

# State of Washington: Office of Insurance Commissioner

## Benchmark Plan Benefit Valuation Report

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## Introduction and Background

The Washington state Office of the Insurance Commissioner (Washington, WA OIC, 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. As part of this process, OIC established a [website](#) for the project, held four public meetings, and provided ongoing opportunities for public comment. The OIC posted a draft of the full EHB update application submission on its website on April 1<sup>st</sup>, 2024 for public review and comment. The comment period is 11 days, with comments due on April 12<sup>th</sup>, 2024.

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; or
3. Selecting a set of benefits to become the state benchmark plan.

This is the actuarial report, which is part of Washington's application for a change in the Federal CMS Plan Year 2026 Essential Health Benefit Benchmark Plan using Selection Option 3. All of the other states that have updated their EHB benchmark plans have chosen this option as well. There are two actuarial requirements in order for a change in the benchmark plan 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 Washington state. 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

Washington is proposing to add benefits to their EHB that would include coverage for:

- human donor milk,
- an annual hearing exam and one hearing aid for each ear every 3 years, and
- artificial insemination.

Pursuant to 45 CFR 156.111, Washington has elected to take public comment on a draft set of benefits that comprise the proposed new EHB benchmark plan. Per Washington's request, we specifically priced the marginal cost of offering the proposed benefits relative to the current (2017) Washington Benchmark Plan.

The Washington State legislature directed the Office of the Insurance Commissioner in SSB 5338<sup>1</sup> to review the Essential Health Benefits (EHB) benchmark plan and determine whether to request approval from the federal Centers for Medicare and Medicaid Services (CMS) to modify Washington state's EHB benchmark plan.

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

## Proposed Benchmark

The current Washington benchmark plan is the Regence Direct Gold+ (Gold+). This benchmark has been in effect since 2017. Under 45 CFR 156.111, the State can propose a new benchmark plan by selecting a set of benefits, provided they meet certain requirements.

As part of its review process, Wakely discussed potential changes with WA OIC and Washington EHB stakeholder groups, which included Washington'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 are the recommended changes and the potential impact of each benefit.

Note that no proposed changes to the Washington EHB benchmark plan relate to pediatric dental or vision benefits. Washington does not intend to change these benefits.

### **Recommendation: Human Donor Milk Coverage**

#### **DESCRIPTION**

The State is proposing to add a human donor milk benefit that includes medically necessary human donor milk in an inpatient setting for an infant who is medically or physically unable to receive maternal human milk to the proposed benchmark plan. RCW 48.43.815 includes several clinical criteria to qualify for this benefit. Adding access to the recommended human donor milk benefit will improve health outcomes for infants, including a reduced risk of infections and sudden infant death syndrome. It will increase opportunities for babies to receive human milk. Industry

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<sup>1</sup> <https://lawfilesexext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Senate%20Bills/5338.pdf?q=20231213193345>

research suggests that pasteurized donor milk provides the nutritional and immunologic benefits of breast milk and reduces infectious complications in preterm or low birthweight infants compared with formula milk. As of April 2022, 14 states have enacted coverage of human donor milk for their Medicaid and/or commercial populations, with many advocacy groups pushing for coverage in more markets.<sup>2</sup>

## **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 ear every 3 years to the proposed benchmark plan. Adding the recommended hearing benefit will align the benchmark plan with the State's health care policy goals to improve health equity across insured populations by implementing benefit designs serving Washington's whole population, regardless of disability or age. Adding the recommended hearing benefit to Washington's benchmark plan will bring their hearing coverage more in-line with other Western states' EHBs and improve the health, educational attainment, employment opportunities and quality of life for affected members.

The \$3000 dollar limit on hearing instruments included in RCW 48.43.135 is not an allowable EHB benefit under current federal regulations. When pricing this benefit, Wakely did not include a dollar limit on the covered amount.

## **Recommendation: Artificial Insemination**

### **DESCRIPTION**

The State is considering adding an artificial insemination in vivo benefit to the benchmark plan. This benefit will improve the mental and physical wellbeing of members of the population who are otherwise unable to conceive via natural methods and rely on artificial insemination as a form of infertility treatment. Further, it will lead to improved support for organic state population growth.

The benefit will not include donor semen, donor eggs, and services related to their procurement and storage.

## **Methodology and Results**

To perform the analysis, Wakely used a variety of sources to estimate the cost for adding human donor milk, an annual hearing exam and a hearing aid for each ear every 3 years, and artificial

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<sup>2</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8979482/>

insemination in vivo. The primary data source was the Wakely Internal Databases<sup>3</sup> (WID) data and internal ACA data from the West Region. Where WID data for a particular service was not credible or available, Wakely used available industry data and prior Wakely publications<sup>4</sup> to support our estimates. The estimates are based on ongoing costs. Any pent-up demand that may occur in the initial years of coverage is not incorporated into the estimates. The estimates only include the cost of the specific benefits being considered. Downstream impacts such as maternity care costs resulting from artificial insemination, and potential savings due to increased well-being resulting from having hearing aids, are not included.

## HUMAN DONOR MILK

Human donor milk costs were calculated using industry data and research regarding the average cost and utilization of human donor milk services. A publication in the National Library of Medicine noted that 72% of preterm infants received donor human milk with a mean of 3,007 millimeters (mL) throughout the NICU stay<sup>5</sup>. An article by Oakbend Medical Center suggests that between 10% and 15% of babies need care in the NICU.<sup>6</sup> Of those infants, it's estimated that as few as 20% of their mothers may experience milk supply concern, thereby suggesting eligibility for human donor milk.<sup>7</sup> Several public articles, including an article from the National Conference of State Legislatures (NCSL), suggests that the average cost per ounce of donor milk is between \$3 and \$5, and the average infant needs between 32 and 48 ounces of milk per day.<sup>8</sup> Wakely used these data points and other industry research to vary assumptions and create a range of potential human donor milk costs. Considering the prevalence of infants in the United States population, the prevalence of pre-term NICU stays, as well as the need for human donor milk, Wakely determined the resulting cost estimate to add human donor milk to be 0.02% of the total allowed claims.<sup>9</sup>

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<sup>3</sup> Additional details on Wakely's Internal Databases can be found in Appendix A

<sup>4</sup> <http://www.insurance.wa.gov/sites/default/files/documents/2021-hearing-instrument-analysis-provided-by-wakely.pdf>

<sup>5</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3663453/#:~:text=Based%20on%20the%20price%20of,%2427.04%20and%20%24590.90%20per%20infant>

<sup>6</sup> <https://oakbendmedcenter.org/which-babies-need-care-in-the-nicu/#:~:text=Few%20parents%20expect%20it%2C%20but,very%20early%20or%20very%20ill>

<sup>7</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6860094/>

<sup>8</sup> <https://www.ncsl.org/state-legislatures-news/details/donor-human-milk-more-valuable-than-gold#:~:text=A%20handful%20of%20hospitals%20have,to%20%24150%2C000%20annually%20to%20maintain.&text=Even%20if%20a%20hospital%20prescribes,ounces%20of%20milk%20per%20day>

<sup>9</sup> 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.

## HEARING AID COVERAGE

Hearing aid exams and hearing aid costs were estimated from a 2021 research paper conducted by Wakely for the WA OIC.<sup>10</sup> The paper analyzed the cost of requiring coverage for hearing instruments and an annual hearing visit, projected to potential implementation years of 2023 through 2027. The data used hearing aid utilization and claim costs for 2019 provided by the largest health carriers in Washington. Calendar year 2020 and emerging 2021 data was considered but ultimately not used due to confounding COVID-19 impacts. Wakely utilized the 2026 allowed per member per month (PMPM) estimates as the basis for our range. As the paper's claims were confined to an annual benefit limit of \$3000, Wakely adjusted the PMPM costs in the paper to remove the impact of the annual benefit limit. Wakely also reviewed more recent research and industry data to ensure the 2021 research paper's assumptions, methodology, and results were reasonable. The resulting cost estimate is 0.07% of total allowed claims.

## ARTIFICIAL INSEMINATION

Artificial insemination costs were identified in WID data using the most recent Wakely ACA Claims Grouper code set to identify CPT codes assigned to artificial insemination alongside CPT codes gathered from industry research and resources.<sup>11</sup> 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 West region data, which includes Washington state. However, not all states in the West region cover artificial insemination. As a result, we reviewed the benefit coverage, where available, for all states in the West region. Preliminary infertility evaluation and diagnosis is currently covered under the current benchmark plan and may be required prior to receiving the artificial insemination benefit. We then adjusted the calculated PMPM amounts to account for the percentage of members insured in states where artificial insemination is currently a covered benefit. This adjustment was performed to ensure our estimated claim cost was not understated due to lack of coverage. The resulting cost estimate is 0.01% of the total allowed claims.

For all three estimates above, Wakely also referenced other internal claim databases to confirm the reasonability of the results.

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<sup>10</sup> <https://www.insurance.wa.gov/sites/default/files/documents/2021-hearing-instrument-analysis-provided-by-wakely.pdf>

<sup>11</sup> The full list of CPT codes used to identify artificial insemination is included in Appendix D.

## Additional Clarifications on Certain Benefits

### RECOMMENDATIONS

In addition to the benefit changes listed above, Washington 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 Washington 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.

### Summary of Benefit Additions

After performing the above pricing exercises for the listed benefit changes, the projected total increase of the recommended benefits is 0.09% 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 <sup>12</sup>
Human Donor Milk	0.02%
Annual Hearing Aid Exam & Hearing Aids Every 3 Years	0.07%
Artificial Insemination in Vivo	0.01%
<b>Total</b>	<b>0.09%</b>

There are two separate tests that a new benchmark must meet to be approved. The first test is the typical employer plan test. In particular, a new benchmark plan must provide a scope of benefits that is equal to a typical employer plan. The second test 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 Federal Government Employees Health Association, Inc. Benefit Plan (GEHA). GEHA is among the top 3 federal employee enrollment plans in the nation. The GEHA also met other requirements in 45 CFR 156.111 and therefore can be used for the typicality test under 45 CFR 156.111(b)(2)(i). GEHA's similarities and differences to the current benchmark plan are outlined in Table 3. It does not sufficiently cover the pediatric vision EHB category under 45 CFR 156.110(a). As a result, the pediatric vision EHB categories from the FEDVIP Vision plan was used to supplement the plan as allowed and required under 45 CFR

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<sup>12</sup> Figures were rounded to the second decimal place and may not equal the total due to rounding.



156.110(b). The GEHA plan does sufficiently cover pediatric dental EHB services under 45 CFR 156.110(a), so no supplementation for pediatric dental was necessary.

For the generosity test, Wakely selected a state employee plan that met the standards under 45 CFR 156.100, or the 2014 Group Health Cooperative of Washington's Classic Plan for active public employee benefit board (PEBB) employees. Since the Classic Plan does not sufficiently cover the dental EHB category under 45 CFR 156.110(a), the FEDVIP Dental plan was used to supplement the plan as allowed and required under 45 CFR 156.110(b). The Classic Plan sufficiently covers the vision EHB category under CFR 156.110(a), so no vision supplementation was necessary. The Classic Plan and preceding supplementation are herein collectively referred to as PEBB.

Overall, the three plans described above had identical pediatric vision benefit offerings equivalent to those under the FEDVIP Vision plan. The three plans had slightly different dental benefit offerings, which are quantified in the generosity and typicality test sections below. 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
Gold+	Current Benchmark	No Supplementation	No Supplementation
GEHA	Typicality Comparison	No Supplementation	Federal VIP
PEBB	Generosity Comparison	Federal VIP	No Supplementation

The primary differences between Gold+, GEHA, and the PEBB 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	Gold+	GEHA	PEBB
Description	Current Benchmark	Typicality Comparison	Generosity Comparison
Home Health Care Services	Covers up to 130 visits/year	Covers up to 50 visits/year	No Limit
Acupuncture	Covers up to 12 visits/year	Covers up to 20 visits/year	Covers up to 8 visits/year
Chiropractic Care	Covers up to 10 visits/year	Covers up to 12 visits/year	Covers up to 10 visits/year
Bariatric Surgery	Not Covered	Covered with certain criteria	Covered once every 10 years
PT / OT / ST / Massage	Covers up to 25 combined days/year	Covers up to 60 combined visits/year (no massage)	Covers up to 60 combined visits/year
Habilitative Services	Coverage is limited to 30-inpatient days/year and 25-outpatient visits/year.	Covered without limit	Covers up to 60 combined visits/year

Plan Name	Gold+	GEHA	PEBB
Description	Current Benchmark	Typicality Comparison	Generosity Comparison
Cardiac rehabilitative therapy visits	Covered without limit	Covered without limit	Not Covered
Applied Behavioral Analysis Therapy (ABA)	Covered	Not Covered	Covered
Hearing Aids	Not Covered	Covered once every 5 years	Covered once every 3 years
Routine Hearing Exams	Not Covered	Covered	Covered
Pediatric Dental <sup>13</sup> (differences relative to BMP)	N/A	Does not cover Sealants, Endodontics, Periodontics, or Prosthodontics	Also covers Extractions

## Changes to Federal Regulations

This report was originally written prior to the release of the final 2025 Notice of Benefit and Payment Parameters (2025 NBPP)<sup>14</sup>. The 2025 NBPP finalized several revisions to the EHB application process effective for the 2026 plan year.

One revision removed the requirement to submit a formulary drug list as part of the application when there are no proposed changes to the state's prescription drug EHBs. Since this application is not proposing any changes to the prescription drug EHBs, a formulary has been not included.

Another revision removed the generosity standard and revised the typicality standard. Historically, the generosity standard placed a ceiling, or maximum richness, on the benchmark plan while the typicality standard required the proposed benchmark plan to be exactly equal to one of the benchmark plan options. While the generosity standard was removed as a requirement, Wakely still ran this test for the analysis.

The revised typicality standard now states a benchmark plan must be at least as generous as the least generous typical employer plan and as or less generous than the most generous typical employer plan. In other words, the typicality standard places a floor and ceiling on the benchmark plan's richness.

<sup>13</sup> There are other more detailed benefit differences not noted here. All known benefit differences are captured in the generosity and typicality tests in Tables 4 and 5.

<sup>14</sup> <https://www.cms.gov/files/document/cms-9895-f-patient-protection-final.pdf>

The revised typicality standard requirements are broader and less restrictive than the previous typicality and generosity standard requirements. Therefore, a proposed benchmark plan that is more generous than one of the base benchmark plans (in this case the current benchmark plan) but not more generous than one of the base benchmark plans (in this case the state employee plan) will meet the new EHB requirements for revising a benchmark plan listed at 45 CFR 156.111.

## 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.<sup>15</sup>

Wakely analyzed the expected relative cost difference of the benefits of the proposed benchmark plan and GEHA, 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 benchmark plan, relative to the current benchmark plan is 0.09% (see Table 1). Other benefit differences, specifically benefit differences between GEHA and the current benchmark plan, were also estimated<sup>16</sup> and determined to be 0.09% 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 GEHA covered the same benefits apart from those listed in Table 4 below. GEHA offers richer benefits than the proposed benchmark with the exception of the new proposed benefits, pediatric dental, home health care services, and applied behavioral therapy (ABA). The below section details the benefit differences between the two plans.

For pediatric dental, it was determined that both the proposed benchmark plan and the GEHA have sufficient pediatric dental coverage under 45 CFR 156.110(a), so no supplementation was necessary for either plan. Wakely identified several differences in pediatric dental benefit coverage between the proposed benchmark and GEHA plans. The differences identified are that the GEHA does not cover sealants, endodontics, periodontics, prosthodontics, or anesthesia while the proposed benchmark plan does. Both plans cover clinical oral examinations, prophylaxis, fluoride treatments, oral surgery, and crowns, among other services.

Since the GEHA plan does not offer coverage for the aforementioned services relative to the proposed benchmark plan, overall cost in the pediatric dental category would be lower than in the proposed benchmark plan. Wakely relied on a proprietary dental model to value the difference in benefits. This is discussed in greater detail in Appendix A. Lastly, the prevalence of children in

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<sup>15</sup> [https://www.regtap.info/uploads/library/PMSC\\_Slides\\_022421\\_5CR\\_022421.pdf](https://www.regtap.info/uploads/library/PMSC_Slides_022421_5CR_022421.pdf)

<sup>16</sup> Only benefit differences estimated to have a value greater than 0.00% are shown.

the market was taken into account to arrive at an ultimate percentage of allowed costs differential of 0.11% as shown in Table 4.

All other benefit differences were calculated using the WID data, consistent with the explanation in the “Methodology and Results” section above. For ABA, emerging industry data indicates that utilization has been increasing in recent years leading to higher allowed costs.

As seen in Table 4, the benefit differences between the proposed benchmark and the typical employer plan (as defined by GEHA) 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	GEHA
Starting Value - Current Benchmark	100.00%	100.00%
<b>Benefit Differences</b>		
New Benefits in Proposed Benchmark (See Table 1)	0.09%	
Home Health Care Services		-0.01%
Acupuncture		0.01%
Chiropractic Care		0.03%
Bariatric Surgery		0.02%
PT / OT / ST / Massage		0.09%
Habilitative Services		0.01%
Applied Behavioral Therapy (ABA)		-0.02%
Hearing Aids		0.07%
Pediatric Dental		-0.11%
<b>Total Value of Plan</b>	<b>100.09%</b>	<b>100.09%</b>

## 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.<sup>17</sup> Wakely has supported over twelve states with EHB analyses since 2019 and leveraged some of that prior work to identify the plans most likely to be the most generous. In particular, Wakely has a strong sense of which

<sup>17</sup> [https://www.regtap.info/uploads/library/PMSC\\_Slides\\_022421\\_5CR\\_022421.pdf](https://www.regtap.info/uploads/library/PMSC_Slides_022421_5CR_022421.pdf)

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:

1. The current benchmark is the Regence Direct Gold+ 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, two of the three State Employee plans cover nearly 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 PT, OT, and ST therapy and hearing aids and exams benefits. The result of the analysis revealed the PEBB plan was the richest State Employee Plan.
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 PEBB plan required supplementation for pediatric dental only. The FEDVIP Dental plan was used for supplementation. The FEHB GEHA plan did not need supplementation for pediatric dental but was supplemented with the FEDVIP vision plan.
7. The result of the analysis, details which follow, is that the PEBB plan is the most generous of the options.

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

As seen in Table 5, this results in the proposed benchmark being less generous than the PEBB 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	PEBB
Starting Value - Current Benchmark	100.00%	100.00%
<b>Benefit Differences</b>		
New Benefits in Proposed Benchmark (See Table 1)	0.09%	
Home Health Care Services		0.01%
Acupuncture		-0.01%

Benefits	Proposed Benchmark	PEBB
Bariatric Surgery		0.01%
PT / OT / ST / Massage		0.09%
Habilitative Services		0.01%
Cardiac Rehabilitative Therapy Visits		-0.03%
Hearing Aids		0.07%
Pediatric Dental		0.03%
All Other Benefit Variances		0.00%
<b>Total Value of Plan</b>	<b>100.09%</b>	<b>100.18%</b>

## 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 Washington's 2026 Essential Health Benefit Benchmark Plan pending CMS approval.

## Appendix A: Data and Methodology

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The primary data source to estimate benefit costs contained in this report was the Wakely Internal Databases (WID) data, which includes de-identified EDGE Server input and output files (including enrollment, claims, and pharmacy data) from the 2021 benefit year submitted through April 2022 representing approximately 4 million lives from the individual and small group ACA markets. The analysis utilized data from West Region.

Although the WID data contained data for most benefits, certain benefits such as human donor milk and hearing aids were either not present in the data or determined to have a more appropriate pricing source. In these instances, industry research, prior Wakely publications, and other internal databases were used to estimate benefit costs and make appropriate adjustments to the base information.

For the WID data sources, Wakely pulled 2021 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 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 WID data used to align the percent of allowed cost estimates. The data was also calibrated to the west region similar to the medical benefit analysis. Finally, based on estimates that children account for approximately 25% of Washington on-Exchange enrollment, the value of the benefit was reduced to spread the costs over the entire ACA population.

## Appendix B: Reliances and Caveats

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The following is a list of the data Wakely relied on for the analysis:

- 2021 Wakely Internal Databases (WIDs)
- 2021 Washington Analysis of Requiring Coverage for Hearing Instruments
- 2017 Washington benchmark plan information, sourced from CMS
- The benefits and formulary for select plans including:
  - Regence Direct Gold +
  - Public Employees Benefits Board Plan (PEBB)
  - Government Employees Health Association Inc. (GEHA) Benefit
  - Federal Employees Dental & Vision Insurance Program (FEDVIP)
  - State CHIP Dental Plan
- Information gained from regular conversations with the State and other market stakeholders, including commercial issuers in the state of Washington.
  - 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 Wakely ACA Database (WID) is an aggregated database based on de-identified EDGE Server input and output files (including enrollment, claims, and pharmacy data) from the 2021 benefit year submitted through April 2022, along with supplemental risk adjustment transfer and issuer-reported financial information, representing approximately 4 million lives from the individual and small group ACA markets. We added in publicly available data published by CMS such as the 2021 plan finder data and the MLR data. The de-identification applies to identifiers specific to enrollee, issuer, and detailed location (only regional information retained). We performed reasonability tests on the data but did not audit or verify the data. The dataset is subject to change if issues are found or reported to us. We may release updates to the dataset if the changes are significant and relevant to the analyses.



- Results will be affected by issuer-specific data management. Omitted claims, erroneously coded claims, erroneous enrollment records, and other data issues may not reflect actual ACA cost and diagnosis experience.
  - A subset of issuers nationwide submitted data to the database. We believe the database represents a fair cross-section of nationwide experience, but limitations in this regard will affect results.
- **Enrollment Uncertainty.** This report was produced based on 2021 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 2021 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, OIC 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 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, pent up demand, downstream impacts, and drugs that they choose to include in their formulary, etc.

## Appendix C: Disclosures and Limitations

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**Responsible Actuaries.** Matt Sauter is the actuary responsible for this communication. He is a member of the American Academy of Actuaries and an Associate of the Society of Actuaries. He meets the Qualification Standards of the American Academy of Actuaries to issue this report. Julie Peper, Jenna Stefan, and Michael Cohen contributed to this report.

**Intended Users.** This information has been prepared for the sole use of Washington OIC. 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 Washington 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 Wakely's WID database. 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.

**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

ASOP No. 56, Modeling

## Appendix D: Benefit Detail

Category	Code	Description
Artificial Insemination	58321	ARTIFICIAL INSEMINATION; INTRA-CERVICAL
Artificial Insemination	58322	ARTIFICIAL INSEMINATION; INTRA-UTERINE
Artificial Insemination	58323	SPERM WASHING FOR ARTIFICIAL INSEMINATION
Artificial Insemination	89260	SPERM ISOLATION; SIMPLE PREP (EG, SPERM WASH AND SWIM-UP) FOR INSEMINATION OR DIAGNOSIS WITH SEMEN ANALYSIS
Artificial Insemination	89261	SPERM ISOLATION; COMPLEX PREP (EG, PERCOLL GRADIENT, ALBUMIN GRADIENT) FOR INSEMINATION OR DIAGNOSIS WITH SEMEN ANALYSIS