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State of Alaska: Division of Insurance

Benchmark Plan Benefit Valuation Report

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Introduction and Background

The Alaska Division of Insurance (Alaska, AK DOI, 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 fully-insured commercial markets including the individual and small group Affordable Care Act (ACA) markets. Wakely was tasked to analyze the cost impact of a new benchmark and to determine if the new benchmark met the actuarial requirements as stated in 45 CFR 156.111. Alaska provided ongoing opportunities for public comment as part of this process.

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

This is the actuarial report, which is part of the State of Alaska's application for a change in the Federal CMS Plan Year 2026 Essential Health Benefit Benchmark Plan under Selection Option 3. All the other states that have updated their EHB benchmark plans have chosen this option as well. There are two actuarial requirements in order for a change in the benchmark to be accepted. The first is that the new EHB benchmark plan must be equal to a typical employer plan. The second is that the new EHB benchmark plan does not exceed the generosity of the most generous among a set of comparison plans.

This document has been prepared for the sole use of Alaska. 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

Alaska is proposing to add benefits to their EHB benchmark plan that would include coverage for:

- an annual hearing exam and one hearing aid for each ear every 3 years,
- an additional 8 chiropractic visits per year (increasing the limit from 12 to 20),
- 20 massage therapy visits per year,
- treatment for temporomandibular joint disorders (TMJ), and
- weight loss drugs.

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

We tested this new benchmark to ensure it met both the generosity test and the typical employer test as defined under 45 CFR 156.111, both of which are discussed in greater detail in a subsequent section of this report. Wakely found that if the proposed benefits were included in the new benchmark plan it would meet both regulatory requirements.

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 Alaska benchmark plan is the Premera Heritage Select Envoy (Premera). This plan was the initial benchmark plan for plan year 2014 and was set again in 2017 in accordance with the EHB rules, and approved by CMS. Under 45 CFR 156.11, the State is allowed to 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 Alaska and Alaska EHB stakeholder groups, which included Alaska's individual and small group issuers as well as providers and consumer advocacy organizations. Wakely also conducted analysis on the potential actuarial impact of the various proposed benefit changes. Several of the benefits considered for change were not ultimately recommended as a change. Listed below are the recommended changes and the potential impact of each.

Note that no proposed changes to the Alaska EHB benchmark plan relate to pediatric dental or vision benefits. Alaska does not intend to change any of the supplemented benefits.

Recommendation: Hearing Aid Coverage

DESCRIPTION

The State is proposing 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 improve the alignment of the benchmark plan with the State's health care policy goals to create equity among insured populations by implementing benefit designs serving Alaska's whole population, regardless of disability or age. Adding the recommended hearing benefit to Alaska's benchmark plan will bring their hearing coverage more in-line with other Western states' EHBs and improve the health and quality of life of affected members.

METHODOLOGY AND RESULTS

To estimate benefit costs, Wakely used the Wakely Internal Databases[1] (WID) data, which includes de-identified ACA EDGE Server data. Since the WID data is not available at the state level, we used data from states in the West US Census region since Alaska is included in the region. While the West region data was used, not all states in the West region cover an annual hearing exam or hearing aids. We reviewed the benefit coverage, where available, for all states in the West region and determined that Hawaii, Idaho, Montana, New Mexico, Utah, and Washington data does not include annual hearing exam coverage and Idaho, Utah, Montana, and Wyoming data does not include hearing aid coverage. We adjusted the calculated PMPM amounts to account for the percentage of members insured in states where each benefit is currently a covered benefit. This adjustment was performed to ensure our estimated claim cost was not understated due to lack of coverage.

Annual hearing exam and hearing aid costs were identified in the WID data using the most recent Wakely ACA Claims Grouper code set to identify annual hearing exam and hearing aid CPT codes alongside CPT codes gathered from industry research and resources.[2] We then created a range of potential costs that reasonably represents the marginal cost of adding the benefit. This estimate does not consider factors such as pent-up demand or downstream impacts.

The cost estimate used from the range estimate was 0.05% of the total allowed claims.

Recommendation: Additional Chiropractic Visits

DESCRIPTION

The State is proposing expanding the chiropractic benefit from 12 visits to 20 visits per year in the proposed benchmark plan. Studies have shown[3] that chiropractic care can be used as an alternative to opioids to help control acute and chronic pain. Expanding the chiropractic benefit in Alaska's benchmark plan will provide increased access to the benefit and improve the health and quality of life of affected members.

METHODOLOGY AND RESULTS

To estimate benefit costs, Wakely used the Wakely Internal Databases[4] (WID) data, which includes de-identified ACA EDGE Server data. Since the WID data is not available at the state level, we used data from states in the West US Census region since Alaska is included in the region. We reviewed the benefit coverage, where available, for all states in the West region and

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

[2] The full list of CPT codes used to identify each benefit is included in Appendix D.

[3] https://pubmed.ncbi.nlm.nih.gov/32142140/

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

determined that California, Hawaii, Oregon, and Utah data do not include chiropractic coverage. We adjusted the calculated PMPM amounts to account for the percentage of members insured in states where each benefit is currently a covered benefit. This adjustment was performed to ensure our estimated claim cost was not understated due to lack of coverage.

Chiropractic visit costs were identified in the WID data using the most recent Wakely ACA Claims Grouper code set to identify chiropractic CPT codes alongside CPT codes gathered from industry research and resources. Wakely pulled member-level claim experience and used this to create a Claims Probability Distribution (CPD) based on the annual number of visits per person reported in a calendar year. We then created a range of potential costs that reasonably represents the marginal cost of increasing the visit limit from 12 visits to 20 visits. This estimate does not consider factors such as pent-up demand or downstream impacts.

The cost estimate used from the range estimate was 0.05% of the total allowed claims.

Recommendation: Massage Therapy Visits

DESCRIPTION

The State is proposing adding a massage therapy benefit that includes 20 visits per year to the proposed benchmark plan. Massage therapy visits are covered when part of a physical therapy treatment plan or when otherwise medically necessary. Adding the recommended massage therapy benefit to Alaska's benchmark plan will improve the health and quality of life of affected members and may help control acute or chronic pain.

METHODOLOGY AND RESULTS

To estimate benefit costs, Wakely used the Wakely Internal Databases[5] (WID) data, which includes de-identified ACA EDGE Server data. Since the WID data is not available at the state level, we used data from states in the West US Census region since Alaska is included in the region. While the West region data was used, not all states in the West region covered massage therapy equivalent to the proposed benefit addition. Therefore, adjustments were made to account for benefit coverage differences and ensure our estimated claim cost was not understated due to coverage differences.

Massage therapy visit costs were identified in the WID data using the most recent Wakely ACA Claims Grouper code set to identify massage therapy CPT codes alongside CPT codes gathered from industry research and resources. Wakely pulled member-level claim experience and used this to create a Claims Probability Distribution (CPD) based on the annual number of visits per

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

person reported in a calendar year. We then created a range of potential costs that reasonably represents the marginal cost of adding a massage therapy benefit with a 20-visit limit. This estimate does not consider factors such as pent-up demand or downstream impacts.

The cost estimate used from the range estimate was 0.01% of the total allowed claims.

Recommendation: Treatment for Temporomandibular Joint (TMJ) Disorders

DESCRIPTION

The State is proposing adding a TMJ benefit that includes the diagnosis, therapy, and treatment (surgical and nonsurgical) for TMJ disorders to the proposed benchmark plan. TMJ can be resolved with appropriate treatment and management. The addition of TMJ services to Alaska's benchmark plan will improve the health and quality of life of affected members.

METHODOLOGY AND RESULTS

To estimate benefit costs, Wakely used the Wakely Internal Databases[6] (WID) data, which includes de-identified ACA EDGE Server data. Since the WID data is not available at the state level, we used data from states in the West US Census region since Alaska is included in the region. While the West region data was used, it was determined that Hawaii, Idaho, Montana, Oregon, Utah, and Wyoming data do not include TMJ coverage. We adjusted the calculated PMPM amounts to account for the percentage of members insured in states where each benefit is currently a covered benefit. This adjustment was performed to ensure our estimated claim cost was not understated due to lack of coverage.

TMJ costs were identified in the WID data using the most recent Wakely ACA Claims Grouper code set to identify TMJ CPT codes alongside CPT codes gathered from industry research and resources. We then created a range of potential costs that reasonably represents the cost of adding the TMJ benefit. This estimate does not consider factors such as pent-up demand or downstream impacts.

The cost estimate used from the range estimate was 0.01% of the total allowed claims.

Recommendation: Weight Loss Drugs

DESCRIPTION

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

The State is proposing adding a weight loss drug benefit that can include coverage of GLP1 and GIP drugs such as semaglutide. The proposal would increase the number of drugs required to be covered in the "Antidiabetic Agents" USP Class by one.

The benchmark plan defines the number of unique drugs required to be covered in each USP Category and Class. However, the EHB benchmark plan does not define the specific drugs issuers must cover. Therefore, issuers have flexibility in choosing the specific drugs they cover in this USP Class.

METHODOLOGY AND RESULTS

The current benchmark plan requires 25 unique drugs in the "Antidiabetic Agents" USP Class. By expanding coverage to include weight loss drugs, Wakely anticipates additional costs would be incurred. Wakely analyzed the unit cost and utilization of weight loss drugs using WID data.

Wakely performed research to understand the characteristics of the population that may be eligible and utilize the weight loss drug benefit. 24.5% of the Alaskan population have a body mass index of 30 or greater.[7] Approximately 1% of the West population in the WID data utilized nutritional counseling services. Wakely anticipates members will receive weight loss drug prescriptions primarily through the nutritional counseling benefit in conjunction with lifestyle change recommendations. Wakely estimates weight loss drug prescriptions will come from both members currently utilizing nutritional counseling and other visits and members who will incur additional visits. Wakely also anticipates plans to apply utilization management and adherence with lifestyle changes in prescribing the drug. Wakely estimates overall utilization of weight loss drugs will be similar to that of current nutritional counseling utilization – approximately 1%. Using WID data, Wakely calculated an average unit cost of approximately $850 per month for brand or high-cost weight loss drugs and an average unit cost of $12 per month for generic or low-cost weight loss drugs in the "Antidiabetic Agents" USP Class. Feedback from commercial issuers in the Alaskan market suggest that a low proportion of plans will choose to cover a high-cost weight loss drug in their formulary. Using a projected mix of 90% low-cost weight loss drugs and 10% high-cost weight loss drugs, Wakely estimates the average monthly cost of covering weight loss drugs to be $96.

Wakely also expects additional utilization of nutritional counseling visits and other doctors' visits as members utilize the new benefit. The unit cost for nutritional counseling visits were $135 in the WID data. Wakely assumed members adhering to the weight loss drugs and management programs would utilize a 12-month supply of drugs and average 4 visits a year. Studies state

[7] https://www.cdc.gov/obesity/stateprograms/fundedstates/pdf/alaska-state-profile.pdf

statin adherence is approximately 80%[8] while a Prime Therapeutics study shows GLP-1a adherence at 32%[9] after 1 year (and lower in subsequent years). Wakely assumed approximately 20% of members would begin the regimen and become non-adherent after one quarter. This adherence assumption was used to align with estimated utilization management, align with our utilization estimates, and for conservatism.

Wakely varied the above assumptions to create a range of potential costs that reasonably represent the marginal cost of adding a weight loss drug benefit. This estimate does not consider factors such as pent-up demand or downstream impacts, which potentially could reduce spending on other types of health care as a result of usage.

The cost estimate used from the range estimate was 0.07% of the total allowed claims.

[8] Adherence to Statin Therapy Among US Adults Between 2007 and 2014 | Journal of the American Heart Association (ahajournals.org)

[9] https://www.primetherapeutics.com/wp-content/uploads/2023/07/GLP-1a-obesity-treatment-1st-year-cost-effectiveness-study-abstract-FINAL-7-11.pdf

Additional Clarifications on Certain Benefits

RECOMMENDATIONS

In addition to the benefit changes listed above, Alaska recommends making additional changes to the language in its current benchmark plan with the goal of clarifying the coverage of select existing benefits, complying with federal requirements, and removing language that is not directly relevant to EHBs. For example, language that references an individual's diagnosis (e.g., diabetes) or age (e.g., covered if over 40) was removed since this language is presumed to be discriminatory under 45 CFR 156.125. Based on conversations with Alaska and CMS, these changes to the benchmark plan document langue do not represent actual changes to any EHB benefit coverages. Therefore, no pricing exercise was performed for any such changes.

To the extent that the Benchmark Plan does not comply with federal requirements, including the mental health parity and addiction equity act (MHPAEA), individual and small group market carriers must conform benefits to meet all applicable federal and state requirements when designing plans that are substantially equal to the Benchmark Plan. This includes ensuring that the availability of benefits is not discriminatory under federal law.

Summary of Benefit Additions

After performing the above pricing exercises for the listed benefit changes, the projected total increase of the recommended benefits is 0.19% as a percent of total allowed claims relative to the current benchmark. This is shown in Table 1 below.

Table 1: Impact of Added Benefits – Proposed Benchmark

Benefit Difference	Allowed Cost Impact*
Hearing Exam & Hearing Aids	0.05%
Chiropractic (increase from 12 to 20)	0.05%
Massage Therapy	0.01%
TMJ	0.01%
Weight Loss Drugs	0.07%
Total	**0.19%**

There are two separate tests that a new benchmark must meet in order for it to be approved. The first test that needs to be met is the typical employer plan test. In particular, a new benchmark must provide a scope of benefits that is equal to a typical employer plan. The second test for a new benchmark is the generosity test. In particular, a state's EHB-benchmark plan must not exceed the generosity of the most generous among plans listed at 45 CRR 156.111(b)(2)(ii)(A) and (B).

For the typicality test, Wakely selected the Federal Government Employees Health Association, Inc. Benefit Plan (GEHA). GEHA is among the top 3 federal employee enrollment plans in the nation. It also met other requirements in 45 CFR 156.111 and therefore can be used for the typicality test under 45 CFR 156.111(b)(2)(i). GEHA's similarities and differences to the current benchmark plan are outlined in Table 3. It does not sufficiently cover the pediatric vision EHB category under 45 CFR 156.110(a). As a result, the pediatric vision EHB categories from the Federal VIP plan were used to supplement the plan as allowed and required under 45 CFR 156.110(b). The GEHA plan does sufficiently cover pediatric dental EHB services under 45 CFR 156.110(a), so no supplementation for pediatric dental was necessary.

For the generosity test, Wakely selected a state employee plan that meets the standards under 45 CFR 156.100, or the ASEA/AFSCME Local 52 Health Benefits Trust plan (referred to as the ASEA plan). The ASEA plan sufficiently covers the dental and vision EHB categories under 45 CFR 156.110(a), so no supplementation was needed.

Overall, the three plans described above were determined to have equivalent values of pediatric dental and vision offerings. Table 2 provides an overview of the above plans and their pediatric dental and vision offerings.

Table 2: Pediatric Dental and Vision Supplementation

Plan Name	Description	Dental Offering	Vision Offering
Premera	Current Benchmark	Federal VIP	Federal VIP
GEHA	Typicality Comparison	No Supplementation	Federal VIP
ASEA	Generosity Comparison	No Supplementation	No Supplementation

The primary differences between the current benchmark, GEHA, and the ASEA plan (the current benchmark, typicality comparison plan, and generosity plan respectively) are as follows:

Table 3: Benefit Comparison – Current Benchmark and Comparison Plans

Plan Name Description	Premera Current Benchmark	GEHA Typicality Comparison	ASEA Generosity Comparison
Fertility Drugs	Not Covered	Not Covered	Covered
Lifestyle Drugs	Not Covered	Not Covered	Covered, quantity limits apply
PT/ST/OT	Covers 45 visits/year (combined)	Covers 60 visits/year (combined)	Covered, no visit limit
Acupuncture	Covers 12 visits/year	Covers 20 visits/year	Covers 20 visits/year (acupuncture / chiropractic / massage combined)
Chiropractic Care	Covers 12 visits/year	Covers 12 visits/year	Covers 20 visits/year (acupuncture /

Plan Name Description	Premera Current Benchmark	GEHA Typicality Comparison	ASEA Generosity Comparison
			chiropractic / massage combined)
Massage therapy	Not Covered	Not Covered	Covers 20 visits/year (acupuncture / chiropractic / massage combined)
Bariatric Surgery	Not Covered	Covered	Covered
TMJ	Not Covered	Covered	Covered
SNF	Covers 60 days/year	Covers 14 days/year	Covered, no day limit
Hearing Aids & Exam	Not Covered	Covers 1 hearing aid/ear every 5 years	Covers 1 hearing aid/ear every 3 years
Applied Behavioral Therapy	Covered	Not Covered	Covered

Typicality Test

In order for the proposed benchmark plan to pass the typicality test, the value of the proposed benchmark plan needs to equal the scope of a typical employer plan.[10]

Wakely analyzed the expected relative cost difference of the benefits of the proposed benchmark plan and GEHA, which is an option for the typicality test, under CFR 156.111(b)(2)(i). As demonstrated in the previous analysis, the difference in the new benefits in the proposed benchmark plan, relative to the current benchmark plan is 0.19% (see Table 1). Other benefit differences, specifically benefit differences between GEHA and the current benchmark plan, were also estimated[11] and determined to be 0.19% as shown in Table 4. The methodology used to determine these estimates are explained in Appendix A.

Through review of the plan documents and discussions with the plan sponsors, it was determined that the proposed benchmark and GEHA covered the same benefits except:

- The proposed benchmark covers 45 PT/ST/OT visits per year (combined) and GEHA covers 60 PT/ST/OT visits per year (combined)

[10] https://www.regtap.info/uploads/library/PMSC_Slides_022421_5CR_022421.pdf

[11] Only benefit differences estimated to have a value greater than 0.00% are shown.

- The proposed benchmark covers 12 acupuncture visits per year and GEHA covers 20 acupuncture visits per year
- The proposed benchmark covers 20 chiropractic visits per year and GEHA covers 12 chiropractic visits per year
- The proposed benchmark covers 20 massage therapy visits per year and GEHA does not cover massage therapy
- GEHA covers bariatric surgery
- The proposed benchmark covers hearing exams
- GEHA covers applied behavioral therapy

The benefit differences between the proposed benchmark plan and GEHA were identified in WID data using the most recent Wakely ACA Claims Grouper code set to identify CPT codes assigned to the associated benefits alongside CPT codes gathered from industry research and resources. We then determined the associated allowed PMPM claim cost for each set of CPT codes. For benefits with visit limits, Wakely pulled member-level claim experience and used this to create a Claims Probability Distribution (CPD) based on the annual number of visits per person reported in a calendar year, and determined the associated allowed PMPM claim cost based on the relevant visit limit.

Since the WID data is not available at the state level, we used the West region data since Alaska is included in the West region. However, not all states in the West region cover each of these benefits. As a result, we reviewed the benefit coverage, where available, for all states in the West region. We then adjusted the calculated per member per month (PMPM) amounts to account for the percentage of members insured in states where each benefit is currently a covered benefit. This adjustment was performed to ensure our estimated claim cost was not understated due to lack of coverage. Finally, the cost estimate was then put on a percent of allowed basis and estimated to be 0.19%.

As seen in Table 4, the benefit differences between the proposed benchmark and the typical employer plan (as defined by GEHA) result in the proposed benchmark having the same level of coverage as a typical employer plan. Given that the proposed benchmark is equal to a typical employer plan, the new benchmark meets the typical employer plan test.

Table 4: Comparison of Proposed Benchmark to Typical Employer Plan

Benefits	Proposed Benchmark	GEHA
Starting Value - Current Benchmark	100.00%	100.00%
Benefit Differences		
New Benefits in Proposed Benchmark (See Table 1)	0.19%	
PT/ST/OT		0.06%
Bariatric Surgery		0.07%
TMJ		0.01%
Hearing Aids & Exam		0.05%

Benefits	Proposed Benchmark	GEHA
Applied Behavioral Therapy		-0.02%
Acupuncture		0.01%
Total Value of Plan	100.19%	100.19%

Generosity Test

The second requirement for a new benchmark is the generosity test. In particular, a state's EHB-benchmark plan must not exceed the generosity of the most generous among the set of comparison plans.

Wakely analyzed the generosity among the comparison plans and identified the ASEA plan as the most generous among the set of comparison plans.[12] Wakely has supported over twelve states with EHB analyses over the years and leveraged some of that prior work in identifying 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 ASEA plan as likely the most generous using the following process:

1. The current benchmark is the Premera Heritage Select Envoy plan.
2. Based on a review of the three FEHB plans, Wakely identified the three plans had nearly identical coverage of benefits.
3. Based on a review of the three small group plans, Wakely identified the three plans had nearly identical coverage of benefits.
4. Similarly, the three State Employee plans cover nearly the same benefits, but Wakely determined that the ASEA plan has the most generous coverage, driven by richer TMJ, fertility drug, lifestyle drug, nutritional counseling, and weight loss program benefits. Furthermore, the State Employee plans were found to be more generous than the current benchmark driven primarily by richer PT/OT/ST, acupuncture/chiropractic/massage, bariatric surgery, TMJ, and hearing aids and exams benefits.
5. The result of the analysis, details which follow, is that the ASEA plan is the most generous of the options. The ASEA plan did not require supplementation for pediatric dental or vision.

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

[12] https://www.regtap.info/uploads/library/PMSC_Slides_022421_5CR_022421.pdf

As seen in Table 5, this results in the proposed benchmark being less generous than the ASEA plan[13]. Therefore, the proposed benchmark plan meets the requirements of the generosity test.

Table 5: Comparison of Proposed Benchmark to Generosity Comparison Plan

Benefits	Proposed Benchmark	ASEA
Starting Value - Current Benchmark	100.00%	100.00%
Benefit Differences		
Fertility Drugs		0.09%
Lifestyle Drugs		0.06%
PT / ST / OT		0.06%
Acupuncture / Chiropractic Care / Massage Therapy	0.06%	0.02%
Bariatric Surgery		0.07%
TMJ	0.01%	0.01%
Hearing Aids & Exam	0.05%	0.05%
Weight Loss Drugs	0.07%	
Total Value of Plan	**100.19%**	**100.36%**

Conclusion

The analysis and results presented in this report, particularly Tables 4 and 5, show the proposed benchmark plan satisfies the actuarial requirements as stated in 45 CFR 156.111. Furthermore, the methodology and adjustments used to produce the results are reasonable and in compliance with Actuarial Standards of Practices (ASOPs). Therefore, we believe the proposed benchmark plan, this report, and associated documents satisfy all requirements for Alaska's 2026 Essential Health Benefit Benchmark Plan pending CMS approval.

[13] Only benefit differences estimated to have a value greater than 0.00% are shown.

Appendix A: Data and Methodology

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

Wakely also used available industry data and public resources to support our estimates where WID data for a particular service was not credible, available, or additional data was warranted.

For the WID data sources, Wakely pulled 2021 allowed information by service line and used this data to assess utilization and unit cost data for select benefits. We used information in the data including (but not limited to) CPT / HCPCS codes, Revenue Codes, Inpatient DRGs, and NDCs to estimate cost impacts and relativities. Wakely assumed the distribution of benefits and services is the same over time. Wakely focused on the percent of allowed cost impact to account for cost estimates being made at different points in time.

Once CPT-level (in some cases NDC & member-level was also used) data was acquired, we made any appropriate adjustments to the base information in order to isolate the projected costs pursuant to the specific benefit recommendations outlined in prior sections of this document. Specific adjustments by EHB benefit may have included:

- Cost relativities between benefits and visit limits
- Coverage utilization adjustments to account for specific benefits not being included in all state benchmarks within the region being analyzed
- Unit Cost adjustments to reflect coverage for only a portion of NDCs within a class or for changes in drug offerings (e.g., more generics available compared to the data period), where appropriate

For the pediatric dental and vision benefit differences, Wakely relied on additional data resources. For the dental benefits, Wakely relied on a proprietary dental model to value the difference in benefits. Based on estimates that children account for approximately 27% of Alaska on-Exchange enrollment, the value of the benefit was reduced to spread the costs over the entire ACA population. Wakely determined that benefits were equivalent across the benchmark plan, typicality plan, and generosity plan.

For the vision benefit, Wakely determined that benefits were equivalent across the benchmark plan, typicality plan, and generosity plan.

Appendix B: Reliance and Caveats

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

- 2021 Wakely Internal Database (WID)
- 2017 Alaska benchmark plan information, sourced from CMS
- The benefits and formulary for select plans including:
    - Premera Heritage Select Envoy
    - ASEA/AFSCME Local 52 Health Benefits Trust
    - Government Employees Health Association Inc. (GEHA) Benefit
    - Federal Employees Dental & Vision Insurance Program (FEDVIP)
- Information gained from regular conversations with the State and other market stakeholders, including commercial issuers in the state of Alaska.
    - 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 Internal 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, Alaska 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. Julie Peper, Michael Cohen, and Lisa Winters also contributed significantly to this report.

Intended Users. This information has been prepared for the sole use of the Alaska Division of Insurance. 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 Alaska or its issuers will attain the estimated values included in the report. It is the responsibility of those receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. Wakely provides actuarial services to a variety of clients throughout the health industry. Our clients include commercial, Medicare, and Medicaid health plans, the federal government and state governments, medical providers, and other entities that operate in the domestic and international health insurance markets. Wakely has implemented various internal practices to reduce or eliminate conflict of interest risk in serving our various clients. Except as noted here, the responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis.

Data and Reliance. The current cost estimates rely on Wakely's WID database. As such, we have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly.

Subsequent Events. These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this report. Material changes as a result of Federal or state regulations may also have a material impact on the results. There are no specifically known relevant events subsequent to the date of engagement that would impact the results of this document.

Contents of Actuarial Report. This document (the report, including appendices), alongside the 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 D: CPT Codes

Category	Codes
Annual Hearing Exam	92551, 92559, 92560, 92590, 92591, 92592, 92593, 92594, 92595, 92597
Hearing Aids	92590, 92591, 92592, 92593, 92594, 92595, V5010, V5011, V5014, V5020, V5030, V5040, V5050, V5060, V5070, V5080, V5090, V5100, V5110, V5120, V5130, V5140, V5150, V5160, V5170, V5180, V5190, V5200, V5210, V5220, V5230, V5240, V5241, V5242, V5243, V5244, V5245, V5246, V5247, V5248, V5249, V5250, V5251, V5252, V5253, V5254, V5255, V5256, V5257, V5258, V5259, V5260, V5261, V5263, V5264, V5265, V5266, V5267, V5268, V5269, V5270, V5271, V5272, V5274, V5298
Chiropractic	98940, 98941, 98942, 98943
Massage Therapy	97124
TMJ	20605, 21010, 21050, 21060, 21073, 21116, 21240, 21242, 21243, 21480, 21485, 21490, 29800, 29804, 70328, 70330, 70332, 70336, D0320, D0321