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Washington Office of the Insurance Commissioner

Essential Health Benefit Benchmark Plan Update

December 2023

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Introduction

The Washington State legislature directed the Office of the Insurance Commissioner (OIC) in SSB 5338[1] 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 legislation directed OIC to analyze the potential impacts of adding the following benefits as essential health benefits: donor human milk, hearing instruments, fertility services, biomarker testing, contralateral prophylactic mastectomies, treatment for PANS/PANDAS, and magnetic resonance imaging for breast cancer screenings.

OIC retained Wakely Consulting Group, LLC, an HMA Company (Wakely) to analyze potential changes to its state Essential Health Benefit benchmark plan in the individual and small group Affordable Care Act (ACA) markets. As part of this process, OIC established a website for the project, held four public meetings, and provided ongoing opportunities for public comment.

This report discusses the current federal regulations and process for states to update their EHB benchmark plan and Wakely's analysis of the potential for adding benefits to Washington's EHB benchmark plan. It supplements the presentation made at the fourth public meeting on December 13, 2023, which is included as Appendix C.[2] This report also discusses the potential changes to the process of updating state EHB benchmark plans that have been proposed in the 2025 Notice of Benefit and Payment Parameters[3] (NBPP) rule.

This document has been prepared for the sole use of the state of Washington. Wakely understands that this report may be made public. Any distribution of this report should be made in its entirety. This document contains the results, data, assumptions, and methods used in our analyses. The combination of this report and the fourth public meeting slides presented on December 13, 2023 satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements. Using the information in this report for other purposes may not be appropriate.

Background

The Affordable Care Act (ACA) and resulting federal regulations set forth ten benefit categories that non-grandfathered plans in the individual and small group markets are required to cover. Each state has its own unique set of benefit requirements that are set through designation of an EHB benchmark plan. Consequently, Washington has its own unique benchmark plan.[4]

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[1] https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Senate%20Bills/5338.pdf?q=20231213193345

[2] https://www.insurance.wa.gov/sites/default/files/documents/wakely-wa-ehb-benchmark-12132023.pdf

[3] https://www.federalregister.gov/documents/2023/11/24/2023-25576/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2025

[4] https://www.cms.gov/marketplace/resources/data/essential-health-benefits#Washington

The Washington State legislature directed the Office of the Insurance Commissioner in SSB 5338[5] 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 legislation directed OIC to analyze the potential impacts of adding the following benefits as essential health benefits: donor human milk, hearing instruments, fertility services, biomarker testing, contralateral prophylactic mastectomies, treatment for PANS/PANDAS and magnetic resonance imaging for breast cancer screenings.

Process of Updating the EHB Benchmark Plan

In the final 2019 HHS Notice of Benefits and Payment Parameters, the federal government created a new process for states to update their EHB benchmark plan for benefit year 2020 and beyond. Under the new process, nine states have updated their EHB benchmark plan. The following summarizes the EHB benchmark plan update process, which appears at 45 CFR 156.111.[6]

States have three options for selecting a new benchmark plan. These options are:

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

To select a new EHB-benchmark plan, states must obtain approval from CMS by submitting updated plan documents as well as an actuarial certification and report. The actuarial certification and report must demonstrate that the proposed new benchmark meets two actuarial requirements: the typicality test and the generosity test.

Under the typicality test, a new EHB benchmark plan must be equal to a typical employer plan. The generosity test requires that a new EHB benchmark plan not exceed the generosity of the most generous among a set of comparison plans. That is, a new benchmark plan's generosity, or total benefits, is effectively capped by the most generous plan among a set of comparison plans that are defined by the federal regulations.

States are required to notify CMS by the first Wednesday in May for proposed changes that are two years before the effective date. An application before May 2024 could go into effect for the 2026 benefit year, at the earliest.[7]

[5] https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Senate%20Bills/5338.pdf?q=20231213193345

[6] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-156/subpart-B/section-156.111

[7] The 2025 NBPP proposes to change the EHB updating process effective starting after the May 2024 submission window closes. The proposed changes will be discussed later in the paper.

The OIC intends to pursue Option 3 above. It will select a set of benefits to become the state EHB benchmark plan. All the other states that have updated their EHB benchmark plans have chosen this option as well. The next section will discuss Wakely's analysis of the potential for adding benefits to the current EHB benchmark plan in relationship to the typicality and generosity tests.

Analysis

In accordance with SSB 5338 and in collaboration with the OIC, Wakely analyzed the extent to which additional benefits could meet the generosity and typicality tests. EHB regulations evaluate benefit differences based on allowed costs (insurer paid plus member paid). Therefore, Wakely evaluated benefit differences between plans based on the value of the benefit differences, shown as a percentage of allowed costs.

Generosity Test

Wakely identified the Public Employees Benefits Board Plan (PEBB) as the most generous among the set of comparison plans. As a result, the PEBB plan effectively places a ceiling on how rich total benefits can be for a new EHB benchmark plan.

Wakely then analyzed the benefit differences between the current EHB benchmark plan and the PEBB plan to identify the amount of allowed costs that can be added to the existing EHB benchmark plan. The primary benefit differences between the benchmark plan and the PEBB plan are listed below in Table 1 as a percent of total allowed costs.

Table 1: Comparison of Benchmark Plan and PEBB Plan

Benefit	Benchmark Plan	PEBB	Difference in Allowed Costs
Home Health Care Services	130 visits/year	No Limit	0.00% to 0.02%
Acupuncture	12 Visit(s) per Year	8 visits/yr	-0.01% to -0.02%
Bariatric Surgery	Not Covered	Once every 10 years	0.01% to 0.04%
PT / OT / ST / Massage	25/year Combined	60 visits/yr Combined	0.21% to 0.40%
Habilitative Services	IP 30 OP 25 visits/yr	60 visits/yr	0.00% to 0.01%
Cardiac Rehabilitation	Covered	Not Covered	-0.02% to -0.04%
Hearing Aids	Not Covered	Once every 3 years	0.04% to 0.12%
Routine Hearing Exams	Not Covered	Covered	0.00% to 0.01%
All Other Benefit Differences			0.00% to 0.00%
Total (%)			**0.24% to 0.54%**
Total (PMPM $ estimate)			**$1.69 to $3.87**

Based on the analysis, Wakely estimates that the PEBB plan is approximately 0.24% to 0.54% more generous than the current EHB benchmark plan on an allowed cost basis (allowed costs

are the total eligible claims cost for a service). For example, if total allowed costs were assumed to be $712.50 per member per month (based on 2021 Individual and Small Group Washington experience from the 2023 Unified Rate Review Templates (URRTs), trended to 2026), the PEBB plan has approximately $1.69 to $3.87 of additional benefits per member per month.[8] Consequently, the maximum in allowed costs associated with new benefits that can be added in a new benchmark plan is 0.24% to 0.54%.

Benefit Pricing

In accordance with SSB 5338, the OIC directed Wakely to analyze several benefits. All estimated benefit costs were based on our understanding of the benefit and federal regulations on EHBs. In all cases, estimated ranges of the cost of the benefit were provided. The estimated benefit costs are shown below.

Table 2: Allowed Costs of Potential New Benefits

Benefit	Notes	Allowed Cost Range
Donor Human Milk	Human milk when infant is unable to receive maternal milk or whose parent is unable to produce maternal human milk in sufficient quantities or caloric density. Coverage is only while the infant is in an inpatient setting. Additional criteria apply (see bill[9]).	0.01% to 0.05%
Hearing Exam and Hearing Instruments	Hearing exam and hearing instruments each ear every three years.	0.04% to 0.12%
Artificial Insemination	Artificial insemination in vivo.	0.01% to 0.02%
In Vitro Fertilization	In vitro fertilization including medication, one extraction, fertilization, culture, preservation, and up to 3 transfers.	0.60% to 1.10%

In addition to the above benefits, biomarker testing, contralateral prophylactic mastectomies, magnetic resonance imaging for breast cancer screening, and treating for pediatric acute-onset neuropsychiatric syndrome (PANS & PANDAS) were also considered. Biomarker testing, contralateral prophylactic mastectomies, and magnetic resonance imaging for breast cancer screening were found to be covered in the current EHB benchmark plan in some manner. Coverage is based upon the health insurer's medical necessity criteria. Treatment of PANS & PANDAS also was identified to be covered in certain circumstances. However, it was noted that

[8] The 2026 allowed PMPM of $712.50 was calculated by trending 2021 Individual and Small Group Washington experience using an annual trend of 5.5%. The trend was calculated as the membership-weighted Individual and Small Group annualized trends from 2023 issuer-submitted URRTs in Washington.
[9] https://app.leg.wa.gov/RCW/default.aspx?cite=48.43.815

historical coverage has varied and been limited due, in part, to the treatment being deemed experimental without sufficient medical evidence and best practices by issuers. PANS and PANDAS coverage could change in the future based on how clinical criteria and best practices and medical evidence evolves.

EHB Pathways

RCW 48.43.715[10] requires that Human Donor Milk and a Hearing Benefit be added to any new proposed EHB benchmark plan, pursuant to the standards outlined in 48.43.815[11] and 48.43.135[12], respectively. The human donor milk benefit would cover medically necessary human donor milk in an inpatient setting for an infant who is medically or physically unable to receive maternal human milk. The hearing benefit would cover one hearing aid per ear every three years and includes the initial hearing exam. The $3000 dollar limit on hearing instruments included in RCW 48.43.135 is not allowable as an EHB benefit under current federal regulations. When pricing this benefit, Wakely did not include a dollar limit on the covered amount for each hearing instrument.

Wakely compared the estimated cost of the benefit additions to the generosity test to identify potential EHB pathways with RCW 48.43.715 in mind. This produced the options below, which would add the listed benefits to the current EHB BMP. Under both options it is expected that there would be a small amount of room for additional benefits to be added, if desired, in the future (pending any changes to federal generosity test rules).

Table 3: Potential EHB Benchmark Plan Additions

Benefit Additions	Allowed Cost Range	Remaining Room
Option A: Donor Milk & Hearing Benefit*	0.05% to 0.17%	0.07% to 0.49%
Option B: Donor Milk, Hearing Benefit, & Artificial Insemination	**0.06% to 0.19%**	**0.05% to 0.48%**

** Minimum required benefit additions if EHB benchmark plan is changed*

While other benefits were analyzed and other combinations of benefits were considered, both options in Table 3 were found to comply with relevant Washington State legislation and comply with the current federal guidelines for the generosity test, based on preliminary analysis. Wakely determined that the cost of a more comprehensive fertility benefit (e.g., including in vitro fertilization) would exceed the amount of room for benefit additions under the generosity test. OIC plans to include the benefits in Option B above in its EHB benchmark plan update submission to CMS so that artificial insemination services can be covered.

[10] https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.715

[11] https://app.leg.wa.gov/RCW/default.aspx?cite=48.43.815

[12] https://app.leg.wa.gov/RCW/default.aspx?cite=48.43.135

Additional analysis is needed to verify all federal regulations will be met for the new benchmark plan, namely the typicality test.

While the above estimates are based on allowed total costs, actual impacts to premiums will differ. Drivers of differences may include differences in key assumptions in rate setting, cost sharing for the added benefits, administrative costs, anti-selection, and utilization management, among others.

2025 Proposed Notice of Benefit Payments and Parameters (2025 NBPP)

Recently, CMS proposed several changes to the EHB benchmark plan update process as part of the 2025 NBPP. The proposed changes would simplify the application process and potentially increase the number and/or richness of benefits that could be added to the current EHB benchmark plan in Washington. If finalized as proposed, it would allow routine adult dental benefits to be considered EHBs and give the state greater flexibility as to which plans can be included in the typicality test.[13] These are proposed rules, with final rules anticipated in April or May 2024. Given uncertainty regarding the policy that will be included in the final rule and the clear direction from the legislature in SSB 5388, OIC plans to proceed with submission of the EHB benchmark plan update to CMS on or before May 1, 2024.

Conclusion

Based on preliminary estimates, the analysis and results presented in this report evaluated the benefits for analysis in SSB 5338 and show the proposed benchmark plan options could satisfy 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 options could be pursued by the state of Washington for a new benchmark plan as early as 2026.

[13] EHB benchmarks must be plans that are considered typical plans in Washington. For further details on what plans can be considered please see 45 CFR 156.100 and 45 CFR 156.111.

Appendix A: Reliances and Caveats

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

- 2021 Wakely Internal Databases (WIDs)
- 2021 Wakely ACA Database (WACA)
- 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
- 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 (WACA) 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 B: 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. 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 WACA 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), alongside the 4th stakeholder meeting slides, 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

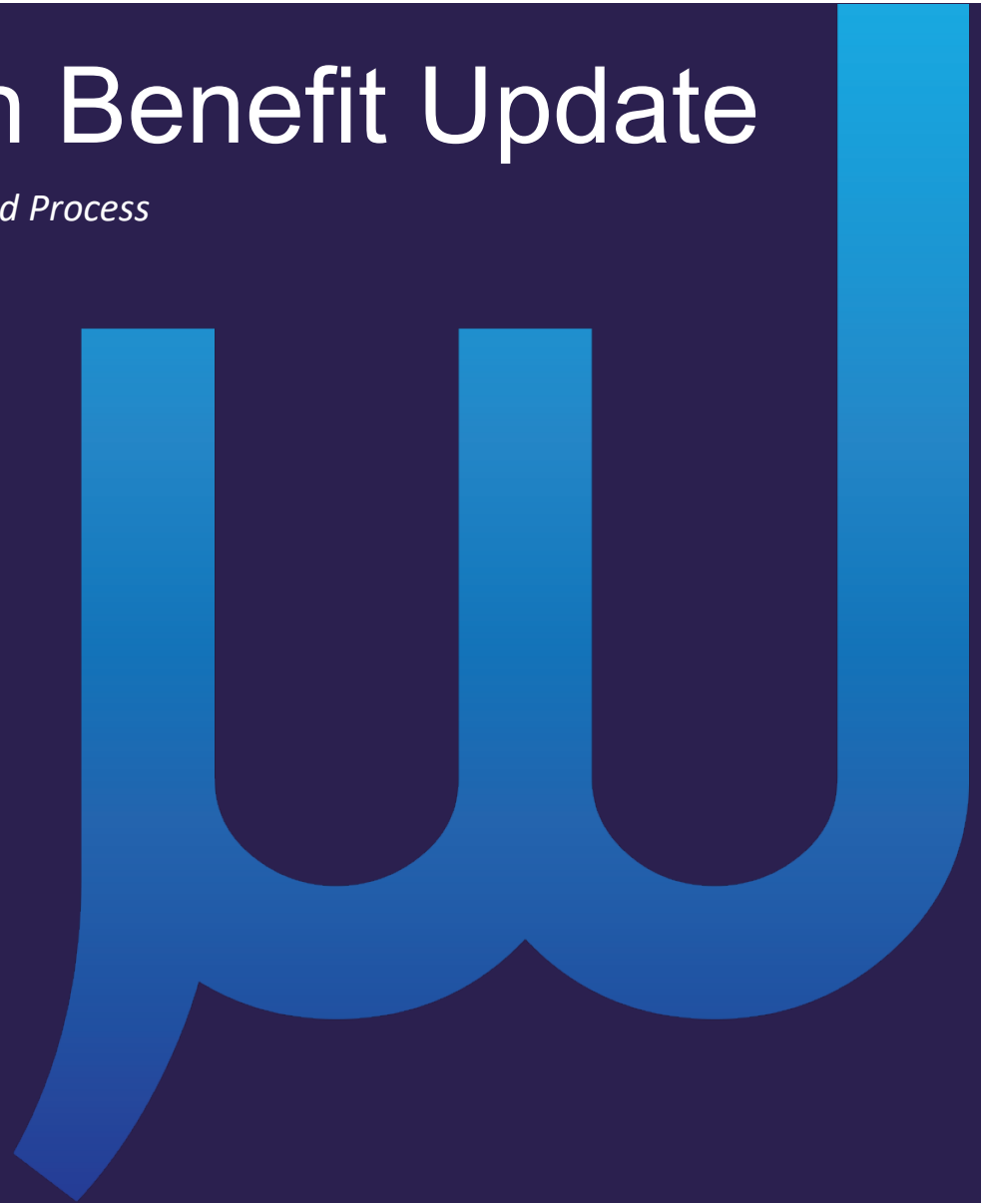
Appendix C: December 13, 2023 EHB Benchmark Plan Update Public Meeting Materials

Wakely EHB Presentation follows

Wakely
BEYOND THE NUMBERS

Essential Health Benefit Update

EHB Benchmark Plan Application Overview and Process



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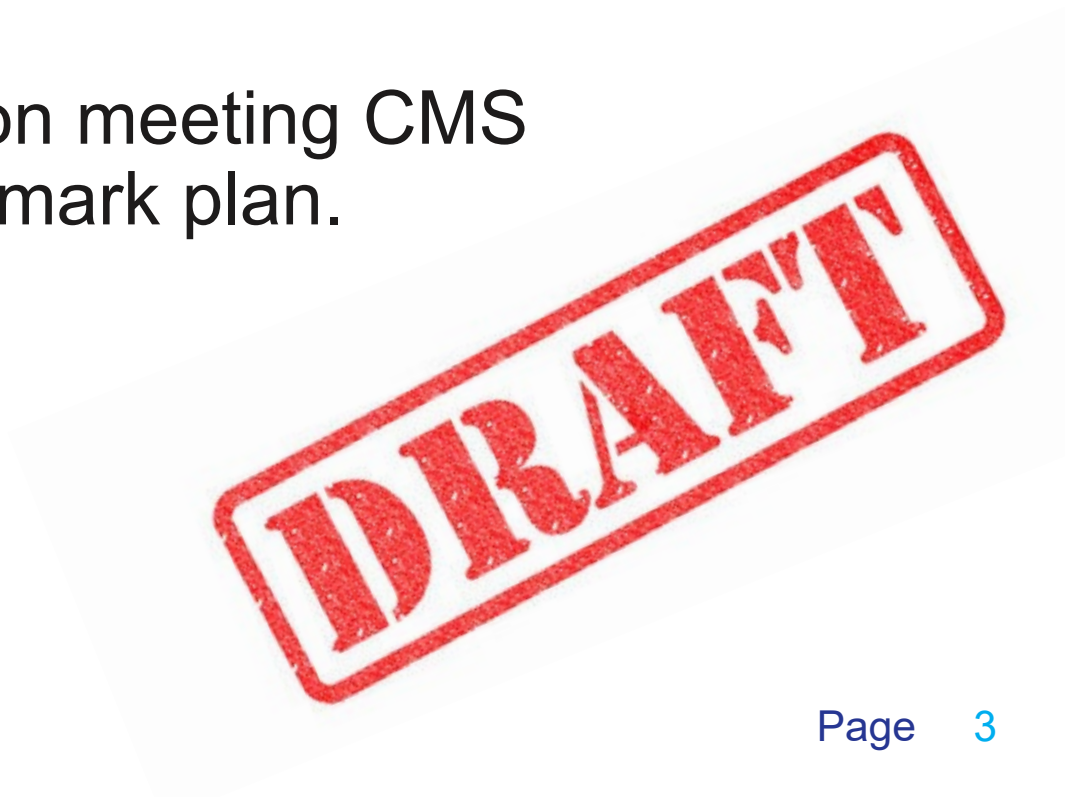
December 2023

Agenda and Table of Contents

Estimates are Draft for Illustrative & Discussion Purposes

The current estimates are still being refined and peer reviewed. Estimates shown today should be considered draft for illustrative and discussion purposes only.

Additionally, the application is contingent on meeting CMS regulations after deciding on a new benchmark plan.



Essential Health Benefit Overview

Objective

Washington is pursuing a new Essential Health Benefit (EHB) Benchmark Plan (BMP) to better serve members, better align with the State's goals, and increase overall benefits.

If approved by CMS, the new EHB BMP will be effective for the 2026 plan year.

The EHB BMP affects fully-insured commercial individual and small group markets. A new EHB BMP would require insurers to update their benefits.

EHB Overview

What are EHBs?

- A set of benefits, set by the benchmark plan (BMP), that all issuers are required to cover.
- EHBs define the coverage of a benefit, not administration. Think “What” not “How.”
- Benefit administration (utilization management, cost sharing) are not governed by EHBs.

What is a Benchmark Plan?

- In order for a plan to meet EHB plan standards it must offer benefits across 10 benefit categories.
- HHS regulations define EHB based on State-specific EHB BMP.
- Washington has its own unique BMP.

Current Flexibilities

- States were given greater flexibility to revise the benchmark plan beginning with the 2020 benefit year (BY).
- As of 12/1/2023, 9 States have revised their EHB BMP, with more expected.

Project Plan

- Review WA's current EHB holistically and against other States
- Discuss with Wakely, issuers, and stakeholders
- Evaluate potential benefit additions according to *SSB 5338*
- Identify options in accordance with federal regulations
- **Define new EHB benchmark plan** *[Current Status - December 2023]*
- Submit application in April 2024, effective for the 2026 benefit year

Recently Approved EHB BMP Changes

Summary Table

Category	Themes	# of States
Drug	Opioid reversal agent (naloxone)	5
Drug	Removal of barriers to medication-assisted treatment for opioids	3
Drug	Alternatives to opioids	1
Drug	Limits opioid prescription length for acute pain	1
Drug	Anti-hepatitis C Agents	1
Medical	Mental wellness, psychiatric	3
Medical	Acupuncture	2
Medical	Chiropractic	1
Medical	Gender affirming care	1
Medical	Artery Calcification Testing	1
Medical & Drug	Weight loss for obese members	1

Recently Approved EHB BMP Changes

Detailed Table (as of 4/1/2022)

State	Category	Benefit	Allowed $	% of Allowed
CO	Adds	Acupuncture		0.08%
CO	Adds	Gender Affirming Care		0.04%
CO	Adds	Mental Wellness Exam		0.02%
CO	Adds	Expanded USP Drug Classes		0.02%
NM	Adds	Artery Calcification Testing	$0.09	0.03%
NM	Adds	Weight loss treatment for obese members	$0.05	0.02%
NM	Adds	Opioid Reversal Agents (naloxone)	$0.02	0.00%
NM	Adds	Anti-Hepatitis C Agents	$1.10	0.33%
NM	Removes	Benefit limits of prosthetics	$0.08	0.02%
IL	Adds	At least one intranasal opioid reversal agent (naloxone)		0.06%
IL	Adds	A Topical anti-inflammatory medication for acute and chronic pain		0.00%
IL	Limits	Opioid prescriptions for acute pain to no more than 7 days		0.00%
IL	Removes	Barriers to medication-assisted treatment (MAT) of opioid use disorder, such as prior authorization		0.00%
IL	Adds	telepsychiatry care		0.01%
MI	Adds	At least one intranasal opioid reversal agent (naloxone)	$0.00 - $1.73	
MI	Removes	Barriers to medication-assisted treatment (MAT) of opioid use disorder, such as prior authorization	$0.00	
OR	Adds	Up to 20 spinal manipulation visits per year	$1.89	
OR	Adds	Up to 12 acupuncture visits per year	$0.95	
OR	Adds	At least one intranasal opioid reversal agent (naloxone)	$0.00	
OR	Removes	Barriers to medication-assisted treatment (MAT) of opioid use disorder, such as prior authorization	$0.00	
SD	Adds	Applied Behavioral Analysis for the treatment of ASD (Autism Spectrum Disorder)		0.30%

Federal Regulations

Federal Regulations

- States may select a new EHB BMP beginning on or after 2020 BY using the process described at 45 CFR 156.111.
- May 2024 application deadline for BY 2026.
- CMS must approve any changes EHB BMP.
- BMP cannot contain any:
  - Lifetime or annual limits or maximum dollars.
  - Discriminatory benefits. E.g., foot care for diabetics revises to foot care as medically necessary.

Federal Regulations

Typicality and Generosity Tests

- There are two actuarial requirements a proposed benchmark plan must meet, the typicality test and generosity test. The benefit plans that can be used for each test are defined by federal regulations.

- Generosity Test - Ensure the new EHB-benchmark plan does not exceed the generosity of the most generous among a set of comparison plans. Exceeding the most generous plan is defined as anything above 0.0% beyond the most generous plan.

- Typicality Test - Provide a scope of benefits in the new EHB-benchmark plan that are equal to the scope of benefits provided under a typical employer plan selected by the state.

Generosity Test

Plan Comparisons

Generosity Test

Comparison of Benefits

1. Identify and gather plan documents for eligible comparison plans for use in CMS testing.

2. Compare benefits between current benchmark plan and plans used for Generosity testing.

3. Determine total benefit difference; the comparison plan with the richest benefits (assuming richer than the current benchmark) dictates the “room” available to modify benefits (Generosity test).

Plan Comparisons

Generosity Test

1. Plans eligible for the generosity test are defined by federal regulations.

2. The PEBB was identified as the richest of all options for the generosity test.

3. The PEBB effectively places a ceiling on how rich total benefits can be for the new benchmark plan under current Federal regulations.

Plan Comparisons

Claim and Premium Impact Considerations

- EHB regulations focus on the change in allowed costs (insurer paid plus member cost share) but the impact to premium is also important for consumers.
- Wakely estimated the impacts using proprietary ACA data sets. Washington issuer input, additional commercial data, and, where necessary, public sources, were also used to assess reasonability or where benefits were not credible in the ACA data.
- Key considerations for the allowed cost included in the analysis
  - The estimates are based on ongoing costs. Any pent-up demand that may occur in the initial years of coverage is not incorporated.
  - The estimates only include the cost of the specific benefits being considered, and downstream impacts (e.g., maternity costs for infertility, potential savings from increased well-being from having hearing aids) are not included.
- Actual impacts included in future premiums by the issuers may vary, potentially significantly, based on the above considerations as well as each issuer's underlying data, assumptions, and fixed administrative costs.

Generosity Test

Primary Differences between Benchmark and PEBB

Benefit	Current Benchmark Plan	PEBB (Most Generous)	Range of Allowed Cost - BMP Relative to PEBB
Home Health Care Services	130 visits/year	No Limit	0.00% to -0.02%
Acupuncture	12 Visit(s) per Year	8 visits/yr	0.01% to 0.02%
Naturopath	Not Covered	3 visits/yr	-0.04% to -0.09%
Bariatric Surgery	Not Covered	Once every 10 years	-0.01% to -0.04%
PT / OT / ST / Massage	25/year Combined	60 visits/yr Combined	-0.21% to -0.40%
Habilitative Services	IP 30 OP 25 visits/yr	60 visits/yr	0.00% to -0.01%
Cardiac rehabilitative therapy visits	Covered	Not Covered	0.02% to 0.04%
Hearing Aids	Not Covered	Once every 3 years	-0.04% to -0.12%
Routine hearing exams	Not Covered	Covered	0.00% to -0.01%
All other benefit differences			0.00% to 0.00%
Total (%)			**-0.28% to -0.63%**
Total (PMPM $)			**-$1.98 to -$4.51**

- Cost estimates are a percentage of total allowed costs
- All pricing estimates in the analysis are based on the ongoing cost of the services. Neither downstream costs (e.g. maternity costs for infertility) nor pent up demand costs are included. Totals may not add due to rounding.
- *PMPM ranges were calculated assuming a total allowed Medical and Rx cost of ~$700 PMPM.

Benefit Pricing & EHB Pathways

Additions to Benchmark Plan

Benefit Pricing & Selection

Changes to EHB

Benefit Selection Process

1. SSB 5338 set forth a list of benefits that should be considered.
2. RCW 48.43.715 mandated Human Donor Milk and a Hearing Benefit be added to any new BMP, pursuant with the standards outlined in 48.43.815 and 48.43.135, respectively.
3. Benefits were priced based on our understanding of the benefit and current coverage. In all cases, a range was provided.
4. Benefit additions must comply with generosity and typicality tests.
5. Ultimately, the premium impact of the changes will vary based on insurer pricing, cost sharing of the benefits, and changes, if any, to administrative costs due to the changes.

https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.715

Benefit Pricing

Description and Cost of Benefits

Benefit	Notes	Costs as a percent of total allowed costs
Human Donor Milk	Human milk when infant is unable to receive maternal milk or whose parent is unable to produce maternal human milk in sufficient quantities or caloric density. Additional criteria apply (see bill).	0.01% to 0.05%
Hearing Exam and Hearing Aids	Hearing exam and hearing aids each ear every three years.	0.04% to 0.12%
Artificial Insemination	Artificial insemination in vivo.	0.01% to 0.02%
IVF	In vitro fertilization including medication, one extraction, fertilization, culture, preservation, and up to 3 transfers.	0.60% to 1.10%
Treatment for Pediatric Acute-onset Neuropsychiatric Syndrome and Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections	Potentially covered when medically necessary in accordance with best practices. Additional information on benefit coverage and potential gaps may be needed.	N/A
Biomarker testing	Identified to be covered when medically necessary in accordance with best practices.	N/A
Contralateral prophylactic mastectomies	Identified to be covered when medically necessary in accordance with best practices.	N/A
Magnetic resonance imaging for breast cancer screening	Identified to be covered when medically necessary in accordance with best practices.	N/A

New Benchmark Pathways

Cost of Additional Benefits

- Human donor milk and a hearing benefit are required to be added in any new benchmark plan.
- There is potentially an additional 0.11% to 0.58% still available after adding these benefits.
- An IVF benefit is unlikely to fit within the generosity test allowance.

Benefit	Price Range
Donor Human Milk	0.01% to 0.05%
Hearing Exam and Hearing Aids	0.04% to 0.12%
1: Required EHB Additions	**0.05% to 0.17%**
2: Room in Generosity Test	0.28% to 0.63%
3 = 2 - 1: Remaining Room	**0.11% to 0.58%**
4: - IVF	0.60% to 1.10%
5: - Artificial Insemination	0.01% to 0.02%

Pathway Options
Option A: Donor Milk & Hearing Benefit
Option B: Donor Milk, Hearing, & AI
Likely unable to add IVF since option A is required, and leaves insufficient room

All pricing estimates in the analysis are based on the ongoing cost of the services. Neither downstream costs (e.g. maternity costs for infertility) nor pent up demand costs are included. Totals may not add due to rounding.

Human Donor Milk
Benefit Pricing

Benefit Definition

- Coverage for medically necessary donor human milk **for inpatient use** for an infant who is medically or physically unable to receive maternal human milk or participate in chest feeding or whose parent is medically or physically unable to produce maternal human milk in sufficient quantities or density.
- Must meet criteria such as low birth weight, less than 34-week gestational age, or a variety of other criteria.

Background

- Additional details provided in 48.43.820.
- Inpatient use limitation impacts price notably.

Hearing Aids & Exams
Benefit Pricing

Benefit Definition
- Hearing exams and hearing aids for adults and children.
- Hearing aids are limited to one per ear every three years.

Background
- Adult hearing benefits for adults are not prevalent in the ACA markets, with only 12 states explicitly requiring adult hearing aids to be offered. However, more than half of states require coverage for children. Given discriminatory requirements, many states who only covered child hearing aids, are now also covering adults under the benefit (not a change to EHB when done for discriminatory design purposes).
- While significant variation exists in services covered, limits, and cost-sharing, the most common offering is covering hearing aids every 36 months.
- **Under current federal regulations, annual or lifetime dollar limits are not allowed on EHB benefits.***

*https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-147/section-147.126

Fertility Services

Benefit Pricing & Considerations

In Vitro Fertilization (IVF) – 0.60% to 1.10%

- Unlikely to be added to benchmark due to high cost and limitations of Generosity test.
- Priced three cycles of in-vitro fertilization, including evaluation, counseling, egg preservation, and other related services.
- Majority of costs is in the preliminary fertility drugs and extraction. Preservation and fertilization are lower in costs.
- How a “cycle” is defined may alter the comparison - need to define exactly what constitutes a cycle.

Artificial Insemination – 0.01% to 0.02%

- Lower price than IVF due to availability and price of sperm, as well as lower or non-existent drug costs.

Benefit Considerations

- Increased claim cost related to additional maternity cycles.
- Improved mental wellbeing for affected members.
- Improved support for organic state population growth.

Figures from Milliman’s study were used to assess the reasonability of Wakely’s estimates:
https://www.insurance.wa.gov/sites/default/files/documents/2023fertility-treatment-cost-analysis-report.pdf

Next Steps

Next Steps

Finalize Benchmark and CMS Testing

1. **December** – Decide on benefits to add to benchmark
2. **January** – Generosity Test: Finalize pricing and ensure benefits being added are compliant
3. **January** – Typicality Test: Identify comparison benchmark plan exactly equal to proposed benchmark plan

Submission

1. **February** – Draft Report
2. **April** – Public comment period
3. **May** – Official Submission

2025 Proposed NPBB Changes Effective BY2027

Proposed Changes to the EHB Selection and Application Process

PROPOSED Federal Regulation Changes Effective BY2027

Goal: reduce the burden of the EHB-benchmark plan update process

- As part of the 2025 Proposed Noticed of Benefit and Payment Parameters, HHS proposes several key changes to the EHB-benchmark plan update process.
- Revisions to EHB selection process (effective for the 2027 benefit year):
  - Remove the current generosity test requirement.
  - Revise typicality standard in 156.11(b)(2): New EHB-benchmark plan provides a scope of benefits that is **as or more generous than the scope of benefits in the state's least generous typical employer plan**, and **as or less generous than the scope of benefits in the state's most generous typical employer plan.**
  - Large Group plan changes over time can be captured.
- Remove need to submit formulary unless explicitly changing formulary.

PROPOSED Federal Regulation Changes Effective BY2027 (cont.)

Goal: reduce the burden of the EHB-benchmark plan update process

- Other changes HHS proposes may increase the generosity of a typical employer plan (i.e., additional room to add benefits).
  - Remove the prohibition on including routine non-pediatric dental services (i.e., states can now add adult dental as an EHB).
  - Prescription drugs in excess of the benchmark are now considered EHB.
  - Allow newer Large group plans to be included as a comparison plan.

PROPOSED Federal Regulation Changes - Considerations

Benefits and implications of waiting until 2027

- Benefits of waiting to change the State's EHB
  - Proposed changes may increase the "room" to add benefits (generosity test).
    - Note adult dental is in current "generosity test plan" but as standalone plan
    - Note if additional room not needed than this would not have an impact.
  - Proposed changes may make submission easier/more likely to be approved.

- Risks/Drawback
  - No guarantees the rule will be finalized as proposed or not changed in the future.
  - Premium affordability: Adding additional benefits (e.g., dental benefits) could increase premiums substantially, especially if IRA subsidies not renewed.
  - Would not go into effect until benefit year 2027, a year after the current timeline.

Questions?

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Disclosures and Limitations

Disclosures and Limitations

- **Responsible Actuaries.** Julie Peper and Matt Sauter are the actuaries responsible for this document. Julie is a Fellow of the Society of Actuaries and Matt is an Associate of the Society of Actuaries. Both Julie and Matt are Members of the American Academy of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this document.
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- **Data and Reliance.** The current cost estimates rely on available data including Wakely's proprietary ACA data set, Large Group data, WA stakeholder insight, online publications, and third party subject matter experts. 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 is not an actuarial report and does not comply with Actuarial Standards of Practice on communication. Once the analysis is complete, a full report will be provided the lists all data and assumptions used in the comparison of benefits for purposes of supporting EHB changes to CMS.

Appendix

Useful Links and Regulations

Links & Resources

- CMS EHB Reference Page
  https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb

- CMS' EHB Process Overview (February 2021)
  https://www.regtap.info/uploads/library/PMSC_Slides_022421_5CR_022421.pdf

Federal Regulations

Typicality Test

- Step 1 – Select a typical employer plan among the options at §156.111(b)(2)(i): One of the state's 10 base-benchmark plans or one of the five largest group plans

- Step 2 – Calculate the expected value of covering all of the benefits at 100 percent actuarial value in the proposed EHB-benchmark plan and in the typical employer plan, including any necessary supplementation

- Step 3 – Compare the expected value of covering all of the benefits (at 100 percent actuarial value) in the typical employer plan to that of the state's proposed EHB-benchmark plan

Federal Regulations

Generosity Test

- Step 1 – Determine the most generous plan among this set of comparison plans
- Step 2 – Calculate the expected value of covering all of the benefits at 100 percent actuarial value in the proposed EHB-benchmark plan and in the most generous plan among the set of comparison plans, including any necessary supplementation
- Step 3 – Compare the expected value of covering all of the benefits (at 100 percent actuarial value) in the most generous plan among the set of comparison plans to that of the proposed state's EHB-benchmark plan