June 1, 2021

Evan Klein
Senior Policy Analyst
Washington Health Benefit Exchange
Via email: evan.klein@wahbexchange.org

RE: Additional Benefit Standardization Considerations for 2023 Standard Medical Plan Designs

Dear Evan:

The Washington Health Benefit Exchange (WAHBE) has engaged Wakely Consulting, LLC (Wakely) to discuss considerations in standardizing additional benefits beyond those found within the 2022 standardized plan designs. As background, the 2022 standardized plans follow the general inputs contained within the Federal Actuarial Value calculator as well as some additional benefits. It is Wakely's understanding that WAHBE is considering defining additional benefits for 2023 to help carriers in understanding how to appropriately administer the benefits under these plans. This report is meant to be a brief overview of some considerations in determining whether or not to standardize additional benefit categories.

As noted below, the impact of additional standardization of the benefits can vary significantly depending on several factors. The impact will ultimately depend on the number of additional benefits chosen, which benefits are chosen, how the new benefit cost sharing compares to the current design, and the complexity of the benefit structure. If you have any questions or would like to discuss more specific changes further, please call or email us at the contacts below.

Sincerely,

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Current Standard Plans

The Center for Consumer Information and Insurance Oversight (CCIIO) provides an Actuarial Value Calculator (AVC)[1] that issuers must use to determine the AV of a plan. While the calculator is not a comprehensive tool of all available benefits, it focuses on highly utilized, in-network benefits. Washington's 2022 standard plans standardize all benefits included in the federal AV calculator.

The AVC is intended to reflect an estimate of the actuarial value for a wide range of individuals for a standard population. However, it does not include specific inputs for all service categories or situations and individual might encounter. The 2022 standardized plan designs already include a few service categories beyond those included in the AVC.

The table below shows the current categories standardized in the 2022 plan designs and whether or not they are included, specifically in the AVC. The shaded rows reflect benefits that are not explicitly included in the AVC.

Table 1: Federal AV Calculator Inputs and Impact

Type of Benefit	Included in AVC?
Deductible	Yes
MOOP	Yes
Medical Benefits	
Emergency Room Services	Yes
Urgent Care	No
All Inpatient Hospital Services (Inc. MHSU)	Yes
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	Yes
Specialist Visit	Yes
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	Yes
Imaging (CT/PET Scans, MRIs)	Yes
Speech Therapy	Yes
Occupational and Physical Therapy	Yes
Preventive Care/Screening/Immunization	Yes
Laboratory Outpatient and Professional Services	Yes
X-rays and Diagnostic Imaging	Yes
Skilled Nursing Facility	Yes
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes
Outpatient Surgery Physician/Surgical Services	Yes
Ambulance	No
Routine Eye Exam for Children	No
Pharmacy Benefits	
Generics	Yes
Preferred Brand Drugs	Yes
Non-Preferred Brand Drugs	Yes
Specialty Drugs (i.e. high-cost)	Yes

[1] http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html

Plan & Benefits Template Service Categories

The Plan & Benefits Template, required for rate filings in the Individual and Small Group Markets, details the member cost sharing for several services beyond those included in the AVC. It is our understanding that WAHBE is considering standardizing some or all of the additional benefits in the Plan & Benefits Template, beyond those currently included in the standard plan designs. The table below outlines the services included in the Plan & Benefits Template that are not included in the AVC. The the impact of standardizing these additional services will be largely dependent on the structure and cost sharing considered and is discussed in more detail below.

Table 2: Non-Standardized Benefits in the Plan and Benefits Template

Category of Service	Category of Service
Other Practitioner Office Visit (Nurse, Physician Assistant)	Dialysis
Hospice	Allergy Testing
Infertility Treatments	Chemotherapy
Private-Duty Nursing	Radiation
Home Health	Prosthetic Devices
Bariatric Surgery	Infusion Therapy
Delivery and All Inpatient Services for Maternity Care	Treatment for Temporomandibular Joint Disorders
Prenatal and Postnatal Care	Nutritional Counseling
Habilitation Services	Reconstructive Surgery
Chiropractic Care	Transplant
Durable Medical Equipment	Eye Glasses for Children
Hearing Aids	Dental Care - Child

Impact on Federal Actuarial Value

As the additional service categories being considered for standardization are not explicitly included in the federal AVC, we anticipate the additional standardization will have a negligible impact on the federal AV developed for the 2022 plan designs. However, the final impact will depend on which benefits are standardized, their structure, and the relative member cost sharing compared to the plan's average cost sharing.

While CCIIO developed the AVC as to accommodate most plans, some plan designs have features that are not supported by the AVC. In these instances, either an actuary can modify the inputs to most closely represent the plan design or an actuary can modify the results of the AVC to account for the features not supported by the AVC. Therefore, the impact on the federal AV will depend on whether the additional standardization is considered substantive and not supported by the AVC. For example, standardizing the member cost sharing for a low-utilized

category may not warrant an adjustment to the AVC results and would have no impact on federal AV. However, standardizing a bundled payment for maternity services, may be deemed substantial and warrant an adjustment.

Premium Impact

The AVC determines and actuarial value for purposes of bucketing plans into their respective metal levels. However, carriers will utilize their own pricing model and experience to determine the pricing AV that will ultimately affect the premium rates. The carrier's pricing models likely contain more benefit categories than that reflected in the federal AVC and likely allow for more flexibility in pricing the impact of these benefits. The carriers will ultimately determine the pricing impact when they file the premium rates for the 2023 plan designs, but the impact will generally depend on:

- Whether the standardized member cost sharing is higher or lower than what carriers included for the 2022 plan designs.
- The utilization of the benefit in the carrier's experience and data underlying their pricing assumptions. For example, the newly standardized benefit may be drastically different from the current market, but if it is a rarely utilized service, the premium impact may be negligible. On the other hand, a small change on a highly utilized service may have larger premium implications.

Wakely's Pricing Model includes additional benefits beyond those reflected in the AVC. As noted above, the premium impact will be greater for more highly utilized services. Table 3 lists a few of the benefits that are highly utilized, based on Wakely's ACA data that contribute to a plan's overall cost and aren't currently standardized under the 2022 plan designs.

Table 3: Highly Utilized Non-Standardized Benefits

Category of Service
Chiropractic
Durable Medical Equipment
Home Health
Inpatient - Maternity

Note that each carrier's pricing model will differ in terms of the underlying data, level of specificity concerning benefit categories, and methodology used to evaluate the pricing AV. The highly utilized services reflected above are based on Wakely's Pricing Model and level of data aggregation. These benefits are meant to be demonstrative of potential services that may have larger impacts on pricing and the federal AV than others. However, these are not the only services that can affect either the federal AV or pricing AV used to determine premiums.

Additional Considerations

Impact of Timing

It is possible to take the Plan Benefit Template and develop defined cost sharing for each category. This would include more testing and stakeholder discussions around what is appropriate which would lead to requiring more time to complete as well.

Any level of additional standardization will increase the time and effort needed to update and certify the standard plan designs each year. However, the actual impact on timing and effort will largely depend on the number of additional benefits and which additional benefits are chosen for standardization and the complexity of the standard benefit. This implementation would require more effort in the first year, with subsequent updates being less time intensive. However, the actual timing will depend on regulatory and other changes required in a given year.

In addition, each carrier is required to test each plan for actuarial value and mental health parity compliance. Standardizing the inputs currently found within the Federal AVC while leaving the various other benefits open allows the carriers to have more freedom in order to maintain compliance with these tests. If more benefits are standardized, this has the potential to lead to additional mental health parity concerns or issues with actuarial value testing. These additional concerns could increase the time needed for testing and thus extend the time required for plans to all confirm they can offer these plans on the exchange.

When developing the standardized plans for plan year 2021, some carriers stated having difficulty with appropriately adjudicating and administering some benefits. This became apparent in terms of how the federal AV calculator assumed cost sharing would be applied for copays that are incurred before the deductible. While this issue has been resolved, it does point out that some carriers' operational processes and capabilities differ from one another. It is possible that standardizing more benefits could lead to operational complications amongst carriers if they are unable to administer the given benefits in the manner they are defined. Allowing flexibility among non-defined benefits is an approach for avoiding this complication.

Another factor to consider is the timing of the release of the AVC, Notice of Benefit and Payment Parameters (NBPP), and Uniform Rate Review Template (URRT), which varies from year to year, making it difficult to standardize benefits. This would be made all the more difficult, the more benefits that are standardized. Plans are required to comply with these regulations and therefore, it may not be known what changes are necessary until these documents are finalized and released. The final AVC and NBPP have been released anywhere from December through May for plans being offered in the following year. In 2021 (for the CY2022 plan offerings), these requirements were released in early May, which is much later than in past years and led to a shortened time period for testing and implementation of standard plans in the rate filings.

Standard Plan Designs in Other States

Eight states[2], including Washington and the District of Columbia, have standard plan designs. Of those, the level of standardization varies across each of the states. In general, most states are standardizing the benefit categories that are included in the AVC, and select others, though the list of standard benefits varies from state to state. The most common benefits that are standardized in other states with standard plan designs, but are not standardized in Washington are:

- Durable Medical Equipment
- Home Health Care
- Hospice
- Dental Services for Children

Note that while the above services are commonly included in other states with standard plan designs, not all states standardize these services. Some states standardize several other services as well. For example, New York's standard plans include most (but not all) services in the Plan & Benefit Template and Connecticut is the only state that standardizes out-of-network benefits. There may be substantial variation in the current plan designs regarding out-of-network benefits and therefore standardizing these, may have a meaningful impact which may vary greatly by carrier.

Operational Considerations for Carriers

Carriers have certain adjudication practices in place to account for which services are mapped to which benefits and cost sharing. To the extent that the standard plans differ from those current practices, there may be significant time and effort on the carrier's part in order to implement these changes. For example, if the standard plans include bundled services (such as diabetes management or maternity care) and a carrier is not currently offering bundled services, this may require significant operational effort and cost in order to implement.

In addition, it is important to note that while additional standardization of the plan designs will limit the differences a member may experience across carriers within the standard plan designs, each carrier may have slightly different adjudication procedures that can result in certain procedures being assigned different benefits. Trying to standardize aspects of the adjudication process would require significant operational resources and time to implement. It may also require carriers to implement these adjudication procedures across all their plans, not only the standard plan designs, requiring substantial buy-in from the carriers for any changes that would be necessary.

In both instances above, it is possible that not all carriers will be able to fully implement these changes by CY2023, though may be possible to implement in future years with additional lead time or a grace period. Both in terms of time and costs of these changes, it will be important to

[2] California, Connecticut, Massachusetts, New York, Oregon, Vermont, Washington, District of Columbia

work with carriers on any operational changes that may be necessary, otherwise you risk carriers leaving the market.

Disclosures and Limitations

Responsible Actuary. Brittney Phillips and Brad Heywood are the actuaries responsible for this communication. Brittney and Brad are both members of the American Academy of Actuaries and Associates of the Society of Actuaries. Both meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Intended Users. This information has been prepared for the use of WAHBE and WAHBE exchange plan issuers. Wakely does not intend to benefit third parties and assumes no duty or liability to those third parties. Any third parties receiving this work should consult their own experts in interpreting the results. This report, when distributed, must be provided in its entirety and include caveats regarding the variability of results and Wakely's reliance on information provided by WAHBE.

Risks and Uncertainties. The assumptions and resulting estimates included in this report 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 any estimates.

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. In addition, Wakely is organizationally and financially independent from WAHBE.

Data and Reliance. Wakely relied on information supplied by WAHBE and CCIIO in this 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. Any errors in the data will affect the accuracy of the analysis and the conclusions drawn in this report. When performing financial and actuarial analyses on the current data, assumptions must be made where there is incomplete data. Improvements in data will allow for more accurate analyses and consistent reporting.

Subsequent Events. Subsequent events to the date of this report that could affect the plan designs presented include, but are not limited to:

Contents of Actuarial Report. This document and the supporting exhibits constitute the entirety of the actuarial report and supersede any previous communications on the project.

Deviations from ASOPS. Wakely completed the analysis using sound actuarial practice. To the best of our knowledge, the report and methods used in the analysis comply with the appropriate Actuarial Standards of Practice (ASOP) with no known deviations.