

Tennessee Plan Year 2029 Benchmark Plan Change Actuarial Report

PREPARED FOR THE TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE

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Introduction and Background

Lewis & Ellis, LLC (L&E) was engaged by the Tennessee Department of Commerce and Insurance (TDCI) to assess and certify a proposed change to Tennessee's Benchmark Plan (BMP) for plan year 2029. This engagement follows Tennessee Public Chapter (PC) 932 of the 114th Tennessee General Assembly, which requires TDCI to submit a proposed BMP revision within 90 days of the act's effective date.

For plan years beginning on or after January 1, 2026, a State may change its EHB-benchmark plan by selecting a set of benefits that would become the State's EHB-benchmark plan¹. Modifications must be communicated to CMS by the first Wednesday in May, two years prior to the effective date of the revised plan.

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 of benefits of a typical employer plan in the State.

The scope of benefits in a typical employer plan is defined as a scope of benefits that falls within a range that is as or more generous than the least generous plan and as or less generous than the most generous plan among the following options:

- *Base-Benchmark Plan Options*
One of the selecting State's 10 base-benchmark plan options established under §156.100.
- *Large Group Health Insurance Plans*
The largest health insurance plan, by enrollment, within one of the five largest large group health insurance products by enrollment in the state. These products and plans must meet the following criteria:
 - 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

¹ 45 CFR 156.111(a)(2)

- The benefits in the plan are from a plan year beginning after December 31, 2013. L&E will refer to these requirements as the “required testing.”

Proposed Benchmark Plan

The current BMP is the Small Group HDHP offered by BlueCross BlueShield of Tennessee. This BMP was set for plan year 2017 and has remained unchanged through plan year 2027.

For plan year 2029, Tennessee is proposing the following changes to the current BMP:

Change Description	Additional Detail
<p>Coverage for Gender Detransition Services</p>	<p>As required by PC 932, Tennessee proposes to add coverage for gender detransition services to the state's essential health benefits (EHB) for qualified health plans (QHPs) offered on the marketplace exchange. Coverage for gender detransition services refers to health insurance benefits for individuals seeking to reverse or modify prior gender-affirming medical treatments. This may include services such as hormone therapy adjustments or cessation, surgical revisions (e.g., removal or reconstruction procedures), and related medical care. Coverage typically follows the same medical necessity criteria, prior authorization requirements, and cost-sharing provisions that apply to other covered services and may also include behavioral health support as part of a comprehensive treatment plan. The change does not alter the benchmark formulary and applies only to otherwise covered/formulary drugs, as applicable.</p>

Benchmark Plan Assessment

In accordance with guidance issued by CMS/CCIIO, L&E conducted the required testing to ensure compliance with federal standards. This testing involved comparing the expected value of fully paying for all covered benefits, i.e., with no member cost-sharing, across the following plans:

1. The Proposed Benchmark Plan
2. The Selected "Least Generous Plan"
3. The Selected "Most Generous Plan"

This analysis ensures that the proposed benchmark plan’s scope of benefits aligns with the range established by the least and most generous plans within the state, as required under 45 CFR §156.111.

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 plan was one of Tennessee’s ten base-benchmark plan options available for selection for the 2017 plan year.

In comparing the expected value of the proposed benchmark plan (BMP) to the Least Generous Plan, the only difference identified is the additional benefit detailed in the previous section of this report. As a result, the expected value of the proposed BMP exceeds the Least Generous Plan by the expected value of these expanded or added benefits.

To estimate the value of the expanded or added benefits, L&E utilized the following resources:

- Benefit estimates completed as part of other state benefit mandates or changes to benchmark plans.
- L&E’s Medical Manual².
- Other publicly available research.

Further details regarding the sources used to estimate the value of benefits are provided in Appendix A.

Based on this analysis, L&E estimates that the value of the added benefit is \$0.09 per member per month (PMPM) after adjusting for full coverage (i.e., no member cost-sharing).

Accordingly, L&E estimates that the expected value of the proposed BMP exceeds the Least Generous Plan by \$0.09 PMPM.

Benefit Differences	Proposed Benchmark Plan ³	Least Generous Plan
Gender Detransition Services	\$0.09 PMPM; 0.01%	No Coverage
Total Benefit Differences	\$0.09 PMPM; 0.01%	\$0.00

² Based on IBM MarketScan data, a large, proprietary collection of de-identified, patient-level healthcare claims data.

³ Percentage impacts are based on an estimated average allowed cost in Tennessee for 2026 of \$1,031. This is based on KFF- reported 2026 marketplace average premium of \$838 for Tennessee ([Link](#)), an assumed loss ratio of 80%, and an average paid-to-allowed ratio of 0.65 based KFF-reported 2026 metal level plan selections for Tennessee ([Link](#)).

The 2014 Tennessee State Employee Health Benefit Premier Plan was selected to be the “Most Generous Plan”, or the “ceiling” of a typical employer plan. This plan meets the requirements of 45 CFR §156.111 because it was one of the 10 base-benchmark plan options established at §156.100, and available for the selecting State’s selection for the 2017 plan year.

L&E compared the benefits of the proposed benchmark to the Most Generous Plan and found benefit differences as shown in the table below. Other than the benefits listed below, the two plans cover the same services based on an Appendix C reconciliation between the two plans. Each benefit estimate below was developed based on data from benefit estimates completed as part of other state benefit mandates or changes to benchmark plans, L&E’s medical manual, and other publicly available research. The estimates are based on full coverage (i.e., no member cost sharing).

Benefit Differences	Proposed Benchmark Plan³	Most Generous Plan
Private Duty Nursing	Not Covered	\$2.10 PMPM; 0.2%
Home Health Care	+\$0.20 PMPM; 0.02% 60 Visits	30 Visits
Skilled Nursing	60 Days	+\$0.20 PMPM; 0.02% Unlimited
PT/OT/ST⁴	20 Visits/Therapy	+\$1.00 PMPM; 0.1% Unlimited
Bariatric Surgery	Not Covered	\$1.05 PMPM; 0.1%
Chiropractic Care	20 Visits	+\$0.45 PMPM; 0.04% Unlimited
Pediatric Dental	\$1.50 PMPM; 0.1%	Not Covered
Gender Detransition Services	\$0.09 PMPM; 0.01%	No Coverage
Total Benefit Differences	\$1.79 PMPM; 0.2%	\$4.80 PMPM; 0.5%

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.

⁴ Physical Therapy, Occupational Therapy, and Speech Therapy.

Conclusion

Tennessee is proposing a new Essential Health Benefits Benchmark Plan for the 2029 plan year. The proposed plan enhances the current EHB benchmark by adding coverage for gender detransition services. 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 is estimated to fall within the typical-employer-plan scope range required under 45 CFR §156.111(b)(2).

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Appendix A

GENDER DETRANSITION SERVICES

The estimated benefit value for covering gender detransition services was calculated as outlined in the table below, using the referenced sources.

Assumption Description	Assumption	Source
Prevalence of Gender Dysphoria (a)	0.8%	The Williams Institute, UCLA School of Law
Percentage of People with Gender Dysphoria that Medically Transition (b)	60%	U.S. Transgender Survey
Percentage of People that Medically Transition that Subsequently Detransition (c)	0.4%	U.S. Transgender Survey
Utilization of Gender Detransition Services (d)	0.002%	$(d) = (a) * (b) * (c)$
Average Cost of Detransition Services (e)	\$65,000	Cambridge University Press
Estimated PMPM Impact (f)	\$0.09	$(f) = [(d) * (e)] / 12$

Line items (a), (b), and (c) reflect lifetime prevalence, transition, and detransition rates rather than annual incidence or utilization rates. While these assumptions could be converted to annualized rates, doing so would further reduce the estimated utilization and PMPM impact. Given the already very low estimated lifetime utilization rate, L&E elected to retain the lifetime assumptions as a conservative approach to the analysis. Accordingly, the estimated PMPM impact is likely overstated relative to an annualized framework, however, the testing conclusions would remain unchanged.

PRIVATE DUTY NURSING

The estimated benefit value for private duty nursing coverage was based on the following information:

- North Dakota's Actuarial Report for PY2025 BMP changes valued private duty nursing coverage at \$1.40-\$1.70 PMPM impact.
- New Mexico's Actuarial Report for PY2022 BMP changes valued private duty nursing coverage at 0.4% benefit impact.
- The impact is set at \$2.10 PMPM, which is approximately equivalent to a 0.2% allowed cost impact.

HOME HEALTH CARE

The estimated benefit value for the difference between home health care covered at a 60-visit limit versus a 30-visit limit was based on the following information:

- The value difference between a home health care benefit of 50 visits and 130 visits is estimated to be approximately 0.01% of cost based on Washington's Actuarial Report for PY2026 BMP changes.
- The L&E Medical Manual indicates a PY2029 benefit value for home health coverage, limited to 30-visits of \$1.82 PMPM, and limited at 60-visits (same as unlimited), \$2.02 PMPM – a difference of \$0.20 PMPM.
- The impact is set at \$0.20 PMPM, which is approximately equivalent to a 0.02% allowed cost impact.

BARIATRIC SURGERY

The estimated benefit value for bariatric surgery coverage was based on the following information:

- Alaska's Actuarial Report for PY2026 BMP changes valued bariatric surgery benefits at 0.07% benefit impact.
- Virginia's Actuarial Report for PY2025 BMP changes valued bariatric surgery benefits at \$1.00-\$1.75 PMPM.
- The impact is set at \$1.05 PMPM, which is approximately the average of these two sources.

CHIROPRACTIC CARE

The estimated benefit value for the difference between chiropractic care covered at a 20-visit limit versus unlimited coverage was based on the following information:

- The L&E Medical Manual indicates a PY2029 benefit value for chiropractic coverage, limited to 20-visits of \$2.66 PMPM, and unlimited, \$3.12 PMPM – a difference of \$0.46 PMPM.
- Oregon's Actuarial Report for PY2022 BMP changes valued chiropractic benefits, limited to 20 visits, at \$1.89 – comparable to the L&E Medical Manual when annual trend is considered.
- The impact is set at \$0.45 PMPM.

PT/OT/ST

The estimated benefit value for the difference between PT/OT/ST covered at a 20-visit limit/therapy versus unlimited coverage was based on the following information:

- Alaska's Actuarial Report for PY2026 BMP changes valued a combined 45-visit limit combined (~15 visits/therapy) versus unlimited coverage at 0.06% benefit impact.
- The L&E Medical Manual indicates a PY2029 benefit value for PT/OT/ST coverage, limited to 20-visits of \$14.09 PMPM, and unlimited, \$16.53 PMPM – a difference of \$2.44 PMPM.
- The impact is set at \$1.00 PMPM, which is approximately equivalent to a 0.01% allowed cost impact.

SKILLED NURSING

The estimated benefit value for the difference between skilled nursing covered at a 60-day limit versus unlimited coverage was based on the following information:

- Alaska's Actuarial Report for PY2026 BMP changes valued no benefit difference between a 60-day limit and unlimited coverage.
- The L&E Medical Manual indicates a PY2029 benefit value for skilled nursing coverage, limited to 70 days of \$1.26 PMPM, and unlimited, \$1.68 PMPM – a difference of \$0.42 PMPM.
- The impact is set at \$0.20 PMPM, which is approximately equivalent to a 0.02% allowed cost impact.

PEDIATRIC DENTAL

The estimated benefit value for pediatric dental coverage was based on the following information:

- North Dakota's Actuarial Report for PY2025 BMP changes valued pediatric dental coverage between \$1.20-\$1.50 PMPM.
- The impact is set at \$1.50 PMPM, given the valuation is for PY2029.

ASOP 41 Disclosures

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations⁵, 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 Conduct⁶, 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, Principal & Senior Consulting Actuary
- 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 May 26, 2026. The date (a.k.a. “latest information date”) through which data or other information has been considered in performing this analysis is May 5, 2026.

Disclosures in Actuarial Reports

- The contents of this report are intended for the use of the Tennessee Department of Commerce and Insurance. 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 Tennessee Department of Commerce and Insurance in assessing and certifying a proposed change to Tennessee’s Benchmark Plan.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.

⁵ 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.

⁶ These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

- Lewis & Ellis has reviewed the data provided by the insurers and Tennessee Department of Commerce and Insurance 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, misrepresentations, 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.
- CMS-required Appendices A, B, and C, as well as the plan document for the proposed benchmark plan accompany this report.

Actuarial Findings

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