearing Aid	V5160	DISPENSING FEE BINAURAL
Hearing Aid	V5170	WITHIN EAR CROS HEARING AID
Hearing Aid	V5180	BEHIND EAR CROS HEARING AID
Hearing Aid	V5190	GLASSES CROS HEARING AID
Hearing Aid	V5200	CROS HEARING AID DISPENS FEE
Hearing Aid	V5210	IN EAR BICROS HEARING AID
Hearing Aid	V5220	BEHIND EAR BICROS HEARING AI
Hearing Aid	V5230	GLASSES BICROS HEARING AID
Hearing Aid	V5240	DISPENSING FEE BICROS
Hearing Aid	V5241	DISPENSING FEE, MONAURAL
Hearing Aid	V5242	HEARING AID, MONAURAL, CIC
Hearing Aid	V5243	HEARING AID, MONAURAL, ITC

Category	Code	Description
Hearing Aid	V5244	HEARING AID, PROG, MON, CIC
Hearing Aid	V5245	HEARING AID, PROG, MON, ITC
Hearing Aid	V5246	HEARING AID, PROG, MON, ITE
Hearing Aid	V5247	HEARING AID, PROG, MON, BTE
Hearing Aid	V5248	HEARING AID, BINAURAL, CIC
Hearing Aid	V5249	HEARING AID, BINAURAL, ITC
Hearing Aid	V5250	HEARING AID, PROG, BIN, CIC
Hearing Aid	V5251	HEARING AID, PROG, BIN, ITC
Hearing Aid	V5252	HEARING AID, PROG, BIN, ITE
Hearing Aid	V5253	HEARING AID, PROG, BIN, BTE
Hearing Aid	V5254	HEARING ID, DIGIT, MON, CIC
Hearing Aid	V5255	HEARING AID, DIGIT, MON, ITC
Hearing Aid	V5256	HEARING AID, DIGIT, MON, ITE
Hearing Aid	V5257	HEARING AID, DIGIT, MON, BTE
Hearing Aid	V5258	HEARING AID, DIGIT, BIN, CIC
Hearing Aid	V5259	HEARING AID, DIGIT, BIN, ITC
Hearing Aid	V5260	HEARING AID, DIGIT, BIN, ITE
Hearing Aid	V5261	HEARING AID, DIGIT, BIN, BTE
Hearing Aid	V5262	HEARING AID, DISP, MONAURAL
Hearing Aid	V5263	HEARING AID, DISP, BINAURAL
Hearing Aid	V5264	EAR MOLD/INSERT
Hearing Aid	V5265	EAR MOLD/INSERT, DISP
Hearing Aid	V5266	BATTERY FOR HEARING DEVICE
Hearing Aid	V5267	HEARING AID SUP/ACCESS/DEV
Hearing Aid	V5268	ALD TELEPHONE AMPLIFIER
Hearing Aid	V5269	ALERTING DEVICE, ANY TYPE
Hearing Aid	V5270	ALD, TV AMPLIFIER, ANY TYPE
Hearing Aid	V5271	ALD, TV CAPTION DECODER
Hearing Aid	V5272	TDD
Hearing Aid	V5273	ALD FOR COCHLEAR IMPLANT
Hearing Aid	V5274	ALD UNSPECIFIED
Hearing Aid	V5275	EAR IMPRESSION
Hearing Aid	V5281	ALD FM/DM SYSTEM, MONAURAL
Hearing Aid	V5282	ALD FM/DM SYSTEM BINAURAL
Hearing Aid	V5283	ALD NECK, LOOP IND RECEIVER
Hearing Aid	V5284	ALD FM/DM EAR LEVEL RECEIVER
Hearing Aid	V5285	ALD FM/DM AUD INPUT RECEIVER
Hearing Aid	V5286	ALD BLU TOOTH FM/DM RECEIVER
Hearing Aid	V5287	ALD FM/DM RECEIVER, NOS
Hearing Aid	V5288	ALD FM/DM TRANSMITTER ALD

Category	Code	Description
Hearing Aid	V5289	ALD FM/DM ADAPT/BOOT COUPLIN
Hearing Aid	V5290	ALD TRANSMITTER MICROPHONE
Hearing Aid	V5298	HEARING AID NOC
Hearing Aid	V5299	HEARING SERVICE
Hearing Aid	V5336	REPAIR COMMUNICATION DEVICE
Hearing Aid	Z461	Encounter for fitting and adjustment of hearing aid
Hearing Aid	Z974	Presence of external hearing-aid
Hearing Aid	69710	IMPLTJ/RPLCMT EMGNT BONE CNDJ DEV TEMPORAL BONE
Hearing Aid	69711	RMVL/RPR EMGNT BONE CNDJ DEV TEMPORAL BONE