

TESTIMONY

Presented by: Adam Hamm
Insurance Commissioner
North Dakota Insurance Department

Before: Health Care Reform Review Committee
Representative George Keiser, Chairman

Date: September 6, 2012

Good morning, Chairman Keiser and members of the committee. My name is Adam Hamm and I am the North Dakota Insurance Commissioner.

Although today my hope is for the committee to provide direction as to the state's essential health benefit (EHB) decision, I was also asked to update you on the status of states' implementation of the health benefit exchange requirements under the Patient Protection and Affordable Care Act (PPACA).

Exchanges and a New NAIC Working Group

As we know, many states are still trying to decide what to do regarding the Exchange issue and not much has changed since this committee met on July 25. At that point, the Kaiser Family Foundation indicated that 16 jurisdictions had established a state-run Exchange (that number includes the District of Columbia, as well as Utah and Massachusetts who had passed their own Exchange legislation prior to the passage of PPACA); 1 jurisdiction was planning for a Partnership Exchange; 17 jurisdictions were studying options; 10 jurisdictions had no significant activity; and 7 jurisdictions had decided not to create a state-run Exchange. The Kaiser Family Foundation's latest report dated August 1, 2012, indicates that 16 jurisdictions have established a state-run Exchange; 3 jurisdictions are planning for a Partnership Exchange; 16 jurisdictions are studying options; 9 jurisdictions had no significant activity; and 7 jurisdictions decided not to create a state-run Exchange.

Jurisdiction Status	July 25, 2012	August 1, 2012
Established State-Run Exchanges	16	16
Planning Partnership Exchange	1	3
Studying Options	17	16
No Significant Activity	10	9
Decision to Not Run State Exchange	7	7

At the NAIC's Atlanta national meeting, the Executive Committee voted to create a new Health Care Reform Regulatory Alternatives Working Group, which North Dakota has joined. The working group's charges are to:

1. Provide a forum for discussion of and guidance on the alternatives to implementing a state-based Exchange and the implications of such alternatives on state regulatory authority;
2. Identify and assist states in resolving open issues that need to be addressed with regard to non-state Exchange alternatives;
3. Analyze the impact of PPACA on existing state regulatory authority both inside and outside of a federal Exchange as well as the impact on NAIC Model Laws (Unfair Insurance Practices Act, Producer Licensing Model Act, Model Law on Examinations, etc.); and
4. Identify opportunities for states to continue to innovate and regulate outside of a federal Exchange.

Essential Health Benefits (EHB)

As I mentioned, today my request of the committee and stakeholders is to have a discussion of the “choices” available to the state in making an EHB decision. I would like to be able to tell you that we have all of the guidelines from HHS to make the best decision possible, but as of today we still do not have final regulatory guidance on EHB and were told by HHS last week there is no specific date we can expect it.

In other words, North Dakota and all of the other states are expected to make an extremely important “choice,” affecting almost all of our consumers and businesses as well as providers, without knowing the rules of the game. PPACA specifically says the HHS Secretary shall make this EHB decision but as I have told you in past meetings, the December 2011 Bulletin stated states were to make a “choice” from a list of plans prescribed by HHS even though none of those plans on the list meets the 10 benefit categories required in an EHB.

Also, since the December 2011 Bulletin HHS has made surprising unwritten clarifications as to the options for states and the deadline for a decision. We still do not know if our “choice” of an EHB will be accepted, rejected or modified by the HHS Secretary.

With that in mind, I want to take a little time to go through a reference document attached to my testimony that will remind you of the background of the EHB process and the potential impact of “choosing” a relatively basic or rich plan. Ultimately, that is the decision—does North Dakota want to “choose” a basic plan as a floor to which insurers can build upon; does the state want to “choose” a richer option to ensure all consumers have a more extensive set of benefits in their health insurance plans; or does the state, for all the reasons that I have discussed above, want to decline to make a “choice” and send this whole matter back to HHS, along with our consultant’s report (as we have previously discussed, if the state does not make a “choice” the default

option according to HHS would be the non-grandfathered small group plan with the largest enrollment in the state)?

I also want to point to another attachment, which is a chart of what we know at this point regarding other states and their decisions on EHB. To date, there is not much final activity by states.

Finally, the last attachments contain the final EHB analysis report and the comments submitted on the final draft. The final draft was sent to all stakeholders. We received three comments prior to the comment period deadline and made several changes and clarifications based on those comments. We received two additional sets of comments after the deadline.

Following my testimony and any questions you might have, I will introduce the consultant engaged by the Insurance Department to analyze the EHB choices in North Dakota and prepare this report. Joe Higgins is an Actuary with INS Consultants, Inc., from Pennsylvania. He is here to go through the analysis report and take additional questions.

Thank you and I would be happy to answer any questions.

Essential Health Benefits stakeholder comments

In response to draft report sent August 22, 2012

Fonkert, Andrea L.

From: Joan Connell [jmconnellmd@msn.com]
Sent: Monday, August 27, 2012 4:13 PM
To: Fonkert, Andrea L.; Gallup-Millner, Tammy L.; ckoebele@ndmed.com; chris tiongson; Joan
Subject: North Dakota American Academy of Pediatrics response to consultative report

Dear Ms. Fonkert,

My name is Joan Connell. I am a pediatrician in Bismarck, ND. I currently serve as the vice president for the North Dakota Academy of Pediatrics. I appreciate you requesting feedback with regard to the consultative report that was provided regarding our state's options for choosing a health care benefit plan and what we value as essential health benefits. I appreciated the latter portion of this document which compared and contrasted the various options. I would like to reinforce some of the essential items relevant to children's health care benefits. Please note that the cost of the first 5 areas mentioned is really trivial in the grand scheme of the health care budget.

1. Provision for well child care using AAP endorsed Bright Futures criteria/recommendations for frequency of well checks. Essentially, this recommends well checks frequently in the first year of life, less frequently between ages 1 and 2 years, then annually thereafter. With well checks comes the necessity for coverage of CDC recommended immunizations. This too needs to be a part of essential health benefits. It was not clear that the plans described will cover all recommended well checks, particularly those annual well checks occurring after age 2. These visits provide opportunities for a healthcare provider to monitor for signs of chronic disease, suboptimal development, discuss parenting and discipline issues, as well as establish a relationship with the child that will grow into an adolescent who may have needs related to risky behaviors and/or depression. Remember, the ND High School Activities Assn mandates a sports physical annually for all participants. This is one additional reason why annual well checks should be considered an essential health benefit in children >2 years of age. Also, given the broad scope of material that needs to be covered and the time required to do that in a comprehensive way, provision of these services must be associated with fair reimbursement.

2. Provision of habilitative and rehabilitative services. There are many studies that document the cost savings of early intervention services that can be utilized to optimize children's development. If we want to provide care in the most cost effective way, we need to take opportunities to intervene and fix small problems before they become large problems. Optimizing children's outcomes will optimize their future productivity as citizens. It appears that rehabilitative services will be included as part of essential health benefits. The particulars of these benefits must be customized for children and their needs as when it comes to meeting the healthcare needs of children, they cannot be considered "little adults". Children grow and develop, frequently with good responses to therapy. They therefore need to have items such as hearing aids and many pieces of durable medical equipment modified to account for their growing and changing bodies. Their therapy needs are also unique. This too may make their needs different from the adult population.

3. Provision for pharmaceuticals. I noticed that this was included in most/all of the plans. This provision should include medical food for patients with inborn errors of metabolism, including PKU. Our state currently mandates that formula be provided to all children and some adults with phenylketonuria and maple syrup urine disease, two diseases resulting from inborn errors of metabolism. Since the 1960s when this legislation was introduced, additional inborn errors of metabolism have been discovered. Those diseases often require specialty formula to optimize patient outcomes. Optimizing patient outcomes often times leads to overall less financial expenditure and superior patient outcomes, many times resulting in a more productive citizen. Currently ND Medicaid does not provide for specialty formula for these other disease states. This is illogical and needs to be made a part of essential health benefits.

4. Provision for treatment of mental illness. I noticed that not all plans included benefits for detoxification and residential treatment. I recently heard that North Dakota is currently the #1 binge drinking state in the nation. The experimental and risk taking behaviors typical of adolescence requires that detoxification be a component of health plans. I also believe that significant interventions, including residential treatment programs, may be most beneficial in the adolescent who is still somewhat capable of change and modification of bad behaviors. Furthermore, relocation of these particular children away from their dysfunctional environments to a setting that role models a healthier lifestyle may be imperative for successful long lasting changes in behavior to occur. We must stop thinking about short term costs and start thinking about investing in optimizing long term outcomes that will be overall financially efficient and result in a more productive citizen.

5. Vision and dental care. I understand that this is a new frontier. Children must be able to see the chalk/smart board, their books, etc to learn. Eyeglasses may be necessary. They must have good dentition to eat a standard healthy diet. These provisions, again, allow them to grow into healthy productive adults. I must say that refusing to pay for a dilated eye exam in a diabetic pediatric patient seems illogical. I would defer to the Children's Diabetes specialists/optometrists/ophthalmologists for recommendations on what is necessary for an appropriate annual eye exam in a child with diabetes.

6. Children with special health care needs. These children do account for the majority of pediatric health care expense. Determining health care benefits that will optimize their outcomes in a cost effective way is important. This applies to children with physical disabilities as well as mental/behavioral/developmental disabilities, including autism. Helping the families of these children avoid personal financial ruin due to holes in their children's health care coverage is also important and needs to be considered when determining a benefit plan. Keep in mind that one of the main goals of the Affordability Care Act is to prevent patients from "falling through the cracks". This is clearly an underinsured population.

Again, thank you for considering my comments. I would like to participate in the meeting September 6. However, I am in clinic that morning, which cannot be rescheduled. If it is possible to discuss issues relevant to the pediatric population later in the afternoon or if I may be of service to you at some other time, I would love to participate in this process. Thanks again for your time and consideration... Joan Connell, MD/Professor of Pediatrics, UND School of Medicine/
Pediatrician-UND Center for Family Medicine/Medical Director Children's Special Health Services

Fonkert, Andrea L.

From: Rod St. Aubyn [Rod.St.Aubyn@bcbsnd.com]
Sent: Monday, August 27, 2012 4:36 PM
To: Fonkert, Andrea L.
Cc: Dan Ulmer
Subject: RE: Essential health benefits analysis

Thank you for the opportunity to comment. Our staff noted the following:

- The report references Basic Dental Services. It is unclear if that reference is for adults or the pediatric Basic Dental Services. Nowhere in the ACA or the Bulletin does HHS infer that dental services for adults are to be included - only pediatric dental and vision services.
- On page 12 the report references that Medica pays for elective abortion services. That may be incorrect in that state law prohibits insurers paying for elective abortions unless provided as a separate rider (NDCC 14-02.3-03) or it should be clarified that the option is by purchase of a rider.
- Is it appropriate or permissible to use the "grandfathered" PERS plan for a benchmark option, since HHS did not consider grandfathered plans in the total enrollment numbers when calculating the top 3 small group plans? We recognize that a "grandfathered" plan would have to supplement all the ACA near term requirements in addition to any other missing benefits from the 10 categories, but just questioned if a "grandfathered" plan could or should be considered as an option.
- The report never addressed the prohibition of lifetime or annual dollar limits for Essential Health Benefits - ie TMJ mandate (NDCC 26.1-36-09.3)
- . On page 14, Category 9 ii) the consultant report indicates the NDPERS GF plan doesn't offer Preventive Care for Women. It does go on to clarify on page 23 paragraph 4 preventive care for women "as promulgated by the Act", which we presume to mean the Women's Preventive Care benefits scheduled to go into effect on 8/1/12 for NGF plans. The NDPERS GF plan does pay for basic women's preventive care such as one annual visit, one pap smear with associated office visit, mammograms. The statement on page 14 appeared to be a little misleading

Thanks again for the opportunity to comment on the analysis report.

Rod St. Aubyn
Manager - Government Relations
4510 13th Avenue S.
Fargo, ND 58121-0001
701-282-1847

From: Fonkert, Andrea L. [<mailto:afonkert@nd.gov>]
Sent: Wednesday, August 22, 2012 4:46 PM
To: Fonkert, Andrea L.
Subject: Essential health benefits analysis
Importance: High

To: North Dakota Insurance Department

From: Constance Hofland & Amy Davis, Public Policy Representatives of North Dakota Academy of Nutrition and Dietetics

Date: August 27, 2012

Subject: Comments on Essential Health Benefits Analysis

Thank you for the opportunity to comment on the analysis on Essential Health Benefits ("EHB") conducted by INS Consultants, Inc., dated August 2012.

The North Dakota Academy of Nutrition and Dietetics (formerly the North Dakota Dietetics Association) is committed to improving the health of North Dakotans. As the EHB package is being designed, we believe it should include access to nutrition services in the form of medical nutrition therapy ("MNT") provided by registered dietitians ("RDs").

Coverage of the EHB of Nutrition Counseling in the Ten Benchmark Choices

INS provided a comparison of the nutrition counseling covered by the 10 plans that are candidates for the benchmark plan for North Dakota. As outlined on page 47 of the draft report, nutrition counseling is covered similarly for the three Small Group Insurance Plans. This is consistent our prior analysis of these three plans. However, the reference on the bottom of page 11, paragraph(ix) regarding the Medica plan is misleading. It states that Medica covers nutrition counseling in general but only mentions diabetes, but we understand that this does not mean that only diabetes is covered. Rather, we understand the Medica plan covers any individual nutrition therapy sessions, not limited to a specific diagnosis when referred by a physician. It is also important to note that group nutrition therapy sessions are not covered in the Medica plan and that group sessions are covered in the other benchmark plans.

Similarly, we would like to clarify the chart on page 56 on limits on the number of annual visits for nutrition counseling. The Medica Choice plan is listed as not explicitly specifying the number of visits. We understand the number of nutrition counseling sessions allowed in the Medica plan is determined by physician referrals. We want to be sure this "NS" not interpreted to mean that no visits are covered, when there is no set limit on the number of annual visits with an RD for nutrition counseling in the Medica plan .

Looking at all 10 benchmark plan candidates, we favor a plan that covers nutrition therapy for a minimum of the following medical conditions: anorexia, bulimia, chronic renal failure, diabetes, gestational diabetes, hyperlipidemia, hypertension, obesity, and phenylketonuria. Because of the effectiveness of nutrition counseling in disease prevention, additional coverage for other diagnoses; such pre-diabetes, could result in a cost savings for health care in North Dakota.

Registered Dietitians are uniquely qualified to provide cost effective nutrition therapy and preventive and wellness services

The role of nutrition in health promotion, disease prevention and disease management has become a progressively more significant public health issue. Overweight and obesity runs rampant in the United States. In fact, it is considered to be one of the leading causes of deaths of adults. In preventing chronic diseases, nutrition and diet must be incorporated into a daily regimen. The importance of nutrition is underscored by the role of nutrition in the prevention of the leading causes of death including cardiovascular disease, type 2 diabetes, hypertension, osteoporosis, and some forms of cancer. Four of the top six leading causes of death, diseases of the heart, cancer, cerebrovascular disease and diabetes can be influenced by diet and nutrition.

RDs are the most cost-effective, qualified health care professional to provide MNT. MNT is distinctly different than nutrition education and requires advanced skills beyond those of other professionals. According to the Institute of Medicine, “the registered dietitian is currently the single identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy.”

MNT provided by RDs for prevention, wellness and disease management can improve a consumer’s health and increase productivity and satisfaction levels through decreased doctor visits, hospitalizations and reduced prescription drug costs. Also, MNT provided by RDs impacts productivity. For example, the RD-led lifestyle intervention provided to patients with diabetes and obesity reduced the risk of having lost work days by 64.3% and disability days by 87.2%, compared with those receiving usual medical care without the RD-led lifestyle intervention. (*Diabetes Care*. 2004; 27:1570-6).

RDs are the most qualified practitioners to provide such services and by utilizing RDs to provide nutrition services there will be a significant impact on chronic disease and will result in cost savings.

For questions or more information, please contact Constance Hofland, MS, RD, LRD, JD at chofland@zkslaw.com or Amy Davis, RD, LRD at adavis@mohs.org.

Deb Knuth | Director of Government Relations

Great West Division | American Cancer Society Cancer Action Network, Inc.

Benchmark Plan/EHB Comments

North Dakota

Prescription Drugs

- Although the analysis states that all plans cover brand drugs, generic drugs and off-label use, it lacks specifics on information about:
 - Prior Authorization requirements
 - Step Therapy requirements
 - Tiered Drug Benefits
- Drug benefits are extremely important to cancer patients and limitations on drug access can be detrimental to a cancer patient's health outcome. Do any of the benchmark plan options have the above three components as part of their drug benefit? If so will the prior authorization, step therapy or tiered benefit be applied to all plans offered in the exchange?
- The analysis also indicates that the BCBSND PPO plan does not cover smoking/tobacco cessation drugs. This coverage gap is of obvious concern for cancer prevention purposes.
- Although the analysis indicates "coverage" for tobacco cessation drugs, often this benefit is very limited. Do the other benchmark plan options limit coverage for tobacco cessation drugs (ex. Cap on number of prescriptions per plan year; cap on number of "quit attempts" per year)

Hair Loss Supplies

- Only two of the Federal Employee Health Plans (BCBS Standard and Basic) cover wigs and scalp prosthetics for chemotherapy related hair loss. Although this benefit is not our highest coverage priority compared to other prevention and treatment services, this benefit can often contribute greatly to a cancer patient's quality of life and should be noted.

Genetic Testing

- ACS CAN is still looking into the issue of genetic testing as a form of prevention and early detection for those with a strong family history of cancer. Although we don't have a formal policy position on whether cancer related genetic testing should be a priority covered benefit, it is worth noting instances of non-coverage.
- Coverage for Genetic testing is not covered at all by the FEHBP- GEHA plan.
- Genetic testing is listed as a covered benefit for all other benchmark plan options. Are there limits on this coverage? Is the benefit subject to a high risk determination by the insurer? Is the coverage limited to genetic testing for certain disease/condition areas?

Smoking/Tobacco Cessation Services

- See “prescription drugs” section for concerns related to cessation drugs.
- Smoking/Tobacco cessation services are listed as NOT COVERED by the ND State Employee Plan (PPO). This is of concern from a cancer prevention perspective. Although the USPSTF includes “tobacco cessation treatment” as an “A” recommendation (and is therefore a required benefit under ACA) the language of the recommendation is quite vague so it is important for the selected benchmark plan to not only cover these services but cover these services, but to define and adequately cover these services.
- For the benchmark plans that do cover “smoking/tobacco cessation services”, four plans (Small group BCBS Classic Blue and Comp Choice, State Employee Health Plans BCBSND NDPERS NGF and BCBSND HDHGP NGF) only cover two “quit attempts” per year. What is actually covered for a “quit attempt”? How long is the duration of covered services for one attempt?
- The Sanford HMO plan only covers one “quit attempt” per lifetime. This is a very inadequate benefit as most smoking do not quit successfully after one attempt.

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September 4, 2012

MEDICA®

North Dakota Insurance Department
Attention: Andrea Fonkert, Public Information Officer
600 E. Boulevard Ave., Dept. 401
Bismarck, ND 58505-0320

Re: Analysis of Essential Health Benefits Under the Patient Protection and Affordable Care Act

Dear Ms. Fonkert:

Thank you for the opportunity to provide comments to the North Dakota Insurance Department (“the Department”) with respect to the Analysis of Essential Health Benefits Under the Patient Protection and Affordable Care Act (“Analysis”), which was prepared for the Department by INS Consultants, Inc. (“INS”). Medica Insurance Company and Medica Health Plans (collectively referred to as “we,” “our,” and “Medica”) respectfully submit the following comments to the Department.

Generally, Medica supports the selection of an Essential Health Benefits (“EHB”) benchmark plan that meets the minimum requirements of the EHB set, including providing coverage for all state-mandated benefits. This would be the most cost-effective approach for the State and will ensure that less expensive products are available to consumers. It will also maximize flexibility for carriers as they determine when and how it makes the most sense to modify their product offerings, including by adding additional benefits.

As a more specific point of feedback, Medica disagrees with what we understand (from a recent conversation with the Department) to be the underlying assumption in Item No. 2 of the Analysis that the final EHB regulations will outline specific benefits that must be covered within each of the ten statutory EHB categories, and therefore that specific benefits will need to be added to the EHB benchmark plan. This interpretation appears to conflict with HHS’ regulatory approach as set forth in its December 16, 2011 bulletin, in which it states that it “[intends] to propose that EHB be defined by a benchmark plan selected by each State. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a ‘typical employer plan’ in that State as required by section 1302(b)(2)(A) of the Affordable Care Act” and “[g]enerally, we intend to propose that if a benchmark is missing other categories of benefits, the State must supplement the missing categories using the benefits from any other benchmark option.”

By instructing states to select an EHB benchmark plan from a list of already-existing plan options instead of outlining a detailed list of benefits that must be covered as part of any EHB set, it appears as though HHS’ intention is to use what is already available in the marketplace,

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Medica Comments re Analysis of Essential Health Benefits Under the Patient Protection and Affordable Care Act
September 4, 2012
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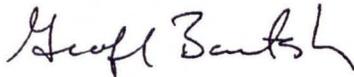
instead of prescribing a new set of benefit criteria that a plan must comply with in order to meet the requirements of the EHB set.

In addition, the bulletin discusses supplementing missing *categories*, not missing *benefits* within each category. We believe it is premature to assume that the final EHB regulation will go further than this broad standard by requiring that categories be supplemented with specific benefits.

For these reasons, we do not believe that this assumption should be a factor in the selection of a benchmark plan. In fact, if the State requires additional benefits to be added to the benchmark, we believe that this could be construed as a benefit mandate and generate additional cost to the State.

Thank you once again for the opportunity to provide these comments. Please do not hesitate to contact me if you have any questions or would like to discuss Medica's comments in more detail. I can be reached directly via telephone at: (952) 992-2461; via email at: geoffrey.bartsh@medica.com; or at the following address: Medica Health Plans, Inc., 401 Carlson Parkway, Mail Route CP250, Minnetonka, MN 55305.

Sincerely,



Geoff Bartsh
Vice President, Public Policy & Government Relations
Medica

Essential Health Benefits

Background and Potential Decision Implications

North Dakota Insurance Department

September 6, 2012

Background

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (PPACA) charges the Secretary of the U.S. Department of Health and Human Services (HHS) with further defining Essential Health Benefits (EHB), and instructs the Secretary to ensure that they are equal to the scope of benefits provided under a typical employer plan, supplemented as necessary to ensure that plans cover each of the 10 statutory categories of EHB. It requires all non-grandfathered health insurance plans offered in the small group and individual markets to cover all EHB by January 1, 2014. The EHB package must be included in plans inside and outside of the Exchange.

HHS has defined the requirements of an EHB benchmark package and described the method for states to choose an EHB package through a Bulletin issued on December 16, 2011 and other non-regulatory guidance. No formal rule has been released and, as of today, we do not know when the final rule will be issued or what type of specific information it will include.

Making the Choice

The current information provided to states lays out the following process.

1. The state determines the potential benchmark plans from the following four options as they existed on March 31, 2012:
 - a. The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market (as suggested by HHS);
 - b. Any of the largest three state employee health benefit plans by enrollment;
 - c. Any of the largest three national FEHBP plan options by enrollment; or
 - d. The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state.
2. The State selects one of the benchmark health plans by September 30, 2012. (Recent indications from HHS are that this is a "soft" date.)
3. The Secretary will review the choice to determine if the plan:
 - a. Meets the requirement for coverage in ten broad categories of health benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
 - b. Reflects typical employer health benefit plans reflects balance among the categories;
 - c. Accounts for diverse health needs across many populations;
 - d. Ensures there are no incentives for coverage decisions, cost sharing or reimbursement rates to discriminate impermissibly against individuals because of their age, disability, or expected length of life;
 - e. Ensures compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);

- f. Provides states a role in defining EHB; and
 - g. Balances comprehensiveness and affordability for those purchasing coverage.
4. Should a state not choose a benchmark plan, the default benchmark plan would be the small group plan with the largest enrollment in the state.
5. The chosen plan would be the benchmark for the years 2014 and 2015. HHS intends to review and update EHB for 2016 and beyond.

Plan Benefits

The benefits covered in the chosen plan become the EHB package for that state, subject to the addition of any missing categories. For example, most health insurance plans do not include pediatric dental services which are a required category of EHB. Limits in the scope and duration of benefits in the benchmark plan are incorporated in EHB requirements. However, there can be no dollar value limits on EHB benefits. If an insurer wants to substitute a service for an EHB required category of benefits, the substitution must be actuarially equivalent. Cost sharing requirements are not considered a part of the EHB definition and are separately regulated under the PPACA.

In designating a benchmark, the state is designating that benchmark plan's benefit package as the minimum benefit package required for all non-grandfathered small group and individual plans sold in North Dakota. If the designated benchmark plan does not include benefits in all ten required EHB categories, the state must supplement the benchmark plan by selecting missing benefits from other benchmark options or from the state's Children's Health Insurance Program (CHIP). States may only supplement benefits that are not covered in the benchmark or the state must pay for any added mandates. State mandate laws still apply.

Potential Decision Implications

States may choose any plan in the benchmark options. Some of these plans are considered more basic in the coverage of benefits and others richer. All of the North Dakota benchmark choice plans will require additional benefits to be added to them to meet the ten required categories and all must be modified to take out the dollar limits on the existing benefits.

Specific coverage that is included in specific plans may cause a plan to be more or less expensive as it relates to the premium cost of that particular coverage, i.e., coverage for certain fertility benefits with no dollar limitations is a more expensive benefit to add to plans than certain laboratory services without dollar limitations.

Given that all non-grandfathered small group and individual plans must include the EHB benefits after 2014, this set of benefits is often thought of as a floor. Insurers may add to those benefits in any way they like (and price the products accordingly), but they may not take benefits away.

The impacts of choosing a basic plan versus a rich plan are various and include potential premium pricing increases, premium value as it compares to the necessity of specific coverage, market disruption, insurer competition, network adequacy and provider payments.

Choosing a richer plan, especially given no dollar limitations, will most likely cause most existing insurers to request higher premium rate increases due to the additional benefits likely to be paid. Affordability becomes a serious concern for policyholders.

Some policy holders may want to know most benefits are covered by their plans, thereby wanting a rich plan. Choosing a richer plan may force employers and individuals to purchase insurance they do not want or need.

Choosing a basic plan in a state like North Dakota where most of the existing small group and individual plans have traditionally been fairly rich may cause market disruption. Small employers may terminate previous, richer plans especially if the more basic plans cost less. This may leave employees with far fewer benefits than previously or without an employer-sponsored plan at all.

A perceived positive impact of choosing a basic plan is that it would allow insurers to design plans in a unique way to compete against other insurers by adding select benefits that distinguish one plan from another. This would also allow for better variation when employers and individuals shop for insurance whether inside or outside of the Exchange.

Certain areas of the state may not have adequate provider networks for all benefits in a rich plan. Just because the benefit is covered doesn't mean every policyholder will be able to take advantage of that coverage easily.

Providers are likely to want more benefits covered instead of fewer because insurance is a better payer than an individual who has to pay for his/her own services, Medicaid or Medicare.

There are likely more potential positive and negative impacts of the various EHB benchmark choices specific to unique groups of consumers, employers and insurers.

Open Feedback Dialog (<http://statereform.uservoice.com/forums/97753?lang=en&referrer=http%3A%2F%2Fwww.statereform.org%2Fstate-progress-on-essential-health-benefits>)

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State Progress on Essential Health Benefits

*Chart updated on August 27, 2012

Sort table: Click the headers to sort this table by column

Table tip: Click orange text to view relevant source materials

State	Formed a workgroup on essential health benefits	Conducted an analysis of existing state benefit mandates	Assessed benchmark plan options	Held a public comment period	Decided on a benchmark plan	Benchmark plan type
AL		X (http://www.statereform.org/sites/default/files/al_ehb_4_plan_comparison_062512_v6.pdf)	X (http://www.statereform.org/sites/default/files/al_ehb_4_plan_comparison_062512_v6.pdf)	X (http://www.statereform.org/discussions/essential-health-benefits#comment-9393)		
AR	X (http://www.insurance.arkansas.gov/Legal%20DataServices/NOH/NOH-PropRule103.pdf)	X (http://www.arkleg.state.ar.us/healthcare/Insurance/Documents/EHB%20issue%20brief%20for%20arkansas%20may%2029%20revision.docx)	X (http://www.arkleg.state.ar.us/healthcare/Insurance/Documents/EHB%20issue%20brief%20for%20arkansas%20may%2029%20revision.docx)			EHB Benchmark Plan: Any of the state's three small group plans (preliminary recommendation)
AZ		X (http://www.statereform.org/sites/default/files/ehb_report_v8_june_12.pdf)	X (http://www.statereform.org/sites/default/files/ehb_report_v8_june_12.pdf)	X (http://www.surveymonkey.com/s/ZP5QDNL)		
CA	X (http://www.insurance.ca.gov/0100-consumers/0020-	X (http://www.statereform.org/sites/default/files	X (http://www.statereform.org/sites/default/files/ehbbenefitcom	X (http://www.statereform.org/sites/default/files/ehbhearingtran	X (http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_0951-1000	EHB Benchmark Plan: Kaiser small group HMO plan (http://www.insurance.ca.gov/0100-consumers/0020-health-related/upload/KaiserSmallGroupHMO.pdf)
Total	29	23	26	22	2	

State	Formed a workgroup on essential health benefits	Conducted an analysis of existing state benefit mandates	Assessed benchmark plan options	Held a public comment period	Decided on a benchmark plan	Benchmark plan type
	health-related/ehbh.cfm	/ehbbenefitcomparison20120621.pdf	parison20120621.pdf	script.pdf	/sb_951_bill_20120416_amended_sen_v97.html 1 (Legislation)	
CO	X http://www.getcoveredco.org/News-Events/Blog/May-2012/Next-Steps-for-Essential-Health-Benefits ²	X http://www.statereforum.org/sites/default/files/ehb-comparison-chart-6-26-12-carrier-approved-no-cost-sharing.pdf	X http://www.statereforum.org/sites/default/files/ehb-comparison-chart-6-26-12-carrier-approved-no-cost-sharing.pdf	X http://www.getcoveredco.org/Resources/Essential-Health-Benefits		
CT	X http://www.ct.gov/hix/cwp/view.asp?a=4299&Q=506202	X http://www.cqa.ct.gov/2012/rpt/2012-R-0022.htm	X http://www.cqa.ct.gov/2012/rpt/2012-R-0022.htm			
DC	X http://app.calendar.rrc.dc.gov/eventDetail.aspx?eventId=16064&eo=29385&thisDate=7.9.2012&cdlCalendars=111			X http://app.calendar.rrc.dc.gov/monthView.aspx?thisDate=8/19/2012&cdlCalendars=111		
DE	X http://dhss.delaware.gov/dhcc/	X http://dhss.delaware.gov/dhcc/files/ehbstakeholderpacket061512.pdf	X http://dhss.delaware.gov/dhcc/files/benchmarkplancomparison061512.pdf	X http://dhss.delaware.gov/dhcc/files/ehbpressrelease061512.pdf		
HI	X http://www.hawaiihealthconnector.com/Home_Page.html					
IA	X http://www.idph.state.ia.us/hcr_committees					
Total	29	23	26	22	2	

State	Formed a workgroup on essential health benefits	Conducted an analysis of existing state benefit mandates	Assessed benchmark plan options	Held a public comment period	Decided on a benchmark plan	Benchmark plan type
	/common/pdf/hbes/053012_slides.pdf					
IL	X (http://insurance.illinois.gov/hirc/consumer-protection.asp)					
KS	X (http://www.ksinsurance.org/hbexplan/index.php?pgid=7)			X (http://www.statereform.org/sites/default/files/public_hearing_09-05-2012.pdf) (Upcoming public meeting on 9/5)		
KY	X (http://insurance.ky.gov/static/info.aspx?static_id=140&Div_id=17)		X (http://insurance.ky.gov/static/info.aspx?static_id=140&Div_id=17)	X (http://insurance.ky.gov/static/info.aspx?static_id=140&Div_id=17)		State will recommend its choice of EHBs to the Secretary of the HHS prior to September 30, 2012.
MA	X	X	X	X		
MD	X (http://dhm.maryland.gov/exchange/pdf/EHB%20Benchmark%20Selection%20Proposed%20Workplan%20and%20Timeline_may82012.pdf)	X (http://www.statereform.org/sites/default/files/copy-of-md-ehb-exhibits-benchmark-options-comparison-of-state-mandates-7.10.12-draft.pdf)	X (http://www.statereform.org/sites/default/files/copy-of-md-ehb-exhibits-benchmark-options-comparison-of-benefits-7.10.12-draft.pdf) ³	X (http://www.healthreform.maryland.gov/2012/07/draft-analysis-of-essential-health-benefits-benchmark-options/)		
ME		X (http://www.statereform.org/sites/default/files/essential_health_benefits_comparison2.xls)	X (http://www.statereform.org/sites/default/files/essential_health_benefits_comparison2.xls)			
MI	X (http://www.michigan.gov)	X	X ⁴	X (http://www.michigan.gov)		
Total	29	23	26	22	2	

State	Formed a workgroup on essential health benefits	Conducted an analysis of existing state benefit mandates	Assessed benchmark plan options	Held a public comment period	Decided on a benchmark plan	Benchmark plan type
	/lara/0,4601,7-154-35299-10555-278783--00.html			/lara/0,4601,7-154-35299-10555-279006--00.html		
MN	X (http://mn.gov/health-reform/images/Task-Force-2012-03-01-Feedback-and-Recommendations-on-EHB.pdf)	X (http://mn.gov/health-reform/images/Task-Force-2012-02-06-EHB-State-Mandates.pdf)	X (http://mn.gov/health-reform/images/WG-Access-2012-02-09-Essential-Benefit-Set-Default.pdf)			
MS	X (http://www.mid.state.ms.us/pages/health_care_reform.aspx)		X (http://www.mid.state.ms.us/pdf/FinalRecommendations/ExchangeBoardBenefits.pdf)			
NC	X (http://www.ncdoi.com/lh/LH_Health_Care_Reform.aspx)	X (http://www.statereforum.org/shinecomments/view_document_link/10182?ref=http%3A//www.ncdoi.com/lh/Documents/HealthCareReform/Analysis%20of%20Benchmark%20Plan%20Options%20Study%20Report.pdf)	X (http://www.statereforum.org/shinecomments/view_document_link/10182?ref=http%3A//www.ncdoi.com/lh/Documents/HealthCareReform/Analysis%20of%20Benchmark%20Plan%20Options%20Study%20Report.pdf)			
NE	X (http://www.doi.ne.gov/healthcarereform/exchange/EHB_letter.pdf)		X (http://www.doi.ne.gov/healthcarereform/exchange/EHB_letter.pdf)	X (http://www.statereforum.org/sites/default/files/ehb_presentation_final.pdf)		
Total	29	23	26	22	2	

State	Formed a workgroup on essential health benefits	Conducted an analysis of existing state benefit mandates	Assessed benchmark plan options	Held a public comment period	Decided on a benchmark plan	Benchmark plan type
NH	X (http://www.gencourt.state.nh.us/legislation/2012/2012-HB0627.html) ⁵	X (http://www.statereform.org/sites/default/files/nh_mand_benefits_presentation.pdf)	X (http://www.statereform.org/sites/default/files/nh_mand_benefits_presentation.pdf)			
NM	X (http://www.statereform.org/sites/default/files/nm_hsd_ehb_primer_v2.pdf)					
NV	X (http://exchange.nv.gov/uploadedFiles/exchange.nv.gov/Content/About/Board%20Approved%20Recommendations%20012%2007%2005.pdf)	X	X	X (http://exchange.nv.gov/Meetings/Plan_Certification_Management/) <small>(Upcoming public meetings on 8/29 and 9/13)</small>		EHB Benchmark Plan: <u>Small Employer HMO Plan</u> (http://www.statereform.org/sites/default/files/04_essentialhealthbenefits-pcm.pdf) <small>(preliminary recommendation, analysis is ongoing)</small>
NY	X	X (http://www.statereform.org/sites/default/files/2012-08-02_milliman_exhibit1_app_a.pdf) <small>(Draft)</small>	X (http://www.statereform.org/sites/default/files/2012-08-02_milliman_exhibit1_app_a.pdf) <small>(Draft)</small>	X (http://www.healthcarereform.ny.gov/)		
OR	X (http://cms.oregon.gov/oha/OHPR/pages/ehb/index.aspx)	X	X ⁶	X (http://www.oregon.gov/oha/OHPR/EHB/docs/EHB_Request_for_PC_7-6-12.pdf)		EHB Benchmark Plan: <u>PacificSource Preferred CoDeduct small group plan</u> (http://www.statereform.org/sites/default/files/ehb_illustration.pdf) <small>(preliminary recommendation)</small> Pediatric Dental Supplemental Plan: <u>HealthyKids Plan</u> (http://www.oregon.gov/oha/OHPR/EHB/docs/FinalRecLetter.pdf) <small>(preliminary recommendation)</small> Vision Supplemental Plan: <u>FEDVIP - BlueVision High Plan</u> (http://www.statereform.org/sites)
Total	29	23	26	22	2	

State	Formed a workgroup on essential health benefits	Conducted an analysis of existing state benefit mandates	Assessed benchmark plan options	Held a public comment period	Decided on a benchmark plan	Benchmark plan type
						/default/files/ehb_illustration.pdf <i>(preliminary recommendation)</i>
RI	X http://www.healthcare.ri.gov/documents/EHB%20Work%20Group%20Presentation%205-11-12.pdf	X http://www.healthcare.ri.gov/documents/Essential%20Health%20Benefits%20Report%20to%20OHIC%20rfs.pdf	X http://www.healthcare.ri.gov/documents/EHB%20work%20group%20benchmark%20analysis%20(1).pdf	X http://www.healthcare.ri.gov/commission/workgroups/ehb_comment.php		EHB Benchmark Plan: United Health Care - Choice Plus http://www.staterforum.org/sites/default/files/ehb_071612.pdf <i>(preliminary recommendation)</i> Pediatric Dental Supplemental Plan: FEDVIP MetLife http://www.staterforum.org/sites/default/files/ehb_071612.pdf <i>(preliminary recommendation)</i>
TN	X http://www.tn.gov/nationalhealthreform/forms/stakeholderupdate110512.pdf	X http://www.staterforum.org/sites/default/files/tnehbcomparisonsurvey.pdf	X http://www.staterforum.org/sites/default/files/tnehbcomparisonsurvey.pdf	X http://www.staterforum.org/sites/default/files/ehb-august2012-comments.pdf		
TX	X http://www.senate.state.tx.us/75r/senate/commit/c570/pdf/0801%20TDI%20Testimony%20EHB%20Summary.pdf			X http://www.tdi.texas.gov/alert/event/2012/event2012198.html <i>(Upcoming public meeting on 8/28)</i>		
UT	X http://le.utah.gov/asp/interim/Commit.asp?Year=2012&Com=TSKHSR	X http://www.staterforum.org/sites/default/files/ut_ehb_benchmark_comparison_matrix.pdf <i>(Draft)</i>	X http://www.staterforum.org/sites/default/files/ut_ehb_benchmark_comparison_matrix.pdf <i>(Draft)</i>	X http://www.staterforum.org/sites/default/files/summary_of_public_comments.pdf		EHB Benchmark Plan: Utah Basic Plus State Employee Plan http://www.staterforum.org/sites/default/files/essential_health_benefits_recommendation_letter_8-16-12.pdf <i>(preliminary recommendation by legislature)</i>
VA	X	X	X	X http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/EssentialHealthBenefitPublicComment.pdf		EHB Benchmark Plan: Anthem Small Group PPO http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/EssentialHealthBenefitSubcommitteeRecommendations.pdf <i>(preliminary recommendation)</i> Pediatric Dental Supplemental Plan: CHIP dental benefit plan (Smiles for Children) http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/EssentialHealthBenefitSubcommittee
Total	29	23	26	22	2	

State	Formed a workgroup on essential health benefits	Conducted an analysis of existing state benefit mandates	Assessed benchmark plan options	Held a public comment period	Decided on a benchmark plan	Benchmark plan type
						Recommendations.pdf (preliminary recommendation) Habilitative Services Plan: TBD
VT	X (http://www.leq.state.vt.us/docs/2012/bills/House/H-559.pdf)	X (http://hcr.vermont.gov/sites/hcr/files/Exchange%20benefits%20report%20Feb%202012%20FINAL.pdf)	X (http://www.statereform.org/discussions/essential-health-benefits#comment-9925)	X (http://hcr.vermont.gov/public_engagement/benefits)		EHB Benchmark Plan: Blue Cross Blue Shield Vermont (http://dvha.vermont.gov/advisory-boards/ehb-one-page-review.pdf) (preliminary recommendation) Pediatric Dental Supplemental Plan: CHIP dental benefit plan (http://dvha.vermont.gov/advisory-boards/ehb-one-page-review.pdf) (preliminary recommendation) Habilitative Services Plan: State preliminarily recommends same coverage as rehabilitative services (http://dvha.vermont.gov/advisory-boards/ehb-one-page-review.pdf)
WA		X (http://www.statereform.org/sites/default/files/essential_benefits_milliman_analysis.pdf)	X (http://www.statereform.org/sites/default/files/essential_benefits_milliman_analysis.pdf)	X (http://www.insurance.wa.gov/laws_regs/rules_pending.shtml) <small>(Comment period open until 9/18)</small>	X (http://www.statereform.org/sites/default/files/2319-s2.pl.pdf) <small>(Legislation)</small>	EHB Benchmark Plan: Regence Innova Small Employer Plan (http://wainurance.blogspot.com/2012/07/rule-making-starts-for-essential-health.html)
Total	29	23	26	22	2	

About this chart

The ACA requires that health insurance plans sold to individuals and small businesses provide a minimum package of services in 10 categories called “essential health benefits.” HHS has decided to allow each state to choose from a set of plans to serve as the benchmark plan for their state. As we [highlighted \(http://www.statereform.org/blog/states-react-essential-health-benefits-bulletin\)](http://www.statereform.org/blog/states-react-essential-health-benefits-bulletin) in a recent blog post, states are required to establish benchmark plans based on one of four options outlined in a [bulletin \(http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf\)](http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf) on essential health benefits. A recent [FAQ \(http://www.statereform.org/sites/default/files/ehb-faq-508_0.pdf\)](http://www.statereform.org/sites/default/files/ehb-faq-508_0.pdf) document clarified many of the questions that states had on the bulletin. States will need to select a benchmark plan by the fourth quarter of 2012, but many began analyzing options earlier this year.

This chart highlights activity around selecting benchmark plans that states have shared publicly or on State Reform. If your state is working on benchmark plan selection, [tell us here \(http://www.statereform.org/discussions/essential-health-benefits\)](http://www.statereform.org/discussions/essential-health-benefits) and we'll be sure its noted in the chart.

Notes

¹SB 951 passed both the state Senate and Assembly. SB 951 requires a plan to cover pediatric oral services at par with the largest federal plan by enrollment, the federal Blue Cross and Blue Shield Standard Option Service Benefit Plan. This bill also requires habitative services to be covered at parity with rehabilitative services.

²Colorado issued a [FAQ document \(http://www.statereform.org/sites/default/files/ehb-faqs-7-6-12.docx\)](http://www.statereform.org/sites/default/files/ehb-faqs-7-6-12.docx) which answers many questions the state has received from stakeholders about its EHB selection process.

³Maryland contracted with Wakely Consulting to produce an [analysis \(http://www.statereform.org/sites/default/files/md-ehb-premium-impact-of-benchmark-options-hcrcc-meeting-draft1.pdf\)](http://www.statereform.org/sites/default/files/md-ehb-premium-impact-of-benchmark-options-hcrcc-meeting-draft1.pdf) of the potential impact that each benchmark plan option might have on premiums.

⁴Michigan's Department of Licensing and Regulatory Affairs also developed a [comparison chart \(http://www.statereform.org/sites/default/files/ehb_comparison_dental_and_vision_393337_7.pdf\)](http://www.statereform.org/sites/default/files/ehb_comparison_dental_and_vision_393337_7.pdf) for dental and vision benefits.

⁵HIB 0627 would establish designate the state legislature's Joint Health Care Reform and Oversight Committee to select a benchmark plan. The bill is currently in conference committee.

⁶Oregon's EHB workgroup also developed [decision-making criteria \(http://www.statereform.org/sites/default/files\)](http://www.statereform.org/sites/default/files)

[/or_ehb_decision_making_criteria.pdf](#)) to help assess benchmark plan options.

Produced by [Chris Cantrell \(http://www.statereform.org/user/chriscantrell\)](http://www.statereform.org/user/chriscantrell), National Academy for State Health Policy

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