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State of California: Department of Managed Health Care

Benchmark Plan Benefit Valuation Report

March 28, 2025

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Table of Contents

Introduction and Background

The California Department of Managed Health Care (California, DMHC, 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 effective benefit year 2027 and to determine if the new benchmark met the actuarial requirements as stated in 45 CFR 156.111. As part of this process, California held four public meetings and provided ongoing opportunities for public comment. The DMHC posted a draft of the full EHB update application submission on its website on March 28, 2025, for public review and comment. The comment period is 14 days, with comments due on April 14, 2025.

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.

According to 45 CFR 156.111(b)(2)(ii), for plan years on or after January 1, 2026, the typicality standard requires the revised EHB benchmark plan to have a scope of benefits that is as or more generous than the scope of benefits in the least generous typical employer plan, and as or less generous than the scope of benefits in the most generous typical employer plan in the State, where the typical employer plan is defined as either:

1. One of the State's 10 base-benchmark plan options established at § 156.100(a)(1) and supplemented under § 156.110; or
2. The largest large group plan by enrollment among the five largest large group products by enrollment in the State, provided other criteria laid out in 45 CFR 156.111(b)(2)(ii)(B) are met.

This is the actuarial report, which is part of California's application for a change in the Federal CMS Plan Year 2027 Essential Health Benefit Benchmark Plan using Selection Option 3. This document fulfils the typicality test actuarial requirement as described above.

This document has been prepared for the sole use of California and the DMHC. 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

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

- an annual hearing exam and one hearing aid for each ear every 3 years,
- expanded durable medical equipment (DME) benefits,
- infertility diagnosis,
- artificial insemination in vivo, and
- in vitro fertilization benefit (IVF).

Pursuant to 45 CFR 156.111, California is required to take public comment on a draft set of benefits that comprise the proposed new EHB benchmark plan. Per Wakely's analysis, the marginal cost of the net benefits, relative to the current (2017) California benchmark plan, were estimated and are compliant with federal regulations. More specifically, the proposed benchmark plan has a scope of benefits that is more generous than the least generous typical employer plan and less generous than the most generous typical employer plan and therefore meets the Typicality Test. 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 California benchmark plan is the Kaiser Small Group HMO 30 product supplemented with the State CHIP's pediatric dental and the Federal Employees Dental and Vision Insurance programs' (FEDVIP) pediatric vision benefits (herein collectively referred to as the current BMP). 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 DMHC and California stakeholders, which included California's individual and small group issuers, 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. Listed below are the recommended changes and the potential impact of each benefit.

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

Recommendation: Hearing Aid Coverage

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 ensure all populations have access to hearing aids,, regardless of disability or

age, and will improve the health, educational attainment, employment opportunities and quality of life for affected members.

Recommendation: Expanded Durable Medical Equipment (DME) Coverage

The state is proposing to expand the definition of their DME benefit to include additional benefits that are not covered under the current benchmark plan. Additionally, the state is removing the DME limitation related to home use. The new definition of DME benefits will include DME for use outside of an institutional setting. The benefits being considered are wheelchairs, portable oxygen, CPAP machines, walkers, scooters, hospital beds, and augmented communication devices (ACC). Inclusion of these expanded benefits in the benchmark plan would bring benefits more in line with that of the most generous typical employer plan as well as support individuals that require these devices to live accessible lives.

Recommendation: Infertility Diagnosis

The State is proposing adding an infertility diagnosis benefit to the benchmark plan. This benefit would cover services to evaluate and diagnose the presence of infertility for an individual. Adding this benefit to the proposed benchmark plan will help individuals and couples who have not been able to conceive naturally work with their doctor to determine the reason for the complication and map an appropriate plan of action for family planning.

Recommendation: Artificial Insemination

The State is proposing adding an artificial insemination in vivo (AI) 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.

The AI benefit cost does not include coverage for donor semen, donor eggs, and services related to their procurement and storage

Recommendation: In Vitro Fertilization (IVF)

The State is proposing adding an in vitro fertilization benefit to their benchmark plan. The benefit would include the following services, as specified in the benchmark plan document:

- 3 attempts to retrieve gametes, including drugs required for retrieval
- 3 attempts to create embryos
- 3 rounds of pre-transfer testing
- 2 years of cryopreservation and storage of embryos
- Unlimited embryo transfers

- 2 donor sperm vials
- 10 donor eggs
- Unlimited cryopreservation and storage of donor eggs and sperm
- Surrogacy coverage for the aforementioned services, as well as health testing of the surrogate for each attempted round of covered services.

This benefit would not include administrative costs or cost to compensate the surrogate.

The addition of this benefit in the state of California would benefit many individuals and families who are not able to conceive without medical intervention. Many families are not able to afford IVF services without insurance coverage of the benefits. Adding an IVF benefit will improve reliable access and affordability to IVF in addition to improving the mental and physical wellbeing of members who rely on IVF or surrogacy for family planning.

Methodology and Results

To perform the analysis, Wakely used a variety of sources to estimate the cost for adding hearing aids, expanded DME coverage, infertility diagnosis, artificial insemination in vivo, and in vitro fertilization with surrogacy coverage. The primary data source was the Wakely Internal Databases[1] (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, publicly available vendor cost estimates, and prior Wakely publications 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 fertility benefits, and potential savings due to increased well-being resulting from having hearing aids, are not included.

HEARING AID COVERAGE

Hearing aid and exam costs were identified in WID data using the most recent Wakely ACA Claims Grouper code set to identify CPT codes assigned to hearing aid and exam coverage alongside CPT codes gathered from industry research and resources. 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 the state of California. However, not all states in the West region cover hearing aids and exams. As a result, we reviewed the benefit coverage, where available, for all states in the West region. We then adjusted the calculated PMPM amounts to account for the percentage of

[1] Additional details on Wakely's Internal Databases can be found in Appendix A

members insured in states where hearing aids or exams are currently covered benefits. This adjustment was applied separately for hearing aids and hearing exams, as coverage of these two benefits varies by state. It was performed to ensure our estimated claim cost was not understated due to lack of coverage. The resulting cost estimate is 0.21% of the total allowed claims.

Wakely also referenced prior work from a 2021 research paper conducted by Wakely for the State of Washington regarding the cost of adding hearing aids and exams to the Washington market.[2] 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. Wakely reviewed the findings relative to the output from WID to ensure that results were reasonable.

EXPANDED DME COVERAGE

The DME benefits being considered as additions to the existing DME benefits were estimated using publicly available data and industry research, as CPT-level data was not credible in WID for these expanded services. Rather, Wakely relied on reputable industry data and vendor cost estimates, specific to California when available, to estimate a range of unit cost and utilization values for each benefit considered. Organization publications Wakely leveraged include but are not limited to the National Council on Aging (NCOA)[3], United States Society for Augmentative and Alternative Communication (USSAAC)[4], and the National Library of Medicine (NLM)[5]. Wakely worked with the State and DMHC to define the benefit considered according to the specifications that the State wished to cover. More details regarding the coverage specifications for each benefit are outlined in the revised benchmark plan document.

Below are the estimated costs for each of the DME benefits considered for addition to the benchmark plan. The resulting cost estimate of adding each of these DME benefits is 1.03% of the total allowed claims.

[2] https://www.insurance.wa.gov/sites/default/files/documents/2021-hearing-instrument-analysis-provided-by-wakely.pdf
[3] https://www.ncoa.org/adviser/oxygen-machines/best-portable-oxygen-concentrators/#:~:text=The%20price%20of%20portable%20oxygen,cover%20part%20of%20the%20cost.
[4] https://ussaac.org/about-us/
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10881926/

Table 1: Impact of Added Benefits – Expanded DME Benefits

Potential DME Benefit Additions	Allowed Cost Impact[6]
Wheelchairs	0.11%
Portable Oxygen	0.01%
CPAP Machines	0.50%
Walkers	0.01%
Scooters	0.09%
Hospital Beds	0.03%
Augmented Communication Devices (ACC)	0.26%
Total Expanded DME Benefit Cost	**1.03%**

While CPT-level data was non-credible for purposes of estimating utilization for these services, Wakely did reference the WID database as a reasonability check for unit costs. First, utilization considered the estimated number of people requiring these benefits as a percentage of the total population from the latest US Census Data[7]. Adjustments were made, where appropriate and possible, to represent the individual and small group markets. For benefits that primarily pertain to an aged population, such as portable oxygen, an adjustment was applied to consider the proportion of users that will fall be seeking coverage for these services on an ACA market plan.

INFERTILITY DIAGNOSIS

Infertility diagnosis costs were identified in WID data using CPT codes gathered from an analysis that the California Health Benefits Review Program (CHBRP) conduced to assist in a proposed fertility bill for the State.[8] To be consistent with CHBRP's analysis, Wakely also limited the data to episodes of care that contain an infertility diagnosis ICD-10 code. We then determined the associated allowed PMPM claim cost for the set of CPT codes under these limitations.

As described for the hearing aid benefit, an adjustment was applied to account for the percentage of members insured in states where infertility diagnosis is currently a covered benefit to ensure our estimated claim cost was not understated due to lack of coverage. The resulting cost estimate is 0.03% of the total allowed claims. As mentioned later in this report, an identical scope of infertility diagnosis coverage is already included in the most generous typical employer plan.

[6] Figures were rounded to the second decimal place and may not equal the total due to rounding.
[7] https://www.census.gov/
[8] https://www.chbrp.org/sites/default/files/bill-documents/SB729/SB%20729%20Infertility%20Abbreviated%20Analysis%20Final.pdf

ARTIFICIAL INSEMINATION

Artificial Insemination costs were identified in WID data using CPT codes gathered from an analysis that the California Health Benefits Review Program (CHBRP) conduced to assist in a proposed fertility bill for the State.[9] We then determined the associated allowed PMPM claim cost for the set of CPT codes.

As described for the infertility diagnosis benefit, an adjustment was applied to account for the percentage of members insured in states where artificial insemination is currently a covered benefit to ensure our estimated claim cost was not understated due to lack of coverage. The resulting cost estimate is 0.03% of the total allowed claims. As mentioned later in this report, an identical scope of artificial insemination coverage is already included in the most generous typical employer plan.

IN VITRO FERTILIZATION

The in vitro fertilization and related benefits being considered as additions to the benchmark plan were estimated using publicly available data and industry research, as CPT-level data was not credible in WID for these services. Wakely relied on reputable industry data and vendor cost estimates, specific to California when available, to estimate a range of unit cost and utilization values for the benefit. Organization publications Wakely leveraged include but are not limited to the Health and Human Services (HHS)[10], Johns Hopkins Medicine[11], the National Library of Medicine (NLM)[12], the Fertility Center of California[13], and Centers for Disease Control (CDC)[14]. Wakely worked with the State and DMHC to narrow scope of benefits offered such that the proposed number of treatments covered would fit within the room allotted by the typicality test. The resulting cost estimate is 0.87% of the total allowed claims. More details regarding the coverage specifications for IVF are outlined in the revised benchmark plan document.

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

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[9] https://www.chbrp.org/sites/default/files/bill-documents/SB729/SB%20729%20Infertility%20Abbreviated%20Analysis%20Final.pdf
[10] https://www.hhs.gov/about/news/2024/03/13/fact-sheet-in-vitro-fertilization-ivf-use-across-united-states.html#:~:text=A%20large%20proportion%20of%20all,(Table%203%20in%20Appendix).
[11] https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/sperm-banking#:~:text=How%20much%20does%20it%20cost,physician%20to%20understand%20the%20costs.
[12] https://pubmed.ncbi.nlm.nih.gov/34223221/
[13] https://www.spermbankcalifornia.com/our-california-sperm-bank/pricing-fees
[14] https://www.cdc.gov/art/reports/2020/summary.html

Additional Clarifications on Certain Benefits

RECOMMENDATIONS

In addition to the benefit changes listed above, California 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 California 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 2.18% as a percent of total allowed claims relative to the current benchmark. This is shown in Table 1 below.

Table 2: Impact of Added Benefits – Proposed Benchmark

Benefit Difference	Allowed Cost Impact[15]
Hearing Aids and Annual Exam	0.21%
Expanded DME Coverage (See Table 1)	1.03%
Infertility Diagnosis	0.03%
Artificial Insemination in Vivo	0.03%
In Vitro Fertilization	0.87%
Total	**2.18%**

As outlined in 45 CFR 156.111(b)(2)(ii), a new benchmark plan must provide a scope of benefits that is greater than or equal to the least generous and less than or equal to the most generous among a set of comparison plans listed at 45 CRR 156.111(b)(2)(ii)(A) and (B).

According to 45 CFR 156.111(b)(2)(ii), for plan years on or after January 1, 2026, the typicality standard requires the revised EHB benchmark plan to have a scope of benefits that is as or more generous than the scope of benefits in the least generous typical employer plan, and as or less generous than the scope of benefits in the most generous typical employer plan in the State. 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 will meet the new EHB requirements for revising a benchmark plan listed at 45

[15] Figures were rounded to the second decimal place and may not equal the total due to rounding.

CFR 156.111. Given California is not considering a reduction in benefits relative to the current benchmark plan, this logic was exercised to fulfill the lower range of the typicality test standard.

Wakely analyzed the generosity among the comparison plans and identified the 2024 Kaiser Large Group University of California Traditional Plan (Kaiser UC Plan) as the most generous plan. This was determined by comparing the complete set of benefits between all comparison plans and quantifying the net differences in benefits. The Kaiser UC Plan met other requirements in 45 CFR 156.111 and therefore can be used for the typicality test under 45 CFR 156.111(b)(2)(ii). The Kaiser UC Plan's similarities and differences to the current benchmark plan are outlined in Table 3. It does not sufficiently cover the pediatric dental or vision EHB categories under 45 CFR 156.110(a). As a result, the pediatric dental EHB categories from the State CHIP Dental and pediatric vision EHB categories from the FEDVIP Vision plans were used to supplement the plan as allowed and required under 45 CFR 156.110(b).

According to the California Current BMP summary file, pediatric services for dental and vision are covered pursuant to benefits offered under the State CHIP and FEDVIP plans, respectively.[16] Overall, the Current BMP and Kaiser UC Plan (with supplementation) have identical pediatric vision benefit offerings equivalent to those under the State CHIP Dental and FEDVIP Vision plans.

Table 3: Pediatric Dental and Vision Offerings

Plan Name	Description	Dental Offering	Vision Offering
Current BMP	Current Benchmark	State CHIP	Federal VIP
Kaiser UC Plan	Typicality Comparison	State CHIP	Federal VIP

The primary differences between the Current BMP the Kaiser UC plan (the current benchmark and typicality comparison plan, respectively) are as follows:

Table 4: Benefit Comparison – Current Benchmark and Comparison Plans

Plan Name Description	Kaiser Small Group Plan Current Benchmark	Kaiser UC Plan Typicality Comparison
Acupuncture	Covered	Covered up to 24 visits (Combined Acupuncture & Chiropractic Care)
Chiropractic Care	Not Covered	
Infertility Diagnosis	Not Covered	Covered
Artificial Insemination	Not Covered	Covered
In Vitro Fertilization	Not Covered	Covered

[16] https://www.cms.gov/media/87826

Plan Name Description	Kaiser Small Group Plan Current Benchmark	Kaiser UC Plan Typicality Comparison
Durable Medical Equipment	Partially Covered*	Covered*
Hearing Aids and Exams	Not Covered	Specific Allowance Every 3 Years

*The scope of DME benefits covered in the Kaiser Small Group Plan (current benchmark) was a subset of the more generous DME benefit coverage in the Kaiser UC plan.

Typicality Test

In order for the proposed benchmark plan to pass the typicality test, the value of the proposed benchmark plan must equal the scope of benefits in a typical employer plan, where a typical employer plan is defined as any scope of benefits that is as or less generous than the scope of the most generous typical employer plan and as or more generous than the scope of the least generous typical employer plan among a set of comparison plans.[17] As mentioned in the previous section, given California is not considering a reduction in benefits to the proposed benchmark plan, the proposed benchmark plan will be more generous than the current benchmark plan, thereby meeting the requirements of the low end of the typicality test.[18] For this reason, a thorough analysis was completed only for the high end of the typicality test.

Wakely analyzed the generosity among the comparison plans and identified the Kaiser UC Plan as the most generous among the set of typical employer plans. 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 benefits are significant in value, and which have minimal impact on the overall generosity of the plan. Wakely identified the Kaiser UC Plan as likely the most generous using the following process:

1. The current benchmark is the Kaiser Small Group HMO 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 very similar coverage of benefits, all of which were less rich than the GEHA plan.

[17] https://www.ecfr.gov/current/title-45/part-156/section-156.111#p-156.111(b)(2)(ii)

[18] The current benchmark plan is one of the 10 base benchmark comparison plans established at § 156.100(a)(1) and supplemented under § 156.110.

4. Wakely's review of the State Employee plans found them to be more generous than the current benchmark driven primarily by DME and hearing aids and exams benefits. The Kaiser Basic HMO plan was determined to be the richest among the State Employee plans due to richer coverage for acupuncture, bariatric surgery, and biofeedback.

5. Finally, Wakely worked with Kaiser and Blue Shield, two of the highest enrollment large group health plans in the state, to determine which of their products fulfilled the requirements described in 45 CFR 156.111(b)(2)(i)(A)(2).[19] While plans from any year after 2013 could be considered for this analysis, due to time and budget constraints Wakely focused on 2024 as those were the latest plan year documents available at the time of the analysis. Through conversations with the health plans regarding enrollment and relative richness of their products along with supplemental Wakely analysis, the 2024 Kaiser Traditional Plan for the University of California (Kaiser UC Plan) was determined to be the most generous among the large group plans considered.

6. Based on the assessment that the Federal GEHA, Kaiser Basic HMO State Employee plan, and the Kaiser UC large group plan were likely among the most generous, these three plans were priced compared to the benchmark plan to determine which was the most generous.

7. The results of the analysis, details of which follow, identified the Kaiser UC large group plan to be the most generous among the plan options primarily driven by rich DME benefits and infertility benefits (namely, in vitro fertilization coverage).

Wakely analyzed the expected relative cost difference of the benefits of the proposed benchmark plan and the Kaiser UC Plan, which is an option for the typicality test, under CFR 156.111(b)(2)(ii). As demonstrated in the previous analysis, the difference in the new benefits in the proposed benchmark plan, relative to the current benchmark plan is 2.18% (see Table 2). Other benefit differences, specifically benefit differences between Kaiser UC Plan and the current benchmark plan, were estimated[20] and determined to be 2.23% as shown in Table 5. The methodology used to determine these estimates are explained in Appendix A and in the "Methodology and Results" section of this report.

Through review of the plan documents and discussions with the plan sponsors, it was determined the proposed benchmark, and the Kaiser UC Plan covered the same benefits apart from those listed in Table 4 below. Kaiser UC Plan offers richer benefits than the proposed benchmark with the exception of the newly proposed benefits and acupuncture. The below section details the benefit differences between the two plans.

[19] "Plan" and "product" are defined as outlined in § 144.103.
[20] Only benefit differences estimated to have a value greater than 0.00% are shown.

For pediatric dental and vision, it was determined that both the proposed benchmark plan and the Kaiser UC Plan required supplementation in accordance with 45 CFR 156.110(a). The State CHIP plan was used for pediatric dental supplementation and the FEDVIP plan was used for pediatric vision supplementation for both plans, so pediatric services did not contribute any differences towards the typicality test.

All other benefit differences were calculated using the WID data, with the exception of DME and IVF services, consistent with the explanation in the "Methodology and Results" section above.

As seen in Table 4, the benefit differences between the proposed benchmark and the most generous typical employer plan (Kaiser UC Plan) result in the proposed benchmark having a scope of coverage less than the most generous typical employer plan. Given that the proposed benchmark is as or less generous than the most generous typical employer plan, and the new benchmark meets the typical employer test requirement.

Table 5: Comparison of Proposed Benchmark to Most Generous Typical Employer Plan

Benefits	Proposed Benchmark	Kaiser UC Plan
Starting Value - Current Benchmark	100.00%	100.00%
Benefit Differences		
New Benefits in Proposed Benchmark (See Table 2)	2.18%	
Acupuncture		-0.13%
Chiropractic Care		0.71%
Infertility Diagnosis		0.03%
Artificial Insemination		0.03%
In Vitro Fertilization		0.61%
Durable Medical Equipment		0.77%
Hearing Aids and Exams		0.21%
Total Value of Plan	**102.18%**	**102.23%**

Conclusion

The analysis and results presented in this report, particularly Table 5, shows the proposed benchmark plan satisfies the actuarial requirements as stated in 45 CFR 156.111(2)(ii). 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 California's 2027 Essential Health Benefit Benchmark Plan pending CMS approval.

Appendix A: Data and Methodology

The primary data source to estimate benefit costs contained in this report was the 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 Durable Medical Equipment (DME) and In Vitro Fertilization (IVF) 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, Diagnosis Codes, 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 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
- Differences in membership mix
- Coverage utilization adjustments to account for specific benefits not being included in all state benchmarks within the region being analyzed

Appendix B: Reliances and Caveats

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

- 2021 Wakely Internal Databases (WIDs)
- 2023 California Health Benefits Review Program (CHBRP) Analysis regarding the Treatment for Infertility and Fertility Services
- The benefits and formulary for select plans including:
    - Kaiser small group HMO Copay Plan
    - Government Employees Health Association Inc. (GEHA) Benefit
    - Kaiser Basic HMO State Employee Plan
    - Kaiser Traditional Plan for the University of California
    - 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 California.
    - Plan benefit and cost-sharing summaries
    - Large group membership estimates
    - Confirmation that the Kaiser Traditional Plan for the University of California is the richest plan among the Kaiser plans considered for the typicality test with respect to benefit offerings (rather than cost sharing)
    - Confirmation that the formularies are negligibly different between the current benchmark plan and the Kaiser Traditional Plan for the University of California
- 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, DMHC 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

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. Jenna Hegemann, Darren Johnson, and Michael Cohen contributed to this report.

Intended Users. This information has been prepared for the sole use of the State of California Department of Managed Health Care (DMHC). 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 California 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. Changes to the enrollment composition of either market could also impact results. Changes to the economy, federal regulations, or other major market dynamics could also impact 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