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Essential Health Benefits

ESSENTIAL HEALTH BENEFITS PACKAGE.

A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.

Benchmark Plan

- Plan of reference based on employer-sponsored coverage in the marketplace today, supplemented as necessary to ensure that plans cover each of the 10 statutory categories of EHB.
- Serves as the standard for qualified health plans inside the Exchange operating in their State and plans offered in the individual and small group markets in their State.
- Benchmark Plan defines the EHB package.

Purpose of Report

The primary purpose of this report is to assist North Dakota in its selection of a benchmark plan.

The report lists the ten benchmark plans and indicates the benefits provided by each benchmark plan including the coverage of North Dakota's mandated benefits and the optional benefits that might be considered as supplements to each plan.

Essential Health Benefit Categories

The Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(1) Ambulatory patient services.
(2) Emergency services.
(3) Hospitalization.
(4) Maternity and newborn care.
(5) Mental health and substance use disorder services, including behavioral health treatment.
(6) Prescription drugs.
(7) Rehabilitative and habilitative services and devices.
(8) Laboratory services.
(9) Preventive and wellness services and chronic disease management.
(10) Pediatric services, including oral and vision care.

Essential Health Benefits

The Secretary shall ensure that the scope of the essential health benefits is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary.

Benchmark Plan

A state must choose a single benchmark plan in the third quarter of 2012, and the services covered by the benchmark plan at that time will be the benchmark services for 2014 and 2015.

In each state, the same benchmark plan will apply to both the individual and small group markets.

A state may not pick and choose on a benefit-by-benefit basis to customize their benchmark EHBs.

Benchmark Plan

Insurance policies must cover the benefits within the ten categories in order to be certified and offered in Exchanges.

HHS intends to require that a health plan offer benefits that are substantially equal to the benchmark plan selected by the state and modified as necessary to reflect the ten coverage categories.

Benchmark Plan

The benchmark plan does not define how specific cost-sharing requirements will be applied by health plans. The EHB package is not intended to define allowed cost-sharing, some of which is mandated in other provisions of the Act.

Benchmark Plan

Note that under the Act, plans may not establish lifetime limits on the dollar value of benefits for any participant or beneficiary. Any such limits contained in the existing benchmark plan will not apply in the future.

Essential Health Benefits

On December 16, 2011, HHS released a Bulletin describing the approach it intends to take in defining EHB under the Affordable Care Act. This Bulletin provides a general outline of the process to be taken by the states in defining the EHB package.

Further guidance was contained in a document discussing frequently asked questions published by HHS' Centers for Medicare and Medicaid Services.

HHS' General Goals

Bulletin outlined HHS' general goals:

- Encompass the ten categories of services identified in the Act;
- Reflect typical employer health benefit plans;
- Reflect balance among the categories;
- Account for diverse health needs across many populations;
- Ensure 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;
- Ensure compliance with the Mental Health Parity and Addiction Equity Act of 2008;
- Provide states a role in defining EHB; and
- Balance comprehensiveness and affordability for those purchasing coverage. (Already done by insurers?)

Essential Health Benefits

Several considerations influence a state's choice of an EHB benchmark plan.

- Differences in the coverage of state mandated benefits.
- Total cost of the benchmark plan compared to other options.
- Nature of covered benefits.
- Extent to which the benchmark plan would need to be supplemented to provide benefits within each EHB category.

Would benchmark plan need to be supplemented?

Initial guidance regarding Essential Health Benefits did not list any specific benefits that would be required within each of the categories of coverage.

The final rule regarding Essential Health Benefits has not been released.

The Department of Health and Human Services may or may not require coverage for specific benefits in the final rule.

Benchmark Plan Choices

States may choose a benchmark plan from one of the following four benchmark plan types for 2014 and 2015:

- The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;
- Any of the largest three state employee health benefit plans by enrollment;
- Any of the largest three national Federal Employees Health Benefits Plan (FEHBP) plan options by enrollment; or
- The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state.

Note there are ten possible benchmark choices among the above four plan types.

Benchmark Plan Choices

I. Largest non-grandfathered small group insurance products in North Dakota's small group market:

1. Medica Insurance Company. Medica Choice Passport.
2. Blue Cross Blue Shield of North Dakota. Classic Blue.
3. Blue Cross Blue Shield of North Dakota. CompChoice 80.

Benchmark Plan Choices

II. Largest three state employee health benefit plans by enrollment.

1. North Dakota Public Employees Retirement System (NDPERS). Health Care Coverage (grandfathered). Plans are issued by Blue Cross Blue Shield of North Dakota.
2. North Dakota Public Employees Retirement System. Health Care Coverage (non-grandfathered). Plans are issued by Blue Cross Blue Shield of North Dakota.
3. North Dakota Public Employees Retirement System. High deductible health plan. Plans are issued by Blue Cross Blue Shield of North Dakota.

Benchmark Plan Choices

III. Largest three national Federal Employees Health Benefits Plans (FEHBP).

1. Blue Cross Blue Shield Standard Option.
2. Blue Cross Blue Shield Basic Option.
3. Government Employees Health Association, Inc. Benefit Plan. Administered by the Government Employees Health Association, Inc.

Benchmark Plan Choices

IV. Largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state.

1. Group Sanford Health Plan.

Key Findings

There are variations in covered benefits among the ten benchmark plans within the ten general categories.

The differences among the ten plans are indicated in Appendix E.

Key Findings

None of the ten benchmark plans cover all specific benefits within each of the ten categories as outlined in this report.

Appendix F lists for each of the ten potential benchmark plans those benefits not covered by the plan that are covered by another potential benchmark plan.

Key Findings

Generally, plans comply with North Dakota's mandated benefits with the exception of the national Federal Employees Health Benefits Plans.

Appendix B contains a discussion of North Dakota's mandated benefits.

Key Findings

If any of the three Federal Employees Health Benefits Plans are selected, they would need to be supplemented by certain benefits required by North Dakota's mandates.

This would require North Dakota to pay for the costs of these additional benefits.

Key Findings

The three Federal Employees Health Benefits Plans might be considered as plans providing benefits on a nationwide basis and to a specific subset of the U.S. population. They may not be the best representation of the specific needs of North Dakota residents.

Key Findings

Of the ten benchmark plan choices, seven are Blue Cross Blue Shield plans.

Five are issued by Blue Cross Blue Shield of North Dakota or, in the case of two Federal Employees Health Benefits Plans, are sponsored and administered by Blue Cross and Blue Shield Association.

For these seven plans there are few variations among the benefits provided by these plans (with the possible exception of the two Federal Employees Health Benefits Plans).

Key Findings

The Sanford Health HMO plan appears to provide fewer benefits than the other nine plans.

Key Findings

HHS may or may not require coverage for specific benefits in their final rule. It appears that the two small group insurance products issued by Blue Cross Blue Shield of North Dakota would require the fewest benefit additions.

Key Findings

By choosing a plan already covering significant numbers of North Dakota residents, there may be fewer problems associated with providing an adequate number of in-network primary care and specialty physicians.

Other Issues

- Coverage areas that may not be included in most North Dakota plans. Bulletin identifies habilitative services, pediatric vision and dental.
- North Dakota mandated benefits. The Act would require the state to defray the cost of those mandated benefits in excess of EHB as defined by the selected benchmark.

Other Issues (continued)

- Network adequacy - ability of plans to deliver the EHBs.
- Whether the EHB package is too rich for plan sustainability and premium affordability in the North Dakota marketplace.
- Individuals moving to and from Medicaid.
- Issues where federal guidance is unclear and may impact the final decision.
- Post 2015.

Questions?

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

Prepared for the North Dakota Insurance Department

August, 2012

Executive Summary

The North Dakota Insurance Department (NDID) has engaged INS Consultants, Inc., (INS) to prepare a report regarding Essential Health Benefits under the federal Patient Protection and Affordable Care Act.

The Patient Protection and Affordable Care Act requires all non-grandfathered health insurance plans offered in the small group and individual market to cover all essential health benefits by January 1, 2014. Essential health benefits are defined to include ten broad categories of health benefits. The primary purpose of this report is to assist North Dakota in its selection of a benchmark plan. The report lists the ten benchmark plans and indicates the benefits provided by each benchmark plan including the coverage of North Dakota's mandated benefits and the optional benefits that might be considered as supplements to each plan.

Key Findings

1. There are some variations in covered benefits among the ten benchmark plans. The differences among the ten plans are indicated in Appendix E.

2. Generally, plans comply with North Dakota's mandated benefits with the exception of the national Federal Employees Health Benefits Plans. Appendix B contains a discussion of North Dakota's mandated benefits.

3. None of the ten benchmark plans cover all benefits outlined in this report. Appendix F lists for each of the ten potential benchmark plans those benefits not covered by the plan that are covered by another potential benchmark plan.

4. INS does not take any opinion with respect to which of the benchmark plans should be selected by North Dakota. However, INS has noted the following that may influence the final selection of the benchmark plan.

   a) If any of the three Federal Employees Health Benefits Plans are selected, they would need to be supplemented by certain benefits required by North Dakota's mandates. This would require North Dakota to pay for the costs of these additional benefits.

   b) The three Federal Employees Health Benefits Plans might be considered as plans providing benefits on a nationwide basis and to a specific subset of the U.S. population. They may not be the best representation of the specific needs of North Dakota residents.

   c) Of the ten benchmark plans, seven are Blue Cross Blue Shield plans. Five are issued by Blue Cross Blue Shield of North Dakota or, in the case of two Federal Employees Health Benefits Plans, are sponsored and administered by Blue Cross and Blue Shield Association. For these seven plans there are few variations among the benefits provided by these plans (with the possible exception of the two Federal Employees Health Benefits Plans).

   d) The Sanford Health plan appears to provide fewer benefits than the other nine plans.

e) HHS may or may not require coverage for specific benefits in their final rule. It appears that the two small group insurance products issued by Blue Cross Blue Shield of North Dakota would require the fewest benefit additions.

f) If North Dakota chooses a plan needing few potential added benefits, it may eliminate the need for adding any supplemental benefits, which could streamline the plan design for carriers.

g) By choosing a plan already covering significant numbers of North Dakota residents, there may be fewer problems associated with providing an adequate number of in-network primary care and specialty physicians.

Background

The Patient Protection and Affordable Care Act (hereinafter "Act") is a federal statute signed into law on March 23, 2010 along with the Health Care and Education Reconciliation Act of 2010. This legislation makes sweeping changes to the U.S. health care system. These changes will be implemented over the next several years.

The Act requires health plans offered in the individual and small group markets, both inside and outside of the Exchanges, to offer a comprehensive package of items and services, known as Essential Health Benefits (EHB). EHBs must include items and services within at least ten categories (see Appendix A). Insurance policies must cover the benefits within these categories in order to be certified and offered in Exchanges. To meet the EHB coverage standard, the Department of Health and Human Services (HHS) intends to require that a health plan offer benefits that are substantially equal to the benchmark plan selected by the state and modified as necessary to reflect the ten coverage categories.

A state must choose a single benchmark plan in the third quarter of 2012, and the services covered by the benchmark plan at that time will be the benchmark services for 2014 and 2015. In each state, the same benchmark plan will apply to both the individual and small group markets.

On December 16, 2011, HHS released a Bulletin[i] (Bulletin) describing the approach it intends to take in defining EHB under the Affordable Care Act. This Bulletin provides a general outline of the process to be taken by the states in defining the EHB package. Further guidance was contained in a document discussing frequently asked questions published by HHS' Centers for Medicare and Medicaid Services.

The Bulletin also outlined HHS' general goals in pursuing an approach to define EHB as:

i) Encompass the ten categories of services identified in the Act;

ii) Reflect typical employer health benefit plans;

iii) Reflect balance among the categories;

iv) Account for diverse health needs across many populations;

v) Ensure 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;

vi) Ensure compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);

vii) Provide states a role in defining EHB; and

viii) Balance comprehensiveness and affordability for those purchasing coverage.

In adopting the benchmark approach, the EHB package contained in the benchmark plan defines the benefits and services that must be covered. The benchmark plan does not define how specific cost-sharing requirements will be applied by health plans. The EHB package is not intended

to define allowed cost-sharing, some of which is mandated in other provisions of the Act. Instead, the actuarial value requirement will shape how companies design their cost-sharing requirements.

Several considerations influence a state's choice of an EHB benchmark plan. Differences in the coverage of state mandated benefits, the total cost of the benchmark plan compared to other options, the nature of covered benefits, and the extent to which the benchmark plan would need to be supplemented to provide benefits within each EHB category.

Note that under the Act, plans may not establish lifetime limits on the dollar value of benefits for any participant or beneficiary. Any such limits contained in the existing benchmark plan will not apply in the future.

Scope of Work

The scope of the report is limited to the following items:

1. Review all benchmark choices for North Dakota using the Bulletin including the type and level of benefits, the number of policies issued and lives covered.
2. Compare the benchmark choices to the HHS ten specified areas to determine the extent to which they provide coverage of the EHB package as defined in PPACA and subsequent guidance and summarize the benefits that would have to be added to the potential EHB benchmark to be inclusive of the ten statutory categories.
3. Discuss the specific impact of any of the ten coverage areas that are not included in most North Dakota plans (i.e. habilitative services, pediatric vision and dental).
4. Estimate the potential premium rate impact of adding currently noncovered benefits that will be required taking into account, among other things, the cost-sharing provisions associated with each benchmark plan.

5. Consider the cost to the state of a potential EHB benchmark plan that does not include North Dakota mandated benefits.

6. Consider the capacity of both individual and group health plans in their ability to provide the potential EHB benchmark plan. Capacity could be assessed by considering:

   i) Network adequacy in terms of the ability of plans to deliver the EHBs.

   ii) Whether the EHB package is too rich for plan sustainability and premium affordability in the North Dakota marketplace.

7. Consider the impact, if any, of individuals moving to and from Medicaid.

8. Note any specific issues related to existing North Dakota state mandates.

9. Note any issues where federal guidance is unclear and may impact the final decision.

10. Analyze whether the State should consider some other definition of the EHB package in North Dakota for plan years 2014 and 2015.

11. Would it be more or less beneficial in terms of premium costs to have stand-alone dental plans offered through the Exchange?

Item No. 1. Review all benchmark choices for North Dakota using the Bulletin released by HHS on December 16, 2011, including the type and level of benefits, the number of policies issued and lives covered.

The EHB package is defined by a benchmark plan that must be selected by each state by the third quarter of 2012. Under HHS' intended approach, states are permitted to select a single benchmark to serve as the standard for qualified health plans inside the Exchange operating in their state and plans offered in the individual and small group markets in their state. A state may not pick and choose on a benefit-by-benefit basis to customize their benchmark EHBs.

States may choose a benchmark plan from one of the following four benchmark plan types for 2014 and 2015:

1. The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;
2. Any of the largest three state employee health benefit plans by enrollment;
3. Any of the largest three national Federal Employees Health Benefits Plan (FEHBP) plan options by enrollment; or
4. The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state.

Note there are ten possible benchmark choices among the above four plan types. Based on information supplied by the NDID to INS, the following plans comprise the ten possible benchmark choices:

1. Largest non-grandfathered small group insurance products in North Dakota's small group market[ii]:

a) Medica Insurance Company. Medica Choice Passport (PPO). Latest enrollment figures from Centers for Medicare & Medicaid Services (CMS): 5,830.

b) Blue Cross Blue Shield of North Dakota. Classic Blue (PPO). Latest enrollment figures from CMS: 3,428.

c) Blue Cross Blue Shield of North Dakota. CompChoice 80 (PPO). Latest enrollment figures from CMS: 2,588.

2. Largest three state employee health benefit plans by enrollment[iii].

a) North Dakota Public Employees Retirement System (NDPERS). Health Care Coverage (grandfathered). Plans are issued by Blue Cross Blue Shield of North Dakota.

b) North Dakota Public Employees Retirement System. Health Care Coverage (non-grandfathered). Plans are issued by Blue Cross Blue Shield of North Dakota.

c) North Dakota Public Employees Retirement System. High deductible health plan. This benefit plan is a high deductible health plan designed to comply with Section 223 of the U.S. Internal Revenue Code and is intended for use with a Health Savings Account (HSA). Plans are issued by Blue Cross Blue Shield of North Dakota.

3. Largest three national Federal Employees Health Benefits Plans[iv] (FEHBP).

a) Blue Cross Blue Shield Standard Option (PPO).

b) Blue Cross Blue Shield Basic Option (PPO). Note that covered services are generally the same for BCBS Standard Option and BCBS Basic Option.

c) Government Employees Health Association, Inc. Benefit Plan. Sponsored and administered by the Government Employees Health Association, Inc.

4. Largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state[v].

a) The group Sanford Health Plan is the HMO option.

If a state fails to choose one of the benchmark plans, HHS intends to use as a default the largest plan by enrollment in the largest product in the state's small group market. For North Dakota, this is the Medica Choice Passport plan.

The Bulletin did not specify the definition of a plan. HHS subsequently provided guidance[vi] which clarified that a plan is a unique combination of benefits, which may include optional benefits available for an additional premium (often referred to as "riders") if those benefits are part of the most commonly purchased set of benefits within the product by enrollment.

The benefits outlined and discussed in this report for the Medica Choice Passport plan include many of such riders. Going forward, HHS will require insurers to submit requested benefit data on the largest plan by enrollment within that product. The largest plan by enrollment will be comprised of the most commonly purchased unique set of benefits, which may include riders. The Medica Choice Passport plan may not be considered as the largest plan by enrollment in the state's small group market under these new procedures.

Appendix C lists the ten benchmark choices for North Dakota and includes a listing of the type of benefits by each of the ten categories of services identified in the Act. INS was supplied copies of written documents describing plan benefits. These documents vary widely and some were formal documents providing comprehensive information while others were much less comprehensive. The language used in the documents is not standardized across insurers and, at times, is open to interpretation.

Item No. 2. Compare the benchmark choices to the HHS ten specified areas to determine the extent to which they provide coverage of the EHB package as defined in PPACA and subsequent guidance, and summarize the benefits that would have to be added to the potential EHB benchmark to be inclusive of the ten statutory categories.

Appendix C lists the ten benchmark choices for North Dakota and includes a listing of the general types of benefits by each of the ten categories of services identified in the Act. Of the ten benchmark plans, five are issued by Blue Cross Blue Shield of North Dakota (BCBSND) and two are Federal Employees Health Benefits Plans, which are sponsored and administered by the Blue Cross and Blue Shield Association. So, for these seven plans, benefits are similar.

The following is a discussion of the ten general benefit categories and the coverage provided relative to each of the ten benchmark choices. The discussion will focus on those benefits where coverage varies among the ten plans. If an item is not mentioned, it is due to the fact that coverage is provided by all ten benchmark plans and would be included in the EHB package regardless of the choice made. Items that are generally not covered by all benchmark choices and thus would not be considered in the benchmark package are indicated in Appendix G.

The following discussion is also summarized in Appendix E.

Category 1. Ambulatory Patient Service.

i) Accupressure/Acpuncture. These benefits are typically not covered. The Medica plan is the only one that provides acupressure benefits. The Medica and FEHBP plans do provide some acupuncture services.

ii) Biofeedback. Only the Medica plan and the two BCBSND small group insurance plans offer such services

iii) Preventive Dental Services and Oral Surgery. These benefits are typically not covered. The FEHBP plans do provide some preventive dental benefits. The FEHBP Basic plan provides more extensive benefits than the FEHBP Standard plan, but the Basic plan actually pays small first-dollar benefits for the covered services. The FEHBP Standard plan also provided some basic dental services. The Medica plan offers preventive dental services as an optional benefit. Only the Medica and the FEHBP plans also provide for the removal of impacted teeth.

iv) Hearing Exams. These benefits are not covered by the two small group BCBSND insurance products. The Medica, NDPERS, the FEHBP plans and the Sanford Health plan do provide some hearing testing benefits.

v) Infertility Treatment. Coverage varies in the benchmark plan options, with some plans covering infertility services and others not. Also, there is a variety of covered and non-covered infertility treatments. The small group and NDPERS insurance plans appear to offer the most benefits. The FEHBP plans cover only diagnostic services. The Sanford Health plan offers no infertility treatment services.

vi) Private Duty Nursing. Only the BCBSND small group and NDPERS insurance plans offer such services.

vii) Routine Eye Exams. Only the Medica plan offers such benefits.

viii) Eyeglasses following cataract surgery. All but the Sanford Health plan provide this benefit.

ix) Nutritional Counseling. The BCBSND small group, NDPERS and FEHBP insurance plans provide nutritional counseling services covered relative to itemized illnesses. The Sanford Health plan covers nutritional counseling in general, but only mentions diabetes.

Category 2. Emergency Services.

Similar emergency services are provided by each benchmark plan.

Category 3. Hospitalization.

i) Private Duty Nursing. Only the BCBSND small group and NDPERS insurance plans offer such services.

ii) Organ Transplants. All benchmark plans provide transplant services. Each plan lists the specific organs that are covered and appear to cover the major organs currently subject to transplants (e.g., heart, lung, liver, pancreas, kidney, cornea, bone marrow). Some plans further indicate that the list in the plan document is not a comprehensive list of eligible organ and bone marrow transplant services. There are differences with regard to coverage of ancillary services such as lodging, donor search and transportation.

Category 4. Maternity and Newborn Care.

i) Elective Abortions. Only the Medica plan provides benefits for elective abortions. Note that all plans provide benefits for medically necessary abortions.

ii) Contraceptives. All non-grandfathered benchmark choices with the exception of the Sanford Health plan cover some contraceptives. The NDPERS grandfathered plan does not offer contraceptive benefits. Beginning in August of 2012, women will have access to all FDA-approved contraceptive methods, education and counseling. Consequently, going forward all non-grandfathered benchmark plans will cover contraceptives.

Category 5. Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment.

i) Residential Treatment Services. Based on a review of the plan documents, it appears that the two FEHBP plans do not cover treatment in residential treatment centers.

ii) Detoxification - Only the Medica plan generally excludes benefits for detoxification. Exceptions are made for medically necessary services.

iii) Habilitative/Rehabilitative Service for Autism. The NDPERS and FEHBP plans do not specifically address autism. The Sanford Health plan does not cover autism habilitative services, but does provide benefits for autism rehabilitative services.

Category 6. Prescription Drugs.

All ten benchmark plans provide for prescription drugs. The actual drugs provided by each plan are contained in the plan's formulary. The formulary is a listing of both the brand name and generic prescription medications or drugs covered by the plan. Nonformulary drugs may be provided but with higher co-pays or coinsurance. Typically, the formulary is not part of the plan document and is made available to insureds on the company's website. Additional drugs may be periodically added or removed from the formulary. A plan's formulary often contains the medical terminology used for drugs and can be difficult to decipher by the average person.

Plan documents usually specify that certain specialty drugs are not covered.

i) Specialty Drugs – Infertility. Coverage varies in the benchmark plan options. The small group and NDPERS insurance plans appear to offer prescription drugs related to infertility treatment. The FEHBP plans and the Sanford Health plan offer no infertility treatment drugs.

ii) Specialty Drugs – Sexual Dysfunction. The FEHBP-GEHA and the Sanford Health plan offer no drugs for the treatment of sexual dysfunction.

iii) Specialty Drugs – Smoking/Tobacco Cessation. The NDPERS grandfathered plan does not offer smoking cessation drugs. The other nine plans do cover such drugs.

iv) Specialty Drugs – Weight Loss. The Medica and FEHBP plans do not cover weight loss drugs.

Category 7. Rehabilitative and Habilitative Services and Devices.

i) Hearing Aids. All plans with the exception of the Sanford Health plan provide for hearing aids to those under age 18. Only the FEHBP plans provide hearing aids for adults.

ii) Orthotics. All but the FEHBP-GEHA plan provides such benefits.

iii) Wigs and Scalp Prosthetics for hair loss due to chemotherapy. Only the FEHBP Standard and Basic plans cover this benefit.

Category 8. Laboratory Services.

i) Genetic Testing. All but the FEHBP-GEHA plan provides such benefits.

Category 9. Preventive and Wellness Services and Chronic Disease Management.

i) Smoking/Tobacco Cessation Services. The grandfathered NDPERS plan does not offer this benefit. The other nine do provide this benefit.

ii) Preventive Care for Women. The grandfathered NDPERS plan provides limited benefits which do not fulfill all the required benefits of the Act.

Category 10. Pediatric Services, Including Oral and Vision Care.

i) Pediatric Preventive Oral Services. Only the three FEHBP plans cover this. The Medica plan offers preventive dental services as an optional benefit.

ii) Pediatric Basic Oral Services. Only the FEHBP Standard and FEHBP Basic plans cover this.

iii) Pediatric Routine Eye Exams. The Medica and FEHBP plans cover this.

iv) Pediatric Dilated Eye Examination for Diabetes Related Diagnosis. All but the three FEHBP plans cover this.

v) Pediatric Eyeglasses or Contact Lenses Following Cataract Surgery. The Sanford Health plan does not cover this. The other nine plans do cover this.

vi) Pediatric Visual Services to Children under Age 10 for Amblyopia. The FEHBP-GEHA and the Sanford Health plans do not cover this benefit.

Item No. 3. Discuss the specific impact of any of the ten coverage areas that are not included in most North Dakota plans (i.e. habilitative services, pediatric vision and dental).

Section 1302(b)(2)(A) of the Act states: "The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary." Section 1302(a)(4)(C) of the Act states that: "In defining the essential health benefits under paragraph (1), the Secretary shall…take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups."

Three general areas have been defined as benefits that might be included in the definition of EHB but are generally not covered by typical health plans. These are:

i) Habilitative services;

ii) Pediatric vision services; and

iii) Pediatric dental services.

There would appear to be some inconsistencies in the Act with regard to services specified in the above three items. While the Act specifies that the scope of benefits provided should equal those under a typical employer plan (which typically may not cover habilitative, pediatric vision and pediatric dental care services), the Act singles out children as a segment of the population with special needs that should be addressed.

The EHB package might be thought of as a basic plan that would meet the statutory requirements of typical employer plans and any required expansion to the ten categories. However, without some constraint on the size of the EHB package, insurers may seek premium increases or have to alter benefit designs.

Habilitative Services

The term habilitative service is often not well defined and in general, health insurance plans do not identify habilitative services as a distinct group of services. Suggested definitions of habilitative services often focus on learning new skills or functions as distinguished from rehabilitation, which focuses on relearning existing skills or functions. As anticipated in the EHB Bulletin, most of the benchmark plan options do not cover habilitative services. This may be due to the lack of uniformity in defining habilitative services in the individual and small group health insurance market. Only the two BCBSND small group plans make any mention of habilitative benefits.

The National Association of Insurance Commissioners has proposed a definition of habilitative services as:

> "Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings."

Certain benefits such as physical therapy, occupational therapy, and speech therapy for habilitative purposes may be covered under the rehabilitation benefit of health insurance plans. The Bulletin discusses two alternative options under consideration:

1. A plan would be required to offer the same services for habilitative needs as it offers for rehabilitative needs and offer them at parity.
2. A plan would decide which habilitative services to cover and report the coverage to HHS. HHS would evaluate and further define habilitative services in the future.

Under either approach, a plan would be required to offer at least some habilitative benefits. HHS will be issuing additional guidance on the definition of coverage areas. This will be especially important for habilitative services.

Pediatric Services - General

Coverage of both dental and vision care services are typically not covered by health insurance plans. They may be provided through a mix of comprehensive health coverage plans and stand-alone coverage separate from the major medical coverage. Few Americans get their medical, vision and dental policies in one policy from the same carrier or benefits administrator. The Act does not specifically address providing dental or vision care services to adults. Oral and vision care services provided to adults, if any, would be included in Category 1 (ambulatory patient services). But the Act specifically identifies pediatric services, including oral and vision care in Category 10 (see Appendix A). One unanswered question is what limiting age would be used to define pediatric.

Pediatric Vision Services

The Bulletin indicates that for pediatric vision care, HHS is considering the proposal that the state would supplement the benchmark plan with the benefits covered in the Federal Employees Dental and Vision Insurance Program (FEDVIP) plans with the highest enrollment (the vision plan is identified by HHS as the FEP Blue Vision-High plan)[vii]. Under FEDVIP supplemental dental and vision benefits are made available to federal employees, retirees, and their dependents on an enrollee pay-all basis.

The following approaches to providing pediatric vision services can be considered:

1. Conclude that the overriding consideration is that any benefit should be the same as that under a typical employer plan and thus EHB would not include pediatric vision services more generous than those provided in a typical employer plan in the EHB definition.
2. Conclude that the overriding consideration is to recognize the special needs of children and provide for vision benefits within the EHB similar to that provided for in either a typical FEDVIP vision plan or Children's Health Insurance Program (CHIP). Using the CHIP program rather than a FEDVIP plan would ensure that all children receive the same vision benefits regardless of income levels.

Vision care services provided under a typical FEDVIP vision plan consist of routine diagnostic eye exams and the costs of prescription glasses or contact lenses. There are no additional benefits provided to children who are only covered if the federal employee chooses a family coverage option. Benefits provided under FEDVIP plans may not be suitable since they cover routine services not typically covered under a typical employer plan and make no special provisions addressing the special needs of children.

North Dakota's Children's Health Insurance Plan ("Healthy Steps") provides the following specific vision services:

i) Visual training for children under age 10;

ii) Dilated eye examination for diabetes-related diagnosis;

iii) Eyeglasses or contact lenses following a covered cataract surgery; and

iv) Visual training services, including orthoptics and pleoptic training, provided to children under age 10 for the treatment of amblyopia (commonly referred to as lazy eye).

Pediatric Dental Services.

For oral care today, most medical policies cover oral health assessments performed by pediatricians as part of well child visits and provide some coverage for oral care connected to medical conditions[viii]. Also, typical medical policies may already cover oral services such as oral health assessments and dental services related to accidents. It is of note that the Bulletin states that HHS' intention is not to include non-medically necessary orthodontic benefits in the EHB definition.

The Bulletin indicates that HHS is considering proposing that, for pediatric oral care, the state would supplement the benchmark plan with benefits from either:

1. The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment (identified by HHS as the MetLife Federal Dental Plan-High[ix]); or
2. The state's separate Children's Health Insurance Program (CHIP).

The following approaches to providing pediatric dental services can be considered:

1. Conclude that the overriding consideration is that any benefit should be the same as that under a typical employer plan and thus EHB would not include pediatric dental services more generous than those provided in a typical employer plan in the EHB definition.
2. Conclude that the overriding consideration is to recognize the special needs of children and provide for dental benefits within the EHB similar to that provided for in a Children's Health Insurance Program (CHIP). Using the CHIP program rather than a FEDVIP plan would ensure that all children receive the same dental benefits regardless of income levels.

Dental care services provided under a typical FEDVIP dental plan consist of extensive diagnostic and treatment services. There are no additional benefits provided to children who are only covered if the federal employee chooses a family coverage option. Benefits provided under FEDVIP plans may not be suitable since they cover services not typically covered under a typical employer plan and make no special provisions addressing the special needs of children.

North Dakota's Children's Health Insurance Plan ("Healthy Steps") provides the following specific dental services:

i) Dental services related to accidental injury;

ii) Dental anesthesia and hospitalization for dental care to children under age 9, children who are severely disabled or children who have a medical condition that requires hospitalization or general anesthesia.

Healthy Steps specifically excludes dental processes and related charges, including extraction of teeth, dental appliances, removal of impacted teeth, root canal therapy and other specified procedures.

Note that including in the EHB package pediatric dental services more generous than those provided in a typical employer plan would emphasize cost considerations over the comprehensiveness of EHB[x].

In the interest of evaluating supplemental pediatric dental plan options, INS has reviewed what it believes are the three dental options: the MetLife FEDVIP plan[xi], the dental benefits within the FEHBP BCBS Standard plan, and North Dakota's CHIP coverage. INS found the MetLife FEDVIP plan to be the richest benefit among the three, then the FEHBP BCBS Standard followed by the North Dakota CHIP benefits.

Item No. 4. Estimate the potential premium rate impact of adding currently noncovered benefits that will be required taking into account, among other things, the cost-sharing provisions associated with each benchmark plan.

Each of the possible ten benchmark plans excludes certain benefits that may be covered by the other plans. Appendix E lists the differences among the ten benchmark choices. Following is a brief discussion of the significant benefits missing from each plan and the potential benefits that might be added. Appendix F contains a complete list of the potential added benefits to each benchmark plan.

1. Medica Insurance Company. Medica Choice Passport. The significant benefits missing from this plan include basic dental services, in vitro fertilization and private duty nursing. According to the Centers for Disease Control (CDC), more than 99% of assisted reproductive technology procedures were for in vitro fertilization[xii]. Several of the benchmark plans also do not cover in vitro fertilization. The costs associated with these benefits are typically high. Most of the other missing benefits appear to have relatively low incidence rates and/or moderate benefit costs. Preventive dental services can be added as an option.

2. Blue Cross Blue Shield of North Dakota. Classic Blue. With the possible exception of dental services, there do not appear to be many significant benefits missing from this plan. Most of the other missing benefits appear to have relatively low incidence rates and/or moderate benefit costs.

3. Blue Cross Blue Shield of North Dakota. CompChoice. The benefits missing from this plan are very similar to those for the Classic Blue plan.

4. North Dakota Public Employees Retirement System. Health Care Coverage (grandfathered). The significant benefits missing from this plan include dental services and preventive care for women as promulgated by the Act. The costs associated with these benefits are typically high. This plan is a grandfathered plan and is not required to cover all benefits covered by the Act. Most of the other missing benefits appear to have relatively low incidence rates and/or moderate benefit costs.

5. North Dakota Public Employees Retirement System. Health Care Coverage (non-grandfathered). A significant benefit missing from this plan includes dental services. The other benefits missing from this plan are very similar to those for the BCBSND Classic Blue plan. Most of the other missing benefits appear to have relatively low incidence rates and/or moderate benefit costs.

6. North Dakota Public Employees Retirement System. High deductible health plan. The benefits missing from this plan are very similar to those for the non-grandfathered plan (#5).

7. FEHBP Blue Cross Blue Shield Standard Option. The significant benefits missing from this plan include artificial insemination, in vitro fertilization, private duty nursing and residential treatment for mental health and substance abuse disorders. The costs associated with these benefits are typically high. Most of the other missing benefits appear to have relatively low incidence rates and/or moderate benefit costs. Since this is a national plan, there are several North Dakota mandated benefits not included.

8. FEHBP Blue Cross Blue Shield Basic Option. The benefits missing from this plan are very similar to those for the FEHBP Blue Cross Blue Shield Standard Option (#7).

9. FEHBP Government Employees Health Association, Inc. Benefit Plan. The significant benefits missing from this plan include basic dental services, artificial insemination, in vitro fertilization, private duty nursing and genetic testing. The costs associated with these benefits are typically high. Most of the other missing benefits appear to have relatively low incidence rates and/or moderate benefit costs. Since this is a national plan, there are several North Dakota mandated benefits not included.

10. Sanford Health Plan. There are numerous benefits missing from this plan some of which have high associated costs. The large number of missing benefits would likely mean a significant increase in costs if they were to be added.

Appendix G contains a list of benefits not included in any potential EHB package. These benefits are not covered by any of the ten benchmark plans. There appears to be very little justification for including any of these benefits in the EHB package.

Item No. 5. Consider the cost to the state of a potential EHB benchmark plan that does not include North Dakota mandated benefits.

The Affordable Care Act requires states to defray the costs of state-mandated benefits in Qualified Health Plans (QHPs) that are in excess of the EHB. If a state were to choose a benchmark plan that does not include all state-mandated benefits, the Affordable Care Act would require the state to defray the cost of those mandated benefits in excess of EHB as defined by the selected benchmark.

By choosing a benchmark plan that includes the state mandated services, a state can avoid having to make a choice between covering such services with state funds or repealing existing mandates for the small group and individual markets.

Item #8 includes a discussion of the North Dakota mandated benefits. Appendix C lists the ten benchmark choices for North Dakota and includes a listing of the type of benefits by each of the ten categories of services identified in the Act. With the notable exception of the FEHBP plans, North Dakota's benefit mandates are included in the plans from which the state will be able to select as the benchmark plan.

Item No. 6. Consider the capacity of both individual and group health plans in their ability to provide the potential EHB benchmark plan. Capacity could be assessed by considering:

i) Network adequacy in terms of the ability of plans to deliver the EHBs and

ii) Whether the EHB package is too rich for plan sustainability and premium affordability in the North Dakota marketplace.

Network adequacy refers to a health plan's ability to meet the medical needs of its enrollees by providing reasonable access to a sufficient number of in-network primary care and specialty physicians, as well as all other health care services for which benefits are included under the terms of the health care contract.

The Act requires HHS to establish criteria for the certification of health plans as QHP. The regulations include certain specified criteria that a plan must satisfy in order to be certified as a QHP and, as such, eligible to be offered on an Exchange. Among the criteria listed is criteria related to plan network adequacy requirements. Specifically, as related to network adequacy, the Act requires the certification criteria to:

i) Ensure a sufficient choice of providers, and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers; and

ii) Include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals.

Blue Cross Blue Shield of North Dakota has indicated to INS that they believe their plans maintain a network adequate to deliver the EHBs.

Item No. 7. Consider the impact, if any, of individuals moving to and from Medicaid.

The Act requires that state Medicaid programs cover all individuals under age 65 with incomes at or below 138% of the Federal Poverty Level (FPL) effective January 1, 2014. Currently, Medicaid does not cover adults who do not have dependent children and who are not disabled, regardless of income. The Supreme Court ruled on June 28, 2012 that the Medicaid expansion was constitutional as long as states would not lose all their existing federal funding if they choose not to expand coverage as called for in the Act. States now have the option of not expanding the Medicaid program.

This expansion of Medicaid will extend coverage to large numbers of the nation's uninsured population, especially adults, since children from poor families may already be covered under states' CHIP programs.

The implications of the expansion include:

1. Increase in the number of Medicaid enrollees.
2. Reduction in the number of uninsured.
3. The federal government will pay a large share of new Medicaid costs in all states.
4. Increases in state spending.

The numbers of Medicaid enrollees are expected to increase due to:

1. The increase in the number of people eligible.
2. Migration from employer and individual coverage. Some who now have employer sponsored or individual coverage may see Medicaid as a preferred alternative, due to low or no premiums, better benefits, and lower or no cost sharing.
3. Fewer eligible people falling through the cracks due to the publicity surrounding the Act and

the Exchanges. As people start to use the Exchanges expecting to enroll in private insurance plans, they will find that they may be eligible for Medicaid instead.

Under the Act, the federal government will finance the majority of spending for those newly eligible for Medicaid. The federal funding to the states for all new eligible enrollees will be 100% in 2014 to 2016. Future federal financing levels are 95% in 2017, 94% in 2018, 93% in 2019 and 90% for 2020 and subsequent years.

The Kaiser Commission on Medicaid and the Uninsured issued a report[xiii] in May, 2010 and estimated anywhere from 29,000 to 40,000 new enrollees in North Dakota by 2019. The higher estimate assumes higher participation in the program due to more aggressive outreach campaigns by community-based organizations and the federal and state governments. This report also estimated that total funding by North Dakota during the period from 2014 to 2019 would range from $32 million to $57 million[xiv]. Another study[xv] puts the cost for the similar period at $88 million.

One of the many unknowns in any such analysis is the effect of individuals who are eligible under the old rules but did not enroll and who may now enroll because of the publicity surrounding the Act and the Exchanges. The NDID indicated that federal funding under the old rules will be approximately 52% in North Dakota for fiscal year 2014. This would imply that the state's costs will rise even if it opts out of the expansion.

The Act contains a provision that offers states the option of implementing a more affordable alternative to health insurance Exchanges – the Basic Health Plan (BHP). A BHP is a Medicaid-like insurance plan targeted at people with incomes just above Medicaid levels (up to 200% of FPL) and for certain legal immigrants. A state may be able to integrate BHP, Medicaid, and CHIP into a single, rebranded program serving all uninsured residents with incomes up to 200 percent FPL. If

North Dakota were to implement a BHP, this could affect the Medicaid population depending on the design of the program.

Item No. 8. Note any specific issues related to existing North Dakota state mandates.

A provision of the Act pertains to a state's benefit mandates that affect the selection of the benchmark essential health benefits packages. According to the Affordable Care Act, if a state requires benefits that exceed those included in the essential health benefits package, then the state has to directly pay the cost of these additional mandates.

Except for the FEHBP plans, North Dakota's benefit mandates are included in the other plans from which the state will be able to select as the benchmark plan. Under the benchmark approach adopted by HHS, a state can avoid having to pay any extra cost by choosing as its benchmark plan one that includes all benefits mandated for the small group and individual markets in the state.

A discussion of the relevant North Dakota mandates are contained in Appendix B. Appendix C also indicates which mandated benefits are provided for each of the ten benchmark choices. All ten benchmark plans cover the mandated benefits with the following exceptions:

i) 26.1-36-06.1. Coverage for off-label uses of drugs. It was not always easy to ascertain from the plan documents whether this mandate was being complied with.

ii) 26.1-36-07. Health insurance coverage for newborn and adopted children. The FEHBP plans cover newborns, but it is unclear whether they comply with the mandate since there is no mention of the thirty-one day notice.

iii) 26.1-36-08. Group health policy and health service contract substance abuse coverage. The FEHBP Standard and Basic plans do not provide residential benefits.

iv) 26.1-36-09.1. Mammogram examination coverage. The FEHBP plans make no mention of required mammograms by age.

v) 26.1-36-09.3. Coverage for treatment of certain disorders. The FEHBP-GEHA plan does not comply with this mandate since surgical treatment is not covered.

vi) 26.1-36-09.6. Prostate-specific antigen test coverage. The Medica plan, the FEHBP Standard and Basic plans indicate that tests are covered but make no mention of required tests by age.

vii) 26.1-36-09.7. Foods and food products for inherited metabolic diseases. The FEHBP-GEHA plan does not comply with this mandate.

viii) 26.1-36-09.9. Dental anesthesia and hospitalization coverage. All three of the FEHBP plans do not comply with this mandate.

Item No. 9. Note any issues where federal guidance is unclear and may impact the final decision.

INS noted several areas where current guidance is unclear:

Balance Comprehensiveness and Affordability for Those Purchasing Coverage.

As noted earlier, there would appear to be some inconsistencies in the Act with regard to services specified in some of the ten general benefit categories. While the Act specifies that the scope of benefits provided should equal those under a typical employer plan, the Act singles out specific benefit categories and specific segments of the population with special needs that should be addressed. HHS has also indicated that one of its goals is to balance comprehensiveness and affordability for those purchasing coverage.

Defray the Costs of State-Mandated Benefits.

HHS has not yet clarified how it will assess financial liability for state benefit mandates. The Act does not specify and HHS has offered no guidance as to how this money will be paid or where it will go.

Ensure Compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

The Bulletin included this as one of HHS' general goals in pursuing an approach to define EHB. Mental health and substance use disorder services, including behavioral health treatment, comprise one of the ten General Benefit Categories (see Appendix A). However, little specific guidance was included in the Bulletin.

Historically, many health insurance plans provided far less coverage for mental health services compared to physical health (medical/surgical) services. MHPAEA requires private health

insurance plans to provide equal coverage for mental and physical health services. MHPAEA does not exclude any mental and substance use disorders diagnoses. Under the federal law, parity requirements apply to all services covered by a health plan.

It is of note that MHPAEA does not require private health insurance plans to include mental health benefits, only that if such benefits are included they must be treated on an equal footing with physical health benefits.

Habilitative Services.

Habilitative services are included in one of the ten general benefit categories (see Appendix A). As indicated earlier in this report, the term habilitative service is often not well defined and in general, health insurance plans do not identify habilitative services as a distinct group of services.

Pediatric Dental and Vision Services.

Coverage of both dental and vision care services are typically not covered by health insurance plans. However, pediatric oral and vision services are included in one of the ten general benefit categories (see Appendix A). A fundamental unanswered question is what limiting age should be used to define pediatric. North Dakota's CHIP program covers children who are 18 years of age or younger. In absence of any guidance from HHS, North Dakota might want to use 18 as the limiting age when defining pediatric services.

Item No. 10. Analyze whether the state should consider some other definition of the EHB package in North Dakota for plan years 2014 and 2015.

As indicated in the Bulletin, the specific set of benchmark benefits selected in the third quarter of 2012 would apply for plan years 2014 and 2015. This approach for 2014 and 2015 would provide a transition period for states to coordinate their benefit mandates while minimizing the likelihood the state would be required to pay the costs of these mandates in excess of EHB. A consistent set of benefits across these two years would limit market disruption during this transition period. As indicated in the Bulletin, HHS' intention is to propose a process for updating EHB in future rulemaking and intends to revisit this approach for plan years starting in 2016.

The Bulletin offers few options with regard to the process for determining the EHB package for plan years 2014 and 2015. However, if the designated benchmark plan does not include benefits in all ten required EHB categories, the state may supplement the benchmark plan by selecting missing benefits from other benchmark options for that state.

The original benchmark selection will only be in effect for two years (until 2016), which would allow time for further consideration and monitoring of the effects on the marketplace. Since the small group plans may have benefits common in the individual market, one could argue that the small group commercial plans offer the best opportunity to mitigate market disruption.

Item No. 11. Would it be more or less beneficial in terms of premium costs to have stand-alone dental plans offered through the Exchange?

Dental Insurance is typically not included in medical insurance policies and is typically sold as a separate policy. Roughly 98% of those with dental coverage in the U.S. have a dental policy separate from their medical policy[xvi]. Virtually all Americans with a dental policy obtain it through some kind of group – a large or small employer, union or public program[xvii].

It can be argued that dental benefits fail as an insurance benefit. To be insurable a risk must be low frequency, high economic impact and out of the control of the insured. Dental benefits fail all three criteria[xviii]. Dental insurance can be successful in the group market since it benefits from certain tax advantages. The employer can deduct the premium as a business expense and the employee does not have to report the value of the benefit as taxable income. Dental insurance bought by individuals will not have the same advantages.

Another concern with dental insurance sold in the individual market is from the selling companies' perspective. Because the timing of the receipt of dental benefits is under the control of the insured (the insurance question as discussed in the previous paragraph), the antiselection associated with dental insurance can be a significant problem. Group dental benefits typically include coinsurance percentages, annual deductibles and maximum benefits. When the individual is paying the entire premium, these cost sharing items may seem inappropriate from the buyer's perspective. Carriers will face a challenge in designing products that provide meaningful benefits, at an affordable cost and that control the antiselection problem.

With regard to stand-alone dental plans, a state can decide to allow or not allow dental plans to be sold on its Exchange. Furthermore, if dental plans are allowed to be sold on its Exchange, a

state could also decide that dental plans could not be sold anywhere but on its Exchange. When a stand-alone dental policy is offered on the Exchange, the Exchanges must also allow carriers to offer their EHB package without pediatric oral services[xix]. This might be an argument against offering stand-alone dental plans on the Exchange.

There is the issue of transparency with respect to cost if a separate dental plan is offered in the Exchange. Transparency could be achieved by requiring medical plans that integrate dental services in their medical policies to also offer a medical policy without dental services. This would require carriers that choose to offer dental policies to also offer a separately priced child-only dental policy covering just the required pediatric oral services in the EHB package.

Allowing stand-alone dental plans to be sold on the Exchange could lead to confusion concerning how consumers purchase pediatric oral services. This is especially true if consumers in a household with children are allowed to select a policy not covering pediatric oral services. Stand-alone dental plans could be purchased outside of the Exchange.

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Appendix A - Essential Health Benefits - Ten General Benefit Categories

(1) Ambulatory patient services (medical care provided to outpatients).

(2) Emergency services.

(3) Hospitalization.

(4) Maternity and newborn care.

(5) Mental health and substance use disorder services, including behavioral health treatment.

(6) Prescription drugs.

(7) Rehabilitative and habilitative services and devices.

(8) Laboratory services.

(9) Preventive and wellness services and chronic disease management.

(10) Pediatric services, including oral and vision care.

Appendix B – North Dakota's Mandates

The relevant North Dakota state mandates are discussed below. Generally, North Dakota's mandates cover both individual and group plans. The exceptions are #1, #4 and, #5 which apply to group plans only.

1. **26.1-36-06. Group health policy and medical service contract options for drugs and chiropractic care.** Plans must provide for all drugs and medicines prescribed by the provider of health services and services provided by chiropractors.

   Each of the ten benchmark plans provides coverage for prescription drugs and services provided by chiropractors.

2. **26.1-36-06.1. Coverage for off-label uses of drugs**. Plans cannot exclude coverage of a drug on the grounds the drug has not been approved by the federal Food and Drug administration if the drug is recognized for treatment of the condition in one of the standard reference compendia or medical literature.

   It was not always easy to ascertain from the plan documents whether this mandate was being complied with. For example, the BCBSND plans refer only to "All FDA approved Prescription Medications or Drugs." The NDPERS plans (which are BCBSND plans) contain similar language. The Medica plan document indicates "Medica utilizes medication request guidelines to determine whether a drug should be considered a covered drug." It is reasonable to presume that all plans currently issued by North Dakota companies would comply with all North Dakota mandates. The FEHBP plans make no mention of the eligibility requirements for drugs on their formulary.

3. **26.1-36-07. Health insurance coverage for newborn and adopted children - Scope of coverage - Notification of birth or adoption.** Plans must provide benefits for a newly born child of the insured from the moment of birth or from the date of physical placement by a licensed child placement agency with respect to an adopted child. Notice must be given within thirty-one days after the date of birth or date of adoption.

The BCBSND, NDPERS and Sanford Health plans comply with the mandate. The FEHBP plans cover newborns, but it is unclear whether they comply with the mandate since there is no mention of the thirty-one day notice.

4. **26.1-36-08. Group health policy and health service contract substance abuse coverage.** Requires inpatient treatment, treatment by partial hospitalization, and outpatient treatment for the diagnosis, evaluation, and treatment of alcoholism, drug addiction, or other related illness. Note that 26.1-36-08.1 provides for an alternative to 26.1-36-08 with different required days of service and includes residential treatment.

Additionally, this mandate requires the following coverages:

Benefit	Inpatient	Partial Hospitalization	Outpatient
Required days per year	60	120	20 visits

Or, 26.1-36-08.1 requires:

Benefit	Inpatient	Partial Hospitalization	Outpatient	Residential
Required days per year	45	120	20 visits	60

These are simplifications of the actual requirements since inpatient treatment benefits may be traded for treatment by partial hospitalization. In addition, plans must provide

benefits of the same type offered under the policy or contract for other types of illnesses as required by the Mental Health Parity Act.

Generally, plans comply with this mandate by providing benefits for substance abuse that are similar to those for other illnesses and make no mention of maximum days or visits. The exception is the FEHBP Standard and Basic plans, which do not provide residential benefits.

5. **26.1-36-09. Group health policy and health service contract mental disorder coverage.** Requires inpatient treatment, treatment by partial hospitalization, residential treatment, and outpatient treatment for health services relating to the diagnosis, evaluation, and treatment of mental disorder and other related illness.

Additionally, this mandate requires the following coverages:

Benefit	Inpatient	Partial Hospitalization	Outpatient	Residential
Required days per year	45	120	30 hours	120

These are simplifications of the actual requirements since insureds requiring residential treatment service beyond the minimum of 120 days may trade unused inpatient treatment benefits provided for inpatient benefits. In addition, plans must provide benefits, of the same type offered under the policy or contract for other types of illnesses as required by the Mental Health Parity Act.

Generally, plans comply with this mandate by providing benefits for mental disorders that are similar to those for other illnesses and make no mention of maximum days

or visits. The exception is the FEHBP Standard and Basic plans which do not provide residential benefits.

6. **26.1-36-09.1. Mammogram examination coverage.** Requires baseline mammogram examination for each woman who is at least thirty-five but less than forty years of age and one mammogram examination every year, or more frequently if ordered by a physician, for each woman who is at least forty years of age.

   The BCBSND, NDPERS and Sanford Health plans comply with the mandate and contain language that mirrors the mandate itself. Medica refers to "other imaging services" and "routine screening procedures for cancer" but there is no mention of required mammograms by age. Likewise, the FEHBP plans indicate "breast cancer tests (mammograms)" and no mention of required mammograms by age.

7. **26.1-36-09.2. Involuntary complications of pregnancy coverage.** Plans may not exclude, reduce, or otherwise limit (e.g., deductibles, or coinsurance provisions), with regard to involuntary complications of pregnancy.

   Each of the ten benchmark plans provides coverage for complications of pregnancy.

8. **26.1-36-09.3. Coverage for treatment of certain disorders.** Plans must provide coverage for surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder (CMD). Benefits for the coverage may be limited to a lifetime maximum of ten thousand dollars per person for surgery, and two thousand five hundred

dollars for nonsurgical treatment. Under the Act, plans may not establish lifetime limits on the dollar value of benefits for any participant or beneficiary.

The FEHBP-GEHA plan does not comply with this mandate since surgical treatment is not covered. Otherwise, the remaining benchmark plans provides coverage for TMJ.

9. **26.1-36-09.6. Prostate-specific antigen test coverage.** Plans must provide an annual digital rectal examination and a prostate-specific antigen (PSA) test for an asymptomatic male aged fifty and over, a black male aged forty and over, and a male aged forty or over with a family history of prostate cancer.

The BCBSND, NDPERS and Sanford Health plans comply with the mandate and contain language that mirrors the mandate itself. Medica covers routine screening procedures for cancer but makes no specific mention of PSA test or coverage by age. Likewise, the FEHBP Standard and Basic plans indicate that Prostate Specific Antigen (PSA) tests are covered and no mention of required mammograms by age. Annual coverage of one PSA test for men age 40 and older is covered by the FEHBP GEHA and thus complies with the mandate.

10. **26.1-36-09.7. Foods and food products for inherited metabolic diseases**. Plans must provide coverage for medical foods and low-protein modified food products determined by a physician to be medically necessary for the therapeutic treatment of an inherited metabolic disease. Inherited metabolic disease means maple syrup urine disease (MSUD) or phenylketonuria (PKU). This section applies to any covered individual born after December 31, 1962.

The FEHBP-GEHA plan does not comply with this mandate. Otherwise, the remaining benchmark plans provides coverage for TMJ.

11. **26.1-36-09.8. Post-delivery coverage for mothers and newborns.** Plans must provide inpatient care for at least forty-eight hours for a mother and her newborn child following a normal vaginal delivery, and inpatient care for at least ninety-six hours following a caesarean section. Plans must provide inpatient care in excess of forty-eight hours following a vaginal delivery and ninety-six hours following a caesarean section if the stay is determined to be reasonable and medically necessary.

Each of the ten benchmark plans provides coverage for post-delivery coverage for mothers and newborns and for the required hours.

12. **26.1-36-09.9. Dental anesthesia and hospitalization coverage.** Plans must provide benefits for anesthesia and hospitalization for dental care provided to a covered individual who is a child under age nine, is severely disabled, or who has a medical condition and requires hospitalization or general anesthesia for dental care treatment.

All three of the FEHBP plans do not comply with this mandate. Otherwise, the remaining benchmark plans provide the prescribed dental anesthesia and hospitalization coverage.

13. **26.1-36-09.10. Prehospital emergency medical services**. Plans must provide prehospital emergency medical services benefits in the case of an emergency medical condition.

Each of the ten benchmark plans provides coverage for prehospital emergency medical services.

14. **26.1-36-09.11. Breast reconstruction surgery**. Plans must provide the benefit provisions of the federal Women's Health and Cancer Rights Act of 1998. Under this Act mastectomy benefits must include coverage for reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications at all stages of a mastectomy.

    Each of the ten benchmark plans provides coverage for breast reconstruction surgery.

15. **26.1-36-09.12. Medical services related to suicide.** Plans must provide benefits for injury or illness resulting from suicide, attempted suicide, or self-inflicted injury.

    Each of the ten benchmark plans are presumed to provide benefits for injury or illness resulting from suicide, since no specific mention of exclusion is made.

16. **26.1-36-09.13. Medical services related to intoxication.** Plans must provide benefits for illness resulting from any loss sustained or contracted in the consequence of the insured's being intoxicated or under the influence of any narcotic.

    Each of the ten benchmark plans are presumed to provide benefits for injury or illness resulting from being intoxicated, since no specific mention of exclusion is made.

Appendix C – Comparison of Ten Benchmark Choices.

Four Benchmark Plan Types

1. The largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;
2. Any of the largest three State employee health benefit plans by enrollment;
3. Any of the largest three national Federal Employees Health Benefits Program FEHBP plan options by enrollment;
4. The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

Appendix C – Comparison of Ten Benchmark Choices.

			1.	2.	3.	4.	5.	6.	7.	8.	9.	10.		
			Small Group Insurance Plans			ND State Employee Health Plans			Federal Employee Health Benefit Plans			HMO		
Major Benefit Category		Benefit Subcategories	Medica Choice Passport (I)	BCBSND Classic Blue NGF	BCBSND Comp Choice NGF	BCBSND NDPERS PPO GF	BCBSND NDPERS NGF	BCBSND NDPERS HDHP NGF	FEHBP - BCBS Standard	FEHBP - BCBS Basic	FEHBP - GEHA	Sanford Health Plan	Federal Default Plan*	Healthy Steps (ND) - Reference
1.	Ambulatory Patient Services	Primary Care Office Visits	X	X	X	X	X	X	X	X	X	X	X	
		Specialist Office Visits	X	X	X	X	X	X	X	X	X	X	X	
		Acupressure	X	NC	NC	NC	NC	NC	NC	NC	NC	NC	X	
		Acupuncture	X	NC	NC	NC	NC	NC	X	X	X	NC	X	
		Allergy Services	X	X	X	X	X	X	X	X	X	X	X	
		Bereavement Counseling.	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Biofeedback	X	X	X	NC	NC	NC	NC	NC	NC	NC	X	
		Chemotherapy	X	X	X	X	X	X	X	X	X	X	X	
		Chiropractor Services #1	X	X	X	X	X	X	X	X	X	X	X	
		Cosmetic Surgery	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Dental Related Services (Other than pediatric)	(v)										(v)	
		Preventive dental services (exams, cleaning)	X-opt	NC	NC	NC	NC	NC	X	X	X	NC	X-opt	
		Basic dental services (fillings, periodontal disease, etc.)	NC	NC	NC	NC	NC	NC	X	NC	NC	NC	NC	
		Dental Services Related to Accident	X	X	X	X	X	X	X	X	X	X	X	
		Oral Surgery – removal of impacted teeth	X	NC	NC	NC	NC	NC	X	X	X	NC	X	
		Oral Surgery for Cleft Lip/Palate	X	X	X	X	X	X	X	X	X	X	X	
		Orthodontia	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Orthognathic Surgery (correcting deformities of the jaw)	X	X	X	X	X	X	X	X	X	X	X	
		Diagnostic Services	X	X	X	X	X	X	X	X	X	X	X	
		Hearing Exams	X	NC	NC	X	X	X	X	X	X	X	X	
		Home Health Care	X	X	X	X	X	X	X	X	X	X	X	
		Home Infusion Therapy	X	X	X	X	X	X	X	X	X	X	X	
		Homeopathy	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Hospice	X	X	X	X	X	X	X	X	X	X	X	
		Infertility												
		Artificial insemination	X	X	X	X	X	X	NC	NC	NC	NC	X	
		Donor eggs, sperm	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		in vitro fertilization	NC	X	X	X	X	X	NC	NC	NC	NC	NC	
		Services to diagnose infertility	X	X	X	X	X	X	X	X	X	X	X	
		Services to treat underlying cause of infertility	X	X	X	X	X	X	X	X	X	NC	X	
		Preimplantation genetic diagnosis testing	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Surrogacy	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Injuries from criminal activity (felony	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Marital Counseling	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Nutritional Supplements (other than to sustain life)	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Outpatient Infusion Therapy	X	X	X	X	X	X	X	X	X	X	X	
		Outpatient Surgery	X	X	X	X	X	X	X	X	X	X	X	
		Private Duty Nursing	NC	X	X	X	X	X	NC	NC	NC	NC	NC	
		Radiation Therapy	X	X	X	X	X	X	X	X	X	X	X	
		Reconstructive/Restorative Surgery (non-cosmetic)	X	X	X	X	X	X	X	X	X	X	X	
		Renal Dialysis	X	X	X	X	X	X	X	X	X	X	X	
		Routine Podiatry	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Second opinion (surgery)	X	X	X	X	X	X	X	X	X	X	X	

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	Sterilization - Voluntary												
	Men	X	X	X	X	X	X	X	X	X	X	X	
	Women	X	X	X	X	X	X	X	X	X	X	X	
	Reversal of sterilization	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
	Medical services related to suicide #15	X	X	X	X	X	X	X	X	X	X	X	
	Medical services related to intoxication #16	X	X	X	X	X	X	X	X	X	X	X	
	Treatment of Temporomandibular Joint disorder (TMJ) - #8	X	X	X	X	X	X	X	X	Xsurg	X	X	
	Urgent Care Services	X	X	X	X	X	X	X	X	X	X	X	
	Vision Services												
	Routine Eye Exams	X	NC	NC	NC	NC	NC	NC	NC	NC	NC	X	
	Eyeglasses or contact lenses	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
	Eyeglasses or contact lenses following a covered cataract surgery	X	X	X	X	X	X	X	X	X	NC	X	
	Refractive Eye surgery (e.g. Lasik)	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
	Nutritional Counseling												
	Anorexia	X	X	X	X	X	X	X	X	X	NC	X	
	Bulimia	X	X	X	X	X	X	X	X	X	NC	X	
	Chronic Renal Failure	X	X	X	X	X	X	X	X	X	NC	X	
	Diabetes	X	X	X	X	X	X	X	X	X	X	X	
	Gestational Diabetes	X	X	X	X	X	X	X	X	X	NC	X	
	Hyperlipidemia	X	X	X	X	X	X	X	X	X	NC	X	
	Hypertension	X	X	X	NC	X	X	X	X	X	NC	X	
	Obesity	X	X	X	X	X	X	X	X	X	X	X	
	Phenylketonuria (PKU)	X	X	X	X	X	X	X	X	X	X	X	

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2.	Emergency Services	Physician Charges	X	X	X	X	X	X	X	X	X	X	X	
		Facility Charges (Room, Imaging Testing and Supplies)	X	X	X	X	X	X	X	X	X	X	X	
		Ambulance												
		Ground - #13	X	X	X	X	X	X	X	X	X	X	X	
		Air - #13	X	X	X	X	X	X	X	X	X	X	X	

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3.	Hospitalization	Inpatient Hospital (includes anesthesia, bed, board, general nursing services, diagnostic services and surgery)	X	X	X	X	X	X	X	X	X	X	X	
		Inpatient Medical	X	X	X	X	X	X	X	X	X	X	X	
		Bariatric/Obesity Surgery	X	X	X	X	X	X	X	X	X	X	X	
		Medical services related to suicide #15	X	X	X	X	X	X	X	X	X	X	X	
		Medical services related to intoxication #16	X	X	X	X	X	X	X	X	X	X	X	
		Reconstructive Breast Surgery (Non-cosmetic) -#14	X	X	X	X	X	X	X	X	X	X	X	
		Private Duty Nursing	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Skilled Nursing	X	X	X	X	X	X	X	X	X	X	X	
		Organ Transplants	(iv)										(iv)	
		Surgery	X	X	X	X	X	X	X	X	X	X	X	
		Delivery of donor organ	X	X	X	X	X	X	X	X	X	X	X	
		Removal of donor organ	X	X	X	X	X	X	X	X	X	X	X	
		Transportation of recipient	X	X	X	X	X	X	NC	NC	X	X	X	
		Donor search	X	NC	NC	NC	NC	NC	NC	NC	NC	NC	X	
		Lodging	X	NC	NC	NC	NC	NC	NC	NC	X	X	X	

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4.	Maternity & Newborn Care	Medically necessary abortion	X	X	X	X	X	X	X	X	X	X	X	
		Elective abortion	X	NC	NC	NC	NC	NC	NC	NC	NC	NC	X	
		Birthing centers	X	NC	NC	NC	NC	NC	NC	NC	NC	NC	X	
		Delivery by Mid-wife in home	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Circumcision	X	X	X	X	X	X	X	X	X	X	X	
		Complications of pregnancy - #7	X	X	X	X	X	X	X	X	X	X	X	
		Delivery	X	X	X	X	X	X	X	X	X	X	X	
		Postdelivery (mothers & newborn) -#11	X	X	X	X	X	X	X	X	X	X	X	
		Neonatal Intensive Care	X	X	X	X	X	X	X	X	X	X	X	
		Newborn Child Coverage - #3	X	X	X	X	X	X	X	X	X	X	X	
		Normal pregnancy, newborn nursery & care	X	X	X	X	X	X	X	X	X	X	X	
		Post Partum Care	X	X	X	X	X	X	X	X	X	X	X	
		Prenatal Care	X	X	X	X	X	X	X	X	X	X	X	
		Contraceptives												
		Implanted	X-wph	X-wph	X-wph	NC	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	
		Injectable	X-wph	X-wph	X-wph	NC	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	
		Oral	X-wph	X-wph	X-wph	NC	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	

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5.	Mental Health & Substance Use Disorder Services including Behavioral Health Treatment	Inpatient Mental Health - #5	X	X	X	X	X	X	X	X	X	X	X	
		Outpatient Mental Health - #5	X	X	X	X	X	X	X	X	X	X	X	
		Inpatient Substance Abuse - #4	X	X	X	X	X	X	X	X	X	X	X	
		Outpatient Substance Abuse - #4	X	X	X	X	X	X	X	X	X	X	X	
		Inpatient Residential Treatment Ctr - #4, #5	X	X	X	X	X	X	NC	NC	X	X	X	
		Partial Day Hospitalization	X	X	X	X	X	X	X	X	X	X	X	
		Freestanding Rehab Facility	X	X	X	X	X	X	X	X	X	X	X	
		Supervised Living	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Applied Behavior Analysis	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Group therapy	X	X	X	X	X	X	X	X	X	X	X	
		Learning Disorders/Behavioral Problems	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Psychiatric services	X	X	X	X	X	X	X	X	X	X	X	
		Psychological Testing	X	X	X	X	X	X	X	X	X	X	X	
		Detoxification	NC	X	X	X	X	X	X	X	X	NC	NC	
		Autism Services												
		Habiltative Therapies	X	X	X	NC	NC	NC	NC	NC	NC	NC	X	
		Rehabilitative Therapies	X	X	X	NC	NC	NC	NC	NC	NC	X	X	

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6.	Prescription Drugs - #1, #2	Brand Drug - #1	X	X	X	X	X	X	X	X	X	X	X	
		Generic Drug - #1	X	X	X	X	X	X	X	X	X	X	X	
		Recognized for the particular treatment -#2												
		Specialty Drugs - see note.	(iii)									(iii)	(iii)	
		Drugs for hair loss	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Growth Hormones	X	X	X	X	X	X	X	X	X	X	X	
		Infertility Drugs	X	X	X	X	X	X	NC	NC	NC	NC	X	
		Medical Foods – PKU - #10	X	X	X	X	X	X	X	X	NC	X	X	
		Prenatal Vitamins	X	X	X	X	X	X	X	X	X	X	X	
		Sexual Dysfunction Drugs	X	X	X	X	X	X	X	X	NC	NC	X	
		Smoking/Tobacco Cessation Drugs	X	X	X	NC	X	X	X	X	X	X	X	
		Weight Loss Drugs	NC	X	X	X	X	X	NC	NC	NC	X	NC	

Note: Plan's Formulary will determine covered and noncovered drugs

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7.	Rehabilitative & Habilitative Services & Devices	Cardiac Rehabilitation	X	X	X	X	X	X	X	X	X	X	X	
		Habilitative for congenital or birth defect	X	X	X	X	X	X	X	X	X	X	X	
		Rehabilitation/Habilitative for disability from medical condition	X	X	X	X	X	X	X	X	X	X	X	
		Massage Therapy	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Occupational Therapy following medical surgery, injury, illness	X	X	X	X	X	X	X	X	X	X	X	
		Outpatient Physical Therapy	X	X	X	X	X	X	X	X	X	X	X	
		Pulmonary Rehabilitation	X	X	X	X	X	X	X	X	X	X	X	
		Respiratory Therapy Services	X	X	X	X	X	X	X	X	X	X	X	
		Speech Therapy following medical surgery, injury, illness	X	X	X	X	X	X	X	X	X	X	X	
		Speech Therapy to correct speech impediment	X	X	X	X	X	X	X	X	X	X	X	
		Therapies for job training	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Therapy for general conditioning	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Medical Equipment & Supplies	(ii)										(ii)	
		Breast Prosthesis	X	X	X	X	X	X	X	X	X	X	X	
		Cochlear implants	X	X	X	X	X	X	X	X	X	X	X	
		Diabetes (blood glucose monitors, testing, etc.)	X	X	X	X	X	X	X	X	X	X	X	
		Hearing Aids (less than age 18)	X	X	X	X	X	X	X	X	X	NC	X	
		Hearing aids (18 +)	NC	NC	NC	NC	NC	NC	X	X	X	NC	NC	
		Home exercise or therapy equipment	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Items of Personal Comfort, Convenience, or hygiene items (humidifiers, raised toilet seats, shower chairs)	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Orthotics and special footwear (Medically Appropriate and Necessary)	X	X	X	X	X	X	X	X	NC	X	X	
		Ostomy Supplies	X	X	X	X	X	X	X	X	X	X	X	
		Oxygen	X	X	X	X	X	X	X	X	X	X	X	
		Pools, whirlpools, spas, hydrotherapy	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Prosthetics	X	X	X	X	X	X	X	X	X	X	X	
		Replacement or repair of HME (Home Medical Equipment?)	X	X	X	X	X	X	X	X	X	X	X	
		Wigs and Scalp Prosthetics for hair loss due to chemotherapy	NC	NC	NC	NC	NC	NC	X	X	NC	NC	NC	

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8.	Laboratory Services	Diagnostic (Lab, X-ray, Imaging, etc.)	X	X	X	X	X	X	X	X	X	X	X	
		Genetic Testing	X	X	X	X	X	X	X	X	NC	X	X	

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9.	Preventive & Wellness Services & Chronic Disease Mgmt	Colorectal Cancer Screening	X	X	X	X	X	X	X	X	X	X	X	
		Diabetic Education	X	X	X	X	X	X	X	X	X	X	X	
		Mammography - # 6	X	X	X	X	X	X	X	X	X	X	X	
		Osteoporosis screening	X	X	X	NC	X	X	X	X	X	X	X	
		Personal items such as health club memberships, exercise equipment, personal trainers	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Preventive Health Mandated by ACA (Immunizations, well child and adult care)	X	X	X	X	X	X	X	X	X	X	X	
		Prostate Specific Antigen (PSA) - #9	X	X	X	X	X	X	X	X	X	X	X	
		Smoking/Tobacco Cessation Services	X	X	X	NC	X	X	X	X	X	X	X	
		Weight Control (obesity) Programs (Other than weight control drugs)	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
		Preventive Care for Women (8/1/2012)												
		Minimum one well-woman preventive visit (gynecological exam) annually	X-wph	X-wph	X-wph	NC	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	
		Screening for gestational diabetes between 24 and 28 wks	X-wph	X-wph	X-wph	NC	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	
		Screening for gestational diabetes at 1st prenatal visit at high risk for diabetes	X-wph	X-wph	X-wph	NC	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	
		HPV testing > 29 y/o every 3 years if normal pap	X-wph	X-wph	X-wph	NC	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	
		Annual counseling on sexually transmitted infections for all sexually active women	X-wph	X-wph	X-wph	NC	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	
		Annual screening for HIV for sexually active women	X-wph	X-wph	X-wph	NC	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	
		Contraceptive methods and counseling	X-wph	X-wph	X-wph	NC	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	
		Lactation support and counseling by a trained provider	X-wph	X-wph	X-wph	NC	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	
		Rental of Lactation Equipment	X-wph	X-wph	X-wph	NC	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	
		Screening & counseling for interpersonal and domestic violence	X-wph	X-wph	X-wph	NC	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph	

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10.	Pediatric Services, including oral and vision care	Pediatric Oral Services												
		Preventive dental services (exams, cleaning	X-opt	NC	NC	NC	NC	NC	X	X	X	NC	X-opt	NC
		Basic dental services (fillings, periodontal disease, etc.)	NC	NC	NC	NC	NC	NC	X	X	NC	NC	NC	NC
		Dental Services Related to Accidental Injur	X	X	X	X	X	X	X	X	X	X	X	X
		Dental anesthesia and hospitalization for dental care to children under age 9, children who are severely disabled or children who have a medical condition that requires hospitalization or general anesthesia.- #12	X	X	X	X	X	X	X	X	X	X	X	X
		Pediatric Vision Care												
		Routine Eye Exams	X	NC	NC	NC	NC	NC	X	X	X	NC	X	NC
		Eyeglasses or contact lenses	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
		Dilated eye examination for diabetes related diagnosis	X	X	X	X	X	X	NC	NC	NC	X	X	X
		Eyeglasses or contact lenses following a covered cataract surgery	X	X	X	X	X	X	X	X	X	NC	X	X
		Visual training services, including orthoptics and pleoptic training, provided to children under age 10 for the treatment of amblyopia	X	X	X	X	X	X	X	X	NC	NC	X	X
		Metabolic formula & low protein food for inborn errors of metabolism	X	X	X	X	X	X	X	X	X	X	X	X

X = Covered services that may be subject to medical policy or limitations of the benefit plan such as visit limits or dollar maximums.

X-opt = Covered as an optional benefit

X-wph = Covered or will be covered effective August 2012 as a result of provisions in ACT relative to women and preventive health.

NC = Non coverec

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Appendix C – Comparison of Ten Benchmark Choices.

		1.	2.	3.	4.	5.	6.	7.	8.	9.	10.		
		Small Group Insurance Plans			ND State Employee Health Plans			Federal Employee Health Benefit Plans			HMO		
Major Benefit Category	Benefit Subcategories	Medica Choice Passport [i]	BCBSND Classic Blue NGF	BCBSND Comp Choice NGF	BCBSND NDPERS PPO GF	BCBSND NDPERS NGF	BCBSND NDPERS HDHP NGF	FEHBP - BCBS Standard	FEHBP - BCBS Basic	FEHBP - GEHA	Sanford Health Plan	Federal Default Plan*	Healthy Steps (ND) - Reference

Notes

(i) Medica supplied document with bracketed (variable) items. INS assumed that coverage would include all possible benefits offered.

(ii) Medica does not include the list of eligible durable medical equipment in the Certificate of Coverage. Must call Customer Service to receive current list.

(iii) Company uses a Formulary, which was not provided.

(iv) Medica covers supplies and services related to transplants only if authorized by Medica under their medical criteria which can be reviewed and updated.

(v) Medica provides for an optional benefit for preventive dental services which is not assumed here.

* Medica Choice Passport (Largest Plan by Enrollment in the Largest Product in the State Small Group Marke

Explanation of ND state mandates

1. §26.1-36-06 – Chiropractic mandate. Group health policy and medical service contract options for drugs and chiropractic car

2. §26.1-36-06.1 - coverage for off-label uses of prescription drugs cannot be denied if the drug is recognized for the particular treatment in standard medical reference materials or literature

3. §26.1-26-07 – newborn coverage is required for the first 30 days from birth

4. §26.1-36-08 - substance abuse coverage (e.g., inpatient - 60 days per calendar year; partial hospitalization - 120 days per calendar year; outpatient - 20 visits per calendar year) Visit limits no longer permissible with Mental Health Parity Act

5. §26.1-36-09 - mental disorder coverage (e.g., inpatient - 45 days per calendar year; partial hospitalization - 120 days per calendar year; residential treatment - 120 days per calendar year; outpatient - 30 hours per calendar year) Also cannot impose cost share for the first five visits. Visit limits no longer permissible with Mental Health Parity Act

6. §26.1-36-09.1 - Mammogram examination coverage. One baseline mammogram examination for each woman who is at least thirty-five but less than forty years of age. One mammogram examination every year, or more frequently if ordered by a physician, for each woman who is at least forty years of age

7. §26.1-36-09.2 – coverage for involuntary complications of pregnancy

8. §26.1-36-09.3 – TMJ mandate. FEHBP does not have dollar limits. Also ND mandate only applies to "individual products" should it be considered a mandate for this listing since the benchmarks are based on small group products?)

9. §26.1-36-09.6 - Annual digital rectal examination and prostate-specific antigen test coverage. Male aged fifty and over, a black male aged forty and over, and a male aged forty or over with a family history of prostate canc

10. §26.1-36-09.7 - coverage for medical foods and low-protein modified food products determined by a physician to be medically necessary for the therapeutic treatment of an inherited metabolic disease (e.g., maple syrup urine disease or phenylketonuria) (FEHBP does not have a dollar limit.

11. §26.1-36-09.8 - post-delivery coverage for mothers and newborns (e.g., 48 hours following normal vaginal delivery and 96 hours following caesarean sectior

12. §26.1-36-09.9 - coverage for anesthesia and hospitalization for dental care for covered individual who is under age nine, is severely disabled or has a medical condition and requires dental anesthesia and hospitalization. FEHBP covers to age 22.

13. §26.1-36-09.10 - prehospital emergency services benefits in the case of an emergency medical conditior

14. §26.1-36-09.11 - breast reconstruction surgery coverage

15. §26.1-36-09.12 – services for an injury or illness resulting from suicide, attempted suicide or self-inflicted injur

16. §26.1-36-09.13 – subject to certain limitations, services for an injury or illness resulting from the member's being intoxicated or under the influence of any narcot

Appendix D – Limits Other than Co-pay or Coinsurance

Appendix D – Limits Other Than Co-pay or Coinsurance

	Major Benefit Category	Benefit Subcategories	1. Small Group Insurance Plans: Medica Choice Passport [1]	2. Small Group Insurance Plans: BCBSND Classic Blue NGF	3. Small Group Insurance Plans: BCBSND Comp Choice NGF	4. ND State Employee Health Plans: BCBSND NDPERS PPO GF	5. ND State Employee Health Plans: BCBSND NDPERS NGF	6. ND State Employee Health Plans: BCBSND NDPERS HDHP NGF	7. Federal Employee Health Benefit Plans: FEHBP - BCBS Standard	8. Federal Employee Health Benefit Plans: FEHBP - BCBS Basic	9. Federal Employee Health Benefit Plans: FEHBP - GEHA	10. HMO: Sanford Health Plan
1.	Ambulatory Patient Services	Acupuncture	X	NC	NC	NC	NC	NC	24 visits per yr	24 visits per yr	20 procedues per yr	NC
		Chiropractor Services- #1	X	X	X	X	X	X	12 maniputaive visits per yr / 1 office visit per yr	12 maniputaive visits per yr / 1 office visit per yr	12 maniputaive visits per yr	20 visits per yr
		Preventive dental services (exams, cleaning)	X-opt	NC	NC	NC	NC	NC	X	X	X	NC
		Hearing Exams	X	NC	NC	X	X	X	X	X	X	X
		Home Health Care	120 visits per yr / 56 hrs per week	8 hrs/day	8 hrs/day	8 hrs/day	8 hrs/day	8 hrs/day	2 hrs per day / 25 visits per yr	2 hrs per day / 25 visits per yr	X	4 hrs per day / 40 visits per yr
		Hospice	X	X	X	X	X	X	X	X	X	X
		Infertility	$5,000 annual limit for infertility services. Infertility drugs annual limit of $3,000	$20,000 lifetime per member	$20,000 lifetime per member	$20,000 lifetime per member	$20,000 lifetime per member	$20,000 lifetime per member	X	X	X	X
		Treatment of Temporomandibular Joint disorder (TMJ) - #8	Lifetime max $10,000 surgical; $2,500 nonsurgical	Lifetime max $10,000 surgical; $2,500 nonsurgical	Lifetime max $10,000 surgical; $2,500 nonsurgical	Lifetime max $10,000 surgical; $2,500 nonsurgical	Lifetime max $10,000 surgical; $2,500 nonsurgical	Lifetime max $10,000 surgical; $2,500 nonsurgical	X	X	Xsurg	X
		Nutritional Counseling	determined by physician	4 visits per yr	4 visits per yr	1 to 4 visits per yr varies by condition	2 to 4 visits per yr varies by condition	2 to 4 visits per yr varies by condition				

X = Covered services but limits not indicated in documentatior
NC = Non covered
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3.	Hospitalization	Bariatric/Obesity Surgery	X	1 procedure per member per lifetime	1 procedure per member per lifetime	1 procedure per member per lifetime	1 procedure per member per lifetime	1 procedure per member per lifetime	X	X	X	X
		Skilled Nursing	X	X	X	X	X	X	X	X	X	30 days per 12 month period
		Organ Transplants	X	2 per condition	2 per condition	2 per condition	2 per condition	2 per condition	X	X	X	X

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Appendix D – Limits Other Than Co-pay or Coinsurance

	Major Benefit Category	Benefit Subcategories	1. Small Group Insurance Plans: Medica Choice Passport [1]	2. Small Group Insurance Plans: BCBSND Classic Blue NGF	3. Small Group Insurance Plans: BCBSND Comp Choice NGF	4. ND State Employee Health Plans: BCBSND NDPERS PPO GF	5. ND State Employee Health Plans: BCBSND NDPERS NGF	6. ND State Employee Health Plans: BCBSND NDPERS HDHP NGF	7. Federal Employee Health Benefit Plans: FEHBP - BCBS Standard	8. Federal Employee Health Benefit Plans: FEHBP - BCBS Basic	9. Federal Employee Health Benefit Plans: FEHBP - GEHA	10. HMO: Sanford Health Plan
6.	Prescription Drugs - #1, #2	Medical Foods – PKU - #10	$3,000 per member per yr	$3,000 per member per yr	$3,000 per member per yr	$3,000 per member per yr	$3,000 per member per yr	$3,000 per member per yr	X	X	NC	$3,000 per member per yr

X = Covered services but limits not indicated in documentatior
NC = Non covered
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7.	Rehabilitative & Habilitative Services & Devices	Cardiac Rehabilitation	X	12 visits per episode	12 visits per episode	12 visits per episode	12 visits per episode	12 visits per episode	X	X	X	30 visirs per year
		Rehabilitation/Habilitative for disability from medical condition	X	X	X	X	X	X	X	X	X	X
		Occupational Therapy following medical surgery, injury, illness	X	90 days per condition *	90 days per condition *	90 days per condition *	90 days per condition *	90 days per condition *	75 visits per year	50 visits per year	60 visits per yr	30 visirs per year
		Outpatient Physical Therapy	X	90 days per condition *	90 days per condition *	X	X	X	75 visits per year	50 visits per year	60 visits per yr	30 visirs per year
		Pulmonary Rehabilitation	X	3 visits per lifetime	3 visits per lifetime	3 visits per lifetime	3 visits per lifetime	3 visits per lifetime	X	X	X	X
		Respiratory Therapy Services	X	X	X	X	X	X	X	X	X	X
		Speech Therapy following medical surgery, injury, illness	X	90 days per condition *	90 days per condition *	90 days per condition *	90 days per condition *	90 days per condition *	75 visits per year	50 visits per year	30 visits per yr	30 visirs per year
		Speech Therapy to correct speech impediments	X	90 days per condition *	90 days per condition *	90 days per condition *	90 days per condition *	90 days per condition *	75 visits per year	75 visits per year	30 visits per yr	30 visirs per year
		Hearing Aids (less than age 18)	1 every 3 yrs	$3,000 per 3 yrs.	$3,000 per 3 yrs.	$3,000 per 3 yrs.	$3,000 per 3 yrs.	$3,000 per 3 yrs.	$1,250 per ear, per yr	$1,250 per ear, per yr	1 every 5 yrs	NC
		Hearing aids (18 +)	NC	NC	NC	NC	NC	NC	$1,250 per ear, per yr	$1,250 per ear, per yr	1 every 5 yrs	NC
		Orthotics and special footwear (Medically Appropriate	X	X	X	X	X	X	X	X	NC	X
		Wigs and Scalp Prosthetics for hair loss due to chemotherapy	NC	NC	NC	NC	NC	NC	1 per lifetime	1 per lifetime	NC	NC

* Additional days for rehabilitative obly (not habilitative) if medically appropriate and necessary

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Appendix D – Limits Other Than Co-pay or Coinsurance

			1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
			Small Group Insurance Plans			ND State Employee Health Plans			Federal Employee Health Benefit Plans			HMO
	Major Benefit Category	Benefit Subcategories	Medica Choice Passport [1]	BCBSND Classic Blue NGF	BCBSND Comp Choice NGF	BCBSND NDPERS PPO GF	BCBSND NDPERS NGF	BCBSND NDPERS HDHP NGF	FEHBP - BCBS Standard	FEHBP - BCBS Basic	FEHBP - GEHA	Sanford Health Plan
9.	Preventive & Wellness Services & Chronic Disease	Colorectal Cancer Screening	X	1 every 10 yrs	1 every 10 yrs	X	1 every 10 yrs	1 every 10 yrs	1 per yr	1 per yr	X	X
		Diabetic Education	X	X	X	X	X	X	X	X	X	2 comprehensive per lifetime
		Mammography - # 6	X	equals ND #6	equals ND #6	equals ND #6	equals ND #6	equals ND #6	X	X	X	equals ND #6
		Osteoporosis screening	X	X	X	NC	X	X	X	X	X	X
		Preventive Health Mandated by ACA (well child care)	X	no. visits (1-7) varies by age	no. visits (1-7) varies by age	no. visits (1-7) varies by age	no. visits (1-7) varies by age	no. visits (1-7) varies by age	X	X	X	X
		Preventive Health Mandated by ACA (well adult care)	X	1 per yr.	1 per yr.	1 per yr.	1 per yr.	1 per yr.	X	X	X	X
		Prostate Specific Antigen (PSA) - #9	X	equals ND #9	equals ND #9	equals ND #9	equals ND #9	equals ND #9	1 per yr	1 per yr	1 per yr	equals ND #9
		Smoking/Tobacco Cessation Services	X	2 quit attempts per yr	2 quit attempts per yr	NC	2 quit attempts per yr	2 quit attempts per yr	X	X	X	1 per lifetime

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10.	Pediatric Services, including oral and vision care	Dilated eye examination for diabetes related diagnosis	X	1 per yr.	1 per yr.	1 per yr.	1 per yr.	1 per yr.	NC	NC	NC	X
		Visual training services, including orthoptics and pleoptic training, provided to children under age 10 for the treatment of amblyopia	X	16 visits per member per lifetime	16 visits per member per lifetime	16 visits per member per lifetime	16 visits per member per lifetime	16 visits per member per lifetime	X	X	NC	NC

X = Covered services but
NC = Non covered
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Explanation of ND state mandates

6. §26.1-36-09.1 - Mammogram examination coverage. One baseline mammogram examination for each woman who is at least thirty-five but less than forty years of age. One mammogram examination every year, or more frequently if ordered by a physician, for each woman who is at least forty years of age
9. §26.1-36-09.6 - Annual digital rectal examination and prostate-specific antigen test coverage. Male aged fifty and over, a black male aged forty and over, and a male aged forty or over with a family history of prostate cancer.

Appendix E – Differences Among Ten Benchmark Choices.

Appendix E – Differences Among Ten Benchmark Choices.

			1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
			Small Group Insurance Plans			ND State Employee Health Plans			Federal Employee Health Benefit Plans			HMO
	Major Benefit Category	Benefit Subcategories	Medica Choice Passport [1]	BCBSND Classic Blue NGF	BCBSND Comp Choice NGF	BCBSND NDPERS PPO GF	BCBSND NDPERS NGF	BCBSND NDPERS HDHP NGF	FEHBP - BCBS Standard	FEHBP - BCBS Basic	FEHBP - GEHA	Sanford Health Plan
1.	Ambulatory Patient Services	Acupressure	X	NC	NC	NC	NC	NC	NC	NC	NC	NC
		Acupuncture	X	NC	NC	NC	NC	NC	X	X	X	NC
		Biofeedback	X	X	X	NC	NC	NC	NC	NC	NC	NC
		Dental Related Services (Other than pediatric)										
		Preventive dental services (exams, cleaning)	X-opt	NC	NC	NC	NC	NC	X	X	X	NC
		Basic dental services (fillings, periodontal disease, etc.)	NC	NC	NC	NC	NC	NC	X	NC	NC	NC
		Oral Surgery – removal of impacted teeth	X	NC	NC	NC	NC	NC	X	X	X	NC
		Hearing Exams	X	NC	NC	X	X	X	X	X	X	X
		Artificial insemination	X	X	X	X	X	X	NC	NC	NC	NC
		in vitro fertilization	NC	X	X	X	X	X	NC	NC	NC	NC
		Services to treat underlying cause of infertility	X	X	X	X	X	X	X	X	X	NC
		Private Duty Nursing	NC	X	X	X	X	X	NC	NC	NC	NC
		Treatment of Temporomandibular Joint disorder (TMJ)	X	X	X	X	X	X	X	X	Xsurg	X
		Routine Eye Exams	X	NC	NC	NC	NC	NC	NC	NC	NC	NC
		Eyeglasses or contact lenses following a covered cataract surgery	X	X	X	X	X	X	X	X	X	NC
		Nutritional Counseling	All	All	All	Most	All	All	All	All	All	Some

X = Covered services that may be subject to medical policy or limitations of the benefit plan such as visit limits or dollar maximums
X-opt = Covered as an optional benefit
X-wph = Covered or will be covered effective August 2012 as a result of provisions in ACT relative to women and preventive health
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3.	Hospitalization	Organ Transplants										
		Transportation of recipient	X	X	X	X	X	X	NC	NC	X	X
		Donor search	X	NC	NC	NC	NC	NC	NC	NC	NC	NC
		Lodging	X	NC	NC	NC	NC	NC	NC	NC	X	X

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Appendix E – Differences Among Ten Benchmark Choices.

	Major Benefit Category	Benefit Subcategories	1. Small Group Insurance Plans: Medica Choice Passport [i]	2. Small Group Insurance Plans: BCBSND Classic Blue NGF	3. Small Group Insurance Plans: BCBSND Comp Choice NGF	4. ND State Employee Health Plans: BCBSND NDPERS PPO GF	5. ND State Employee Health Plans: BCBSND NDPERS NGF	6. ND State Employee Health Plans: BCBSND NDPERS HDHP NGF	7. Federal Employee Health Benefit Plans: FEHBP - BCBS Standard	8. Federal Employee Health Benefit Plans: FEHBP - BCBS Basic	9. Federal Employee Health Benefit Plans: FEHBP - GEHA	10. HMO: Sanford Health Plan
4.	Maternity & Newborn Care	Elective abortion	X	NC	NC	NC	NC	NC	NC	NC	NC	NC
		Contraceptives	X-wph	X-wph	X-wph	NC	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph

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5.	Mental Health & Substance Use Disorder Services including Behavioral Health Treatment	Inpatient Residential Treatment Ctr - #4, #5	X	X	X	X	X	X	NC	NC	X	X
		Detoxification	NC	X	X	X	X	X	X	X	X	NC
		Autism Services										
		Habiltative Therapies	X	X	X	NC	NC	NC	NC	NC	NC	NC
		Rehabilitative Therapies	X	X	X	NC	NC	NC	NC	NC	NC	X

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6.	Prescription Drugs	Specialty Drugs - see note.										
		Infertility Drugs	X	X	X	X	X	X	NC	NC	NC	NC
		Medical Foods – PKU - #10	X	X	X	X	X	X	X	X	NC	X
		Sexual Dysfunction Drugs	X	X	X	X	X	X	X	X	NC	NC
		Smoking/Tobacco Cessation Drugs	X	X	X	NC	X	X	X	X	X	X
		Weight Loss Drugs	NC	X	X	X	X	X	NC	NC	NC	X

Note: Plan's Formulary will determine covered and noncovered drugs

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7.	Rehabilitative & Habilitative Services & Devices	Medical Equipment & Supplies										
		Hearing Aids (less than age 18)	X	X	X	X	X	X	X	X	X	NC
		Hearing aids (18 +)	NC	NC	NC	NC	NC	NC	X	X	X	NC
		Orthotics and special footwear (Medically Appropriate and Necessary)	X	X	X	X	X	X	X	X	NC	X
		Wigs and Scalp Prosthetics for hair loss due to chemotherapy	NC	NC	NC	NC	NC	NC	X	X	NC	NC

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8.	Laboratory Services	Genetic Testing	X	X	X	X	X	X	X	X	NC	X

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9.	Preventive & Wellness Services & Chronic Disease Mgmt	Smoking/Tobacco Cessation Services	X	X	X	NC	X	X	X	X	X	X
		Preventive Care for Women (8/1/2012)	X-wph	X-wph	X-wph	NC	X-wph	X-wph	X-wph	X-wph	X-wph	X-wph

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10.	Pediatric Services, including oral and vision care	Pediatric Oral Services										
		Preventive dental services (exams, cleaning)	X-opt	NC	NC	NC	NC	NC	X	X	X	NC
		Basic dental services (fillings, periodontal disease,	NC	NC	NC	NC	NC	NC	X	X	NC	NC
		Pediatric Vision Care										
		Routine Eye Exams	X	NC	NC	NC	NC	NC	X	X	X	NC
		Dilated eye examination for diabetes related diagnosis	X	X	X	X	X	X	NC	NC	NC	X
		Eyeglasses or contact lenses following a covered cataract surgery	X	X	X	X	X	X	X	X	X	NC
		Visual training services, including orthoptics and pleoptic training, provided to children under age 10 for the treatment of amblyopia.	X	X	X	X	X	X	X	X	NC	NC

X = Covered services that may be subject to medical policy or limitations of the benefit plan such as visit limits or dollar maximums
X-opt = Covered as an optional benefit
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Appendix F – Benefits Not Covered But Included In Other Potential Benchmark Plans.

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This Appendix lists for each of the ten potential benchmark plans those benefits not covered by the plan that are covered by another potential benchmark plan. Initial guidance regarding Essential Health Benefits did not list any specific benefits that would be required within each of the categories of coverage. The final rule regarding Essential Health Benefits has not been released. If the Department of Health and Human Services does require coverage for specific benefits in the final rule this Appendix outlines potential additions to each of the ten potential benchmark plans.

Plan	Major Benefit Category	Benefit Subcategories
1. Medica Choice Passport	1. Ambulatory Patient Services	Basic dental services (fillings, periodontal disease, etc.) in vitro fertilization Private Duty Nursing
	5. Mental Health & Substance Use Disorder Services including Behavioral Health Treatment	Detoxification
	6. Prescription Drugs	Weight Loss Drugs
	7. Rehabilitative & Habilitative Services & Devices	Hearing aids (18 +) Wigs and Scalp Prosthetics for hair loss due to chemotherapy
	10. Pediatric Services, including oral and vision care	Preventive dental services - option (exams, cleaning) Dilated eye examination for diabetes related diagnosis

Appendix F - Benefits Not Covered But Included In Other Potential Benchmark Plans.

This Appendix lists for each of the ten potential benchmark plans those benefits not covered by the plan that are covered by another potential benchmark plan. Initial guidance regarding Essential Health Benefits did not list any specific benefits that would be required within each of the categories of coverage. The final rule regarding Essential Health Benefits has not been released. If the Department of Health and Human Services does require coverage for specific benefits in the final rule this Appendix outlines potential additions to each of the ten potential benchmark plans.

Plan	Major Benefit Category	Benefit Subcategories
2. BCBSND Classic Blue NGF	1. Ambulatory Patient Services	Acupressure Acupuncture Preventive dental services (exams, cleaning) Basic dental services (fillings, periodontal disease, etc.) Oral Surgery – removal of impacted teeth Hearing Exams Routine Eye Exams
	3. Hospitalization	Lodging Related to Transplants
	4. Maternity & Newborn Care	Elective abortion
	7. Rehabilitative & Habilitative Services & Devices	Hearing aids (18 +) Wigs and Scalp Prosthetics for hair loss due to chemotherapy
	10. Pediatric Services, including oral and vision care	Preventive dental services (exams, cleaning) Basic dental services (fillings, periodontal disease, etc.) Routine Eye Exams

Appendix F - Benefits Not Covered But Included In Other Potential Benchmark Plans.

This Appendix lists for each of the ten potential benchmark plans those benefits not covered by the plan that are covered by another potential benchmark plan. Initial guidance regarding Essential Health Benefits did not list any specific benefits that would be required within each of the categories of coverage. The final rule regarding Essential Health Benefits has not been released. If the Department of Health and Human Services does require coverage for specific benefits in the final rule this Appendix outlines potential additions to each of the ten potential benchmark plans.

Plan	Major Benefit Category	Benefit Subcategories
3. BCBSND Comp Choice NGF	1. Ambulatory Patient Services	Acupressure Acupuncture Preventive dental services (exams, cleaning) Basic dental services (fillings, periodontal disease, etc.) Oral Surgery – removal of impacted teeth Hearing Exams Routine Eye Exams
	3. Hospitalization	Lodging Related to Transplants
	4. Maternity & Newborn Care	Elective abortion
	7. Rehabilitative & Habilitative Services & Devices	Hearing aids (18 +) Wigs and Scalp Prosthetics for hair loss due to chemotherapy
	10. Pediatric Services, including oral and vision care	Preventive dental services (exams, cleaning) Basic dental services (fillings, periodontal disease, etc.) Routine Eye Exams

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Plan	Major Benefit Category	Benefit Subcategories
4. BCBSND NDPERS PPO GF	1. Ambulatory Patient Services	Acupressure Acupuncture Biofeedback Preventive dental services (exams, cleaning) Basic dental services (fillings, periodontal disease, etc.) Oral Surgery – removal of impacted teeth Routine Eye Exams Nutritional Counseling - Hypertension
	3. Hospitalization	Lodging Related to Transplants
	4. Maternity & Newborn Care	Elective abortion Contraceptives
	6. Prescription Drugs	Smoking/Tobacco Cessation Drugs
	7. Rehabilitative & Habilitative Services & Devices	Hearing aids (18 +) Wigs and Scalp Prosthetics for hair loss due to chemotherapy
	9. Preventive & Wellness Services & Chronic Disease Mgmt	Smoking/Tobacco Cessation Services Preventive Care for Women (8/1/2012)
	10. Pediatric Services, including oral and vision care	Preventive dental services (exams, cleaning) Basic dental services (fillings, periodontal disease, etc.) Routine Eye Exams

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Plan	Major Benefit Category	Benefit Subcategories
5. BCBSND NDPERS NGF	1. Ambulatory Patient Services	Acupressure Acupuncture Biofeedback Preventive dental services (exams, cleaning) Basic dental services (fillings, periodontal disease, etc.) Oral Surgery – removal of impacted teeth Routine Eye Exams
	3. Hospitalization	Lodging Related to Transplants
	4. Maternity & Newborn Care	Elective abortion
	7. Rehabilitative & Habilitative Services & Devices	Hearing aids (18 +) Wigs and Scalp Prosthetics for hair loss due to chemotherapy
	10. Pediatric Services, including oral and vision care	Preventive dental services (exams, cleaning) Basic dental services (fillings, periodontal disease, etc.) Routine Eye Exams

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Plan	Major Benefit Category	Benefit Subcategories
6. BCBSND NDPERS HDHP NGF	1. Ambulatory Patient Services	Acupressure Acupuncture Biofeedback Preventive dental services (exams, cleaning) Basic dental services (fillings, periodontal disease, etc.) Oral Surgery – removal of impacted teeth Routine Eye Exams
	3. Hospitalization	Lodging Related to Transplants
	4. Maternity & Newborn Care	Elective abortion
	7. Rehabilitative & Habilitative Services & Devices	Hearing aids (18 +) Wigs and Scalp Prosthetics for hair loss due to chemotherapy
	10. Pediatric Services, including oral and vision care	Preventive dental services (exams, cleaning) Basic dental services (fillings, periodontal disease, etc.) Routine Eye Exams

Appendix F - Benefits Not Covered But Included In Other Potential Benchmark Plans.

This Appendix lists for each of the ten potential benchmark plans those benefits not covered by the plan that are covered by another potential benchmark plan. Initial guidance regarding Essential Health Benefits did not list any specific benefits that would be required within each of the categories of coverage. The final rule regarding Essential Health Benefits has not been released. If the Department of Health and Human Services does require coverage for specific benefits in the final rule this Appendix outlines potential additions to each of the ten potential benchmark plans.

Plan	Major Benefit Category	Benefit Subcategories
7. FEHBP - BCBS Standard	1. Ambulatory Patient Services	Acupressure Biofeedback Artificial insemination in vitro fertilization Private Duty Nursing Routine Eye Exams
	3. Hospitalization	Transportation of Recipient Related to Transplants Lodging Related to Transplants
	4. Maternity & Newborn Care	Elective abortion
	5. Mental Health & Substance Use Disorder Services including Behavioral Health Treatment	Inpatient Residential Treatment Ctr - #4, #5
	6. Prescription Drugs	Infertility Drugs Weight Loss Drugs
	10. Pediatric Services, including oral and vision care	Dental anesthesia and hospitalization for dental care to children - #12

Appendix F - Benefits Not Covered But Included In Other Potential Benchmark Plans.

This Appendix lists for each of the ten potential benchmark plans those benefits not covered by the plan that are covered by another potential benchmark plan. Initial guidance regarding Essential Health Benefits did not list any specific benefits that would be required within each of the categories of coverage. The final rule regarding Essential Health Benefits has not been released. If the Department of Health and Human Services does require coverage for specific benefits in the final rule this Appendix outlines potential additions to each of the ten potential benchmark plans.

Plan	Major Benefit Category	Benefit Subcategories
8. FEHBP - BCBS Basic	1. Ambulatory Patient Services	Acupressure Biofeedback Basic dental services (fillings, periodontal disease, etc.) Artificial insemination in vitro fertilization Private Duty Nursing Routine Eye Exams
	3. Hospitalization	Transportation of Recipient Related to Transplants Lodging Related to Transplants
	4. Maternity & Newborn Care	Elective abortion
	5. Mental Health & Substance Use Disorder Services including Behavioral Health Treatment	Inpatient Residential Treatment Ctr - #4, #5
	6. Prescription Drugs	Infertility Drugs Weight Loss Drugs
	10. Pediatric Services, including oral and vision care	Dental anesthesia and hospitalization for dental care to children - #12

Appendix F - Benefits Not Covered But Included In Other Potential Benchmark Plans.

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Plan	Major Benefit Category	Benefit Subcategories
9. FEHBP - GEHA	1. Ambulatory Patient Services	Acupressure Biofeedback Basic dental services (fillings, periodontal disease, etc.) Artificial insemination in vitro fertilization Private Duty Nursing Routine Eye Exams
	4. Maternity & Newborn Care	Elective abortion
	6. Prescription Drugs	Infertility Drugs Medical Foods – PKU - #10 Sexual Dysfunction Drugs Weight Loss Drugs
	7. Rehabilitative & Habilitative Services & Devices	Orthotics and special footwear (Medically Appropriate and Necessary) Wigs and Scalp Prosthetics for hair loss due to chemotherapy
	8. Laboratory Services	Genetic Testing
	10. Pediatric Services, including oral and vision care	Basic dental services (fillings, periodontal disease, etc.) Dilated eye examination for diabetes related diagnosis Visual training services, including orthoptics and pleoptic training, provided to children under age 10 for the treatment of amblyopia

Appendix F - Benefits Not Covered But Included In Other Potential Benchmark Plans.

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Plan	Major Benefit Category	Benefit Subcategories
10. Sanford Health Plan	1. Ambulatory Patient Services	Acupressure Acupuncture Biofeedback Preventive dental services (exams, cleaning) Basic dental services (fillings, periodontal disease, etc.) Oral Surgery – removal of impacted teeth Artificial insemination in vitro fertilization Services to treat underlying cause of infertility Private Duty Nursing Routine Eye Exams Eyeglasses or contact lenses following a covered cataract surgery
	4. Maternity & Newborn Care	Elective abortion
	5. Mental Health & Substance Use Disorder Services including Behavioral Health Treatment	Detoxification
	6. Prescription Drugs	Infertility Drugs Sexual Dysfunction Drugs
	7. Rehabilitative & Habilitative Services & Devices	Hearing Aids (less than age 18) Hearing aids (18 +) Wigs and Scalp Prosthetics for hair loss due to chemotherapy
	10. Pediatric Services, including oral and vision care	Preventive dental services (exams, cleaning) Basic dental services (fillings, periodontal disease, etc.) Routine Eye Exams Eyeglasses or contact lenses following a covered cataract surgery Visual training services

Appendix G – Benefits Excluded by All Benchmark Plans.

Appendix G – Benefits Excluded by All Benchmark Plans.

This Appendix lists those benefits not covered by any of the ten benchmark plans. Initial guidance regarding Essential Health Benefits did not list any specific benefits that would be required within each of the categories of coverage. The final rule regarding Essential Health Benefits has not been released.

	Major Benefit Category	Benefit Subcategories
1.	Ambulatory Patient Services	Bereavement Counseling. Cosmetic Surgery Orthodontia Homeopathy Donor eggs, sperm Preimplantation genetic diagnosis testing Surrogacy Injuries from criminal activity (felony) Marital Counseling Nutritional Supplements (other than to sustain life) Routine Podiatry Reversal of sterilization Eyeglasses or contact lenses Refractive Eye surgery (e.g. Lasik)
3.	Hospitalization	Private Duty Nursing
4.	Maternity & Newborn Care	Delivery by Mid-wife in home
5.	Mental Health & Substance Use Disorder Services including Behavioral Health Treatment	Supervised Living Applied Behavior Analysis Learning Disorders/Behavioral Problems
6.	Prescription Drugs	Drugs for hair loss
7.	Rehabilitative & Habilitative Services & Devices	Massage Therapy Therapies for job training Therapy for general conditioning Home exercise or therapy equipment Items of Personal Comfort, Convenience, or hygiene items (humidifiers, raised toilet seats, shower chairs) Pools, whirlpools, spas, hydrotherapy

Appendix G – Benefits Excluded by All Benchmark Plans.

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	Major Benefit Category	Benefit Subcategories
9.	Preventive & Wellness Services & Chronic Disease Mgmt	Personal items such as health club memberships, Weight Control (obesity) Programs (Other than weight control drugs)
10.	Pediatric Services, including oral and vision care	Pediatric Vision Care Eyeglasses or contact lenses

[i] Essential Health Benefits Bulletin. Center for Consumer Information and Insurance Oversight.

[ii] Essential Health Benefits: List of the Largest Three Small Group Products by State. Center for Medicare & Medicaid Services (July 2, 2012).

[iii] Information obtained from North Dakota Public Employees Retirement System website (www.nd.gov.ndpers).

[iv] Essential Health Benefits: List of the Largest Three Small Group Products by State. Center for Medicare & Medicaid Services (July 2, 2012).

[v] Contained in an e-mail sent to INS on June 25 by Vance Magnuson of the NDID.

[vi] 45 CFR Part 156.

[vii] Essential Health Benefits: List of the Largest Three Small Group Products by State. Center for Medicare & Medicaid Services (July 2, 2012).

[viii] Offering Dental Benefits in Health Exchanges A Roadmap for Federal and State Policymakers. National Association of Dental Plans (December 2011).

[ix] Essential Health Benefits: List of the Largest Three Small Group Products by State. Center for Medicare & Medicaid Services (July 2, 2012).

[x] As a reference point, the additional cost for adding periodic dental benefits to a plan covering an adult provided by a typical dental plan is anywhere from $400 to $600 per year, depending on many factors including the coverage and coinsurance parameters of the plan.

[xi] Essential Health Benefits: List of the Largest Three Small Group Products by State. Center for Medicare & Medicaid Services (July 2, 2012).

[xii] http://www.cdc.gov/art/ART2009/PDF/01_ARTSuccessRates09-FM.pdf.

[xiii] Medicaid Coverage and Spending in health reform: national and State-by-state results for Adults at or below 133% FPL. Kaiser Commission on Medicaid and the Uninsured (May, 2010).

[xiv] Using the higher figure of $57 million, this would translate into an average annual increase of approximately $10 million. According to Medicare.gov, the annual amount of North Dakota's share of Medicaid expenditures was approximately $166 million in 2009, which represented the latest available figures. These translate into a 6% increase in annual costs to North Dakota.

[xv] Medicaid Expansion in the New Health Law: Costs to the States. Joint Congressional report by the Senate Finance Committee and the House Energy & Commerce Committee.

[xvi] Dental Coverage and the ACA – Laurence Weissbrot. Society of Actuaries Health Watch, May, 2012.

[xvii] Offering Dental Benefits in Health Exchanges. Presented by the National Association of Dental Plans and the Delta Dental Plans Association. September 2011.

[xviii] Dental Coverage and the ACA – Laurence Weissbrot. Society of Actuaries Health Watch, May, 2012.

[xix] ACA Section 1302(b)(4)(F).