VPLC Comments Regarding Essential Health Benefits Benchmark Plan

The Virginia Poverty Law Center (VPLC) appreciates the opportunity to comment on the adoption of a new Essential Health Benefit Benchmark plan, hereafter referred to as the "benchmark plan," for plan year 2025 and the adoption of a process for updating the benchmark plan in future years. VPLC addresses systemic barriers that keep low-income Virginians in the cycle of poverty. Having worked with the ACA Marketplace and Marketplace enrollees since 2013, we understand the impact that a high-quality benchmark plan can have in addressing the health needs of all Virginians. Updating the benchmark plan provides an opportunity to promote health equity and respond to emergent health needs. We encourage the Bureau of Insurance to adopt a process that prioritizes these things as well as transparency, robust public input, and data driven decision making.

As the process stands now, only benefits that are referred by the legislature to the Health Insurance Reform Commission (HIRC) and undergo the subsequent review directed by Va. Code §30-432 are considered for inclusion in the benchmark plan. The November 2022 study produced by NovaRest did highlight benefits that are currently excluded from the Virginia's benchmark plan, are covered by the benchmark plans of neighboring states, and have not been reviewed by HIRC. However, these benefits did not undergo an actuarial analysis nor were they considered for inclusion in the updated benchmark plan by HIRC members.

Limiting consideration to benefits that were brought to HIRC through the legislative process is naturally prohibitive. The state should take a much broader view and utilize comprehensive health data and plan claims data to determine the greatest need and gaps in coverage. This data would be a powerful tool in determining what benefits would best address current inadequacies. Additionally, the current process prohibits the state from acting quickly to consider ways in which the benchmark plan could be adjusted to address pressing health emergencies. For example, as the NovaRest report also showed, many states recently updated their benchmark plans to better address the opioid epidemic.

The inclusion of a separate workgroup as directed in HB 2199 and SB 1397 does create an alternative pathway for this type of analysis to be done. However, the language is unclear as to what data and metrics this group will use to determine their recommendations as well as who will comprise this group. To clarify these key considerations, we recommend that the workgroup:

1. Be independent and comprised of individuals with expertise in individual or small group health coverage, health benefit plan design, actuarial science, population health, and/or patient advocacy.
2. Be provided data on coverage denial rates of uncovered benefits under the current benchmark plan, utilization rates of mandated benefits, the projected impact of a proposed mandate on the prevalence of medical need, the intensity of that medical need, and the disproportionate disease burden borne by different subpopulations.
3. Be given authority to recommend benefits for inclusion that did not go through the legislative and HIRC processes.