TO: The Honorable Phil Berger, Senate President Pro Tempore
The Honorable Thom Tillis, Speaker of the House
Ms. Denise Weeks, House Principal Clerk
Ms. Sarah Clapp, Senate Principal Clerk

DATE: May 14, 2012

FROM: Ted Hamby, Deputy Commissioner and TAG Chairperson

RE: Study Report pursuant to Session Law 2011-391

Section 49 of S.L. 2011-391 authorized the Department of Insurance ("the Department") to "study the insurance-related provisions of the Affordable Care Act (ACA) and any other matters it deems necessary to successful compliance with the provisions of the ACA and related regulations." S.L. 2011-391 further provided that "the Commissioner shall submit a report to the 2012 Regular Session of the 2011 General Assembly containing recommendations resulting from the study." Pursuant to this legislative authorization and direction, the Department conducted such a study, and offers this report of the study's findings.

To conduct this study, the Department formed a "Market Reform Technical Advisory Group" (TAG) comprised of representatives of insurers, agents, academia, hospitals, providers, business and consumers who reside in North Carolina and have knowledge of North Carolina's health care system and marketplace. (Note that despite efforts to include small business representation in the TAG, invited representatives did not actively participate in TAG discussions.) In addition to the TAG deliberations, the Department study included analysis of the State's options for defining the "Essential Health Benefits" that must be provided by most individual and small group health insurance plans in 2014 and 2015. The results of these studies are attached and include three issue briefs summarizing the recommendations of the TAG, and a report outlining options available to the State for defining North Carolina's Essential Health Benefits.

TAG members gave thorough consideration to possible effects that many of the insurance-related provisions of the ACA may have on the State market. TAG analysis identified certain items as particularly needed to ensuring the continued strength and viability of our State market, and necessary for immediate action by the General Assembly. Action by the General Assembly is vital on these items to provide the State's health insurers adequate time to develop

health benefit plans and premiums in compliance with ACA requirements and timelines. Based on the TAG's deliberations and the unanimous opinion of its members, the Department recommends the following items for General Assembly consideration and action during the 2012 short session:

- *Revise statutory definition of small employer* – As detailed in Issue Brief #1, TAG members unanimously endorsed revising the current statutory definition of small employer and the methodology used for counting employees, to ensure consistency with federal law.

- *Direct the Department to set geographic rating areas* – As detailed in Issue Brief #2, TAG members unanimously endorsed the General Assembly directing the Department to set Geographic Rating Areas for the State's individual and small group health insurance markets.

- *Direct the Department to continue to study insurance-related provisions of federal law* – The TAG identified additional topics appropriate for further deliberation, particularly if the pending Supreme Court decision does not repeal the ACA in its entirety. As such, the Department requests that the General Assembly direct the Department to continue to study insurance-related provisions of federal law with the aim of protecting against detrimental federal intervention in the State insurance market, ensuring the continued operation and health of this market, and preserving the market's ability to successfully serve the needs and interests of the State's consumers and carriers

In addition to the above priority items, TAG discussions identified and endorsed the following provisions that the Department recommends be included in any legislation establishing a North Carolina operated Health Benefit Exchange (HBE):

- Employers participating in the Small Business Health Options Program (SHOP) should not be prohibited from restricting employee choice of plans to one or more specific plan(s) within a single metal level. The rationale for this recommendation is included in the attached Issue Brief #1.

- The Exchange, in consultation with the Department, should be granted the authority to determine the minimum participation rate in the SHOP. The rationale for this recommendation is included in the attached Issue Brief #1.

- The Exchange should be granted the authority to develop a policy regarding insurers' re-entry into the individual and small group Exchanges after exiting either Exchange market.

Note that although the TAG recommended that the State administer its own reinsurance program rather than defer administration to the federal government, the Department believes that the limited flexibility granted to the State in the administration of this temporary 3-year program does not warrant the resources required for State-level implementation. Should the General Assembly think otherwise, however, the Department agrees with the approach for implementation as outlined in Issue Brief #3.

In addition to the work of the TAG, the Department commissioned a detailed report on the benchmark options available to North Carolina for defining the "Essential Health Benefits" (EHB) that must be provided by most individual and small group health insurance plans in 2014 and 2015. The designation (or default) of a benchmark plan will identify the State's EHB package and will contain the covered benefits of the selected benchmark as of the first quarter 2012. Therefore "picking and choosing" benefits to customize an EHB package of benefits is not permitted. Additionally, any changes to State mandated benefits that become effective after the first quarter 2012 will not impact the State's EHB package.

The report indicates that the benchmark plan options available to the State from which to choose the benchmark plan do not differ significantly in either the benefits covered or the overall impact on premiums. Though the State may want to consider seeking stakeholder feedback, the analysis indicates that the plan option that would be selected by default (should the state not make an active choice) does not appear to be detrimental to the citizens of North Carolina in either the range of benefits offered or cost of coverage. Additionally, it appears the default option may result in the least amount of disruption to current policyholders.

Selected Small Group Market Issues and Recommendations

Key Takeaways

- The Affordable Care Act (ACA) offers states the option of merging the individual and small group markets for the purpose of risk pooling. The Technical Advisory Group (TAG) **recommends that the small group and individual markets maintain separate risk pools at this time.** No change is required to North Carolina statute to implement this recommendation.

- The ACA requires that North Carolina's small group market be expanded to employers with 100 or fewer employees by 2016, but offers states the option of expanding the definition prior to 2016. The TAG **recommends the small group market definition remain at 50 or fewer employees until required to change in 2016.** No change is required to North Carolina statute to implement this recommendation.

- The current methodology for counting employees for the purpose of determining employer group size (small or large) under North Carolina law differs from the methodology in the ACA. The TAG **recommends that North Carolina align the methodology for determining employer group size with the ACA effective January 1, 2014**. This change should be reflected in North Carolina statute.

- North Carolina currently allows all sole proprietors to participate in the small group market, while the ACA provides that sole proprietors with no employees (or whose only employee is a spouse) are not eligible to purchase coverage through the Small Business Health Options Program (SHOP). The TAG **recommends that North Carolina's treatment of sole proprietors align with the ACA effective January 1, 2014, allowing sole proprietors with no employees to be eligible for individual but not small group market coverage.** This change should be reflected in North Carolina statute.

- The ACA requires the Exchange to provide employers the option to offer their employees multiple plans within a single metal level. The TAG **recommends that employers should not be prohibited from restricting employee choice of plans to one or more specific plan(s) within a single metal level in the SHOP Exchange.** The TAG also recommends further consideration of the extent to which the employer should be allowed to offer expanded choice. This change should be reflected in North Carolina statute.

- Federal guidance under the ACA gives Exchanges the option of establishing a uniform minimum employee participation requirement as a condition of small businesses participating in the SHOP. The TAG **recommends the establishment of a minimum participation requirement in the SHOP to mitigate adverse selection, and that the Exchange board, in consultation with the North Carolina Department of Insurance, be granted the authority to determine the SHOP participation requirement.** This change should be reflected in North Carolina statute.

Issue #1: Merging of Risk in the Individual and Small Group Markets

Under the ACA, North Carolina has the option of merging the individual and small group markets for the purpose of risk pooling. Merging the risk pools does not require insurers to participate in both markets or offer the same products, nor does it impact whether the individual and small group markets are administered as a single or separate Exchanges. Instead, merging the risk pools would require insurers to set individual and small group premium rates based on the combined claims experience of their individual and small group policies.

The primary benefit of merger is to spread risk across a larger number of subscribers, thereby reducing variation in pricing and creating greater rate stability. However, because participants in the individual market in North Carolina are expected to be less healthy, on average, than their counterparts with small group coverage, merging the two markets would have differential impacts across the two markets. In short, merger is likely to lower premiums for individuals on average, while increasing premiums for small employers.

The current variation in risk profiles is likely to decrease over time as the ACA's insurance reforms and tax subsidies are implemented. For example, the ACA mandates guaranteed issue in the individual market, which requires insurers to offer coverage to individuals irrespective of health status. The ACA also provides tax subsidies to eligible participants in the individual market, which is likely to entice healthier individuals to participate. Finally, the ACA eliminates experience rating in the individual and small group market in North Carolina. North Carolina statute currently allows insurers to rate small groups up or down by twenty-five percent based on claims experience, which reduces premiums for employers with healthier employees. These changes are likely to cause the current differences in risk (and price) between individual and small group participants to decrease over time. It is possible that as these changes occur, merger may become a more viable option.

Milliman projects that merging would prompt small group subscribers to drop coverage, ultimately reducing the number of insured in the merged market by 130,676, or 9% in 2016.[1]

Based on these considerations, the TAG recommends that the individual and small group markets remain separate risk pools at this time. In addition, the TAG recommends that the North Carolina Department of Insurance (NC DOI) revisit market merger after the ACA is fully implemented and the impact on the markets is known.

[1] Milliman, North Carolina Health Benefit Exchange Study, July 18, 2011.

Issue #2: Expanding the Definition of the Small Group Market Prior to 2016

North Carolina law currently defines small employers as businesses that have no more than 50 eligible employees.[2] The ACA requires states to define small employers as businesses with 100 or fewer employees by 2016. However, states have the option to expand the definition of small employers prior to 2016.

Expanding the definition of the small group market requires that groups of 51 to 100 employees, both in and out of the Exchange, be subjected to the same rating requirements as groups of under 50 employees, including guaranteed issue and a prohibition on experience-based rating. This will be a significant change for this market. Similar to market merger, expanding the definition of the small group market prior to 2016 will likely cause premiums to rise for healthy groups, while premiums will fall for less healthy groups. It is likely that the result would be an increase in self insurance among the healthiest groups, leading to even higher premium in the insured market.

The TAG concluded that the market should be given time to adjust to the reforms implemented in 2014 and therefore recommends that the definition of the small group market remain the same until change is required in 2016.

Issue #3: Reconciling the Methodology for Determining Employer Group Size

The ACA methodology for counting employees for the purpose of determining employer group size differs from the current methodology in North Carolina statute. While North Carolina counts each full-time person with a work week of 30 or more hours as an employee, the ACA determines the group size by averaging the total number of employees on business days during the preceding calendar year. The United States Department of Health and Human Services (HHS) has indicated that it may address the methodology for counting employees in more detail in future rule-making.

Adopting the ACA definition is likely to increase the number of countable employees for most employers. Thus, employers with just below 50 full-time employees may no longer qualify as a small group. However, most small groups have significantly fewer than 50 employees, and therefore the number of groups impacted by this change would be a small percent of the market.

The TAG recommends that North Carolina align the methodology for determining employer group size with the ACA, effective January 1, 2014 and that grandfathered groups should be protected from any adverse consequences stemming from the changed counting methodology. To the extent that the federal government offers states flexibility in counting employees, the TAG further recommends that North Carolina align its methodology with federal rules. The TAG found it desirable to have as little variation as possible in the methodology for counting employees across markets, between states for multi-state insurers, and between the state/federal definition in order to reduce complexity and administrative burden.

[2] N.C.G.S. § 58-50-110(22)

Issue# 4: Reconciling the Definition of Sole Proprietors

While North Carolina law currently permits all sole proprietors to be treated as small groups, federal regulations interpret the ACA as excluding sole proprietors with no employees other than a spouse from SHOP eligibility. North Carolina is one of eleven states that currently allows all sole proprietors to purchase small group coverage. In North Carolina this policy is driven by the desire to ensure sole proprietors are subject to guaranteed issue which currently only exists in the small group market. However, beginning in 2014, the ACA requires guaranteed issue in the individual market while excluding sole proprietors with no employees other than a spouse from SHOP eligibility. While some sole proprietors may be negatively impacted by this change (individual coverage is likely to be more expensive than small group for sole proprietors on average), TAG insurer participants observed that the number of those impacted likely will be relatively small. Insurers also noted that moving sole proprietors into the individual market could improve rates for small groups since sole proprietors who seek coverage often are less healthy.

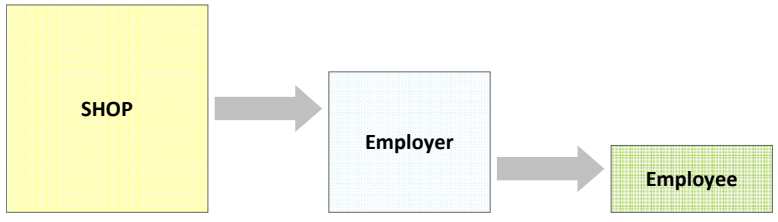
Thus, the TAG recommends that North Carolina align the sole proprietor definition with the SHOP approach, effective January 1, 2014 and that grandfathered groups should be protected from any adverse consequences stemming from the change. Similar to the previous recommendation, to the extent that the federal government offers states flexibility in the treatment of sole proprietors, the TAG further recommends that North Carolina seek to align its definition with federal rules.

Issue #5: Determining Choice in SHOP

The ACA requires that employers be offered an "employee choice" model within the SHOP. Under this model, the employer is able to pick a metal level (platinum, gold, silver, or bronze) within which employees may choose any plan offered by the SHOP. The metal level determines the average level of cost sharing required by the consumer. The ACA allows states to supplement this model with other models in which the employer offers more or fewer choices to employees. The TAG recommends that employers should be able to offer fewer choices, including offering a single plan as is common in the market today.

Currently in the small group market, employers often offer employees a single health insurance plan. The TAG considered the impact of broadening employee choice on rates. Insurers noted that the more choice granted to employees across metal levels, the greater risk of adverse selection, and the greater the need for insurers to increase premium rates to offset this effect. The TAG also discussed whether choice models that are more

Interaction between SHOP, Employer and Employees



- Must permit employers the option of offering a single benefit level
- May offer employers other options—with either more or less choice than above

- Choose among the options the SHOP offers

- Signs up for a plan based on the option the employer selected
- May have many choices or one choice

expansive than ACA requirements, but more limiting than allowing choice across all metal levels, might be effective, such as expanding employee choice to two contiguous coverage levels.

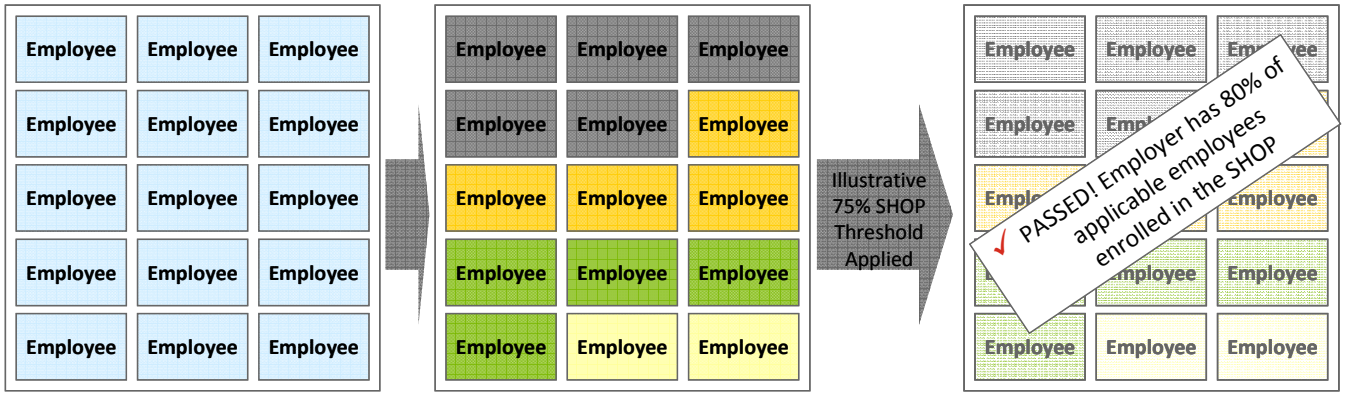
The TAG reached consensus that employers should not be prohibited from restricting employee choice of plans to one or more specific plans within a single metal level. Such an option is consistent with the ACA. It also reflects the way the market currently operates and would be seamless for employers who want to purchase coverage in the same way through the SHOP.

The TAG did not reach consensus regarding the extent to which employers should be allowed to expand choice beyond the ACA mandate, primarily due to concerns about the impact that adverse selection would have on premium costs. The TAG did not reach consensus on how much flexibility to grant the SHOP in designing employers/employee choice models versus what should be legislatively mandated. The issue of expanding employer choice may be discussed more in future TAG meetings.

Issue #6: Group Participation Requirement in the SHOP Exchange

Federal regulations issued pursuant to the ACA give Exchanges the option of establishing a uniform minimum employee participation requirement for small businesses participating in the SHOP. The minimum requirement must be the same across SHOP participating employers and be based on participation in the SHOP, not on the number of individuals enrolled in any particular plan or insurer. The number of employees participating in the SHOP generally is determined based on the number of employees without qualifying existing coverage.[3]

Example of SHOP Participation Requirement



- Small employer has 15 employees
- Purchases health insurance through the SHOP
- Gives employees the choice of a metal level

= 5 employees are covered either under Medicare, Medicaid or a spouse's plan

= 4 employees select Plan A

= 4 employees select Plan B

= 2 employees elect to not pay for coverage; take penalty

- **Since 5 employees have other coverage options, 8 out of 10 (80%) eligible employees are enrolled in SHOP**
- **Basic Plan A and Basic Plan B each have 4 out of 10 enrolled (40%)**

[3] "Qualifying existing coverage" generally means benefits or coverage provided under: (i) Medicare, Medicaid, and other government funded programs; or (ii) an employer based health insurance or health benefit arrangement, including a self insured plan, that provides benefits similar to or in excess of benefits provided under the basic health care plan.

Current North Carolina statute allows insurers to impose "reasonable employer participation" requirements on small employers applying for coverage, which may not vary based on the health benefit plan involved. This minimum participation requirement is determined on an insurer-by-insurer basis and can vary based on employer size. Insurers must follow North Carolina law when determining qualifying existing coverage, and they have the ability to refuse to issue coverage to groups or to non-renew or discontinue coverage if an employer falls below the insurer-defined participation rate.

Establishing a participation requirement in the SHOP may help mitigate adverse selection in the SHOP that could result when employers are permitted to seek coverage for only a few sick employees. However, doing so may also exclude some employers who cannot persuade a sufficient number of their employees to participate. The impact of this exclusion is at least in part mitigated by the availability of individual coverage in the Exchange. Individuals whose employers do not offer coverage due to a failure to meet participation requirements would be able to seek individual coverage and have access to subsidies, if qualified, through the Exchange.

Adverse selection could also occur between the SHOP and the small group market outside the Exchange if participation requirements are different in the two markets. For example, if SHOP participation requirements are lower than in the market outside the Exchange, employers seeking coverage inside the Exchange may tend to have employees who are sicker, on average, and adverse selection could occur.

Based on these considerations, the TAG recommends that North Carolina have an employer participation requirement in the SHOP to reduce adverse selection. The TAG concluded that the Exchange board, in consultation with the NC DOI, should be granted the authority to determine the SHOP participation requirement.

The TAG also recommends that the NC DOI actively monitor participation requirements inside and outside of the SHOP to determine whether adverse selection or other unintended consequences are occurring between the Exchange and non-Exchange markets. If the decision is made to align employer participation requirements across the SHOP and non-SHOP markets, the TAG agreed that the NC DOI is the appropriate entity to determine that participation requirement.

About the Market Reform Technical Advisory Group (TAG)

The TAG is comprised of representatives of insurers, agents, academia, hospitals, providers, business and consumers who reside in North Carolina and have knowledge of North Carolina's health care system and marketplace. The TAG considers and makes recommendations on each issue after a review of applicable State and federal laws, relevant literature, national stakeholder recommendations, and pending or passed legislation in other states.

The TAG evaluates the market reform policy options under consideration by assessing the extent to which they: expand coverage; improve affordability of coverage; provide high-value coverage options in the Exchange; empower consumers to make informed choices; support predictability for market stakeholders, competition among plans and long-term sustainability of the Exchange; support innovations in benefit design, payment and care delivery that can control costs and improve the quality of care; and facilitate improved health outcomes for North Carolinians. The TAG acknowledges that tension exists between these values and seeks to provide policy recommendations that are best aligned with the overall public interest, while ensuring the continued strength and viability of the State marketplace.

The purpose of the TAG is to develop options and considerations and to identify areas of consensus to inform the recommendations to the North Carolina General Assembly (NCGA) on ACA-related market reforms. The TAG was convened pursuant to North Carolina Session Law 2011-391, which authorized the Commissioner of Insurance to study insurance-related provisions of the ACA and any other matters it deems necessary to successful compliance with the provisions of the ACA and related regulations.

For more information on the TAG go to: http://www.ncdoi.com/lh/LH_Health_Care_Reform_ACA.aspx

Issue Brief #2

Rating Areas and Leveling the Playing Field Issues and Recommendations

Key Takeaways

- The Affordable Care Act (ACA) requires that each state establish rating areas that must be applied consistently inside and outside the Exchange. The Technical Advisory Group (TAG) **recommends that the North Carolina Department of Insurance (NC DOI), in consultation with health insurance carriers (insurers), be responsible for the establishment of geographic rating areas for the individual and small group markets.** This change should be reflected in North Carolina statute.

- The ACA requires as a condition of participation in the Exchange that insurers offer at least one silver level and one gold level Qualified Health Plan (QHP) in the Exchange and allows states the option of establishing additional insurer participation requirements. The TAG **recommends that insurers should not be required to participate in additional metal levels as a condition of Exchange participation in 2014 and 2015.** No change is required to North Carolina statute to implement this recommendation.

- North Carolina has a five-year prohibition on market re-entry if an insurer leaves any of the individual, small and large group markets.[1] The TAG discussed putting limitations on insurers' ability to re-enter the Exchange after an exit. The TAG **recommends that the Exchange board have the authority to develop a policy regarding insurers' re-entry into the individual and small group Exchanges after exiting either Exchange market.** This change should be reflected in North Carolina statute.

- While not addressed in the ACA, North Carolina could establish insurer participation requirements across the Exchange and non-Exchange markets. The TAG **recommends that the NC DOI actively monitor the individual and small group markets, including the interplay between the Exchange and non-Exchange markets, and make recommendations to the North Carolina General Assembly (NCGA), in consultation with the Exchange as appropriate, if insurer participation or other adjustments are needed to minimize adverse selection in the individual and small group markets.**

- Most favored nation (MFN) clauses were raised as an issue for discussion in light of ACA implementation. **A significant majority of TAG members strongly believe that the ACA increases the need for the NCGA to act to prohibit the use of MFN clauses which inhibit insurers' ability to negotiate competitive service rates with health care providers.** This change should be reflected in North Carolina statute.

[1] N.C.G.S. § 58-68-65(c)(2)(b), N.C.G.S. § 58-68-45(c)(2)(b)

Issue #1: Development of Geographic Rating Areas

The ACA requires each state to establish one or more rating areas within that state, subject to the review and approval of the Secretary of the Department of Health and Human Services ("the Secretary"). Rating areas are separate from service areas. Service areas are geographic regions in which an insurer elects to operate. Rating areas are geographic areas across which insurers can vary premium costs. In addition to rating areas, which must be established and rated on a non- discriminatory basis, insurers can also vary rates based on age (no more than a 3:1 rate band), family composition, and tobacco use (1.5:1 rate band). Rating areas will apply to all non-grandfathered, fully-insured small group and individual plans and will be applied consistently inside and outside of the Exchange.[2]

Under current North Carolina statute, insurers are required to define geographic rating areas in the small group market around "medical care systems." Medical care system rating factors must: reflect the relative differences in expected costs; produce rates that are not excessive, inadequate, or unfairly discriminatory in the medical care system areas; and be revenue neutral to the small employer carrier.[3]

In practice, most insurers in North Carolina use counties to determine rating areas. Most insurers also use a limited number of geographic rating factors and group counties based on costs, which often creates non-contiguous rating areas. In the individual market the number of rating factors ranges from 2 to 8.[4] In the small group market, the number of rating factors varies from 9 to 23.[5] Several insurers use different geographical rates by market type (*e.g.*, the small group market has different rating than the individual or large group markets).

In developing ACA-compliant rating areas, the State will need to determine whether rating areas can be non-contiguous under the ACA and how much rate variation to allow in geographical rating factors. More variation will better align geographic cost variation and premiums, but it also could increase premiums in rural or otherwise underserved areas, which have less competition among delivery systems.

The TAG recommends that the NC DOI, in consultation with insurers, be responsible for the establishment of geographic rating areas for the North Carolina individual and small group markets pursuant to the ACA. The NC DOI should commission a study analyzing the impact of different rating area options on premiums and risk distribution in the individual and small group markets. At the conclusion of the study, the NC DOI should establish rating areas. Rating areas should be set by December 31, 2012 and reassessed by the NC DOI on an as-needed basis.

In general, the TAG prefers more segmented geographic rating areas, as is the current practice of most major insurers in the State, but it also believes that additional analysis on the impact of different rating regions on premium costs and access is needed before rating areas are configured.

[2] Fully-insured large group plans are only subject to rating areas, and other rating requirements, in states that allow large groups to purchase through the Exchange.

[3] N.C.G.S. § 58-50-130(b)(7)

[4] Analysis based on select insurers with greater than 5,000 lives in North Carolina.

[5] Analysis based on select insurers with greater than 5,000 lives in North Carolina.

The Need to "Level the Playing Field"

The ACA includes multiple measures designed to mitigate adverse selection in the small group and individual markets, including minimum coverage requirements, tax credits for small businesses, premium subsidies, risk adjustment, and reinsurance. However, adverse selection remains a concern. The ACA gives states broad discretion to take additional steps to mitigate adverse selection, which can occur whenever individuals at greater risk of high health spending are more likely to seek coverage or choose a particular coverage option than low-risk individuals. Once a particular market segment begins to attract a disproportionate share of higher-risk individuals, costs will rise in that segment. Unless there is some countervailing action, the higher costs will lead to higher premiums, which will drive the better risks out of that market, thereby driving costs even higher. This process is typically referred to as a premium spiral.[6]

The issues that follow address various options that North Carolina may consider to mitigate adverse selection, including insurer participation and market re-entry requirements. Subsequent issue briefs will cover other risk-mitigation strategies.

In addition to leveling the playing field to prevent adverse selection, there may be a need to level the playing field so that all insurers have the ability to compete in the marketplace under the same terms and conditions. Thus, the issue of most favored nation contracting clauses is also addressed below.

Issue #2: Mitigating Adverse Selection Through Plan Participation Requirements Inside the Exchange

The ACA requires QHP insurers to offer at least one silver level and gold level plan in the Exchange as a condition of participation. States have the option to require that QHP insurers meet additional participation requirements in the Exchange, such as requiring insurers to offer plans at other benefit levels within the Exchange.

Establishing additional participation requirements for QHP insurers in the Exchange may help mitigate adverse selection among insurers and their QHPs. For example, requiring insurers to offer QHPs at all four metal levels may foster competition for both the most healthy and least healthy risks. Such a requirement may also expand choices for consumers purchasing coverage through the Exchange.

QHP Plan Levels

- **Bronze –** covers on average 60% of cost of required benefits
- **Silver -** covers on average 70% of cost of required benefits
- **Gold -** covers on average 80% of cost of required benefits
- **Platinum -** covers on average 90% of cost of required benefits
- **Catastrophic –** high-deductible plan for individuals up to age 30 or individuals exempted from the mandate to purchase coverage.

[6] Definition adapted from the American Academy of Actuaries definition of adverse selection, available at: http://www.actuary.org/pdf/Risk_Adjustment_IB_FINAL_060811.pdf

However, additional requirements could also reduce choices and lessen competition if they discourage insurers from participating in the Exchange. In short, there is a fine balance to be struck, particularly in the start-up period of the Exchange.

The TAG recommends that additional participation requirements that mandate insurer participation in additional metal levels within the Exchange are not advisable in 2014 and 2015.

Issue #3: Mitigating Adverse Selection Through Market Re-Entry Requirements Inside the Exchange

North Carolina currently has a five-year prohibition on market re-entry if an insurer leaves the individual, small or large group markets in the State.[7] Extending this policy to the Exchange would limit market disruptions and potential adverse selection by insurers exiting and re-entering the Exchange at opportune times.

However, any "re-entry policy" should be thoughtfully crafted, especially with regard to the length of time that QHP insurers would be barred from re-entering the Exchange, as the Exchange will be a new entity and will require operational flexibility to ensure adequate participation among insurers to meet consumer demand.

The TAG recommends that the Exchange board have the authority to develop a policy regarding QHP insurers' re-entry into the individual and small group Exchanges after exiting either Exchange market.

Issue #4: Mitigating Adverse Selection Through Plan Participation Requirements Between the Exchange and Non-Exchange Markets

Because it is projected that the Exchange will attract individuals with higher than average risk, some insurers may prefer to participate in the non-Exchange market only, fearing that risk-mitigating mechanisms (such as reinsurance or risk adjustment) will not adequately offset costs. To limit the resulting potential for adverse selection between the Exchange and non-Exchange markets, North Carolina could impose additional insurer participation requirements. Options include requiring that certain insurers participate in the Exchange as a condition of offering products in the non-Exchange market, and putting parameters in place regarding the types of plans that insurers must offer inside and/or outside of the Exchange.

[7] N.C.G.S. § 58-68-65(c)(2)(b), N.C.G.S. § 58-68-45(c)(2)(b)

There are multiple strategies for protecting the Exchange against adverse selection. For example, insurers could be prohibited from offering catastrophic or bronze plans outside the Exchange unless they also offered those same plans inside the Exchange. This would prevent insurers from participating in catastrophic or bronze plans only outside of the Exchange, which would pull good risks out of the Exchange and disadvantage insurers participating in the Exchange.

Individuals enrolling in the Exchange are expected to have health expenditures that are approximately 12% more on average than individuals enrolling in coverage outside the Exchange as a result of health differences beyond those explained by age.[8]

However, imposing additional requirements on insurers operating outside of the Exchange market, or prohibiting them from selling certain products, may cause some insurers to leave the individual and small group markets entirely or dissuade potential new entrants from participating in the market. Despite many theories about possible approaches, insufficient information exists at this time to know how required reforms will play out, or the impact that any additional requirements for carrier product offerings both inside and outside of the Exchange would have on the market.

Accordingly, the TAG recommends that the NC DOI actively monitor the individual and small group markets, including the interplay between the Exchange and non-Exchange markets, and make recommendations to the NCGA, in consultation with the Exchange as appropriate, if plan participation or other adjustments are needed to minimize adverse selection in the individual and small group markets**.**

Issue #5: Most Favored Nation Clauses in Provider Contracts

Most favored nation (MFN) clauses in light of ACA implementation was raised as an issue for discussion. Because this issue was not under the original scope of the TAG, independent information and analysis was not provided to define considerations related to MFN, unlike other issues addressed by the TAG. The TAG defined MFN for the purposes of its discussion as contract clauses between a health care provider and an insurer which give the insurer the ability to do one or more of the following: 1) audit contracts providers have with other insurers to determine if the rates offered to other insurers are more favorable; 2) apply the best rate identified in the audit; and 3) mandate that a corridor exist between the insurer's contracted rate with a provider and the provider's negotiated rates with other insurers, such that if the corridor is breached the insurer would get a price reduction to maintain the corridor.

[8]Milliman, North Carolina Health Benefit Exchange Study, July 18, 2011. Findings based on non-group enrollment, only.

The TAG supports effective implementation of the ACA in North Carolina, which includes anticipating and addressing any potential adverse interactions between ACA and current State statute.

A significant majority of TAG members expressed serious concerns about strategies utilized in health care provider contracting, known as MFN clauses. According to this majority, use of these clauses, particularly in markets that are dominated by a single insurer, inhibits market competition by limiting most other health insurers' ability to negotiate satisfactory health service rates with certain health care providers. Currently in North Carolina, insurers are able to mitigate some of the impact of these clauses on market competition by utilizing available product underwriting and pricing flexibility. Much of that flexibility will be eliminated under ACA. Most TAG members believe that the anti-competitive impact of MFN clauses will be intensified in a post-ACA environment, further limiting competition among carriers and creating barriers to market entry for new carriers, thus restricting consumer choice. Although there was not unanimity within the TAG, a significant majority of TAG members strongly believe that the ACA increases the need for the North Carolina General Assembly to act to prohibit the use of MFN clauses which inhibit insurers' ability to negotiate competitive service rates with health care providers.

The health insurer TAG member with the largest health insurance market share in North Carolina expressed concerns that the TAG was not the forum for MFN consideration. This TAG member further asserted that there was little evidence of the impact of these provisions on prices or competition, and indicated that such clauses may help keep consumer costs low. This TAG member concluded that any consideration of MFN in North Carolina should be based on a thorough assessment of the impact of such change specific to the State's 2014 market, including the impact to health care cost and quality.

About the Market Reform Technical Advisory Group (TAG)

The TAG is comprised of representatives of insurers, agents, academia, hospitals, providers, business and consumers who reside in North Carolina and have knowledge of North Carolina's health care system and marketplace. The TAG considers and makes recommendations on each issue after a review of applicable State and federal laws, relevant literature, national stakeholder recommendations, and pending or passed legislation in other states.

The TAG evaluates the market reform policy options under consideration by assessing the extent to which they: expand coverage; improve affordability of coverage; provide high-value coverage options in the Exchange; empower consumers to make informed choices; support predictability for market stakeholders, competition among plans and long-term sustainability of the Exchange; support innovations in benefit design, payment and care delivery that can control costs and improve the quality of care; and facilitate improved health outcomes for North Carolinians. The TAG acknowledges that tension exists between these values and seeks to provide policy recommendations that are best aligned with the overall public interest, while ensuring the continued strength and viability of the State marketplace.

The purpose of the TAG is to develop options and considerations and to identify areas of consensus to inform the recommendations to the North Carolina General Assembly (NCGA) on ACA-related market reforms. The TAG was convened pursuant to North Carolina Session Law 2011-391, which authorized the Commissioner of Insurance to study insurance-related provisions of the ACA and any other matters it deems necessary to successful compliance with the provisions of the ACA and related regulations.

For more information on the TAG go to: http://www.ncdoi.com/lh/LH_Health_Care_Reform_ACA.aspx

Risk Adjustment and Reinsurance Issues and Recommendations

Key Takeaways

Risk Adjustment

- The Affordable Care Act (ACA) requires the federal government to develop a risk adjustment methodology that will be used to compensate certain plans with membership that is less healthy (more risky) than average by assessing plans with membership that is healthier (less risky) than average. States with a state-based Exchange have the option of developing an alternate risk adjustment methodology, subject to federal review. The Technical Advisory Group (TAG) **recommends that North Carolina defer to the federal risk adjustment model for now, but evaluate the possibility of developing a State-specific model in future years.**

- States implementing a state-based Exchange have the option to administer risk adjustment in the state, or defer administration to the federal government. The TAG **recommends that North Carolina defer administration of the risk adjustment program to the federal government for the first year** and monitor the federal risk adjustment process for potential State administration of the program in the future.

Reinsurance

- The ACA establishes a temporary, transitional reinsurance program to help stabilize premiums for coverage in the individual market for the years 2014 through 2016. Each state must decide if it wants to administer the program and if it wants the federal government to collect contributions. The TAG **recommends that North Carolina administer the reinsurance program within the State, while deferring the responsibility to collect insurer and third-party administrator (TPA) contributions to the federal government.** This recommendation should be reflected in North Carolina statute.

- The federal government sets a national contribution rate each year, which includes the minimum amount insurers and TPAs in each state must contribute to fund the reinsurance program administrative and claims costs. States that administer reinsurance have the option of increasing the federal assessment beyond the federally-required minimum. The **TAG recommends that any increase in the minimum assessment require action by the North Carolina General Assembly (NCGA).** This recommendation should be reflected in North Carolina statute.

- The ACA requires states that elect to establish reinsurance programs to enter into a contract with one or more applicable reinsurance entities (not-for-profit organizations). The TAG **recommends that the NCGA grant the North Carolina Department of Insurance (NC DOI) statutory authority to facilitate the establishment, through a selection and contracting process, of a reinsurance entity to administer the State's program**. The TAG further **recommends that NC DOI be legislatively authorized to serve in a technical advisory capacity to the reinsurance entity's board**, as necessary. These recommendations should be reflected in North Carolina statute.

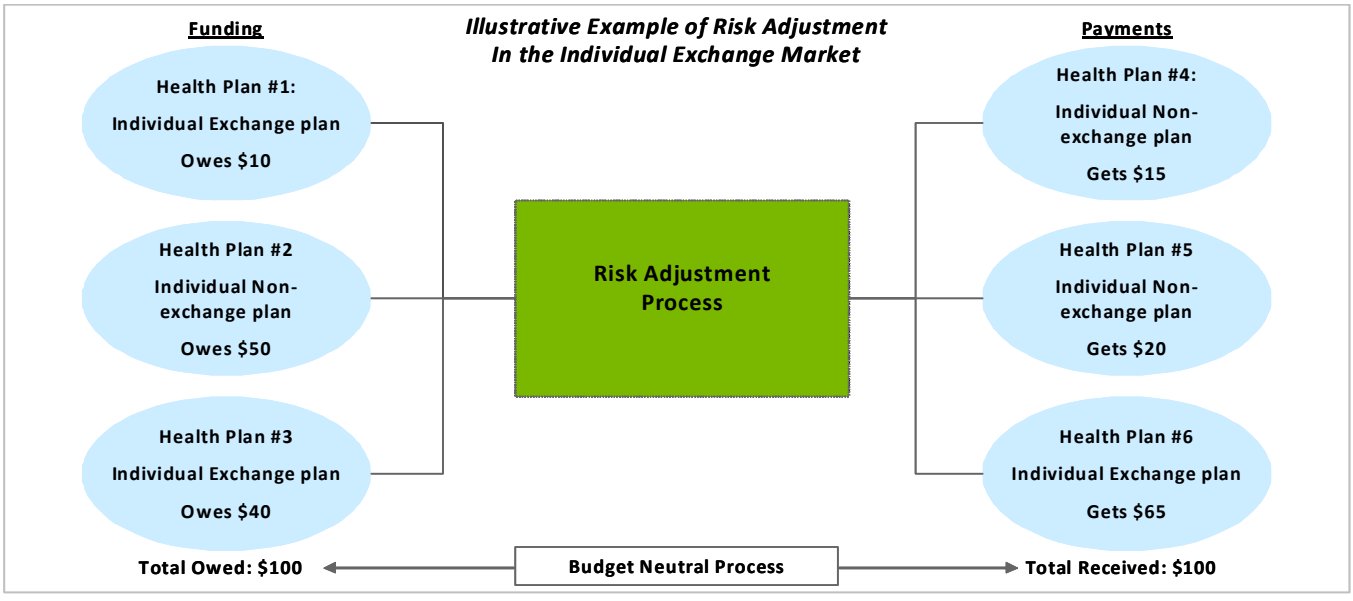
Risk Mitigation Mechanisms Under the ACA

As discussed in Issue Brief #2, adverse selection occurs whenever individuals at greater risk of high health spending are more likely to seek coverage or choose a particular coverage option than low-risk individuals. Once a particular market segment begins to attract a disproportionate share of higher risk individuals, costs will rise in that segment. The ACA includes multiple measures designed to mitigate adverse selection in the small group and individual markets, including minimum coverage requirements, tax credits for small businesses, premium subsidies for individuals, risk adjustment and reinsurance.

This brief covers risk adjustment and reinsurance, which are two of three targeted programs designed to mitigate the impact of potential adverse selection and stabilize premiums in the individual and small group markets as insurance reforms and the Exchanges are implemented in 2014.[1] The remaining program, risk corridors, is not addressed in this brief since it will be administered solely by the federal government and no state policy decisions are required.

Risk Adjustment Program

The ACA requires states to implement in 2014 a permanent risk adjustment program in the individual and small group markets. Risk adjustment is a process through which the collective risk of insurers' enrolled members is assessed across different plans and insurers. Once relative risk is determined, adjustments are made to compensate plans who have higher than average risk, which means sicker than average members. Risk adjustment is funded by non-grandfathered plans with a lower-than-average risk population in or outside the Exchange in a state, while payments are made to non-grandfathered plans with a higher-than-average risk population. These adjustments will likely be implemented separately for the individual and small group markets, unless the State opts to merge them into a single risk pool.[2] Contributions are intended to equal payments, making the program budget neutral.



[1] Preamble to final rulemaking 45 C.F.R. part 153.
[2] In Issue Brief #1, the TAG recommends maintaining separate risk pools.

Issue #1: Development of a State-Specific Risk Adjustment Methodology

The federal government is developing a risk adjustment methodology that can be used to calculate risk adjustment payments in a state. The details of the federal methodology will be released in mid-October 2012, although initial indications suggest that the federal methodology will be similar to the methodology used for Medicare Advantage plans.

States operating a state-based Exchange have the option of developing an alternate risk adjustment methodology. States developing an alternate methodology must submit that methodology to the federal government for approval.

The lack of detail on the federal model makes it challenging to assess if the model is a good fit for North Carolina. TAG members noted that the key considerations in deciding if North Carolina should develop a state-specific risk adjustment model are 1) whether North Carolina would be sufficiently different from other states to require or benefit from a state-specific model and 2) whether a state-developed model would be a significant enough improvement over the federal model to merit the investment of time and resources that would be required to develop it. Since North Carolina does not have a Medicaid Risk Adjustment program or an all-payer claims database—two features often present in other states considering setting forth an alternative risk adjustment methodology—developing a risk adjustment methodology for approval for plan year 2014 would be difficult.

The TAG ultimately agreed that the cost and effort required to develop a state-specific model would not necessarily result in a better methodology than what is currently being developed by the federal government. Additionally, some insurers noted that North Carolina does not differ from other states to such an extent that a state-specific risk adjustment model is required.

The TAG recommends that North Carolina defer to the federal risk adjustment model for now but evaluate the possibility of developing a state-specific model in future years, once the State has had time to evaluate North Carolina's utilization of the federal risk adjustment model and its relative strengths and shortcomings for the state.

Issue #2: Administration of the Federal Risk Adjustment Model in North Carolina

States implementing a state-based Exchange have the option to administer risk adjustment in the state, or defer administration to the federal government. In final rulemaking, the federal government clarified that federal officials will use a distributed model to collect data, whereby insurers will summarize data for submission to the government. The federal government will not collect detailed claims data.

Given the federal selection of a distributed model, the TAG noted only limited benefits at this time to retaining administration of the federal risk adjustment methodology in the State. Those benefits were primarily associated with the potential for better coordination with the reinsurance program (discussed elsewhere in this brief) and faster responses to insurer questions regarding risk adjustment. Those benefits do not outweigh the concerns associated with administration, notably the potential for risk adjustment administration to distract from other areas of health reform implementation and the lack of resources and in-house expertise required for administration.

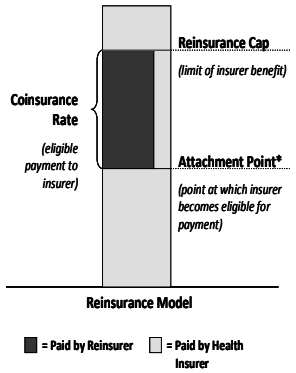
The TAG recommends that North Carolina defer administration of the risk adjustment program to the federal government for the first year and monitor the federal risk adjustment process for potential State administration of the program in the future.

Reinsurance Program

The ACA establishes a temporary, transitional reinsurance program to help stabilize premiums for coverage in the individual market and to protect insurers against migration of an unknown number and risk of high cost individuals for the years 2014 through 2016. Reinsurance will pay a certain amount of the costs between the attachment point and reinsurance cap for high cost individuals.

Reinsurance is funded by all commercial health insurance plans both in and out of the Exchange, including grandfathered plans and third-party administrators (TPAs) on behalf of all self-insured group health plans. Reinsurance payments are made to non-grandfathered individual market plans in or outside of the Exchange. The federal government will set each year a national contribution rate based on aggregate targets set in the ACA, which will include the minimum amount insurers and TPAs in each state must contribute to fund the reinsurance program administrative and claims costs.

Payment Model for Reinsurance



*Attachment point is met when expenses for all covered benefits in a benefit year meet a certain $ amount

Issue #3: Administration of Reinsurance in North Carolina

States have the option to operate a state-based reinsurance program, regardless of whether the state establishes an Exchange, or defer operation of the reinsurance program to the federal government. States that administer reinsurance have the option of increasing the federal assessment beyond the federally required minimum either to fund administrative fees or claims payments. States who administer reinsurance also have the ability to adjust the different "levers" associated with reinsurance for their state, namely the attachment point, coinsurance rate, and reinsurance cap.

Collections of reinsurance contributions was noted by many states to be a key hurdle in establishment of state-based reinsurance programs. However, final rulemaking clarified that regardless of whether a state establishes a state-based reinsurance program, the federal government will collect contribution funds from TPAs on behalf of self-insured plans. The federal government will also collect reinsurance contributions from fully insured plans if requested by the state. The federal collection of reinsurance contributions still enables states to operate a reinsurance program, which would primarily consist of distributing payments to recipient entities and making adjustments to the reinsurance formula. One caveat is that the federal government will only collect additional amounts over the federal rates for administrative expense for a state and will not collect additional amounts for reinsurance payments for a state should the state elect to increase the assessment beyond the federally required minimum payment.

The TAG discussed that having the option to modify the payment model is beneficial since it allows the State to tailor the reinsurance program to meet North Carolina's specific needs. Some concerns were raised that administration of reinsurance at the State level provides an opportunity to increase the reinsurance assessment above what the federal government will require, a move that would not be favorably viewed by some groups (*e.g.*, self-funded groups) who do not receive any benefits from the program. The TAG agreed that decisions about the assessment, which affect the market broadly or impact a large number of stakeholders, should be the province of the North Carolina General Assembly (NCGA) and be subject to the legislative process.

The TAG also noted that it was preferable to defer all collection responsibilities to the federal government, which the TAG viewed as most administratively efficient. However, if the State opts to increase the reinsurance assessment to support additional reinsurance payments, the reinsurance entity would need to perform collections at that point for at least these additional funds, which may impact administrative costs.

The TAG recommends that North Carolina administer the reinsurance program within the State, while deferring the responsibility to collect insurer contributions to the federal government. The group recognized that deferring fully-insured collections responsibility to the federal government, combined with requiring NCGA action to increase the assessment beyond the federal amount, would likely have the effect of setting the contribution amount at the federally established minimum.

Issue #4: Establishment and Oversight of the Reinsurance Entity

States that elect to establish reinsurance programs must enter into a contract with one or more applicable reinsurance entities, defined in ACA as not-for-profit organizations. The TAG discussed at length different capabilities, characteristics, and authority this entity should have, as well as which organization should have responsibility for establishing the reinsurance entity.

Technical/Operational Capabilities of the Reinsurance Entity

In defining the criteria for the selection of a reinsurance entity, the TAG recommends that the entity have:

- the ability to process claims and make payments promptly;
- familiarity with reinsurance programs;
- capacity to house significant amounts of data for a long period of time to comply with federal auditing standards;
- sufficient longevity to pay reinsurance claims after 2016;
- familiarity with use of HIPAA transactions standards for data collection;
- low administrative costs; and
- transparency to build carrier's trust and the ability to perform tasks quickly and efficiently.

Governance Characteristics of the Reinsurance Entity

The TAG recommends that the entity have a governing board composed of insurer and self-funded plan representatives. Board representation should primarily consist of those insurers eligible to receive reinsurance payments, while also including insurers or self-funded plan representatives subject to assessment but not eligible for payments.

Authority to Make Reinsurance Policy Decisions

The TAG recommends that the reinsurance entity be granted the authority to make policy decisions related to program operations. As previously mentioned, the ability to increase the assessment beyond the federal minimum should reside with the NCGA.

The TAG recommends that the NCGA grant the NC DOI statutory authority to facilitate the establishment, through a selection and contracting process, of a reinsurance entity to administer the State's program. The establishment of this entity should take into account the capabilities, characteristics and authority considered by the TAG. The TAG further recommended that NC DOI should be legislatively authorized to serve in a technical advisory capacity to the reinsurance entity's board, as necessary.

About the Market Reform Technical Advisory Group (TAG)

The TAG is comprised of representatives of insurers, agents, academia, hospitals, providers, business and consumers who reside in North Carolina and have knowledge of North Carolina's health care system and marketplace. The TAG considers and makes recommendations on each issue after a review of applicable State and federal laws, relevant literature, national stakeholder recommendations, and pending or passed legislation in other states.

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The purpose of the TAG is to develop options and considerations and to identify areas of consensus to inform the recommendations to the North Carolina General Assembly (NCGA) on ACA-related market reforms. The TAG was convened pursuant to North Carolina Session Law 2011-391, which authorized the Commissioner of Insurance to study insurance-related provisions of the ACA and any other matters it deems necessary to successful compliance with the provisions of the ACA and related regulations.

For more information on the TAG go to: http://www.ncdoi.com/lh/LH_Health_Care_Reform_ACA.aspx

Analysis of Benchmark Plan Options for the Essential Health Benefits Package in North Carolina

Prepared for the North Carolina Department of Insurance

May 14, 2012

MANATT HEALTH SOLUTIONS

OLIVER WYMAN

Report Disclaimers:

The purpose of this paper is to inform North Carolina's options for the development of an Essential Health Benefits package for the State. This report contains observations from the analysis undertaken and the potential implications and considerations of different options in North Carolina.

This report is not intended to provide a recommendation to the North Carolina Department of Insurance, North Carolina General Assembly, Governor or other regulatory or executive entities regarding whether North Carolina should, or should not, select a benchmark plan for the State or rely on the default benchmark selection process. Furthermore, this report is not intended to convey a recommendation as to which plan North Carolina should select if the State defines a benchmark option.

This report was prepared for the sole use of the State of North Carolina. Any and all decisions in connection with the information contained within this report are the sole responsibility of the State. This report is intended to be read and used as a whole and not in parts.

There are no third party beneficiaries with respect to this report, and the authors, including Oliver Wyman, the actuaries undertaking the study, do not accept any liability to any third party. In particular, the authors shall not have any liability to any third party in respect of the contents of this report or any actions taken or decisions made as a consequence of the results set forth herein.

Finally, this report was developed to inform selection of the benchmark plan for applicable plans in North Carolina's individual and small group markets. The Affordable Care Act also requires Essential Health Benefits to be covered in the Medicaid benchmark plan for new Medicaid eligibles in 2014 as well as for the Basic Health Program, if applicable. Federal guidance allows states to select a different Essential Health Benefits benchmark plan for Medicaid.[1] While the analysis undertaken in this report could be used as a reference for Medicaid benchmark decision making, the report does not address the unique benefit needs of the Medicaid population nor the services currently offered in North Carolina's Medicaid program.

[1] *http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf, Question 20.*

ATTACHMENTS

Executive Summary

The Affordable Care Act (ACA) requires all non-grandfathered health insurance plans offered in the small group and individual markets to cover all Essential Health Benefits (EHBs) by January 1, 2014.[2,3] The ACA defines EHBs to include ten broad categories of health benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. The ACA charges the Secretary of the U.S. Department of Health and Human Services (HHS) with further defining the EHBs, and instructs the Secretary to ensure that they are equal to the scope of benefits provided under a typical employer plan.

In guidance issued in December 2011, HHS gave states the option to define EHBs at the state level for 2014 and 2015. Under this process, states may choose a "benchmark" plan from a list of federally designated options. In North Carolina the benchmark options are:

- State Employees Health Plan Option
- Federal Employee Health Benefit Plan (FEHBP) Option 1: Blue Cross Blue Shield (BCBS) Standard Option
- FEHBP Option 2: BCBS Basic Option
- FEHBP Option 3: Government Employees Health Association Basic Plan (GEHABP) Standard Option
- Small Group Option 1: BCBS North Carolina Blue Options
- Small Group Option 2: United Healthcare (UHC) Choice Plus
- Small Group Option 3: BCBS North Carolina UW Small Health Savings Account (HSA)
- Health Management Organization (HMO) Option: WellPath Select, Inc. (WellPath)

The benefits covered as of the first quarter of 2012 in the benchmark plan designated by the state become the EHB package for that state, subject to certain limitations. Limits in the scope and duration of benefits in the benchmark plan are incorporated in EHB requirements. EHB benefits that currently include lifetime or annual limits must be replaced with an actuarially-equivalent benefit. EHB benefits also can not be discriminatory. Cost sharing requirements are not considered a part of the EHB definition and are separately regulated under the ACA.

In designating a benchmark, the state is choosing an entire benchmark plan's benefit package. If the designated benchmark plan does not include benefits in all ten required EHB categories,

[2] ACA Section 2707(a); ACA Section 1302(a)

[3] Applies both in and out of the Exchange. Self-insured employer plans, grandfathered plans and large group health plans are not required to offer EHBs. However, if they do provide any benefits that are EHBs, the ACA prohibits them from applying any annual or a lifetime dollar limit to those benefits. Additionally, these plans must phase out annual dollar limits for any EHB by 2014, with the exception of grandfathered individual health policies.

the state must supplement the benchmark plan by selecting missing benefits from other benchmark options for that state. States may only supplement benefits that are not covered in the benchmark. They may not "pick and choose" on a benefit by benefit basis to customize their benchmark EHBs. Special rules apply for supplementing service categories, such as habilitative care, pediatric oral care and pediatric vision care, when they are not covered by any of the benchmark options. Insurers may substitute the benefits within the ten EHB categories, to the extent such substitutions are actuarially equivalent and consistent with state and federal law. HHS has indicated that it is considering permitting insurers to substitute across the benefit categories, as well.

States that wish to choose a benchmark plan must do so in the third quarter of 2012. Alternatively, states may defer to a federally designated benchmark, or "default benchmark plan." In all states that do not choose a benchmark, HHS will designate the largest plan in the small group market to be the benchmark for the state. If the default benchmark plan does not contain all ten EHB categories, HHS will supplement the small group plan according to an approach outlined in federal guidance.

If the designated benchmark plan does not include one or more services that state law mandates small group and/or individual plans to cover, the ACA requires states to pay for the costs of those mandated services for all Exchange enrollees. Thus, by choosing a benchmark plan that includes the state mandated services, states avoid having to make a choice between covering such services with state funds or repealing existing mandates for the small group and individual markets. Additionally, because the EHBs are based on the benchmark plan's benefits in effect during the first quarter of 2012, the state's EHB package will be unaffected by any changes to state mandated benefits effective after the first quarter of 2012.

Key Findings

The purpose of this report is to inform the State's potential selection of a benchmark plan. The report outlines findings from a comparison of North Carolina's benchmark options including: coverage of state-mandated benefits, relative cost, covered benefits and the need to supplement across benchmark options. Key findings from this analysis follow.

- **All of the benchmark options except the three FEHBP Options cover all state mandates.**[4] If North Carolina designates one of the five non-FEHBP Options as the State benchmark or defers to federal designation of the largest small group plan as the default benchmark plan, it will ensure coverage of all State mandates at no cost to the State. The FEHBP Options lack complete coverage in four state mandates: Temporomandibular Joint Disorder (TMJ), Post-Acute Care for Mastectomies, Hearing Aids up to Age 22 and Prostate Cancer Screening. Actuarial analyses estimate that the cost to the State of covering these benefits outside the EHB package could be about $4

[4] The FEHBPs lack coverage of four state mandates: TMJ, Post-Acute Care for Mastectomies, Hearing Aids up to Age 22 and Prostate Cancer Screening.

million to $5 million in 2014, increasing to about $8.5 million to $10.0 million in 2016. This may make the FEHBP Options less desirable for the State.[5]

- **Relatively little difference exists in the aggregate cost among benchmark options.** The cost of the FEHBP Option 2 is roughly 3% more costly than the baseline option due to the inclusion of dental benefits. However, the other benchmark options in North Carolina are roughly within 0 to 1% of total estimated aggregate costs of each other and the baseline. This suggests aggregate cost is unlikely to be a significant driver in determining North Carolina's benchmark plan.

- **Some variation exists in covered benefits among benchmark options.** A comparison of benchmark options in North Carolina found 36 outliers, defined as services covered by some plans but not others, or covered at different levels among plans. Six outliers that appeared to be higher cost and/or higher frequency services were analyzed for their financial, social and medical implications. While the financial impact of individual outlier benefits are minimal, North Carolina policy makers and stakeholders may be concerned with the medical and social costs associated with covering or not covering certain services. It is important to note, however, that if insurers are permitted to make actuarially-equivalent substitutions within or across each of the ten EHB categories,[6] the choice of a benchmark option will not necessarily determine which specific benefits will be covered by a specific plan.

- **Relatively little variation exists between the benchmark options and individual market coverage.** Although the benchmark options are based on group products, there is little variation overall between benchmark coverage and current individual coverage. This variation is further reduced if Small Group Option 1 is selected as the benchmark option because that plan is similar to the most common coverage in the individual market.

- **The supplementing process will be the same for most benchmark options.** All benchmark options would need to be supplemented for pediatric oral and vision care and most, if not all, options would need to be supplemented for habilitative services, depending on the final definition of habilitative. In addition the HMO plan would need to be supplemented with pharmacy benefits. If the HMO plan is designated as the benchmark, North Carolina would have more control over selecting the pharmacy benefit, but would also need to dedicate more resources to the process.

Based on this analysis, there appear to be few clear reasons for North Carolina to choose one benchmark option over another, although certain factors suggest eliminating the FEBHPs as

[5] Based on the baseline exchange enrollment scenario from the "North Carolina Health Benefit Exchange Study" prepared by Milliman, Inc.; December 9, 2011. http://www.nciom.org/wp-content/uploads/2010/10/NCDOI-Health-Benefit-Exchanges-Report-Version-37_2012-12-9.pdf

[6] HHS is considering substitutions across categories

preferred options. Thus, North Carolina policy makers may reasonably question the benefits of deferring to the default benchmark plan.

- **Selecting the benchmark plan at a state level allows the opportunity for stakeholder input and may allow for some choices in supplementing the benchmark.** North Carolina has an opportunity to build consensus among key parties, including consumers, employers, insurers, and providers in designating a benchmark plan for the State. To the extent that the State has flexibility to supplement the benchmark, selecting the benchmark enables North Carolina to take advantage of this flexibility.

- **Given the minimal variation in benchmark options, deferring to the default benchmark plan would free up resources for other aspects of health reform implementation.** This is a consideration for State policy makers and stakeholders, and is particularly compelling given that the benchmark selection will only be in effect for two years. Since the default plan already covers a large portion of the small group market and has benefits similar to the individual market, the default plan may offer the best and most efficient opportunity to mitigate market disruption.

- **Actively selecting the default benchmark plan as the benchmark offers a middle ground, streamlining the designation process while allowing North Carolina to retain the authority to supplement and otherwise define the benchmark.** If stakeholders are in general agreement on the default benchmark plan, this could minimize the resources expended in the decision making process while preserving State authority over other aspects of defining the EHB package.

I. BACKGROUND

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act (ACA), is sweeping legislation requiring significant changes in how health insurance is purchased, sold and regulated in the states. The ACA mandates the creation of Health Benefit Exchanges (Exchanges), state marketplaces where individuals and small groups may purchase coverage from qualified health plans (QHPs). Individuals purchasing coverage through an Exchange may receive tax subsidies to offset the cost of such coverage. The ACA also creates new standards for health benefit plans offered to individuals and small groups both inside and outside of an Exchange, including requirements that all such plans offer a comprehensive package of Essential Health Benefits (EHBs).

The North Carolina General Assembly (NCGA) authorized the North Carolina Department of Insurance (NC DOI) to "collaborate and plan in furtherance of the requirements of the Affordable Care Act," granting the NC DOI the authority to contract with experts necessary to facilitate preparation for ACA implementation.[7] The NC DOI commissioned Manatt Health Solutions (Manatt) and its partner, Oliver Wyman, via a competitive bidding process[8] to develop a report to the NCGA on EHB options in North Carolina, including the potential implications for benefits currently mandated under State law.

Development of This Report

This report relies on federal guidance issued to date to compare the EHB benchmark options from which the State of North Carolina may choose. The findings are informed by the following activities:

- **Analysis of plans eligible for use as the EHB benchmark in North Carolina.** An assessment of the EHB benchmark plan options for the State was conducted to determine differences among the plans in covered benefits and total relative cost. Benefits from each eligible benchmark plan were catalogued and compared against each other. "Outlier" benefits, defined as benefits covered by some benchmark options but not others, or provided by all plans at varying levels of coverage, were identified and high use and/or high cost outlier benefits were assessed for their financial implications and medical and social impacts.[9] The benefits of each benchmark plan option were reviewed to determine the extent to which each plan offered all State mandated benefits and each of the federally mandated EHB categories (described in Section II). Finally, a holistic pricing analysis was performed to compare the relative costs of the benchmark options.

[7] North Carolina Session Law 2011-391.
[8] North Carolina Department of Insurance Issued RFP #12-001073 on July 20, 2011, Project 2.
[9] Attachment G contains the detailed findings from this assessment.

- **Review and verification of analysis with stakeholders.** The NC DOI's Market Reform Technical Advisory Group (TAG), which is comprised of representatives from insurers, agents, academia, hospitals, providers, business and consumers, met to review and provide input into the preliminary analysis of the benchmark options on April 9, 2012.[10] Each insurer or self-insured entity with eligible benchmark options in the State was also asked to review specific analysis relative to its benchmark plan(s) for accuracy.[11]

- **Distribution of findings.** The analysis was synthesized into a written report for the NC DOI to share with the NCGA, regulators and other stakeholders.

Report Structure and Organization

The report is divided into several sections. Section II provides an overview of EHBs, setting forth the legal definition and describing the guidance issued to date by HHS. Sections III and IV focus on the analyses undertaken in North Carolina for the purposes of this report. Section III discusses in detail the methodology used for this analysis. Section IV discusses the findings from benefit comparisons across the benchmark options and the holistic pricing analysis. Section V provides observations and considerations based on the analysis, and suggests potential next steps for the State.

[10] Under a separate project pursuant to RFP #12-001073, the NC DOI convened a Market Reform Technical Advisory Group (TAG) to assist with market issues related to ACA implementation. The TAG members reside in North Carolina and have knowledge of North Carolina's health care system and marketplace. A copy of the presentation shared with the TAG can be found on http://www.ncdoi.com/lh/LH_Health_Care_Reform_ACA.aspx.
[11] The review of federal plans was not available for the writing of this report.

II. Overview of Essential Health Benefits

Beginning on January 1, 2014, the ACA requires all non-grandfathered plans offered in the small group and individual markets – both inside and outside of an Exchange – to cover all EHBs. [12, 13]

ACA Background

The ACA defines EHBs to include ten broad categories of health benefits.[14] These are:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services, including oral and vision care.

The ACA charges the Secretary of the U.S. Department of Health and Human Services (HHS) with further defining the EHBs, and instructs the Secretary to ensure that they are equal to the scope of benefits provided under a typical employer plan.[15] While EHBs may include limits on the duration and scope of covered services, they may not include annual or lifetime dollar limits[16] and must not be discriminatory.

The ACA distinguishes between the EHBs and the cost sharing requirements of a plan. EHBs define a standard set of services that must be covered by applicable plans without regard to cost sharing. The ACA separately regulates cost sharing requirements, including limits on cost sharing and mandates regarding levels of coverage.[17] EHBs are the full package of covered benefits to which insurers will apply cost sharing requirements, resulting in levels of coverage

[12] ACA Section 2707(a); ACA Section 1302(a)
[13] Self-insured employer plans, grandfathered plans and large group health plans are not required to offer EHBs. However, if they do provide any benefits that are EHBs, the ACA prohibits them from applying any annual or lifetime dollar limit to those benefits. Additionally, these plans must phase out annual dollar limits for any EHB by 2014, with the exception of grandfathered individual health policies.
[14] ACA Section 1302(b)(1)(A-J)
[15] ACA Section 1302(b)(1) and (2)
[16] Lifetime and annual limits for the EHB categories were restricted starting in plan years beginning on or after 9/23/2010 and are prohibited starting January 1, 2014; ACA Section 1001 (amendment to Public Health Service Act 2711)
[17] ACA Section 1302(a)

(bronze/ silver/ gold/ platinum) and their accordant actuarial values[18] (60/70/80/90) outlined in the ACA.

The ACA permits states to require insurers to cover additional services that are not included in the EHB. However, states must pay insurers for any mandates not defined as part of the EHB for Exchange enrollees.[19] States are not required to pay for any mandates for enrollees outside of the Exchange.

HHS Efforts to Define the EHB to Date

HHS has undertaken the following efforts to inform the definition of EHBs:

- A study by the Department of Labor was released in April 2011 which included the National Compensation Survey and analysis on select benefits;[20]
- A report from the Institute of Medicine was released in October 2011 addressing criteria and methods for defining and updating EHB packages; and[21]
- Listening sessions were held around the country in November 2011 to assess key questions, such as how HHS can best meet the dual goals of affordability and balancing the EHBs' comprehensive coverage.

On December 16, 2011, HHS issued the EHB Bulletin, outlining an approach for defining EHB packages in plan years 2014 and 2015, and taking into account the need to "balance comprehensiveness, affordability, and state flexibility and to reflect public input received to date."[22] The Bulletin notes that HHS "intends to assess the benchmark process for the year 2016 and beyond based on evaluation and feedback."[23] A list of Frequently Asked Questions on the EHB Bulletin was released on February 17, 2012 to provide additional guidance on HHS's intended approach to defining EHBs.[24]

Implementation Approach

In the approach outlined for 2014 and 2015, HHS allows each state the flexibility to designate a benchmark plan to serve as the state's EHB. States have a choice from among the following ten possible benchmark plans:

[18] Actuarial value is a measure of the percentage of expected health care costs a health plan will cover.
[19] ACA Section 1311(d)(3)
[20] http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf
[21] http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx
[22] http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf, Page 1
[23] http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf, Page 9
[24] http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf

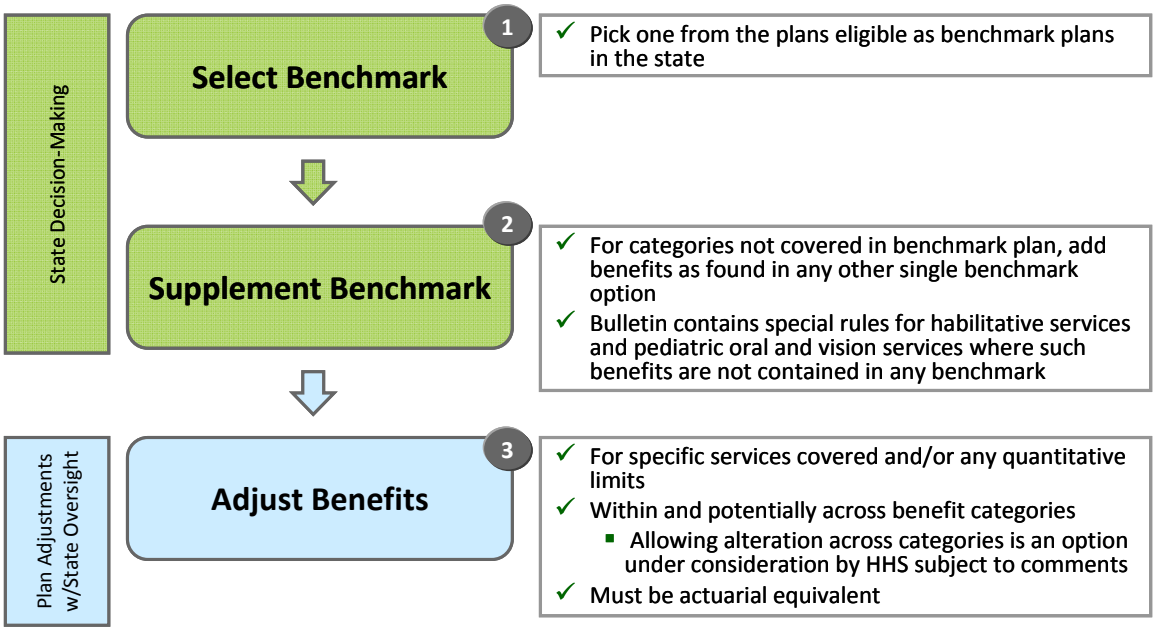
- The largest plan in any of the three largest small group products in the state by enrollment;
- The three largest State employee health plans by enrollment;
- The three largest FEHBP options by enrollment; or
- The largest HMO plan offered in the state's commercial market by enrollment.

If a benchmark plan does not contain all ten categories of benefits identified in the ACA, the state must supplement the benchmark by selecting the missing benefits from one or more of the other benchmark options for that state. Certain categories, such as habilitative care, pediatric oral care and pediatric vision care may not be provided in any benchmark option. In those instances, HHS has outlined special rules which are described in the methodology section of this report (Section III).

HHS guidance also provides that a state may allow insurers to further modify the benefits offered by the chosen (or default) benchmark plan, as supplemented, to the extent such substitution is otherwise consistent with state and federal law. Health insurers must cover "benefits that are 'substantially equal' to the benefits of the benchmark plan selected by a state and modified as necessary to reflect the ten coverage categories,"[25] however insurers have "some flexibility to adjust benefits, including both the specific services covered and any quantitative limits provided they continue to offer coverage for all ten statutory EHB categories."[26] Substituted services within each of the ten statutory categories must be actuarially equivalent.[27] While HHS indicated in its December 2011 Bulletin that it is considering permitting insurers to substitute across the benefit categories, subsequent guidance has been silent on this point. Such substitutions, if permitted, would need to be actuarially equivalent, as well.[28]

[25] http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf, Page 12
[26] http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf, Page 12
[27] http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf, Question 7
[28] http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf, Page 12

Figure 2.1: State EHB Process Outlined by HHS

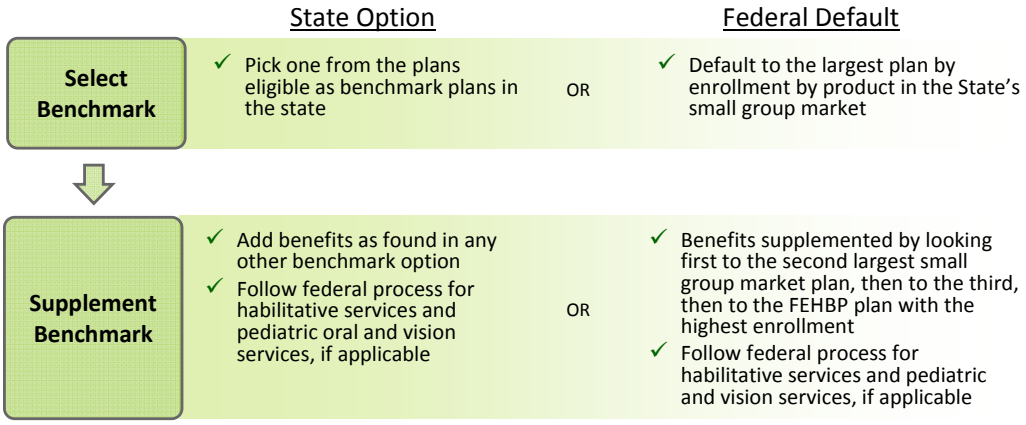


States must select a benchmark health plan "in the third quarter of 2012"[29] to establish EHBs for benefit years beginning in 2014 or 2015. This imminent deadline is driven by health insurers' need to develop and gain approval of new plans in advance of the open enrollment for the Exchange, scheduled to begin October 1, 2013.

If a state does not select a benchmark plan, HHS will designate the small group plan with the largest enrollment as the benchmark,[30] referred to in this report as the default benchmark plan. Supplemental benefits for the default benchmark plan will be determined by a process dictated by federal guidance that looks first to the second-largest small group market benchmark plan, then to the third and then, if none of the small group plans offer benefits in a missing category, to the FEHBP benchmark plan with the highest enrollment.

[29] A specific date has not been proposed.
[30] http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

Figure 2.2: State Option versus Federal Default[31]



If a state chooses or defaults to a benchmark plan that includes any state-mandated benefits, those benefits are considered part of the state's EHBs.[32] States are not required to pay for the cost of mandated services included within the EHBs.

[31] Regardless of the State Option or the Federal Default, plans still have the ability to adjust benefits with oversight.
[32] This does not include any benefits that are mandated after December 31, 2011. States are required to pay for the full cost of including such mandates.

III. METHODOLOGY

The purpose of this analysis is to inform policy makers about the options for defining the EHBs within North Carolina. The methodology is outlined in Figure 3.1 and described in the subsequent sections.

Figure 3.1: Methodological Steps for Benchmark Analysis

Identified Benchmark Options in North Carolina

Federal guidance provides North Carolina the option to select one of up to ten plans as a benchmark plan for 2014 and 2015. While states may select from the three largest state employees health plans by enrollment, North Carolina has only two options (the Basic Plan and the Standard Plan) and the benefits covered under both plans are the same. Since the EHB package is defined by the benefits that are covered and not the cost sharing applied in the plan, North Carolina essentially has only one unique option for the State Employees Health Plan, and eight total unique options from which to select rather than ten. These eight options are described in Figure 3.2.[33]

[33] At the time this analysis was performed, information on the first quarter 2012 plans was not yet available. Therefore, the analysis was based on the list of plans in Figure 3.2 meeting the prescribed requirements during the second quarter of 2011, as released by HHS on January 25, 2012. While there is the potential for the first quarter 2012 plans to differ from those that follow, it is highly likely that they will not.

Figure 3.2. Benchmark Plan Options

Plans Eligible for Benchmark Status	North Carolina Plans	State Enrollment
State Employees Health Plans	• State Employees Option: State Employees Health Plan o State has two plans; difference in cost-sharing, only o Analyzed as one plan	545,509
Federal Employees Health Benefit Plans (FEHBP)	• FEHBP Option 1: BCBS Standard Option	N/A
	• FEHBP Option 2: BCBS Basic Option	N/A
	• FEHPB Option 3: GEHABP Standard Option	N/A
Small Group Insurance Plans	• Small Group (SG) Option 1: BCBSNC Blue Options	151,747
	• Small Group (SG) Option 2: UHC Choice Plus	71,524
	• Small Group (SG) Option 3: BCBSNC UW Small HSA	45,160
Largest Non-Medicaid HMO	• HMO Option: WellPath Select, Inc.	27,595

Initial Comparison of Current Benefits

Benefit booklets for each of the potential benchmark plan options above were reviewed in detail, and compared across all plans. The language used in the benefit booklets is not standardized across insurers and, at times, is open to interpretation. Thus, the comparison occasionally required interpretation based on the consultant's experience of industry practices, particularly in instances where benefits were not specifically listed in the booklets as either a covered or excluded benefit.

Because the guidance provided by HHS indicates that the benchmark plan will reflect both the benefits that are covered as well as any limits on duration or scope of those benefits, the comparison analysis included any applicable limits. While annual or lifetime dollar limits are not permitted for EHBs under the ACA, it was assumed that the actuarial equivalent of such limitations would apply. Restrictions on provider networks and formularies were not considered since these are not part of the EHB definition.

To increase accuracy, the full comparisons were provided to the insurers and self-funded entities offering each of the plans eligible for benchmark status. These entities were asked to review the determinations and provide a revised copy of the summaries making any necessary

corrections. A response to this request for verification was not received for the FEHBP plan options as of the date this report was published. Therefore, the FEHBP benefits reflect the consultant's best judgment. A final summary of the comparison of current benefits, reflecting corrections based on insurers and self funded entities' feedback, is included in Attachment A.

Categorized and Supplemented Benefits

The benefits grid was then examined to determine whether all of the services described in the ten broad EHB categories were covered in the benchmark plan options. As anticipated, all of the plans contain most of the services required. However, as the HHS EHB Bulletin anticipates, most plans do not cover habilitative services or pediatric oral and vision services. Attachment B provides a summary of the EHB categories covered by each of the current plans.

The ACA requires that certain prescribed benefits be included as part of the EHB package for all plans. Therefore, in developing a set of benefits that would represent the EHB package if each plan were selected as the benchmark, each plan was supplemented to ensure it contained the following:

- Women's wellness benefits;[34]
- A and B recommendations from the U.S. Preventive Services Task Force (USPSTF);[35]
- Benefits included in the Bright Futures/American Academy of Pediatrics guidelines,[36] Habilitative services,[37] and Pediatric oral and vision services; and [38]
- Parity requirements in MHPAEA[39]

Attachment C contains a detailed list of the required supplemental benefits for women's wellness benefits, A and B recommendations from the USPSTF, and benefits recommended by the Bright Future/American Academy of Pediatrics guidelines.

HHS guidance provides various options to states when supplementing benchmark options for habilitative and pediatric oral and vision services. For this analysis, it was assumed that habilitative services would be offered at parity with rehabilitative services, and that the definition of these services would be consistent with the definitions currently used in the commercial market. Specifically, these definitions focus on creating skills and functions, rather than "keeping" or "maintaining" function.[40] In supplementing benchmark plans for pediatric

[34] As required under the ACA §1302(b)(1)(I) as further defined in 45 CFR Part 147.130(a)(1)(iv)

[35] As required under the ACA §1302(b)(1)(I) as further defined in 45 CFR Part 147.130(a)(1)(i)
[36] As required by the ACA §1302(b)(1)(I) as further defined in 45 CFR Part 147.130(a)(1)(iii);
[37] as required by the ACA §1302(b)(1)(G);
[38] As required by the ACA §1302(b)(1)(J)
[39] As indicated in the December 16, 2011 EHB Bulletin, http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf
[40] http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

oral services, this analysis used the estimated costs that are equivalent to the state Child Health Insurance Program (CHIP) program as published by the National Association of Dental Plans (NADP).[41] The plan includes preventive and basic dental services as well as advanced dental services. The analysis used the CHIP plan that does not include orthodontia.

Plans that do not contain pediatric vision services must be supplemented with benefits covered by the Federal Employees Dental and Vision Insurance Program (FEDVIP) vision plan with the largest enrollment. HHS guidance indicates that the FEDVIP vision plan with the highest enrollment in 2010 covers routine eye exams with refraction, corrective lenses and contact lenses.[42] Further, the current FEDVIP vision plans include both service and dollar limits in its coverage. As an example, the FEDVIP BlueVision plan covers one set of contact lenses per year, up to $130.[43] This combination of both a limit on the frequency with which vision hardware may be replaced, and a dollar limit on the cost of the hardware, could be considered to effectively create an overall annual dollar limit on the vision hardware benefit that is prohibited by the ACA. For this analysis, an assumption was made that a scheduled dollar allowance per set of vision hardware will be allowed to remain, however restrictions on the frequency with which the hardware may be replaced are lifted. The resulting benefit becomes a benefit with a scheduled allowance per service. It is important to note that a scheduled dollar allowance per service with no limitation on the number of services differs from the prohibition on annual dollar limits.

This benchmark option comparison analysis is not impacted by which option is used for supplementing the benchmark package to include coverage for required habilitative services and pediatric oral and vision coverage. Since any plan selected as the benchmark would be required to cover these benefits, the additional cost added to each plan is the same.

North Carolina Mandated Benefits Comparison

North Carolina law requires certain benefits to be covered by each individual or small group plan offered in the State. In addition, insurers are required to provide these individuals or groups with the option of purchasing certain other benefits. Attachment D contains a comparison of the State mandated benefits currently covered by each of the benchmark plan options. The list of mandated benefits was provided by the NC DOI and was limited to mandates on covered services as opposed to requirements related to administration of the plan. The only plans that were found to exclude some state mandated services were the FEHBP options.

[41] National Association of Dental Plans. "Offering Dental Benefits in Health Exchanges: A Roadmap for Federal and State Policymakers." September 2011.
http://www.nadp.org/Libraries/Newsletter_Links/Dental_Exchange_White_Paper_v9-9-11-3.sflb.ashx
[42] http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf
[43] http://cvw1.davisvision.com/forms/StaticFiles/English/FEP2012BenefitSummary.pdf

Analysis for Benchmark Selection

For the purposes of this analysis, each of the plans was supplemented, resulting in a complete set of benefits that would be required should the plan be selected as the State's benchmark plan and assuming that State mandated benefits continue. A comparison of these supplemented plans is provided in Attachment E.

There are various analyses the State could consider to select a benchmark plan, ranging from a "holistic" approach that focuses on the total cost of covered services under each plan to a "granular" approach that focuses on the specific benefits that would be covered if each option were selected as the benchmark. Both approaches have merit and the specific steps undertaken to conduct these analyses are detailed below.

Holistic Pricing Comparison

Using the supplemented benefit packages described above and shown in Attachment E, a relative claim cost was developed for each plan. The largest small group plan (Small Group Option 1) was selected as a reference plan and actuarial analysis was performed to estimate the cost of covered benefits in each of the other plans relative to the reference plan. The relative cost compared the total cost of covered benefits, but did not consider any cost sharing required under the current plans as cost sharing is not part of the EHB package. Analysis was based on Oliver Wyman's internal pricing model[44] and was supplemented by cost and utilization information on specific benefits as provided by nine of the ten largest small group insurers in the State. For plans that contain benefits which currently have annual dollar limits applied, it was assumed those limits apply in our analysis. However, should a plan with any of these limits be selected as the benchmark plan, the annual dollar limit will need to be removed and an actuarially equivalent benefit added. This substitution would have no impact on the overall relative cost between the plans.

Outlier Analyses

In addition to a holistic view of costs, several outlier analyses were performed. Using the benefits supplemented with all ACA-required changes, reflected in Attachment E, a comparison across plans was conducted to identify benefits where differences in coverage exist among the plans. Where a benefit was covered by one plan and either not covered or covered at a different level by another plan, the benefit was flagged as an "outlier." Since all benefits not flagged as outliers are common across all plans, the outlier benefits drive the differences in

[44] Oliver Wyman's commercial pricing model is a service based model used to determine utilization and cost per service estimates for a wide range of medical and prescription drug services typically covered in comprehensive major medical policies sold to groups and individuals under age 65. The model is based on over $150 billion in allowed claims from over 38 million members, and allows for the development of actuarial estimates of the value of various types of benefits including annual limits as well as cost sharing features including deductibles, coinsurance, copayments, and out-of-pocket maximums.

holistic cost, and represent differences in the EHB package when selecting one plan versus another. A summary of these outlier benefits is provided in Attachment F.

The benchmark plan selected will be EHBs for both the individual and small group markets. Therefore, the analysis also examined the benefits covered under individual plans offered by insurers representing 88% of enrollees in the individual market. The benefits covered in the individual market were compared to the outlier benefits across the benchmark plan options to determine if there were any benefits that are widely covered in the individual market that would not be covered if a particular plan was selected as the benchmark. These comparisons are also included in Attachment F.

Finally, given that differences between the various plan options lie with the outlier benefits, additional detailed analysis was performed on six outlier benefits. This additional analysis included examining the financial impact, as well as research related to the medical efficacy and social impact of the benefit. Selection of benefits for further analysis was based on overall utilization of the benefit by the entire population or financial burden to those utilizing the service if not a covered benefit. It was assumed that the State would not select a FEHBP option as the benchmark plan; therefore, if an outlier benefit was covered similarly for all benchmark options other than the FEHBPs it was not selected for further analysis.

IV. COMPARISON FINDINGS AND HOLISTIC PRICING ANALYSIS

Several analyses were undertaken to compare North Carolina's benchmark plan options in the following respects: coverage of State-mandated benefits, relative cost, benefit variations across benchmark options and comparisons between benchmark options and the individual market. The findings from each of these analyses reveals relatively little variation in the benchmark options with the exception of the FEHBP options which do not include all of the State-mandated benefits. FEHBP Option 2 also has higher relative costs. The detailed findings across each of these analyses are discussed below.

Comparison of State Mandated Benefits to Benchmark Options

As previously discussed, under the ACA states are responsible for the cost of state benefit mandates that are not included in the EHB package for Exchange enrollees. Benefit mandates under North Carolina law currently apply to all of the small group and HMO benchmark options. While mandates in North Carolina insurance laws generally do not apply to the State Employees Plan, the State Employees Plan does contain all mandated benefits in North Carolina. Thus, selecting the small group, HMO and State Employees Plan benchmark options would include the State mandated services in the EHB package with no costs to the State.

State mandates do not apply to the FEHBP and four benefits mandated by North Carolina are not currently covered in full by the FEHBP options.

- TMJ Joint Dysfunction (N.C.G.S. §58-3-121) – The State mandate requires that diagnostic, therapeutic and surgical coverage be provided the same as any other bone or joint; all three FEHBP plans only cover the surgical portion of this benefit.
- Post-Mastectomy Inpatient Care (N.C.G.S. §58-3-168) – The State mandate requires that the decision to discharge an individual from a hospital following a mastectomy procedure be a joint decision made between a patient and her physician, with no specified maximum length of stay; all three FEHBP plans provide coverage only for the first 48 hours unless medically necessary.
- Coverage for Hearing Aids Up to Age 22 (N.C.G.S. §58-3-285) – The State mandate requires coverage for one hearing aid per ear every 36 months up to $2,500 per hearing aid for children up to age 22. FEHBP Options 1 and 2 cover $1,250 per ear per year for children up to age 22. FEHBP Option 3 covers up to $250 per ear towards external hearing aids once every five years.

- Coverage for Prostate Cancer Screening (N.C.G.S. §58-51-58/ §58-65-93/ §58-67-77)[45] – The State mandate does not include an age requirement for coverage and therefore appears to apply regardless of age. FEHBP Option 3 covers the screening but only for men age 40 or older.

Thus, if one of the FEHBP options were selected as the benchmark plan, these benefits would be required to be covered in the individual and small group markets pursuant to North Carolina law, but would not be part of the EHB package. As a result, the State would be required to cover the cost of these mandated benefits for all Exchange enrollees. Alternatively, the State could repeal these mandates, or make them applicable only to grandfathered plans or plans offered outside the Exchange.

The estimated cost to the State of covering State mandates not fully covered in a FEHBP benchmark option could be $4 million to $5 million in 2014, increasing to about $8.5 million to $10.0 million in 2016 for coverage of these benefits.

Relying on analysis previously performed for the NC DOI as part of an earlier Exchange study, it was estimated that the full cost of these four mandated benefits is $0.88 per member per month (PMPM) in 2011 dollars, or 0.26% of claims.[46] However, the FEHBP options cover a portion of the TMJ mandate (i.e., surgical procedures only for TMJ joint dysfunction), a portion of the hearing aid mandate (i.e., $1,250 per ear per year for FEHBP Options 1 and 2 and $250 per ear every five years for FEHBP Option 3), and a portion of the prostate cancer screening mandate (FEHBP Options 1 and 2 cover in full, FEHBP Option 3 covers for ages 40 and greater). Thus, the remaining cost to the State would be less than this amount. The cost for the portion of these four mandates for which the State would be responsible if one of the FEHBP options were selected as the benchmark plan is approximately $0.48 to $0.63 PMPM (again in 2011 dollars), or 0.13% to 0.18% of claims, for each individual enrolled in coverage through the Exchange. The estimated cost to the State could be $4 million to $5 million in 2014, increasing to about $8.5 million to $10.0 million in 2016 for coverage of these benefits.[47]

Holistic Pricing Analysis

A holistic pricing analysis was performed to compare the relative cost, and the rough impact on premiums, of selecting one benchmark plan option over another. It is important to note that this analysis does not reflect the impact on current premiums, as such an analysis would require

[45] The first statute cited applies to commercial insurers, the second to medical service corporations (BCBSNC), and the third to HMOs. All of the mandated benefits cited in this report apply to all three types of entities; the difference between those mandates with one statute cited and those with three is in how the statute is organized for a particular mandate.

[46] http://www.ncmedicaljournal.com/wp-content/uploads/2010/10/NCDOI-Health-Benefit-Exchanges-Report-Version-37_2012-12-9.pdf

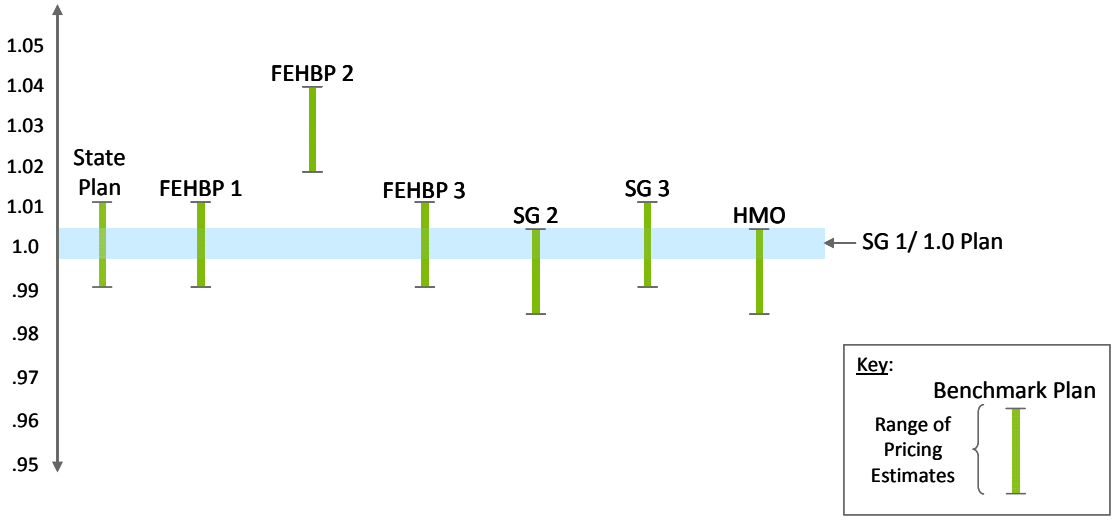
[47] Based on the baseline exchange enrollment scenario from the "North Carolina Health Benefit Exchange Study" prepared by Milliman, Inc.; December 9, 2011. http://www.nciom.org/wp-content/uploads/2010/10/NCDOI-Health-Benefit-Exchanges-Report-Version-37_2012-12-9.pdf

a complete review of all plans currently offered in the market, including an analysis of the underlying costs of each plan.

This analysis shows the total value of the EHB package under each of the benchmark options. Insurers may have flexibility to substitute specific benefits as long as the substitutions are actuarially equivalent. Even if this substitution results in somewhat different benefits than those in the supplemented benchmark plan, the overall value of the resulting benefit package must remain the same as the supplemented benchmark plan.

Small Group Option 1 was selected as a reference plan and actuarial analysis was performed to estimate the relative allowed cost of covered benefits in each of the other supplemented plans. The results of this analysis are displayed graphically in Figure 4.1.

Figure 4.1. Holistic Pricing Results



The range of pricing estimates for each benchmark plan option relative to the reference plan is shown in the chart above. Since allowed costs can vary significantly between carriers, and can vary by differing amounts for different packages of benefits, the cost of adding coverage for certain services may vary. For this reason a range is included around the best estimate of costs.

The impact on premiums in the individual and small group market is not highly dependent upon the benchmark plan option selected, with the exception of FEHBP Option 2.

The chart shows that, with the exception of FEHBP Option 2, there is relatively little difference in the aggregate allowed cost for each benchmark plan option. This indicates that while there are differences in the outlier benefits included in each plan, either the actuarial value of the package of outlier benefits is relatively the same across plans or the value of the outlier benefits is small relative to the total. The driver of the higher cost for FEHBP Option 2 is the generous dental benefit. Recognizing that the aggregate cost of most benchmark plans' benefits are approximately actuarial equivalents, the impact on premiums in

the individual and small group market is not highly dependent upon the benchmark plan option selected, with the exception of FEHBP Option 2.

Benefit Comparisons Among Benchmark Options

Because benefits common to all benchmark plan options will contribute equally to the cost of the EHB package, the analysis focused on an examination of the outlier benefits, or those benefits covered by at least one plan and either not covered or covered with different limitations by one or more other plans. All plans were found to include coverage for services commonly included in small group plans in the market today, such as inpatient hospitalization, outpatient surgery, emergency room visits and physician office visits. All plans also included prescription drug coverage with the exception of the HMO Option which only included this coverage if purchased as a rider. In addition, benefits specifically required by the ACA, such as prescription drugs, preventive services, women's wellness benefits and coverage for habilitative services and pediatric oral and vision services, are by definition common to all supplemented plans, as are any State mandated benefits. Combined, these common benefits are estimated to represent roughly 98% to 99% of the total allowed cost for all but one of the supplemented plans. One plan, FEHBP Option 2, includes a generous dental benefit resulting in the common benefits representing only 96% of total benefits for that plan.

Therefore, the 36 outlier benefits identified comprise only a small portion of the total cost of each supplemented benchmark option plan. A comparison of the differences in coverage for these outlier benefits among the various plan options is shown in detail in Attachment F, as well as in Figure 4.2 below.

Figure 4.2. Outlier Benefits[48]

Key:
[*empty*]= Not Covered
X= Covered and coverage is the same across plans
X*= Covered with lesser coverage versus other plans
X**= Covered with average coverage versus other plans
X***= Covered with more coverage versus other plans

Benefit	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
INPATIENT HOSPITAL								
Bariatric Surgery	X	X	X	X	X		X	
Oral and Maxillofacial Surgery	X*	X**	X**	X**	X*	X*	X*	X*
OUTPATIENT HOSPITAL								
Cardiac Rehab	Unlim	Unlim	Unlim	Unlim	Unlim	36	Unlim	Unlim
Pulmonary Rehab	Unlim	Unlim	Unlim	Unlim	Unlim	20	Unlim	Unlim
Chiropractic Manipulation	30	12	20	12		20		20
Physical Therapy				60	30	20	30	20
Occupational Therapy	30	75	50			20		20
Speech Therapy				30	30	20	30	20
IV/Infusion Therapy	X**	X**	X**	X**	X**	X**	X**	X*
Respiratory Therapy	X			X	X	X	X	X
Hyperbaric Oxygen Therapy					X	X	X	X
Infertility Services	X**	X***	X***	X*	X**		X**	
Dental Implants					X**	X*	X**	
Diagnostic Genetic Testing and Counseling	X	X	X		X	X	X	X
PRESCRIPTION DRUG COVERAGE								
Smoking and Tobacco Cessation Prescription Drugs	X	X	X	X	X		X	X

[48] In some cases, unlimited (unlim) and specific visit limits are noted to show differences in coverage. Other details are provided only when relevant to distinguish between coverage levels. There are slight variations in benefits not highlighted.

Benefit	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
OTHER SERVICES								
Private Duty Nursing in the Home	X *				X**		X**	
Oral Orthotic Devices	X **	X *	X *	X *	X **	X **	X **	X **
Coverage for Needles and Syringes for the Administration of Covered Medications	X **	X **	X **	X **	X **	X *	X **	X **
Home Health Visit	Unlim	25	25	50	Unlim	60	Unlim	30
Skilled Nursing Facility Care	X ***	X ***	X ***	X *	X **	X ***	X **	X **
Respite Care	X	X	X					X
Acupuncture		X*	X**	X*				
Hypnotherapy	X				X		X	
Abortion[49]	X*	X*	X*	X*	X**	X**		X**
Autism Spectrum Disorder	X*	X**	X**	X**	X*	X*	X*	X*
Over-the-Counter Medications	All plans cover some; differences are very minor							
Wigs for Hair Loss due to Chemotherapy Treatment for Cancer		X*	X*					X**
Medical Foods (Food supplements, formulas or special foods)		X	X	X				
ANCILLARY BENEFITS								
Routine Vision Exams – Adult					X**	X*	X**	
Eyeglasses and Contact Lenses – Adults							X	
Eyeglasses Related to an Accident, Surgery or Medical Condition	X	X	X	X	X		X	X
Routine Dental		X*	X**	X*				
Routine Hearing Exams	X							X
Hearing Aids	X**	X***	X***	X*	X**	X**	X**	X**
Speech Generating Devices / Voice Synthesizers		X*	X*		X**	X**	X**	X**

[49] Abortion services are separately regulated under the ACA. For more information, please go to: http://www.kff.org/healthreform/upload/8021.pdf

Of the 36 outliers, there are 21 instances where coverage for a specific benefit is lacking among one or more plans. For example, bariatric surgery is covered by all plans with the exception of Small Group Option 2 and the HMO Option. For the 15 remaining outliers there are differences in the level of coverage. For example, physical therapy, occupational therapy and speech therapy are covered across all benchmark options, but the number of visits covered differ among plans. Since federal guidance issued to date permits insurers to adjust benefits, insurers may opt to adjust benefits covered in the marketplace to include one or more of these outliers, as long as such adjustments are actuarially equivalent.

Additional Detailed Benefit Analysis

Further analysis was performed on a select set of outlier benefits based on an assessment of the relative frequency of use by the population at large and the relative financial burden imposed on an individual who utilizes the service if it is not a covered benefit. Based on these considerations and in consultation with NC DOI, the following six benefits were identified for additional analysis. The financial, medical and social impact of covering versus not covering each of these benefits is discussed in detail in Attachment G.

Respite care provides temporary relief for a caregiver providing daily care to loved ones with a wide array of medical conditions. In today's small group market, respite care is not considered medically necessary and is not normally covered by medical insurance. FEHBP Options 1 and 2 provide up to seven consecutive days of inpatient hospice care, while the State Employees Option and the HMO Option have no stated limit.[50] Based on the 2010 commercial average cost per day of respite care and varying utilization rates it is estimated the cost of the FEHBP inpatient hospice respite benefit is $0.05 - $0.15 PMPM, or 0.01% to 0.04% of premium. Eighty percent of caregivers do not utilize respite services[51] and their individual annual direct out-of pocket costs exceeded $5,000 in 2007.[52]

Infertility is a disease of the reproductive system that impairs the ability to reproduce. It affects roughly 10% of women aged 15 to 44 in the United States.[53] All of the benchmark options provide some level of coverage for the diagnosis and treatment of infertility with the exception of Small Group Option 2 and the HMO Option. None of the plans cover assisted reproductive technology. Depending on which benchmark option providing coverage is examined, the estimated cost ranges from $0.00 - $0.40 PMPM, or 0.00% to 0.11% of premium. Women with infertility often suffer from depression, anger and anxiety[54] and women who become pregnant through the use of infertility drugs have a higher risk of multiple pregnancies

[50] Benefit must be preceded by at least 21 days of traditional home hospice before additional days are covered
[51] http://archrespite.org/images/Lifespan_Reauthorization/2012_Respite_and_Caregiving_Fact_Sheet_3_12.pdf
[52] http://archrespite.org/images/Books/i51-caregiving.pdf
[53] http://www.cdc.gov/reproductivehealth/Infertility/index.htm#2
[54] http://voices.yahoo.com/the-social-implications-womans-infertility-642566.html

and birth defects. Lack of coverage could make treatment cost prohibitive as injectable drugs cost about $1,500 to $3,000 per cycle, in addition to the necessary monitoring during their use.

Routine visions exams - adult are performed by an optometrist or ophthalmologist and are more extensive than a vision screening that may be done by a primary care physician. Small Group Options 1 through 3 are the only benchmark options that currently cover routine vision exams, and 86% of current small group policies in North Carolina provide some level of coverage for routine vision exams. The cost of covering one exam per year is estimated to range from $0.60 to $1.40 PMPM, or 0.17% to 0.40% of premium. Cost or lack of insurance was cited by 48.4% of North Carolina adults aged 40 to 64 years with moderate to severe vision impairment who chose not to seek eye care.[55] Prevent Blindness America estimated the economic impact of vision problems to be about $51.4 billion annually[56].

Private duty nursing services are provided to recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of a hospital or skilled nursing facility. Private duty nursing is infrequently covered in commercial insurance. Only Small Group Options 1 and 3 and the State Employees Option provide coverage for private duty nursing, and that coverage is only for services provided in the home. Given the lack of commercial data on private duty nursing in the home, and using the skilled nursing facility and home health PMPMs as proxies, the cost for private duty nursing would likely range from $0.25 to $1.00 PMPM, or 0.07% to 0.29% of premium. Socially there may be a benefit to allowing people to be cared for in the home because they may be more comfortable, independent and can more easily interact with family.

Bariatric surgery can be defined as "surgery on the stomach and/or intestines to help a person with extreme obesity lose weight."[57] All of the benchmark options provide some level of coverage for the bariatric surgery with the exception of Small Group Option 2 and the HMO Option. The prevalence of obesity in North Carolina increased from 21.8% in 2000 to 28.6% in 2010,[58] and the cost of the surgery ranges from $20,000 to $30,000.[59] The estimate of the cost of coverage is between $0.50 to $3.00 PMPM, or 0.14% to 0.86% of premium. Studies have found the societal cost of obesity to be substantial,[60] and bariatric surgery has been found to be an effective form of treatment.[61,62] In addition to societal costs, obesity financially impacts affected individuals personally through higher medical expenses, adaptation of homes, clothing and lower wages.

[55] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6019a3.htm
[56] http://www.preventblindness.net/site/DocServer/Impact_of_Vision_Problems.pdf?docID=1321
[57] http://www.medterms.com/script/main/art.asp?articlekey=23436
[58] http://apps.nccd.cdc.gov/brfss/
[59] http://mhcc.maryland.gov/smallgroup/bariatricsurgery.pdf
[60] http://www.naturalnews.com/030000_obesity_productivity.html
[61] http://www.mass.gov/eohhs/docs/dph/patient-safety/weight-loss-executive-report.pdf
[62] www.annals.org/cgi/content/full/142/7/547

A **routine hearing exam** includes the testing and evaluation of a person's hearing sensitivity, and is more extensive than a hearing screening that only provides an indication of whether there is a possibility of hearing loss. Only the State Employees Option and the HMO Option currently cover routine hearing exams, and 89% of current small group policies in North Carolina do not provide coverage for routine hearing exams. It is estimated that the cost of covering routine hearing exams ranges from $0.25 to $2.00 PMPM, or 0.07% to 0.57% of premium. The incidence of hearing loss among North Carolinians was 11.6% in 2008 among individuals aged 18-64[63], and the incidence of hearing difficulties increased from 1971 to 1990.[64] Individuals affected by hearing loss report a greater incidence of social rejection, loneliness and depression,[65] and research has found strong links between the degree of hearing loss and the risk of developing dementia[66] and increased chances of falling.[67] Hearing loss also leads to underachievement in terms of job performance and negatively impacts incomes up to $12,000 per year on average.[68]

Comparison of Individual Market to Benchmark Options

Given that the supplemented benefit plan selected to serve as the basis for the EHB package will apply in both the individual and small group markets, a comparison of benefits currently offered in the individual market was performed with the outlier benefits listed above. BCBSNC and WellPath were asked to provide their current individual plans' levels of coverage for each of the outlier benefits above. These insurers' individual policies represent approximately 84% and 4% of the current individual market, respectively.[69] The purpose of this comparison was to determine whether any benefits commonly offered in the individual market today would not be included in the EHB package if certain benchmark plan options were selected. This analysis highlights the extent to which consumers in the individual market who do not maintain grandfathered status may have their policies altered in 2014.

The analysis revealed 18 benefits outlined in Figure 4.3 that are currently covered by one or both of these insurers' individual plans that would not be included in the EHB package or would be included but with greater limitation if certain benchmark plan options are selected. For example, pulmonary rehabilitation would continue to be included in these individual market plans unless the Small Group Option 2 was selected as the benchmark.

The number of outlier benefits in the individual market that may, or may not, be covered is highly dependent on the benchmark plan selected. For example, if the State Employees Health

[63] http://www.ncdhhs.gov/dsdhh/facts/hearing_loss_by_age_2010.pdf
[64] Reis, Peter, W. (1994). Prevalence and Characteristics of Persons with Hearing Trouble: United States, 1990-91 National Center for Health Statistics, Vital and Health Statistics, Series 10, No. 188.
[65] Shield, Bridget, "Evaluation of the Social and Economic Costs of Hearing Impairment," October 2006
[66] http://www.asha.org/Aud/Articles/Untreated-Hearing-Loss-in-Adults/
[67] http://gazette.jhu.edu/2012/03/05/hearing-loss-linked-to-threefold-risk-of-falling/
[68] http://www.betterhearing.org/pdfs/marketrak_income.pdf
[69] 2011 Statutory financial statements, Supplemental Health Care Exhibits

Plan was selected as the benchmark, only two outlier benefits would not be included (Wigs for Hair Loss due to Chemotherapy Treatment for Cancer and Speech Generating Devices). However, if Small Group Option 2 were selected as the benchmark, 13 benefits would be missing from the benefits currently offered by either plan. Similar to the small group comparison noted above, the ability of plans to adjust benefits means that the choice of a benchmark option will not necessarily determine which specific benefits will, or will not, be covered.

Additionally, while some benefits listed in Figure 4.3 may not be fully covered by the EHB benchmark, other benefits could be added that are not covered today. For example, neither of the insurers' individual plans currently provides coverage for dental implants, acupuncture, adult routine vision exams, adult routine dental benefits or routine hearing exams; however coverage for these services would be required to be provided in these individual plans if a benchmark plan option that currently covers them is selected. For more detail please refer to Attachment F.

Figure 4.3. Individual Plan Benefits Differing From Benchmark Options

		Benchmark Plans that Would Preserve Benefits at least as Rich as Current Individual Benefit							
Benefit	Individual Plan(s) Covering Benefit	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
Bariatric Surgery	BCBSNC	X	X	X	X	X		X	
Diagnosis and Treatment of Infertility ($5,000 lifetime; ART Excluded)	BCBSNC	X	X	X		X		X	
Smoking Cessation Drugs	BCBSNC	X	X	X	X	X		X	
Home Health Visits (no limit)	BCBSNC	X				X		X	
Private Duty Nursing in the Home	BCBSNC					X		X	
Hypnotherapy	BCBSNC	X				X		X	
OTC Drugs (covers those included on the formulary or those which are preventive)	BCBSNC	X	X	X	X	X			X
Inpatient Hospice to Provide Caregiver Respite	WellPath	X	X	X					X
Skilled Nursing Facility (no limit on the number of days)	WellPath	X	X	X			X		
Wigs for Hair Loss due to Chemotherapy Treatment for Cancer ($500 lifetime)	WellPath								X
Cardiac Rehab (No Visit Limit)	BCBSNC and WellPath	X	X	X	X	X		X	X
Pulmonary Rehab (No Visit Limit)	BCBSNC and WellPath	X	X	X	X	X		X	X
Physical, Occupational and Speech Therapy	BCBSNC and WellPath	X* (BCBSNC) X* (Wellpath)	X (BCBSNC) X (Wellpath)	X* (BCBSNC) X* (Wellpath)	X (BCBSNC) X (Wellpath)	X (BCBSNC) X* (Wellpath)	X* (BCBSNC) X (Wellpath)	X(BCBSNC) X* (Wellpath)	X* (BCBSNC) X (Wellpath)
Chiropractic Manipulation	BCBSNC and WellPath	X* (BCBSNC) X (Wellpath)	X* (BCBSNC)	X* (BCBSNC) X (Wellpath)	X* (BCBSNC)	X* (BCBSNC) X* (Wellpath)	X* (BCBSNC) X (Wellpath)	X (BCBSNC) X* (Wellpath)	X* (BCBSNC) X (Wellpath)
Needles and Syringes for the Administration of Covered Medications	BCBSNC and WellPath	X	X	X	X	X		X	X

		Benchmark Plans that Would Preserve Benefits at least as Rich as Current Individual Benefit							
Benefit	Individual Plan(s) Covering Benefit	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
(WellPath covers only if prescribed by a physician for use in a home health visit)									
Abortion (BCBSNC Covers during the first 16 weeks of pregnancy, except for dependent children; WellPath covers only if the mother's life is in danger)	BCBSNC and WellPath	X (not as rich as BCBSNC Individual)	X (not as rich as BCBSNC Individual)	X (not as rich as BCBSNC Individual)	X (not as rich as BCBSNC Individual)	X	X		X
Eyeglasses Related to an Accident, Surgery or Medical Condition	BCBSNC and WellPath	X	X	X	X	X		X	X
Speech Generating Devices/Voice Synthesizers	BCBSNC and WellPath					X	X	X	X

Key:
X indicates that benefit would be covered by the benchmark option
X* indicates that benefit could be maintained depending upon the combination of PT/OT/ST and Chiropractic visits that are utilized by the member

V. POLICY CONSIDERATIONS

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, all may inform a state's decision as to which benchmark plan is most appropriate. An examination of the EHB benchmark options in North Carolina reveals that, with the exception of the FEHBP Options, the benchmark plan options appear to be largely similar in cost and covered benefits. Without significant plan variations to drive benchmark plan selection, North Carolina policy makers may question whether to actively engage in selecting an EHB benchmark, or simply defer to the default benchmark plan. The key differences in North Carolina benchmark plan options, and the pros and cons of selecting or defaulting to the benchmark selection are discussed in more detail below.

Differences Among Plans

State Mandated Benefits: If North Carolina selects a benchmark plan that does not include all applicable State mandated benefits, the State will be faced with the choice of either funding the costs of those mandated benefits or repealing the mandates for the small group and individual markets. It is therefore critical for North Carolina policy makers to understand which of the eight benchmark plan options omit applicable mandates and which mandates they omit.

In North Carolina, all of the benchmark options except the FEHBP Options cover all State mandates. The FEHBP Options lack coverage of at least some part of four state mandates: TMJ, Post-Acute Care for Mastectomies, Hearing Aids up to Age 22 and Prostate Cancer Screening. If one of the FEHBP Options is chosen as the benchmark, North Carolina must either pay for these services or amend State law to eliminate the mandates in the small group and individual markets. Actuarial analyses estimate North Carolina's cost in covering these benefits to be approximately $0.48 PMPM to $0.63 PMPM in 2011 dollars, or 0.13% to 0.18% of claims. The estimated cost to the State of covering these benefits outside the EHB package is approximately $4 million to $5 million in 2014, increasing to about $8.5 million to $10.0 million in 2016. The potential added costs associated with selecting one of the FEHBP Options as a benchmark may make these plans a less desirable option for the State.

Holistic Pricing: The relative value of potential benchmark plans is another key driver for benchmark plan selection. A holistic pricing approach, which attempts to standardize benefits across plans by assuming coverage for services within all EHB categories and applicable State mandates, facilitates comparison of the approximate total cost of covered benefits for each plan. Relative costs have implications for both the affordability and richness of the benchmark plan. A benchmark plan that has lower projected premiums is likely to be more affordable to consumers who are either purchasing coverage outside of the Exchange, or purchasing

nonsubsidized coverage through the Exchange. Because premium contributions for subsidized individuals within the Exchange are based on a percentage of the individual's income, not the cost of premiums, subsidized individuals will not be impacted by differentials in plan costs. On the other hand, a benchmark plan with higher projected premiums is likely to offer a richer package of benefits than lower cost options. Such plans will, in effect, increase the value of federal subsidies available to those individuals receiving subsidies through the Exchange.

In North Carolina, the holistic pricing analysis shows relatively little difference in the aggregate allowed cost for each benchmark plan option. With the exception of one plan, aggregate pricing among plans is within a 0 to 1% range. One plan, the FEHBP Option 2, has higher costs due to the inclusion of dental benefits. This plan is roughly 3% more costly than the baseline plan used for this comparison. Nevertheless, the holistic pricing analysis generally suggests benchmark plan selection for North Carolina is not expected to be a key driver of premiums.

Covered Benefits: A third important consideration is the extent to which covered benefits vary across the benchmark plan options, including whether certain services are not covered at all by some plans, the variation in the duration or scope of services that are covered, and the financial, social and medical costs associated with these services. Because the benchmark plans will apply to the individual market, it is also important to evaluate the degree to which different benchmark options would change current coverage offered in the individual market.

It is important to note that the significance of the current variation among benchmark options is limited by the fact that HHS has indicated its intent to allow insurers to substitute benefits within each of the ten EHB categories, as long as the substitutions are actuarially equivalent. HHS is further considering whether to allow substitutions across benefit categories, which would further erode the significance of benefit variations between benchmark options. Depending on the degree of substitution flexibility, insurers may have the ability to swap out services between and among benefit categories so long as the actuarial value of the plan remains the same. Thus, the choice of a benchmark option will not necessarily determine which specific benefits will be covered by a specific plan. Additional guidance from HHS in this area will be helpful in assessing the extent to which variation in services across benchmark options matters to the ultimate definition of EHBs.

As noted in the discussion of holistic pricing above, in North Carolina, the comparison of the benchmark options (once supplemented to include mandated benefits and EHB categories[70]) shows relatively little variation in covered benefits among plans. The comparison revealed 36 services that are either covered by some plans but not others (21 services), or covered at different levels among plans (15 services). From the 36 outlier services, six high cost or high frequency outliers were selected for further analysis to provide more detailed information on their financial, medical and social value: respite care; infertility services; routine adult vision exams; private duty nursing; bariatric surgery; and routine hearing exams. While none of the

[70] As discussed below North Carolina does not have much variation across plans, and EHBs will likely need to be supplemented by looking outside benchmark plan options.

individual outlier benefits appear to significantly influence the overall pricing of the benchmark product, their medical and social costs may be of concern to North Carolina policy makers and stakeholders as they attempt to differentiate among the benchmark options. It is worth noting once again, however, that the actual impact of these differences on North Carolina's EHBs will be heavily influenced by the extent to which HHS permits insurers to substitute benefits within and across categories.

Comparing the outlier benefits to coverage currently offered in the individual market revealed 18 benefits that are currently covered by one or both of the individual plans, but would not be included in the EHB package or included with greater limitation if certain benchmark plan options are selected. While those with individual coverage today could see some currently covered services reduced or eliminated depending on the benchmark option selected, it is likely that other services will be enhanced. Several services, such as adult routine vision and dental implants, currently not covered in the leading plans for the individual market, could be covered under the benchmark plan.

North Carolina might minimize disruption across both the small group and individual markets by selecting Small Group Option 1 as its benchmark. Small Group Option 1 is the largest plan by enrollment by product in North Carolina's small group market, and therefore its benefits are already widely provided in the market. Additionally, because the insurer for this plan is the leading insurer in the individual market, the plan is similar to what is currently offered in the individual market.

Supplementing Benchmarks: A final consideration is whether the various benchmark plans include services within each EHB category, or if a given benchmark would need to be supplemented. If supplementation is required, states have the option of looking to any other benchmark plan for additional benefits. For states in which benchmark plan options vary significantly, supplementing the benchmark may involve meaningful choices as to benefit coverage. Again, the extent to which insurers will have flexibility to substitute benchmark benefits will impact the relevance of the State's approach to supplementing benefits; greater insurer flexibility will minimize the practical implications of the State's benchmark choice.

In North Carolina it appears that most of the benchmark options would need to be supplemented with the same EHBs – namely habilitative services and pediatric oral and vision care. The HMO plan, however, will also require pharmacy benefits. This means North Carolina would have more control over selecting the pharmacy benefit, but would also need to dedicate more resources to the process if the HMO plan is selected as the benchmark. HHS has provided guidance for states supplementing benchmark benefits, and more is expected. However, North Carolina would likely still have the opportunity to exercise some discretion in supplementing the benchmark.

Designation of State Benchmark or Deferral to the Default Plan

North Carolina needs to select a benchmark plan in the third quarter of 2012, or defer to the default benchmark option. Based on the above analysis, there is minimal variation in mandated benefits, cost and covered benefits across the North Carolina benchmark options. Although certain factors suggest eliminating the FEBHP Options as preferred options, few clear drivers otherwise exist for North Carolina policy makers to choose one of the remaining five plans over another. Thus, North Carolina policy makers may reasonably question whether to defer to the default benchmark option.

The primary advantage to selecting the benchmark plan at a State level may be the opportunity for North Carolina stakeholder input into the result. By taking an active role in the decision making process, North Carolina has an opportunity to build consensus among key parties, including insurers, regulators, consumers and employers. A more collaborative process may help minimize market disruption when the benchmark is implemented.

Additionally, North Carolina would retain the authority to make any meaningful choices as to how to supplement the benchmark. All benchmark plan options require some supplementation. North Carolina can only shape the definition of these benefits if it takes the lead in benchmark selection. Conversely, by relying on the default benchmark plan North Carolina cedes this decision making to the federal government.

In contrast, given the analysis showing that plan options in North Carolina are very similar, with little differences in cost, North Carolina policy makers may determine that the time and resources that would be spent on benchmark plan selection may be better utilized on other aspects of health care reform implementation where more is at stake. This may be true for the limited time and resources of not just the State but also impacted stakeholders. The fact that the benchmark selection will only be in effect for two years (until 2016) further supports this position. Moreover, because the default plan by definition already covers a large portion of the small group market, and has benefits common in the individual market, one could argue that the default plan offers the best opportunity to mitigate market disruption.

There is a third approach that North Carolina policy makers may want to consider -- actively selecting the default benchmark plan as the State's benchmark. To the extent there is consensus among policy makers and stakeholders that the default benchmark plan meets the needs of the State, designating the largest small group plan would minimize the resources expended in deciding upon the benchmark plan and, at the same time, allow North Carolina to retain the authority to supplement and otherwise define the benchmark.

Attachment A: EXISTING BENEFIT COMPARISON ACROSS BENCHMARK PLANS

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
WELLNESS BENEFITS INCLUDING PREVENTIVE SERVICES AND SCREENINGS										
Adult Routine Physical Exams	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Well-Baby and Well-Child Care	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Immunizations	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Routine Mammography Screening	YES	YES	1 per Year at Age 35; More Frequent for at Risk Individuals	1 per Year; More Frequent for at Risk Individuals	1 per Year; More Frequent for at Risk Individuals	1 per Year at Age 35; More Frequent for at Risk Individuals	1 per Year at Age 40; Baseline at Age 35; More Frequent for at Risk Individuals	1 Every Other Year at Age 40; Baseline at Age 35; 1 Every Year at Age 50; More Frequent for at Risk Individuals	1 per Year at Age 40; Baseline at Age 35; More Frequent for at Risk Individuals	1 per Year at Age 40 ; Baseline at Age 35; More Frequent or at an Earlier Age for at Risk Individuals
HPV/Cervical Cancer Screening	YES	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Newborn Hearing Screening	YES	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Newborn Screening (Other than Hearing)	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Pediatric Hearing Screening	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Ovarian Cancer Surveillance Tests	YES	NO	Annually for Females Age 25+ Who are at Risk	Covered*	Covered*	Covered*	Annually for Females Age 25+ Who are at Risk	Annually for Females Age 25+ Who are at Risk	Annually for Females Age 25+ Who are at Risk	Annually for Females Age 25+ Who are at Risk
Prostate Cancer Screening	YES	NO	Covered	Covered	Covered	1 per Year at Age 40	Covered	Covered	Covered	Covered
Colorectal Cancer Screening	YES	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Depression Screening (Adolescents and Adults)	NO	YES	Not Covered	Covered	Covered	Not Covered	Covered	Covered	Covered	Covered
Diagnostic Bone Mass Measurement/Density Testing	YES	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Preventive Colonoscopy	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Allergy Testing	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Diabetes Screening	NO	YES	Covered	Covered*	Covered*	Covered*	Covered	Covered	Covered	Covered
Gestational Diabetes Screening	NO	YES	Covered	Covered	Covered	Covered*	Covered	Covered	Covered	Covered
Screening for Sexually Transmitted Infections – HIV	NO	YES	Covered	Covered	Covered	Covered*	Covered	Covered	Covered	Covered
Screening for Sexually Transmitted Infections – Other	NO	YES	Covered	Covered	Covered	Covered*	Covered	Covered	Covered	Covered
Anemia Screening for Pregnant Women	NO	YES	Covered	Covered*	Covered*	Covered*	Covered	Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
Bacteriuria Urinary Tract Screening for Pregnant Women	NO	YES	Covered	Covered*	Covered*	Covered*	Covered	Covered	Covered	Covered
BRCA Screening and Counseling About Genetic Testing	NO	YES	Covered for High Risk Patients	Counseling Covered; Testing is Only Covered for Those with a Cancer Diagnosis	Counseling Covered; Testing is Only Covered for Those with a Cancer Diagnosis	Not Covered	Covered	Covered	Covered	Covered
Domestic Violence Screening and Counseling	NO	YES	Not Covered	Not Covered	Not Covered	Not Covered	Covered	Covered	Covered	Covered
Folic Acid Supplements for Women Who May Become Pregnant	NO	YES	Not Covered	Not Covered	Not Covered	Not Covered	Covered	Not Covered	Covered	Covered
Hepatitis B Screening for Newly Pregnant Women	NO	YES	Covered	Covered*	Covered*	Covered*	Covered	Covered	Covered	Covered
Rh Incompatibility Screening for all Pregnant Women and Follow-up Testing for Women at Higher Risk	NO	YES	Covered	Covered*	Covered*	Covered*	Covered	Covered	Covered	Covered
Allergy Injections	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Weight Loss Program	NO	NO	Covered – Counseling Only	Not Covered – Discounts Only	Not Covered – Discounts Only	Not Covered	Not Covered – Discounts Only	Not Covered	Not Covered	Not Covered
Smoking and Tobacco Cessation Counseling	NO	YES	Covered	Covered	Covered	Covered – 2 Attempts per Year; 4 Counseling Sessions per Attempt	Covered	Not Covered	Covered	Covered
Diabetes Education	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Diabetes Monitoring	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Fitness Membership	NO	NO	Not Covered – Discounts Only	Not Covered – Discounts Only	Not Covered – Discounts Only	Not Covered – Discounts Only	Not Covered	Not Covered	Not Covered	Not Covered
Breastfeeding/Lactation Counseling	NO	YES	Not Covered	Covered	Covered	Covered*	Covered	Covered	Covered	Covered Only as Part of an IP Stay and Post Partum Follow-up Visits
Post Partum Depression Counseling	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Nutritional Counseling	NO	YES	Covered	Covered – Individual Counseling Only	Covered – Individual Counseling Only	Covered	Covered	Covered Only when Assoc. with Self Mgnt. of a Disease	Covered	Covered Except if Related to Weight Loss or Gain
HPV Vaccine	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
Flu Vaccine	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
INPATIENT HOSPITAL										
Room and Board	NO	NO	Semi-private; Private if Medically Necessary or Only Private Rooms	Semi-private; Private if Medically Necessary or Only Private Rooms	Semi-private; Private if Medically Necessary or Only Private Rooms	Semi-private; Private if Medically Necessary or Only Private Rooms	Semi-private; Private if Medically Necessary	Semi-private; Private if Medically Necessary or Only Private Rooms	Semi-private; Private if Medically Necessary	Semi-private; Private if Medically Necessary
Nursing – General	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Private Duty Nursing	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Minimum Inpatient Stays Following Delivery of a Baby (48 Hours Normal; 96 Hours Cesarean)	YES	NO	Covered	Covered	Covered	Covered	Covered (Except for Dependent Children)	Covered	Covered (Except for Dependent Children)	Covered (Except for Dependent Children)
Treatment of Maternity as any Other Illness When Maternity is Provided	YES	NO	Covered	Covered	Covered	Covered	Covered (except for Dependent Children)	Covered	Covered (except for Dependent Children)	Covered (except for Dependent Children)
Complications of Pregnancy	YES	NO	Covered	Covered*	Covered*	Covered*	Covered	Covered	Covered	Covered
Lab	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Pathology Services	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Radiology	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Anesthesia	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Medical Supplies	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Durable Medical Equipment	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Prosthetics	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Drugs	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Blood	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Inpatient Rehab Services	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Minimum Benefit for Mental Illness (30 days)	YES (Group Policies)	NO	Covered Same as Other Illnesses and Conditions	Covered Same as Other Illnesses and Conditions	Covered Same as Other Illnesses and Conditions	Covered Same as Other Illnesses and Conditions	Covered Same as Other Illnesses and Conditions	Covered 30 Days per Year	Covered Same as Other Illnesses and Conditions	Covered
Mental Health Consistent with Federal Parity	NO	NO	Covered	Covered	Covered	Covered	Covered	Not Covered	Covered	Not Covered
Equity in Benefits for Mental Health – State Requirement	YES (Group Policies)	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Minimum Benefit Offering for Alcoholism/Drug Abuse Treatment	YES	NO	Covered Same as Other Illnesses and	Covered	Covered	Covered	Covered Same as Other Illnesses and	YES – Covers $8,000 per year Combined	Covered Same as Other Illnesses and	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
			Conditions				Conditions	IP/OP; $16,000 Over the Policy Life	Conditions	
Alcoholism/Drug Consistent with Federal Parity	NO	NO	Covered	Covered	Covered	Covered	Covered	Not Covered	Covered	Covered
Losses Sustained or Contracted While Being Intoxicated or Under the Influence	YES	NO	Covered	Covered*	Covered*	Covered*	Covered	Covered	Covered	Covered
Transplants	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Reconstructive Breast Surgery Following a Mastectomy	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Surgery to Correct Congenital Anomalies	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Other Reconstructive Surgery	NO	NO	Accident or Injury	Functional Defect or to Restore a Mouth to a Pre-cancerous State	Functional Defect or to Restore a Mouth to a Pre-cancerous State	Surgery to Correct a Condition that Produced a Major Effect on the Member's Appearance	Accident or Injury	Injury, Sickness, or Congenital Anomaly; Medical Condition or to Improve or Restore Physiologic Function	Accident or Injury	Accident or Injury
Bariatric Surgery	NO	NO	Covered	Covered	Covered	Covered	Covered	Not Covered	Covered	Not Covered
LASIK Surgery	NO	NO	Not Covered	Not Covered – Discounts Only	Not Covered – Discounts Only	Not Covered – Discounts Only	Not Covered – Discounts Only	Not Covered	Not Covered	Not Covered
Tubal Ligation	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Vasectomy	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Reversal of Voluntary Sterilization	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Inpatient Hospice	NO	NO	Covered	7 Days Separated by 21 Days Discharged	7 Days Separated by 21 Days Discharged	Covered – Combined Inpatient and Outpatient Maximum of $15,000	Covered	Covered	Covered	Covered
Vision Procedures	NO	NO	Surgical Correction of an Eye Injury and/or Intraocular Surgery	Surgical Correction of an Eye Injury and/or Intraocular Surgery	Surgical Correction of an Eye Injury and/or Intraocular Surgery	Surgical Correction of an Eye Injury and/or Intraocular Surgery	Surgical Correction of an Eye Injury and/or Intraocular Surgery	Surgical Correction of an Eye Injury and/or Intraocular Surgery	Surgical Correction of an Eye Injury and/or Intraocular Surgery	Surgical Correction of an Eye Injury and/or Intraocular Surgery
Anesthesia and Hospital Charges for Dental Procedures for	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
Children Under Age 9 and Persons With Serious Mental, Physical or Behavioral Problems										
Oral and Maxillofacial Surgery	NO	NO	Covered – Accidental Injury, Congenital Deformity, and Disease due to Infection or Tumor	Covered – Accidental Injury, Congenital Deformity, and Disease due to Infection or Tumor, Plus Additional Conditions	Covered – Accidental Injury, Congenital Deformity, and Disease due to Infection or Tumor, Plus Additional Conditions	Covered – Accidental Injury, Congenital Deformity, and Disease due to Infection or Tumor, Plus Additional Conditions	Covered – Accidental Injury, Congenital Deformity, and Disease due to Infection or Tumor	Covered – Accidental Injury, Congenital Deformity, and Disease due to Infection or Tumor	Covered – Accidental Injury, Congenital Deformity, and Disease due to Infection or Tumor	Covered – Accidental Injury, Congenital Deformity, and Disease due to Infection or Tumor
OUTPATIENT HOSPITAL										
Emergency Room Services	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Surgery: Operating Room, Recovery and Treatment Rooms	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Anesthesia	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Laboratory Services	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Pathology	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Radiology – X-rays, Ultrasound, EKG, EEG, CT, MRI, PET, Diagnostic Angiography	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Chemotherapy	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Radiation Therapy	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Diagnostic Colonoscopy	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Cardiac Rehab	NO	NO	No Visit Limit	No Visit Limit	No Visit Limit	No Visit Limit	No Visit Limit	36 Visits per Year	No Visit Limit	No Visit Limit
Pulmonary Rehab	NO	NO	No Visit Limit	No Visit Limit	No Visit Limit	No Visit Limit	No Visit Limit	20 Visits per Year	No Visit Limit	No Visit Limit
Chiropractic Manipulation	NO	NO	30 Visits per Year	12 Visits per Year	20 Visits per Year	12 Visits per Year	30 Visits per Year	20 Visits per Year	30 Visits per Year	20 Visits per Year
Physical Therapy	NO	NO	30 Visits per Year	75 Visits per Year	50 Visits per Year	60 Visits per Year		20 Visits per Year		20 Visits per Year
Occupational Therapy	NO	NO						20 Visits per Year		20 Visits per Year
Speech Therapy	NO	NO				30 Visits per year	30 Visits per year	20 Visits per Year	30 Visits per Year	20 Visits per Year
Habilitative Services and Devices	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Covered	Not Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
IV/Infusion Therapy	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	90 Home Visits per Year; Unlimited Visits Other Locations
Respiratory Therapy	NO	NO	Covered	Not Covered	Not Covered	Covered	Covered	Covered	Covered	Covered
Hyperbaric Oxygen Therapy	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Covered	Covered	Covered	Covered
Dialysis	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Blood and Plasma	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Medical and Surgical Supplies	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Oxygen	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Nuclear Medicine	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Injectible Drugs	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Some Covered
Infertility Services	NO	NO	Covered - $5,000 Lifetime Benefit for Diagnosis and Treatment of Infertility; ART Excluded	Covered ; ART Excluded	Covered ; ART Excluded	Covered - $3,000 per Year; ART and Prescription Drugs Excluded	Covered - $5,000 Lifetime Benefit for Diagnosis and Treatment of Infertility; ART Excluded	Not Covered	Covered - $5,000 Lifetime Benefit for Diagnosis and Treatment of Infertility; ART Excluded	Not Covered
Dental Implants	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Covered Only if Associated With Injury, Congenital Deformity or Removal of Tumors/Cysts	Covered Only if Associated with Accident (Limited to $900 per Tooth; $3,000 per Year)	Covered Only if Associated with Injury, Congenital Deformity or Removal of Tumors/Cysts	Not Covered
Genetic Screening	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Diagnostic Genetic Testing and Counseling	NO	NO	Covered (High Risk Patients Only)	Covered (Some; Diagnostic Genetic Testing)	Covered (Some; Diagnostic Genetic Testing)	Not Covered	Covered (High Risk Patients Only)	Covered (Genetic Testing and Counseling - Maternity)	Covered (High Risk Patients Only)	Covered
PHYSICIAN SERVICES										
Inpatient Visits	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Inpatient Surgery	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Outpatient Surgery	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Emergency Room Services	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Urgent Care Visits	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Physician Office Visits	NO	NO	Covered	Covered	Covered - Preferred Provider Only	Covered	Covered	Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
Laboratory Services	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Diagnostic Imaging	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Treat Maternity as any Other Illness	YES	NO	Covered (Except for Dependent Children)	Covered	Covered	Covered	Covered (Except for Dependent Children)	Covered	Covered (Except for Dependent Children)	Covered (Except for Dependent Children)
Prenatal Care	NO	YES	Covered (Except for Dependent Children)	Covered	Covered	Covered	Covered (Except for Dependent Children)	Covered	Covered (Except for Dependent Children)	Covered (Except for Dependent Children)
Minimum Benefit for Mental Illness (30 Office Visits)	YES (Group Policies)	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Consistent with Federal Mental Health Parity	NO	NO	Not Covered	Covered	Covered	Covered	Covered	Not Covered	Not Covered	Not Covered
Equity in Benefits for Mental Health - State Requirement	YES (Group Policies)	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Minimum Benefit Offering for Alcoholism/Drug Abuse Treatment	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Consistent with Federal Alcoholism/Drug Parity	NO	NO	Not Covered	Covered	Covered	Covered	Covered	Not Covered	Not Covered	NO
Losses Sustained or Contracted While Being Intoxicated or Under the Influence	YES	NO	Covered	Covered*	Covered*	Covered*	Covered	Covered	Covered	Covered
PRESCRIPTION DRUG COVERAGE										
Retail and Mail Order Prescription Drugs	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Not Covered - Unless Rider Elected
Prescription Contraceptives	YES	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Not Covered - Unless Rider Elected (Devices Covered)
Smoking and Tobacco Cessation Prescription Drugs	NO	NO	Covered	Covered	Covered	Covered	Covered	Not Covered	Covered	Covered - $165 Benefit
Access to Non-formulary Drugs	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Prescription Drugs During an Emergency or Disaster	YES	NO	Covered	Covered*	Covered*	Covered*	Covered	Covered	Covered	Covered
Certain Off-label Drugs Used for the Treatment of Cancer	YES	NO	Covered	Covered*	Covered*	Covered*	Covered	Covered	Covered	Covered
OTHER SERVICES										

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
Ambulance Services	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Durable Medical Equipment and Devices	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Private Duty Nursing in the Home	NO	NO	Covered if Medically Necessary (4 Hours perDay for Non-ventilated Patients; 12 Hours per Day for Ventilated Patients)	Not Covered	Not Covered	Not Covered	Covered if Medically Necessary	Not Covered	Covered if Medically Necessary	Not Covered
Home Dialysis Equipment and Supplies	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Oxygen	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Breastfeeding Equipment	NO	YES	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Oral Orthotic Devices	NO	NO	Covered for Accidental Injury, Congenital Deformity, TMJ, Infection or Tumor	Covered for Accidental Injury	Covered for Accidental Injury	Covered for Accidental Injury	Covered for Accidental Injury, Congenital Deformity, TMJ, Infection or Tumor	Covered for Accidental Injury, Congenital Deformity, TMJ, Infection or Tumor	Covered for Accidental Injury, Congenital Deformity, TMJ, Infection or Tumor	Covered for Accidental Injury, Congenital Deformity, TMJ, Infection or Tumor
Prosthetic Devices	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Home Medical Supplies	NO	NO	Covered – with Certain Exclusions	Covered – with Certain Exclusions	Covered – with Certain Exclusions	Covered – with Certain Exclusions	Covered – with Certain Exclusions	Covered – with Certain Exclusions	Covered – with Certain Exclusions	Covered – with Certain Exclusions
Coverage for Needles and Syringes for the Administration of Covered Medications	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered Only as a Diabetic Supply	Covered	Covered Only if Prescribed by a Physician Such as for Use in a Home Health Visit
Home Health Visit	NO	NO	No Limit	25 Visits per Year	25 Visits per Year	50 Visits per Year	No Limit	60 Visits per Year	No Limit	30 Visits per Year
Skilled Nursing Facility Care	NO	NO	100 Days per Year	No Limit	No Limit	$700 per Day for 14 Days After an Inpatient Stay	60 Days per Year	No Limit	60 Days per Year	75 Days per Year
Custodial/Convalescent Care	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Respite Care	NO	NO	Inpatient Hospice for	Inpatient Hospice for	Inpatient Hospice for	Not Covered	Not Covered	Not Covered	Not Covered	Inpatient Hospice for Respite; No

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
			Respite; No Limit Stated	Respite; 7 Days, Separated by 21 Days Discharged	Respite; 7 days, Separated by 21 Days Discharged					Limit Stated
Acupuncture	NO	NO	Not Covered	24 Visits per Year	Covered	20 Visits per Year (Medically Necessary)	Not Covered	Not Covered	Not Covered	Not Covered
Hypnotherapy	NO	NO	Covered to Control Acute or Chronic Pain	Not Covered	Not Covered	Not Covered	Covered to Control Acute or Chronic Pain	Not Covered	Covered to Control Acute or Chronic Pain	Not Covered
HIV/AIDS Treatment	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Certain Treatment of Diabetes	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
TMJ Joint Dysfunction (Diagnostic, Therapeutic, and Surgical Coverage Same as any Other Bone or Joint)	YES	NO	Covered	Covered (Surgery Only)	Covered (Surgery Only)	Covered (Surgery Only)	Covered	Covered	Covered	Covered
Diagnosis and Treatment of Lymphadema	YES	NO	Covered	Covered	Covered	Covered	Covered (Excluding OTC Knee-High or Other Stocking Products)	Covered	Covered (Excluding OTC Knee-High or Other Stocking Products)	Covered
Abortion	NO	NO	Covered Only When the Mother's Life is in Danger or for Rape/Incest	Covered Only When the Mother's Life is in Danger or for Rape/Incest	Covered Only When the Mother's Life is in Danger of for Rape/Incest	Covered Only When the Mother's Life is in Danger or for Rape/Incest	Covered During First 16 Weeks of Pregnancy (Except Dependent Children)	Covered	Not Covered	Covered During the First Trimester (Dependent Children Limited to When Mother's Life is in Danger)
Home Hospice Care	NO	NO	Covered	Covered	Covered	Covered - Combined IP/OP Max of $15,000	Covered (Excludes Homemaker Services)	Covered	Covered (Excludes Homemaker Services)	Covered
Postmastectomy Inpatient Care (Discharge Decision Made by Patient and Physician)	YES	NO	Covered	Covered – Required Discharge After 48 Hours Unless Medically Necessary	Covered – Required Discharge After 48 Hours Unless Medically Necessary	Covered – Required Discharge After 48 Hours Unless Medically Necessary	Covered	Covered	Covered	Covered
Autism Spectrum Disorder	NO	YES (For Screening)	Covered Under PT/OT/ST; Rehabilitative Only	Covered*	Covered*	Covered*	Covered Under PT/OT/ST; Rehabilitative Only	30 Inpatient Days per year; 20 Outpatient Visits per Year	Covered Under PT/OT/ST; Rehabilitative Only	Covered Under PT/OT/ST; Rehabilitative Only
Applied Behavioral Analysis (Beyond PT/OT/ST)	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
Nurse Midwife Services	NO	YES (For Prenatal Services)	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Over-the-Counter Medications	NO	NO	Insulin; Smoking and Tobacco Cessation	Insulin; Smoking and Tobacco Cessation	Insulin; Smoking and Tobacco Cessation	Insulin; Smoking and Tobacco Cessation	Preventive Medicine	Drugs Eligible for Coverage as if it were a Prescription Drug Product	Preventive Medicine	$165 Smoking Cessation Drug Allowance
Experimental Treatments, Services and Drugs	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Wigs for Hair Loss due to Chemotherapy Treatment for Cancer	NO	NO	Not Covered	$350 lifetime	$350 lifetime	Not Covered	Not Covered	Not Covered	Not Covered	$500 lifetime
Coverage for Certain Clinical Trials (Phase II, III, and IV Research Studies, Including Prescription Drugs)	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Medical Foods (Food Supplements, Formulas or Special Foods)	NO	NO	Not Covered	Covered US FDA Approved Foods Administered Orally that Provide 100% of Nutrition to Children up to Age 22 for 1 Year	Covered US FDA Approved Foods Administered Orally that Provide 100% of Nutrition to Children up to Age 22 for 1 Year	Covered – Prescription Required	Not Covered	Not Covered	Not Covered	Not Covered
ANCILLARY BENEFITS										
Routine Vision Exams - Adult	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	1 per Year	1 Exam Every 2 Years	1 per Year	Not Covered
Pediatric Vision Screening	NO	YES	Not Covered	1 per Year	1 per Year	1 per Year; Limited to Ampliopia (lazy eye) and Strabismus (cross eye)	1 per Year	1 Exam Every 2 Years	1 per Year	Covered
Eyeglasses and Contact Lenses – Adults	NO	NO	Not Covered – Discounts Only	Not Covered	Not Covered	Not Covered – Discounts Only	Not Covered – Discounts Only	Not Covered	$50 per Benefit Period (After Deductible)	Not Covered
Eyeglasses and Contact Lenses – Pediatric	NO	NO	Not Covered – Discounts Only	Not Covered	Not Covered	Not Covered – Discounts Only	Not Covered – Discounts Only	Not Covered	$50 per Benefit Period (After Deductible)	Not Covered
Eyeglasses Related to an	NO	NO	First Pair of	Covered for	Covered for	First Pair of	First Pair of	Not Covered	First Pair of	First Pair of

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
Accident, Surgery or Medical Condition			Eyeglasses or Contact Lenses After Cataract Surgery	Accidental Injury, Intraocular Surgery, Nonsurgical Treatment for Amblyopia and Strabismus for Children Birth Through 18	Accidental Injury, Intraocular Surgery, Nonsurgical Treatment for Amblyopia and Strabismus for Children Birth Through 18	Contact Lenses or Standard Ocular Implant After Intraocular Surgery or Accidental Injury	Eyeglasses or Contact Lenses After Cataract Surgery		Eyeglasses or Contact Lenses After Cataract Surgery	Eyeglasses or Contact Lenses After Cataract Surgery
Routine Dental	NO	NO	Not Covered	Scheduled Allowances for Diagnostic and Preventive Services, Fillings, and Simple Extractions	Covers 2 Exams, 2 Cleanings, 2 Fluoride Treatments and $150 in X-rays per Year	Scheduled Allowances for Diagnostic and Preventive Services, Fillings, and Simple Extractions	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental	NO	NO	Not Covered	Scheduled Allowances for Diagnostic and Preventive Services, Fillings, and Simple Extractions	Covers 2 Exams, 2 Cleanings, 2 Fluoride Treatments and $150 in X-rays per Year	Scheduled Allowances for Diagnostic and Preventive Services, Fillings, and Simple Extractions	Not Covered	Not Covered	Not Covered	Not Covered
Routine Hearing Exams	NO	NO	Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Covered - Except for Hearing Aid Fittings
Hearing Aids	YES	NO	1 Hearing Aid per Ear Every 36 Months up to $2,500 per Hearing Aid for Children to Age 22	External and Bone Anchored Hearing Aids; $1,250 per Ear per Year for Children to Age 22; $1,250 per Ear Every 36 months for Adults	External and Bone Anchored Hearing aids; $1,250 per Ear per Year for Children to Age 22; $1,250 per Ear Every 36 Months for Adults	External hearing Aids Covered up to $250 per Ear Every 5 Years; Bone Anchored Hearing aids and Cochlear Implants Covered – All Ages	1 Hearing Aid per Ear Every 36 Months up to $2,500 per Hearing Aid for Children to Age 22	1 Hearing Aid per Ear Every 36 Months up to $2,500 per Hearing Aid for Children to Age 22	1 Hearing Aid per Ear Every 36 Months up to $2,500 per Hearing Aid for Children to Age 22	1 Hearing aid per Ear Every 36 Months up to $2,500 per Hearing Aid for Children to Age 22
Speech Generating Devices / Voice Synthesizers	NO	NO	Not Covered	Covered up to $1,250 per Year	Covered up to $1,250 per Year	Not Covered	Covered	Covered	Covered	Covered

* Benefit was not specifically addressed as a covered benefit but also not listed as an excluded benefit and therefore assumed to be covered

Attachment B: EHB CATEGORIES ACROSS BENCHMARK PLANS

EHB Category	Sub-Category	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
Ambulatory Patient Services		YES	YES	YES	YES	YES	YES	YES	YES
Emergency Services		YES	YES	YES	YES	YES	YES	YES	YES
Hospitalization		YES	YES	YES	YES	YES	YES	YES	YES
Maternity and Newborn Care		YES	YES	YES	YES	YES	YES	YES	YES
Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment	Federal Parity – Mental Health	IP – YES OP – NO	IP – YES OP – YES	IP – YES OP – YES	IP – YES OP – YES	IP – YES OP – YES	IP – NO OP – NO	IP – YES OP – YES	IP – NO OP – NO
	Federal Parity – Substance Use	IP – YES OP – NO	IP – YES OP – YES	IP – YES OP – YES	IP – YES OP – YES	IP – YES OP – YES	IP – NO OP – NO	IP – YES OP – YES	IP – NO OP – NO
Prescription Drugs		YES	YES	YES	YES	YES	YES	YES	NO – Unless Rider Attached
Rehabilitative and Habilitative Services and Devices	Rehabilitative	YES	YES	YES	YES	YES	YES	YES	YES
	Habilitative	NO	NO	NO	NO	YES – Attaining Functionality Never Achieved	NO	YES – Attaining Functionality Never Achieved	YES – Attaining Functionality Never Achieved
Laboratory Services		YES	YES	YES	YES	YES	YES	YES	YES
Preventive and Wellness Services and Chronic Disease Management		NO (Not all USPSTF, Bright Futures, and Women's Wellness Covered Today)	NO (Not all USPSTF, Bright Futures, and Women's Wellness Covered Today)	NO (Not all USPSTF, Bright Futures, and Women's Wellness Covered Today)	NO (Not all USPSTF, Bright Futures, and Women's Wellness Covered Today)	NO (Not all Women's Wellness Covered Today)	NO (Not all Women's Wellness Covered Today)	NO (Not all Women's Wellness Covered Today)	NO (Not all Women's Wellness Covered Today)
Pediatric Services Including Oral and Vision Care	Well Baby and Well Child Visits	YES	YES	YES	YES	YES	YES	YES	YES
	Immunizations	YES	YES	YES	YES	YES	YES	YES	YES
	Routine Oral	NO	YES - Limited Coverage (Pediatric Oral Evaluation, Prophylaxis, Fluoride Treatment, Sealants)	YES - Limited Coverage (Pediatric Oral Evaluation, Prophylaxis, Fluoride Treatment, Sealants)	YES - Limited Coverage (Pediatric Oral Evaluation, Prophylaxis, Fluoride Treatment, Sealants)	NO	NO	NO	NO
	Routine Vision	NO	YES	YES	NO	YES	NO	YES	NO
	Vision Hardware	NO	NO	NO	NO	NO	NO	YES - $50 per Year	NO

Attachment C: LIST OF REQUIRED SUPPLEMENTED BENEFITS

USPSTF A and B Recommendations[71]

Benefit	Description
Abdominal Aortic Aneurysm Screening: Men	One-time screening for abdominal aortic aneurysm by ultrasonography in men aged 65 to 75 who have ever smoked.
Alcohol Misuse Counseling	Screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.
Anemia Screening for Pregnant Women	Routine screening for iron deficiency anemia in asymptomatic pregnant women.
Aspirin to Prevent CVD: Men	Aspirin for men aged 45 to 79 when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
Aspirin to Prevent CVD: Women	Aspirin for women aged 55 to 79 when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.
Bacteriuria Screening: Pregnant Women	Screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks gestation or at the first prenatal visit, if later.
Blood Pressure Screening in Adults	Screening for high blood pressure in adults aged 18 and older.
BRCA Screening, Counseling	Genetic counseling and evaluation for BRCA testing for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes.
Breast Cancer Preventive Medication	Clinician discussion of chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.
Breast Cancer Screening	Screening mammography for women, with or without clinical breast examination, every 1-2 years for women aged 40 and older.
Breastfeeding Counseling	Interventions during pregnancy and after birth to promote and support breastfeeding.
Cervical Cancer Screening	Screening for cervical cancer in women who have been sexually active and have a cervix.
Chlamydial Infection Screening: Non-pregnant Women	Screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.
Chlamydial Infection Screening: Pregnant Women	Screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.
Cholesterol Abnormalities Screening: Men 35 and Older	Screening men aged 35 and older for lipid disorders.
Cholesterol Abnormalities Screening: Men Younger than 35	Screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.
Cholesterol Abnormalities Screening: Women 45 and Older	Screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.

[71] http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm

Benefit	Description
Cholesterol Abnormalities Screening: Women Younger than 45	Screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.
Colorectal Cancer Screening	Screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 and continuing until 75. The risks and benefits of these screening methods vary.
Dental Caries Chemoprevention: Preschool Children	Primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.
Depression Screening: Adolescents	Screening of adolescents (12-18 years of age) for major depressive disorders when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.
Depression Screening: Adults	Screening adults for depression when staff-assisted depression care supports are in place to ensure accurate diagnosis, effective treatment, and follow-up.
Diabetes Screening	Screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
Folic Acid Supplementation	Daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid for all women planning or capable of pregnancy.
Gonorrhea Prophylactic medication: Newborns	Prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.
Gonorrhea Screening: Women	Screening for all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).
Healthy Diet Counseling	Intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.
Hearing Loss Screening: Newborns	Screening for hearing loss in all newborn infants.
Hemoglobinopathies Screening: Newborns	Screening for sickle cell disease in newborns.
Hepatitis B Screening: Pregnant Women	Screening for Hepatitis B virus infection in pregnant women at their first prenatal visit.
HIV Screening	Screening for human immunodeficiency virus (HIV) in all adolescents and adults at increased risk for HIV infection.
Hypothyrodism Screening: Newborns	Screening for congenital hypothyroidism in newborns.
Iron Supplementation in Children	Routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia.
Obesity Screening and Counseling: Adults	Screening of all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.
Obesity Screening and Counseling: Children	Screening of children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
Osteoporosis Screening: Women	Routine screening for women aged 65 and older for osteoporosis beginning at age 60 for women at increased risk for osteoporotic fractures.
PKU Screening: Newborns	Screening for phenylketonuria (PKU) in newborns.
Rh incompatibility Screening: First	Rh (D) blood typing and antibody testing for all pregnant women during their

Benefit	Description
Pregnancy Visit	first visit for pregnancy-related care.
Rh incompatibility Screening: 24-28 Weeks Gestation	Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.
STIs Counseling	High-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
Tobacco Use Counseling and Interventions: Non-pregnant Adults	Clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.
Tobacco Use Counseling: Pregnant Women	Clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.
Syphilis Screening: Non-pregnant Persons	Screening of persons at increased risk for syphilis infection.
Syphilis Screening: Pregnant Women	Screening of all pregnant women for syphilis infection.
Visual Acuity Screening in Children	Screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than 5 years.

Women's Wellness Benefits[72]

Benefit	Description
Gestational Diabetes Screening	Screening for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes.
Contraception, Sterilization and Contraceptive Counseling	Access to all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling. These recommendations do not include abortifacient drugs.
Well Women Visits	Annual well-women preventive care visit for adult women to obtain the recommended preventive services, and additional visits if determined necessary by women and their providers.
HPV DNA Testing	Access to high-risk human papillomavirus (HPV) DNA testing once every 3 years, regardless of pap smear results, for women who are 30 or older.
Counseling for Sexually Transmitted Infections	Access to annual counseling for sexually transmitted infections (STIs) for sexually-active women.
HIV Testing and Counseling	Access to annual screening and counseling on HIV for sexually-active women.
Breastfeeding Support Supplies	Access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment for pregnant and postpartum women.
Domestic Violence Screening	Access to annual screening and counseling for interpersonal and domestic violence for all women.

[72] http://www.healthcare.gov/law/resources/regulations/womensprevention.html

Bright Futures Recommendations for Pediatric Preventive Health Care[73]

Benefit	Interval
Complete Medical History	Age 0 – 21
Length, Height and Weight Measurements	Age 0 – 21
Head Circumference Measurement	Age 0 – 24 months
Body Mass Index Measurement	Age 24 months – 21 years
Blood Pressure	Age 0 – 21
Vision Screening	Age 0 – 21
Hearing Screening	Age 0 – 21
Developmental Screening	Ages 9 Months, 18 Months and 30 Months
Autism Screening	Ages 18 Months and 24 Months
Developmental Surveillance	Ages 0 – 21
Psychosocial/Behavioral Assessment	Ages 0 – 21
Alcohol and Drug Use Assessment	Ages 11 – 21
Physical Exam	Ages 0 – 21
Newborn Metabolic Hemoglobin Screening	Age 3-5 days
Immunizations	Ages 0 – 21
Hematocrit or Hemoglobin	Ages 4 Months, 12 Months, 18 Months, 24 Months, Ages 3 - 21
Lead Screening	Ages 6 Months, 9 Months, 12 Months, 18 Months, 24 Months, Ages 3 - 6
Tuberculin Test	Ages 1 Month, 6 Months, 12 Months, 18 Months, 24 Months, Ages 3 - 21
Dyslipidemia Screening	Age 24 Months, Age 4, Age 6, Age 8, Ages 10 - 21
Sexually Transmitted Infections Screening	Ages 11 – 21
Cervical Dysplasia Screening	Ages 11 – 21
Oral Health	Ages 12 Months, 18 Months 24 Months, 30 Months, Age 3, Age 6
Anticipatory Guidance to Children, Adolescents and Parents	Ages 0 – 21

[73] http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf

Attachment D: STATE MANDATED BENEFITS ACROSS BENCHMARK PLANS

Legal Reference	Mandate Description	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
§58-3-121	TMJ Joint Dysfunction Coverage	Covered	NO - Covers Surgical Procedures Only	NO - Covers Surgical Procedures Only	NO - Covers Surgical Procedures Only	Covered	Covered	Covered	Covered
§58-3-122	Anesthesia and Hospital Charges for Dental Procedures for Children Under Age 9 and Persons With Serious Mental, Physical or Behavioral Problems	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
§58-3-168	Coverage for Postmastectomy Inpatient Care (Discharge Decision Made by Patient and Physician)	Covered	NO - Only Provides 48 Hours of Inpatient Coverage	NO - Only Provides 48 Hours of Inpatient Coverage	NO - Only Provides 48 Hours of Inpatient Coverage, Unless Medically Necessary	Covered	Covered	Covered	Covered
§58-3-169	Minimum Inpatient Stay Following Delivery of a Baby	Covered	Covered	Covered	Covered	Covered (Except for Dependent Children)	Covered	Covered (Except for Dependent Children)	Covered (Except for Dependent Children)
§58-3-170	Treat Maternity as any Other Illness (When Maternity is Provided)	Covered	Covered	Covered	Covered	Covered (Except for Dependent Children)	Covered	Covered (Except for Dependent Children)	Covered (Except for Dependent Children)
§58-3-174	Osteoporosis screening for Women Over Age 60; Bone Mass Measurement	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
§58-3-178	Contraceptive Drugs and Devices Approved by FDA	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered (if Drug Rider Elected)
§58-3-179	Colorectal Cancer Screening	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
§58-3-190	Coverage for Emergency Care	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
§58-3-200(d)	Coverage for Services Provided Outside Provider Networks	Covered	Covered	Covered (Only in an Emergency)	Covered	Covered	Covered	Covered	Covered
§58-3-220(a)	Equity in Benefits for Mental Health - State Requirement (Group Policies)	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered (With Appropriate Rider)
§58-3-220(b)	Mental Illness Minimum Coverage Requirements (Group policies)	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered (With Appropriate Rider)

Legal Reference	Mandate Description	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
§58-3-221	Access to Non-formulary Drugs	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
§58-3-228	Coverage for Prescription Drugs During an Emergency or Disaster	Covered	Covered*	Covered*	Covered*	Covered	Covered	Covered	Covered
§58-3-255	Coverage for Certain Clinical Trials (Phase II, III, and IV Research Studies, Including Prescription Drugs)	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
§58-3-260	Coverage for Newborn Hearing Screening	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
§58-3-270	Coverage for Ovarian Cancer Surveillance Tests	Covered	Covered*	Covered*	Covered*	Covered	Covered	Covered	Covered
§58-3-280	Coverage for the Diagnosis and Treatment of Lymphadema	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
§58-3-285	Coverage for Hearing Aids Up to Age 22 (Up to $2,500 per Ear Every 36 Months)	Covered	Not Covered	Not Covered	Not Covered	Covered	Covered	Covered	Covered
§58-51-16	Coverage for Losses Sustained or Contracted While Being Intoxicated or Under the Influence of Narcotics	Covered	Covered*	Covered*	Covered*	Covered	Covered	Covered	Covered
§58-51-30[74]	Coverage for Newborn, Adopted and Foster Children and Coverage for Congenital Defects and Anomalies	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
§58-51-50/ §58-65-75/ §58-67-70	Minimum Benefit Offering for Alcoholism/Drug Abuse Treatment (Applicable Only to Group and Blanket policies)	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered (With Appropriate Rider)
§58-51-57/ §58-65-92 / §58-67-76	Mammography for Women Over 40	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
§58-51-57/ §58-65-92/ §58-67-76	HPV /Cervical Cancer Screening	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
§58-51-58/ §58-65-93/ §58-67-77	Coverage for Prostate Cancer Screening	Covered	Covered	Covered	Not Covered (Only Covers Beginning at Age 40)	Covered	Covered	Covered	Covered
§58-51-59/ §58-65-94/ §58-67-78	Coverage for Certain Off-label Drugs Used for the Treatment	Covered	Covered*	Covered*	Covered*	Covered	Covered	Covered	Covered

[74] Adopted children are also provided this benefit as §N.C.G.S. 58-51-120 states they shall be treated the same as newborn children under the plan.

Legal Reference	Mandate Description	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
	of Cancer								
§58-51-61/ §58-65-91/ §58-67-74	Coverage for Certain Treatment of Diabetes(Training and Educational Services; Equipment, Supplies, Medications; and Laboratory Procedures Used to Treat Diabetes)	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
§58-51-62/ §58-65-96/ §58-67-79	Coverage for Reconstructive Breast Surgery Following a Mastectomy	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
T11 12.0323	Coverage for Complications of Pregnancy	Covered	Covered*	Covered*	Covered*	Covered	Covered	Covered	Covered
T11 12.0324	Coverage to Treat HIV/AIDS	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered

* Benefit was not specifically addressed as a covered benefit but also not listed as an excluded benefit and therefore assumed to be covered

Attachment E: SUPPLEMENTED BENEFITS ACROSS BENCHMARK PLANS

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
WELLNESS BENEFITS INCLUDING PREVENTIVE SERVICES AND SCREENINGS										
Adult Routine Physical Exams	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Well-Baby and Well-Child Care	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Immunizations	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Routine Mammography Screening	YES	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
HPV/Cervical Cancer Screening	YES	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Newborn Hearing Screening	YES	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Newborn Screening (Other than Hearing)	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Pediatric Hearing Screening	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Ovarian Cancer Surveillance Tests	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Prostate Cancer Screening	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Colorectal Cancer Screening	YES	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Depression Screening (Adolescents and Adults)	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Diagnostic Bone Mass Measurement/Density Testing	YES	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Preventive Colonoscopy	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Allergy Testing	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Diabetes Screening	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Gestational Diabetes Screening	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Screening for Sexually Transmitted Infections – HIV	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Screening for Sexually Transmitted Infections – Other	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Anemia Screening for Pregnant Women	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Bacteriuria Urinary Tract Screening for Pregnant Women	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
BRCA Screening and Counseling About Genetic Testing	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Domestic Violence Screening and Counseling	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Folic Acid Supplements for Women Who May Become Pregnant	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
Hepatitis B Screening for Newly Pregnant Women	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Rh Incompatibility Screening for all Pregnant Women and Follow-up Testing for Women at Higher Risk	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Allergy Injections	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Weight Loss Program	NO	NO	Covered – Counseling Only	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Smoking and Tobacco Cessation Counseling	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Diabetes Education	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Diabetes Monitoring	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Fitness Membership	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Breastfeeding/Lactation Counseling	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Post Partum Depression Counseling	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Nutritional Counseling	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
HPV Vaccine	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Flu Vaccines	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Gonorrhea Prophylactic Medication for Newborns	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Iron Supplementation for Children	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Blood Pressure Screening for Adults	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Cholesterol Screening	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Counseling for Sexually Transmitted Infections	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Abdominal Aortic Screening (Men aged 65-76 who have Smoked)	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Alcohol Misuse Counseling	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Aspirin to Prevent Cardiovascular Disease	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Obesity Screening	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Dental Fluoride Chemoprevention for Children	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Breast Cancer Prevention Medication Counseling	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
HPV DNA Testing Once Every 3 Years	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
INPATIENT HOSPITAL										
Room and Board	NO	NO	Semi-private; Private if	Semi-private; Private if	Semi-private; Private if	Semi-private; Private if	Semi-private Private if	Semi-private; Private if	Semi-private Private if	Semi-private Private if

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
			Medically Necessary or Only Private Rooms	Medically Necessary or Only Private Rooms	Medically Necessary or Only Private Rooms	Medically Necessary or Only Private Rooms	Medically Necessary	Medically Necessary or Only Private Rooms	Medically Necessary	Medically Necessary
Nursing – General	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Private Duty Nursing	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Minimum Inpatient Stays Following Delivery of a Baby (48 Hours Normal; 96 Hours Cesarean)	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Treatment of Maternity as any Other Illness When Maternity is Provided	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Complications of Pregnancy	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Lab	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Pathology Services	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Radiology	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Anesthesia	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Medical Supplies	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Durable Medical Equipment	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Prosthetics	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Drugs	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Blood	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Inpatient Rehab Services	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Mental Health Consistent with Federal Parity	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Alcoholism/Drug Consistent with Federal Parity	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Losses Sustained or Contracted While Being Intoxicated or Under the Influence	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Transplants	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Reconstructive Breast Surgery Following a Mastectomy	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Surgery to Correct Congenital Anomalies	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Other Reconstructive Surgery	NO	NO	Accident or Injury	Functional Defect or to Restore a Mouth to a Pre-cancerous State	Functional Defect or to Restore a Mouth to a Pre-cancerous State	Surgery to Correct a Condition that Produced a Major Effect on the Member's	Accident or Injury	Injury, sickness, or Congenital Anomaly; Medical Condition or to Improve or	Accident or Injury	Accident or Injury

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
						Appearance		Restore Physiologic Function		
Bariatric Surgery	NO	NO	Covered	Covered	Covered	Covered	Covered	Not Covered	Covered	Not Covered
LASIK Surgery	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Tubal Ligation	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Vasectomy	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Reversal of Voluntary Sterilization	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Inpatient Hospice	NO	NO	Covered	7 Days Separated by 21 Days Discharged	7 Days Separated by 21 Days Discharged	Covered – Actuarial Equivalent of Combined Inpatient and Outpatient Maximum of $15,000	Covered	Covered	Covered	Covered
Vision Procedures	NO	NO	Surgical Correction of an Eye Injury and/or Intraocular Surgery	Surgical Correction of an Eye Injury and/or Intraocular Surgery	Surgical Correction of an Eye Injury and/or Intraocular Surgery	Surgical Correction of an Eye Injury and/or Intraocular Surgery	Surgical Correction of an Eye Injury and/or Intraocular Surgery	Surgical Correction of an Eye Injury and/or Intraocular Surgery	Surgical Correction of an Eye Injury and/or Intraocular Surgery	Surgical Correction of an Eye Injury and/or Intraocular Surgery
Anesthesia and Hospital Charges for Dental Procedures for Children Under Age 9 and Persons With Serious Mental, Physical or Behavioral Problems	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Oral and Maxillofacial Surgery	NO	NO	Covered – Accidental Injury, Congenital Deformity, and Disease Due to Infection or Tumor	Covered – Accidental Injury, Congenital Deformity, and Disease Due to Infection or Tumor, Plus Additional Conditions	Covered – Accidental Injury, Congenital Deformity, and Disease Due to Infection or Tumor, Plus Additional Conditions	Covered – Accidental Injury, Congenital Deformity, and Disease Due to Infection or Tumor, Plus Additional Conditions	Covered – Accidental Injury, Congenital Deformity, and Disease Due to Infection or Tumor	Covered – Accidental Injury, Congenital Deformity, and Disease Due to Infection or Tumor	Covered – Accidental Injury, Congenital Deformity, and Disease Due to Infection or Tumor	Covered – Accidental Injury, Congenital Deformity, and Disease Due to Infection or Tumor
OUTPATIENT HOSPITAL										
Emergency Room Services	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Surgery: Operating Room, Recovery	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
and Treatment Rooms										
Anesthesia	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Laboratory Services	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Pathology	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Radiology – X-rays, Ultrasound, EKG, EEG, CT, MRI, PET, Diagnostic Angiography	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Chemotherapy	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Radiation Therapy	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Diagnostic Colonoscopy	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Cardiac Rehab	NO	NO	No Visit Limit	No Visit Limit	No Visit Limit	No Visit Limit	No Visit Limit	36 Visits per Year	No Visit Limit	No Visit Limit
Pulmonary Rehab	NO	NO	No Visit Limit	No Visit Limit	No Visit Limit	No Visit Limit	No Visit Limit	20 Visits per Year	No Visit Limit	No Visit Limit
Chiropractic Manipulation	NO	NO	30 Visits per Year	12 Visits per Year	20 Visits per Year	12 Visits per Year	30 Visits per Year	20 Visits per Year	30 Visits per Year	20 Visits per Year
Physical Therapy	NO	NO	30 Visits per Year	75 Visits per Year	50 Visits per Year	60 Visits per Year		20 Visits per Year		20 Visits per Year
Occupational Therapy	NO	NO						20 Visits per Year		20 Visits per Year
Speech Therapy	NO	NO				30 Visits per Year	30 Visits per Year	20 Visits per Year	30 Visits per Year	20 Visits per Year
Habilitative Services and Devices	NO	NO	Covered – Supplemented as Attaining Functionality Not Yet Achieved	Covered – Supplemented as Attaining Functionality Not Yet Achieved	Covered – Supplemented as Attaining Functionality Not Yet Achieved	Covered – Supplemented as Attaining Functionality Not Yet Achieved	Covered – Attaining Functionality Not Yet Achieved	Covered – Supplemented as Attaining Functionality Not Yet Achieved	Covered – Attaining Functionality Not Yet Achieved	Covered – Attaining Functionality Not Yet Achieved
IV/Infusion Therapy	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	90 Home Visits per Year; Unlimited Visits Other Locations
Respiratory Therapy	NO	NO	Covered	Not Covered	Not Covered	Covered	Covered	Covered	Covered	Covered
Hyperbaric Oxygen Therapy	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Covered	Covered	Covered	Covered
Dialysis	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Blood and Plasma	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Medical and Surgical Supplies	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Oxygen	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Nuclear Medicine	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Injectible Drugs	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Some Covered
Infertility Services	NO	NO	Covered -	Covered ; ART	Covered ; ART	Covered -	Covered -	Not Covered	Covered -	Not Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
			$5,000 Lifetime Benefit for Diagnosis and Treatment of Infertility; ART Excluded	Excluded	Excluded	$3,000 per Year; ART and Prescription Drugs Excluded	$5,000 Lifetime Benefit for Diagnosis and Treatment of Infertility; ART Excluded		$5,000 Lifetime Benefit for Diagnosis and Treatment of Infertility; ART Excluded	
Dental Implants	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Covered Only if Associated with Injury, Congenital Deformity or Removal of Tumors/Cysts	Covered Only if Associated with Accident (Actuarial Equivalent of $900 per Tooth; $3,000 per Year)	Covered Only if Associated with Injury, Congenital Deformity or Removal of Tumors/Cysts	Not Covered
Genetic Screening	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Diagnostic Genetic Testing and Counseling	NO	NO	Covered (High Risk Patients Only)	Covered (Some; Diagnostic Genetic Testing)	Covered (Some; Diagnostic Genetic Testing)	Not Covered	Covered (High Risk Patients Only)	Covered (Genetic Testing and Counseling - Maternity)	Covered (High Risk Patients Only)	Covered
PHYSICIAN SERVICES										
Inpatient Visits	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Inpatient Surgery	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Outpatient Surgery	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Emergency Room Services	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Urgent Care Visits	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Physician Office Visits	NO	NO	Covered	Covered	Covered - Preferred Provider Only	Covered	Covered	Covered	Covered	Covered
Laboratory Services	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Diagnostic Imaging	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Treat maternity as any Other Illness	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Prenatal Care	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Mental Health Consistent with Federal Parity	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Alcoholism/Drug Consistent with Federal Parity	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Losses Sustained or Contracted While Being Intoxicated or Under the Influence	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
PRESCRIPTION DRUG COVERAGE										

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
Retail and Mail Order Prescription Drugs	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered – As Supplemented
Prescription Contraceptives	YES	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered – As Supplemented
Smoking and Tobacco Cessation Prescription Drugs	NO	NO	Covered	Covered	Covered	Covered	Covered	Not Covered	Covered	Covered – Actuarial Equivalent of $165 benefit
Access to Non-formulary Drugs	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Prescription Drugs During an Emergency or Disaster	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Certain Off-label Drug Use for the Treatment of Cancer	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
OTHER SERVICES										
Ambulance Services	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Durable Medical Equipment and Devices	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Private Duty Nursing in the Home	NO	NO	Covered if Medically Necessary (4 Hours perDay for Non-ventilated Patients; 12 Hours per Day for Ventilated Patients)	Not Covered	Not Covered	Not Covered	Covered if Medically Necessary	Not Covered	Covered if Medically Necessary	Not Covered
Home Dialysis Equipment and Supplies	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Oxygen	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Breastfeeding Equipment	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Oral Orthotic Devices	NO	NO	Covered for Accidental Injury, Congenital Deformity, TMJ, Infection or Tumor	Covered for Accidental Injury.	Covered for Accidental Injury.	Covered for Accidental Injury.	Covered for Accidental Injury, Congenital Deformity, TMJ, Infection or Tumor	Covered for Accidental Injury, Congenital Deformity, TMJ, Infection or Tumor	Covered for Accidental Injury, Congenital Deformity, TMJ, Infection or Tumor	Covered for Accidental Injury, Congenital Deformity, TMJ, Infection or Tumor
Prosthetic Devices	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Home Medical Supplies	NO	NO	Covered – with	Covered – with	Covered – with	Covered – with	Covered – with	Covered – with	Covered – with	Covered – with

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
			Certain Exclusions	Certain Exclusions	Certain Exclusions	Certain Exclusions	Certain Exclusions	Certain Exclusions	Certain Exclusions	Certain Exclusions
Coverage for Needles and Syringes for the Administration of Covered Medications	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered Only as a Diabetic Supply	Covered	Covered Only if Prescribed by a Physician such as for Use in a Home Health Visit
Home Health Visit	NO	NO	No Limit	25 Visits per Year	25 Visits per Year	50 Visits per Year	No Limit	60 Visits per Year	No Limit	30 Visits per Year
Skilled Nursing Facility Care	NO	NO	100 days per Year	No Limit	No Limit	Actuarial Equivalent of $700 per Day for 14 Days After an Inpatient Stay	60 Days per Year	No Limit	60 Days per Year	75 Days per Year
Custodial/Convalescent Care	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Respite Care	NO	NO	Inpatient Hospice for Respite; No Limit Stated	Inpatient Hospice for Respite; 7 days, Separated by 21 Days Discharged	Inpatient Hospice for Respite; 7 days, Separated by 21 Days Discharged	Not Covered	Not Covered	Not Covered	Not Covered	Inpatient Hospice for Respite; No Limit Stated
Acupuncture	NO	NO	Not Covered	24 Visits per Year	Covered	20 Visits per Year (Medically Necessary)	Not Covered	Not Covered	Not Covered	Not Covered
Hypnotherapy	NO	NO	Covered to Control Acute or Chronic Pain	Not Covered	Not Covered	Not Covered	Covered to Control Acute or Chronic Pain	Not Covered	Covered to Control Acute or Chronic Pain	Not Covered
HIV/AIDS Treatment	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Certain Treatment of Diabetes	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
TMJ Joint Dysfunction (Diagnostic, Therapeutic, and Surgical Coverage Same as any Other Bone or Joint)	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Diagnosis and Treatment of Lymphadema	YES	NO	Covered	Covered	Covered	Covered	Covered (Excluding OTC Knee-high or Other Stocking Products)	Covered	Covered (Excluding OTC Knee-high or Other Stocking Products)	Covered
Abortion	NO	NO	Covered Only When the Mother's Life is in Danger or for Rape/Incest	Covered Only When the Mother's Life is in Danger or for Rape/Incest	Covered Only When the Mother's Life is in Danger or for Rape/Incest	Covered Only When the Mother's Life is in Danger or for Rape/Incest	Covered During First 16 Weeks of Pregnancy (Except Dependent	Covered	Not Covered	Covered During the First Trimester (Dependent Children Limited

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
							Children)			to When Mother's Life is in Danger)
Home Hospice Care	NO	NO	Covered	Covered	Covered	Covered – Actuarial Equivalent of Combined IP/OP Max of $15,000	Covered (Excludes Homemaker Services)	Covered	Covered (Excludes Homemaker Services)	Covered
Postmastectomy Inpatient Care (Discharge Decision Made by Patient and Physician)	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Autism Spectrum Disorder	NO	YES	Covered Under PT/OT/ST; Rehabilitative Only	Covered	Covered	Covered	Covered Under PT/OT/ST; Rehabilitative Only	Covered Under PT/OT/ST; Rehabilitative Only	Covered Under PT/OT/ST; Rehabilitative Only	Covered Under PT/OT/ST; Rehabilitative Only
Applied Behavioral Analysis (Beyond PT/OT/ST)	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Nurse Midwife Services	NO	YES (For Prenatal Services)	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Over-the-Counter Medications	NO	NO	Insulin; Smoking and Tobacco Cessation	Insulin; Smoking and Tobacco Cessation	Insulin; Smoking and Tobacco Cessation	Insulin; Smoking and Tobacco Cessation	Preventive Medicine	Drugs Eligible for Coverage as if it were a Prescription Drug Product	Preventive Medicine	$165 Smoking Cessation Drug Allowance
Experimental Treatments, Services and Drugs	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Wigs for Hair Loss Due to Chemotherapy Treatment for Cancer	NO	NO	Not Covered	Actuarial Equivalent of $350 Lifetime	Actuarial Equivalent of $350 Lifetime	Not Covered	Not Covered	Not Covered	Not Covered	Actuarial Equivalent of $500 Lifetime
Coverage for Certain Clinical Trials (Phase II, III, and IV Research Studies, Including Prescription Drugs)	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Medical Foods (Food Supplements, Formulas or Special Foods)	NO	NO	Not Covered	Covered US FDA Approved Foods Administered Orally that Provide 100% of Nutrition to Children up to Age 22 for 1 Year	Covered US FDA Approved Foods Administered Orally that Provide 100% of Nutrition to Children up to Age 22 for 1 Year	Covered – Prescription Required	Not Covered	Not Covered	Not Covered	Not Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
ANCILLARY BENEFITS										
Routine Vision Exams - Adult	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	1 per year	1 exam every 2 years	1 per year	Not Covered
Pediatric Vision Screening	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Eyeglasses and Contact Lenses – Adults	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Actuarial Equivalent of $50 per Benefit Period	Not Covered
Eyeglasses and Contact Lenses – Pediatric	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Eyeglasses Related to an Accident, Surgery or Medical Condition	NO	NO	First Pair of Eye Glasses or Contact Lenses After Cataract Surgery	Covered for Accidental Injury, Intraocular Surgery, Nonsurgical Treatment for Amblyopia and Strabismus for Children Birth through 18	Covered for Accidental Injury, Intraocular Surgery, Nonsurgical Treatment for Amblyopia and Strabismus for Children Birth through 18	First Pair of Contact Lenses or Standard Ocular Implant After Intraocular Surgery or Accidental Injury	First Pair of Eyeglasses or Contact Lenses After Cataract Surgery	Not Covered	First Pair of Eyeglasses or Contact Lenses After Cataract Surgery	First Pair of Eyeglasses or Contact Lenses After Cataract Surgery
Routine Dental	NO	NO	Not Covered	Actuarially Equivalent of Scheduled Allowances for Diagnostic and Preventive Services, Fillings, and Simple Extractions	Actuarial Equivalent of Covering 2 Exams, 2 Cleanings, 2 Fluoride Treatments and $150 in X-rays per Year	Actuarially Equivalent of Scheduled Allowances for Diagnostic and Preventive Services, Fillings, and Simple Extractions	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Routine Hearing Exams	NO	NO	Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Covered - Except for Hearing Aid Fittings
Hearing Aids	YES	NO	Actuarial Equivalent of 1 Hearing Aid per Ear Every 36 Months up to $2,500 per Hearing Aid for Children to Age	External and Bone Anchored Hearing Aids; Actuarial Equivalent of One Hearing Aid per Ear Every 36 Months up to	External and Bone Anchored Hearing Aids; Actuarial Equivalent of One Hearing Aid per Ear Every 36 Months up to	Actuarial Equivalent of 1 Hearing Aid per Ear Every 36 Months up to $2,500 per Hearing Aid for Children to Age	Actuarial Equivalent of 1 Hearing Aid per Ear Every 36 Months up to $2,500 per Hearing Aid for Children to Age	Actuarial Equivalent of 1 Hearing Aid per Ear Every 36 Months up to $2,500 per Hearing Aid for Children to Age	Actuarial Equivalent of 1 Hearing Aid per Ear Every 36 Months up to $2,500 per Hearing Aid for Children to Age	Actuarial Equivalent of 1 Hearing Aid per Ear Every 36 Months up to $2,500 per Hearing Aid for Children to Age

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
			22	$2,500 per Hearing Aid for Children to Age 22, $1,250 per Ear Every 36 Months for Adults	$2,500 per Hearing Aid for Children to Age 22, $1,250 per Ear Every 36 Months for Adults	22; Actuarial Equivalent of $250 per Ear Every Five Years for Adults; Bone Anchored Hearing Aids and Cochlear Implants Covered	22	22	22	22
Speech Generating Devices / Voice Synthesizers	NO	NO	Not Covered	Actuarial Equivalent of Covered up to $1,250 per Year	Actuarial Equivalent of Covered up to $1,250 per Year	Not Covered	Covered	Covered	Covered	Covered

Attachment F: OUTLIER ANALYSIS

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
INPATIENT HOSPITAL										
Bariatric Surgery	NO	NO	Covered	Covered	Covered	Covered	Covered	Not Covered	Covered	Not Covered
Oral and Maxillofacial Surgery	NO	NO	Covered – Accidental Injury, Congenital Deformity, and Disease Due to Infection or Tumor	Covered – Accidental Injury, Congenital Deformity, and Disease Due to Infection or Tumor, plus Additional Conditions	Covered – Accidental Injury, Congenital Deformity, and Disease Due to Infection or Tumor, plus Additional Conditions	Covered – Accidental Injury, Congenital Deformity, and Disease Due to Infection or Tumor, plus Additional Conditions	Covered – Accidental Injury, Congenital Deformity, and Disease Due to Infection or Tumor	Covered – Accidental Injury, Congenital Deformity, and Disease Due to Infection or Tumor	Covered – Accidental Injury, Congenital Deformity, and Disease Due to Infection or Tumor	Covered – Accidental Injury, Congenital Deformity, and Disease Due to Infection or Tumor
OUTPATIENT HOSPITAL										
Cardiac Rehab	NO	NO	No Visit Limit	No Visit Limit	No Visit Limit	No Visit Limit	No Visit Limit	36 Visits per Year	No Visit Limit	No Visit Limit
Pulmonary Rehab	NO	NO	No Visit Limit	No Visit Limit	No Visit Limit	No Visit Limit	No Visit Limit	20 Visits per Year	No Visit Limit	No Visit Limit
Chiropractic Manipulation	NO	NO	30 Visits per Year	12 Visits per Year	20 Visits per Year	12 Visits per Year	30 Visits per Year	20 Visits per Year	30 Visits per Year	20 Visits per Year
Physical Therapy	NO	NO	30 Visits per Year	75 Visits per Year	50 Visits per Year	60 Visits per Year		20 Visits per Year		20 Visits per Year
Occupational Therapy	NO	NO						20 Visits per Year		20 Visits per year
Speech Therapy	NO	NO				30 Visits per Year	30 Visits per Year	20 Visits per Year	30 Visits per Year	20 Visits per Year
IV/Infusion Therapy	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered	90 Home Visits per Year; Unlimited Visits Other Locations
Respiratory Therapy	NO	NO	Covered	Not Covered	Not Covered	Covered	Covered	Covered	Covered	Covered
Hyperbaric Oxygen Therapy	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Covered	Covered	Covered	Covered
Infertility Services	NO	NO	Covered - $5,000 Lifetime Benefit for	Covered ; ART Excluded	Covered ; ART Excluded	Covered - $3,000 per Year; ART and	Covered - $5,000 Lifetime Benefit for	Not Covered	Covered - $5,000 Lifetime Benefit for	Not Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
			Diagnosis and Treatment of Infertility; ART Excluded			Prescription Drugs Excluded	Diagnosis and Treatment of Infertility; ART Excluded		Diagnosis and Treatment of Infertility; ART Excluded	
Dental Implants	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Covered Only if Associated with Injury, Congenital Deformity or Removal of Tumors/Cysts	Covered Only if Associated with Accident (Limited to $900 per Tooth; $3,000 per Year)	Covered Only if Associated with Injury, Congenital Deformity or Removal of Tumors/Cysts	Not Covered
Diagnostic Genetic Testing and Counseling	NO	NO	Covered (High Risk Patients only)	Covered (Some; Diagnostic Genetic Testing)	Covered (Some; Diagnostic Genetic Testing)	Not Covered	Covered (High Risk Patients Only)	Covered (Genetic Testing and Counseling - Maternity)	Covered (High Risk Patients Only)	Covered
PRESCRIPTION DRUG COVERAGE										
Smoking and Tobacco Cessation Prescription Drugs	NO	NO	Covered	Covered	Covered	Covered	Covered	Not Covered	Covered	Covered – Actuarial Equivalent of $165 Benefit
OTHER SERVICES										
Private Duty Nursing in the Home	NO	NO	Covered if Medically Necessary (4 Hours per Day for Non-ventilated Patients; 12 Hours per Day for Ventilated Patients)	Not Covered	Not Covered	Not Covered	Covered if Medically Necessary	Not Covered	Covered if Medically Necessary	Not Covered
Oral Orthotic Devices	NO	NO	Covered for Accidental Injury, Congenital Deformity, TMJ, Infection or Tumor	Covered for Accidental Injury	Covered for Accidental Injury	Covered for Accidental Injury	Covered for Accidental Injury, Congenital Deformity, TMJ, Infection or Tumor	Covered for Accidental Injury, Congenital Deformity, TMJ, Infection or Tumor	Covered for Accidental Injury, Congenital Deformity, TMJ, Infection or Tumor	Covered for Accidental Injury, Congenital Deformity, TMJ, Infection or Tumor
Coverage for Needles and Syringes for the Administration of Covered Medications	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered Only as a Diabetic Supply	Covered	Covered Only if Prescribed by a Physician Such

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
										as For Use in a Home Health Visit
Home Health Visit	NO	NO	No Limit	25 Visits per Year	25 Visits per Year	50 Visits per Year	No Limit	60 Visits per Year	No Limit	30 Visits per Year
Skilled Nursing Facility Care	NO	NO	100 Days per Year	No Limit	No Limit	$700 per Day for 14 Days After an Inpatient Stay	60 Days per Year	No Limit	60 Days per Year	75 Days per Year
Respite Care	NO	NO	Inpatient Hospice for Respite; No Limit Stated	Inpatient Hospice for Respite; 7 Days, Separated by 21 Days Discharged	Inpatient Hospice for Respite; 7 Days, Separated by 21 Days Discharged	Not Covered	Not Covered	Not Covered	Not Covered	Inpatient Hospice for Respite; No Limit Stated
Acupuncture	NO	NO	Not Covered	24 Visits per Year	Covered	20 Visits per Year (Medically Necessary)	Not Covered	Not Covered	Not Covered	Not Covered
Hypnotherapy	NO	NO	Covered to Control Acute or Chronic Pain	Not Covered	Not Covered	Not Covered	Covered to Control Acute or Chronic Pain	Not Covered	Covered to Control Acute or Chronic Pain	Not Covered
Abortion	NO	NO	Covered Only When the Mother's Life is in Danger or for Rape/Incest	Covered Only When the Mother's Life is in Danger or for Rape/Incest	Covered Only When the Mother's Life is in Danger or for Rape/Incest	Covered Only When the Mother's Life is in Danger or for Rape/Incest	Covered During First 16 Weeks of Pregnancy (Except Dependent Children)	Covered	Not Covered	Covered During the First Trimester (Dependent Children Limited to When Mother's Life is in Danger)
Autism Spectrum Disorder	NO	YES	Covered Under PT/OT/ST; Rehabilitative Only	Covered	Covered	Covered	Covered Under PT/OT/ST; Rehabilitative Only	30 Inpatient Days per Year; 20 Outpatient Visits per Year	Covered Under PT/OT/ST; Rehabilitative Only	Covered Under PT/OT/ST; Rehabilitative Only
Over-the-Counter Medications	NO	NO	Insulin; Smoking and Tobacco Cessation	Insulin; Smoking and Tobacco Cessation	Insulin; Smoking and Tobacco Cessation	Insulin; Smoking and Tobacco Cessation	Preventive Medicine	Drugs Eligible for Coverage as if it were a Prescription Drug Product	Preventive Medicine	$165 Smoking Cessation Drug Allowance
Wigs for Hair Loss due to Chemotherapy Treatment for Cancer	NO	NO	Not Covered	Actuarial Equivalent of $350 Lifetime	Actuarial Equivalent of $350 Lifetime	Not Covered	Not Covered	Not Covered	Not Covered	Actuarial Equivalent of $500 Lifetime
Medical Foods (Food Supplements, Formulas or Special Foods)	NO	NO	Not Covered	Covered US FDA Approved Foods Administered Orally that	Covered US FDA Approved Foods Administered Orally that	Covered – Prescription Required	Not Covered	Not Covered	Not Covered	Not Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
				Provide 100% of Nutrition to Children up to Age 22 for 1 Year	Provide 100% of Nutrition to Children up to Age 22 for 1 Year					
ANCILLARY BENEFITS										
Routine Vision Exams - Adult	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	1 per Year	1 Exam Every 2 Years	1 per Year	Not Covered
Eyeglasses and Contact Lenses - Adults	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Actuarially Equivalent of $50 per Benefit period	Not Covered
Eyeglasses Related to an Accident, Surgery or Medical Condition	NO	NO	First Pair of Eyeglasses or Contact Lenses After Cataract Surgery	Covered for Accidental Injury, Intraocular Surgery, Nonsurgical Treatment for Amblyopia and Strabismus for Children from Birth through 18	Covered for Accidental Injury, Intraocular Surgery, Nonsurgical Treatment for Amblyopia and Strabismus for Children from Birth through 18	First Pair of Contact Lenses or Standard Ocular Implant After Intraocular Surgery or Accidental Injury	First Pair of Eyeglasses or Contact Lenses After Cataract Surgery	Not Covered	First Pair of Eyeglasses or Contact Lenses After Cataract Surgery	First Pair of Eyeglasses or Contact Lenses After Cataract Surgery
Routine Dental	NO	NO	Not Covered	Actuarial Equivalent of Scheduled Allowances for Diagnostic and Preventive Services, Fillings, and Simple Extractions	Actuarial Equivalent of Covering 2 Exams, 2 Cleanings, 2 Fluoride Treatments and $150 in X-rays per Year	Actuarial Equivalent of Scheduled Allowances for Diagnostic and Preventive Services, Fillings, and Simple Extractions	Not Covered	Not Covered	Not Covered	Not Covered
Routine Hearing Exams	NO	NO	Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Covered - Except for Hearing Aid Fittings
Hearing Aids	YES	NO	Actuarial Equivalent of 1 Hearing Aid per Ear Every 36 Months up to $2,500 per Hearing Aid for	External and Bone Anchored Hearing Aids; Actuarial Equivalent of 1 Hearing Aid per Ear Every 36	External and Bone Anchored Hearing Aids; Actuarial Equivalent of 1 Hearing Aid per Ear Every 36	Actuarial Equivalent of 1 Hearing Aid per Ear Every 36 Months up to $2,500 per Hearing Aid for	Actuarial Equivalent of 1 Hearing aid per Ear Every 36 Months up to $2,500 per Hearing Aid for	Actuarial Equivalent of 1 Hearing aid per Ear Every 36 Months up to $2,500 per Hearing Aid for	Actuarial Equivalent of 1 Hearing aid per Ear Every 36 Months up to $2,500 per Hearing Aid for	Actuarial Equivalent of 1 Hearing aid per Ear Every 36 Months up to $2,500 per Hearing Aid for

Benefit	State Mandate	Required Preventive or Women's Wellness	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3	Small Group Option 1	Small Group Option 2	Small Group Option 3	HMO Option
			Children to Age 22	Months up to $2,500 per Hearing Aid for Children to Age 22, $1,250 per Ear Every 36 Months for Adults	Months up to $2,500 per Hearing Aid for Children to Age 22, $1,250 per Ear Every 36 Months for Adults	Children to Age 22; Actuarial Equivalent of $250 per Ear Every Five Years for Adults; Bone Anchored Hearing Aids and Cochlear Implants Covered	Children to Age 22	Children to Age 22	Children to Age 22	Children to Age 22
Speech Generating Devices / Voice Synthesizers	NO	NO	Not Covered	Actuarial Equivalent of Covered up to $1,250 per Year	Actuarial Equivalent of Covered up to $1,250 per Year	Not Covered	Covered	Covered	Covered	Covered

Attachment G: DETAILED ANALYSIS OF SELECT OUTLIER BENEFITS

Respite Care

Background Info

Respite care provides temporary relief for a caregiver providing daily care to a loved one in need. Those in need of respite care benefits would include those providing care to someone who is chronically ill, a disabled family member, or the elderly. Respite care benefits are covered under the policy of the chronically ill or disabled individual. Respite care services in general include:[75]

Figure G.1 . Overview of In-Home and Out-of-Home Respite Services

In-home respite	Out-of-home respite
Informal family support and relief	Inpatient hospice care
Online caregiver communities and video workshops	Adult day programs
Volunteer or paid companionship	Residential respite care
Personal care or skilled health assistance	Caregiver support groups

Caregivers provide support for loved ones with a wide array of conditions, but based on a National Family Caregivers Association (NFCA) survey five conditions account for roughly 50% of all people in need of a caregiver.[76]

1. Alzheimer's disease (21%)
2. Stroke and related disorders (12%)
3. Multiple sclerosis (8%)
4. Brain damage or traumatic brain disease (6%)
5. Parkinson's disease (5%)

In 2009, roughly 61.6 million caregivers provided care at some point during the year. Published studies discussing the cost of respite care have focused on the economic value of unpaid contributions which are not necessarily representative of the cost to provide respite care. The economic value is representative of the opportunity cost to providing uncompensated care.

[75] http://helpguide.org/elder/respite_care.htm.
[76] http://www.allsup.com/Portals/4/NFCA-Caregiver-Survey10.11.pdf.

The estimated economic value of unpaid contributions for these caregivers was $450 billion in 2009.[77]

As of 2011,[78] among North Carolina's Essential Health Benefit (EHB) benchmark options, only the State Employees Plan, FEHBP Options 1 and 2 and the HMO option provide coverage for respite care.

Current Coverage

Figure G.2. Benchmark Plan Coverage for Respite Care

Plan	Current Coverage
FEHBP Options 1	Inpatient hospice for respite care, up to seven days per admission
FEHBP Option 2	Inpatient hospice for respite care, up to seven days per admission
FEHBP Option 3	Not Covered
State Employees Option	Inpatient hospice for respite care, no limit stated
SG Option 1	Not Covered
SG Option 2	Not Covered
SG Option 3	Not Covered
HMO Option	Inpatient hospice for respite care, no limit stated

In the individual market, BCBSNC does not provide coverage and WellPath provides the same level of coverage that is provided under the HMO Option.

In today's small group market, respite care is not considered medically necessary and is not normally covered by medical insurance. The only respite benefit currently provided is limited to inpatient hospice benefits only for those members who have qualified for home hospice benefits. FEHBP Options 1 and 2 provide up to seven days of inpatient hospice care a month, while the State Employees Option and the HMO Option have no stated limit.[79] The individual WellPath Option also provides coverage with no stated limit. Given the benefit that is provided, the cost estimates provided herein focus only on the cost of providing inpatient hospice benefits.

[77] http://archrespite.org/images/Lifespan_Reauthorization/Cost_Fact_Sheet_01-12.pdf.
[78] At the time this analysis was performed, information on the first quarter 2012 plans was not yet available. Therefore, the analysis was based on the list of plans in Figure 3.2 meeting the prescribed requirements during the second quarter of 2011, as released by HHS on January 25, 2012. While there is the potential for the first quarter 2012 plans to differ from those that follow, it is highly likely that they will not.
[79] Benefit must be preceded by 21 days of traditional home hospice before additional days are covered.

Hospice is focused on providing care to help terminally ill patients live the remainder of their lives with minimal pain and discomfort. Typically a patient's life expectancy is six months.[80] The inpatient hospice respite benefit is intended to provide an interval of relief to the caregiver. Inpatient hospice benefits are also provided when it is necessary to control a patient's pain, manage their symptoms, or death is imminent. The cost that is being addressed within this paper is strictly the cost for inpatient hospice respite benefits. It is likely that the inpatient hospice respite care benefit would be used infrequently due to the limited life span of the patient. It may be used when time away from work is not possible or when caring for the loved one is overwhelming and the caregiver needs a break.

Financial Impact

While respite care benefits are not commonly provided by commercial insurers, hospice benefits are. Using a proprietary database containing 2010 medical and prescription drug claims for more than 45 million people insured in the group or self-insured market, 0.01% of members utilized inpatient hospice services and the average cost per day was $210. Within the Medicare market in 2008, 3.0% of enrollment utilized some form of hospice benefits. The average cost per day for Medicare inpatient hospice benefits was $152 as of October 1, 2010.[81, 82]

Based on the 2010 commercial average cost per day and varying utilization rates, it is estimated the cost of the FEHBP inpatient hospice respite benefit is $0.05 - $0.15 per member per month (PMPM), or 0.01% to 0.04% of premium. The actual PMPM results will vary depending on the number of patients eligible for hospice benefits, the patient's actual life span and the actual frequency of benefit utilization.

Medical and Social Impact

In examining the medical and social impact of providing coverage for respite care, there are several questions that can be addressed.

a. Are the services safe and effective?

Some researchers have completed studies that show a correlation between providing respite care and a realized decrease in hospitalization.[83, 84]

[80] http://www.hospicefoundation.org/uploads/hic_fs_hospice.pdf.
[81] http://www.nahc.org/facts/HospiceStats10.pdf.
[82] http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2013.pdf.
[83] http://archrespite.org/images/Lifespan_Reauthorization/The_Need_for_and_Benefits_of_Respite_for_Children.pdf.
[84] http://archrespite.org/images/Lifespan_Reauthorization/Cost_Fact_Sheet_01-12.pdf.

- *For 28,000 Pennsylvania children with autism ages 5 to 21 enrolled in Medicaid in 2004, the study concluded that for every $1,000 the state spent on respite care the odds of the child being hospitalized decreased 8%.*
- *A Massachusetts social services program providing family-center respite care for children with complex medical needs found that for families participating for more than one year, the number of hospitalizations decreased by 75%.*
- *Respite care is one of the services that Alzheimer's caregivers say they need most. One study found that if respite care delays institutionalization of a person with Alzheimer's disease by as little as a month, $1.12 billion is saved annually. A similar study in 1995 found that as respite use increased, the probability of nursing home placement decreased significantly.*

b. Is the benefit used by a significant portion of the population?

Over 80% of caregivers do not utilize respite services.[85] While it was not addressed why 80% of caregivers do not utilize respite care benefits, it is likely that it is a direct result of lack of coverage, cost and accessibility to care.

c. What are the personal costs associated with being a caregiver for someone chronically ill or disabled?

For these people, being caregivers can have a significant impact on their own personal finances, health and career. In 2007, the direct out-of-pocket costs for a group of surveyed caregivers exceeded $5,000 annually. Of those surveyed, 34% are paying for costs from their savings, 23% cut back on personal preventive and dental care and 38% of caregivers said they have stopped or reduced saving for their future.[86] Not only are the out-of-pocket costs significant for caregivers, they also realize a reduction in wages, loss of productivity at work and increase in health care costs. Based on a study using 2007 data, employers are paying about 8% more in health care related expenses for both younger and older people providing eldercare when compared to non-caregiving employees.[87]

d. What is the level of demand from the public or providers?

Research did not reveal any states that currently mandate inpatient hospice respite care coverage. Medicare coverage does include a hospice inpatient respite care benefit.[88]

[85] http://archrespite.org/images/Lifespan_Reauthorization/2012_Respite_and_Caregiving_Fact_Sheet_3_12.pdf.
[86] http://archrespite.org/images/Books/i51-caregiving.pdf.
[87] http://archrespite.org/images/Books/i51-caregiving.pdf.
[88] http://www.nhpco.org/files/public/regulatory/Inpatient_Respite_Care.pdf.

Infertility Services

Background Info

Infertility is a disease of the reproductive system that impairs the ability to reproduce and affects men and women equally. Infertility is commonly defined as a couple unable to reproduce for a 12 month period for women aged 35 and younger. For women over the age of 35, the inability to reproduce within a 6 month period may be a sign of infertility.[89] For those couples unable to reproduce within 12 months, or 6 months for women at advanced ages, an infertility diagnosis is determined through routine history and physical exam testing provided by a physician. Additional testing may include semen analysis, assessment of ovulation, a hysterosalpingogram and tests for ovarian reserve and laparoscopy.[90]

Infertility affects roughly 10% of women ages 15 to 44 in the United States,[91] and only 70% to 85% of infertile couples are diagnosed through conventional testing as described above.[92] The remaining 15% to 30% are commonly referred to as "unexplained infertility." Fertility treatment can vary widely from timed intercourse and lifestyle changes to the use of medicine and surgical treatments. Surgical treatments include assisted reproductive technology (ART) such as in vitro fertilization (IVF). Other ART procedures include artificial intrauterine insemination (IUI), gamete or intrafallopian transfer (GIFT or ZIFT). According to the 2009 ART report published by the Centers for Disease Control (CDC), over 99% of ART procedures were for in vitro fertilization.[93]

Current Coverage

Coverage varies in the benchmark plan options, with some plans covering infertility services and others not. None of the benchmark plan options cover ART procedures.

[89] http://www.americanfertility.com/faqs/4.php.
[90] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2505167/pdf/RIOG001002_0069.pdf.
[91] http://www.cdc.gov/reproductivehealth/Infertility/index.htm#2.
[92] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2505167/pdf/RIOG001002_0069.pdf.
[93] http://www.cdc.gov/art/ART2009/PDF/01_ARTSuccessRates09-FM.pdf.

Figure G.3. Benchmark Plan Coverage for Infertility Services

Plan	Current Coverage	Exclusions	Definition of Infertility
FEHBP Option 1	Diagnosis and treatment	ART (including drugs used in conjunction)	Not specifically defined
FEHBP Option 2	Diagnosis and treatment	ART (including drugs used in conjunction)	Not specifically defined
FEHBP Option 3	Diagnosis and treatment to $3,000 per year	ART, fertility drugs	Inability to conceive after 12 months or inability to carry to term
State Employees Option	Diagnosis and treatment to $5,000 lifetime	ART	Inability to conceive after 12 months
SG Option 1	Diagnosis and treatment to $5,000 lifetime	ART	Inability to conceive after 12 months
SG Option 2	Not Covered		
SG Option 3	Diagnosis and treatment to $5,000 lifetime	ART	Inability to conceive after 12 months
HMO Option	Not Covered		

FEHBP Options 1 through 3 provide coverage for diagnosis and treatment, however ART and related drugs are excluded. FEHBP Option 3 also limits coverage to $3,000 per year and excludes all fertility drugs, not only those used in conjunction with ART. The State Employees Option and SG Options 1 and 3 provide a $5,000 lifetime benefit which covers diagnosis and treatment of infertility, however ART is excluded. The other plans do not provide any coverage for infertility.

In the individual market, BCBSNC provides the same level of coverage as is provided in Small Group Options 1 and 3 which are BCBSNC small group plans. WellPath does not provide coverage for infertility in the individual market.

Financial Impact

According to the U.S. Census Bureau, there are 4.8 million females in North Carolina,[94] of which, 1.9 million are between the ages of 15 and 44. It is estimated that 190,000 women in North Carolina are unable to reproduce as a result of infertility of the woman or man. Less than 25% of this population will seek infertility treatment in a given year.[95]

A financial impact analysis was performed on the benefit that is included in the State Employees Option and SG Options 1 and 3, which offers $5,000 of coverage lifetime for diagnosis and treatment of infertility excluding ART. The estimated cost of the benefit is $0.05 to $0.20 PMPM, or 0.01% to 0.06% of premium. Details of how this estimate was derived are provided in the following sections. Since the FEHBP Option 3 excludes fertility drugs, it is expected to cost less despite the higher dollar amount of coverage that is available in a person's lifetime. The costs are expected to be similar to diagnosis costs of $0.00 to $0.06 PMPM, or 0.00% to 0.02% of premium. FEHBP Options 1 and 2 are expected to have higher costs due to the absence of a dollar limit on coverage. Using analysis similar to that used for the State Employees Option and SG Options 1 and 3, which is described next, it is estimated the FEHBP Options 1 and 2 benefit would cost $0.05 to $0.40, or 0.01% to 0.11% of premium.

Diagnosis Costs

Costs for the evaluation and diagnosis of infertility can range from $300 for an office visit to $2,000 for an office visit, fertility blood tests and a hysterosalpingogram.[96] The table below details an estimate of the cost to provide coverage for evaluation and diagnostic services. The middle scenario assumes 25% of people with infertility seek services in their lifetime. The low scenario assumes 15% and the high scenario assumes 50% will seek infertility services in their lifetime. It is also assumed that evaluation and diagnosis is done once in a person's lifetime.

Figure G.4. Costs Ranges for Infertility Services

	Cost per Evaluation	NC Population Affected	Total Cost	PMPM*
Low	$ 300	28,302	$ 283,019	$ 0.00
Middle	$ 775	47,170	$ 1,218,552	$ 0.01
High	$ 2,000	94,340	$ 6,289,300	$ 0.06

*Cost spread across entire NC population, 9.25 million people

Limiting coverage to evaluation and diagnosis only can result in average claims costs from $0.00 PMPM to $0.06 PMPM.

[94] Current Population Survey (Population table builder).
[95] http://www.iaac.ca/content/why-do-so-few-couples-seek-infertility-treatment.
[96] http://www.topfertilitydocs.com/costs/average-treatment-costs/ .

Treatment Costs

The cost to treat infertility can be extremely high. Pharmacy costs can be as high as $3,000 to more than $4,000 per course of treatment.[97] IVF is most often not covered by insurers as the cost ranges from $10,000 to $15,000 per cycle of treatment.[98] All of the potential benchmark plans in North Carolina exclude IVF and other ART treatments. In North Carolina, the State Employees Option and SG Group Options 1 and 2 provide coverage for diagnosis and treatment up to a $5,000 lifetime limit. This benefit is the focus of the cost estimates.

Since ART is excluded from all plans in this study, the review of treatment costs is focused on non-ART treatments. The primary treatment for infertility due to ovulation disorders is the use of fertility drugs used to induce or regulate ovulation.[99] The most common drug, Clomid (clomiphene citrate), is taken orally. About half of women taking it are able to get pregnant and do so within three cycles. [100] Each cycle is expected to cost about $50 for the drug cost only.[101] If Clomid is unsuccessful on its own, injectable hormones may be recommended, which cost approximately $1,500 to $3,000 per cycle.[102]

For the roughly half of couples that achieve pregnancy within three cycles of using Clomid, the cost of treatment could be expected to range from $50 - $300 per pregnancy for the drugs alone. Additional pregnancies would likely have similar costs.

Patients using both oral and injectable drugs need to be monitored during treatment, which would include blood tests and ultrasounds. These monitoring procedures cost hundreds of dollars per cycle.[103]

Total Cost of Diagnosis and Treatment

Assuming diagnosis costs of $775 (the middle estimate), treatment costs of $50 - $300 for Clomid drugs, and $300-$900 per cycle for monitoring, it is anticipated that the full $5,000 benefit would not be utilized by the roughly 50% of couples that achieve pregnancy on Clomid, even if the couple had two pregnancies using the drugs. With diagnosis, the cost of injectable drugs, and the cost of monitoring their use, it is more likely that patients using injectable drugs would exhaust the full $5,000 lifetime benefit. If a patient needed more than one cycle of injectable drugs to achieve pregnancy or wanted a second child, the maximum lifetime benefit would certainly be exhausted. Therefore, the full $5,000 benefit would likely be used by patients using injectable drugs.

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[97] http://proquest.umi.com/pqdweb?index=3&did=970653041&SrchMode=5&Fmt=6&retrieveGroup=0&VInst=PROD&VType=PQD&RQT=309&VName=PQD&TS=1141222177&clientId=1579&session=0.
[98] http://infertility.about.com/od/ivf/f/ivf_cost.htm.
[99] http://www.mayoclinic.com/health/infertility/DS00310/DSECTION=treatments-and-drugs.
[100] http://www.webmd.com/infertility-and-reproduction/guide/fertility-drugs.
[101] http://www.babycenter.com/0_fertility-drug-clomiphene_6186.bc?showAll=true.
[102] http://health.costhelper.com/fertility-drugs.html.
[103] http://health.costhelper.com/fertility-drugs.html.

The following table shows estimated lifetime costs by the numbers of pregnancies achieved, applying the $5,000 benefit maximum:

Figure G.5. Cost by Number of Pregnancies

	Pregnancies per lifetime		
Treatment	**1**	**2**	**3**
Clomid	$ 2,325	$ 3,875	$ 5,000
Injectable	$ 5,000	$ 5,000	$ 5,000
Average (50% Clomid, 50% Injectable)	$ 3,663	$ 4,438	$ 5,000
*Assumes $775 for diagnosis (one time), $1,150 per Clomid pregnancy, and injectable users exhaust $5,000 benefit			

Assuming the same prevalence of infertility and utilization of services as was used in estimating the diagnosis costs, and the average lifetime costs in the table above, this benefit is estimated to add between $0.05 and $0.20 PMPM to the cost of covered services. These estimates do not include any indirect costs related to the benefit such as the costs during pregnancy and delivery, or costs related to side effects of the treatments such as the higher costs of multiple births or treating ovarian hyperstimulation syndrome.

In 2014, if coverage for infertility is included in the EHB package, health plans will no longer be able to impose a lifetime or annual dollar limit on this benefit. It is believed that an equivalent non-dollar limit could be imposed. However, it is unclear how such a limit might be imposed for this type of benefit since the services are quite varied. In the financial analyses it is assumed that the benefit in the EHB will be actuarially equivalent to the current benefit if a benchmark plan with this benefit is chosen. If the limits were to be removed without an actuarially equivalent limitation or a substitution of another equivalent benefit, there would be a significant impact on the cost of coverage provided within the North Carolina market relative to the coverage offered today. For example, a Massachusetts study found that costs for mandated fertility diagnosis and treatment cost $2.31 PMPM in direct claims in 2004-2005.[104] Furthermore, an expansion of the mandate that broadened the definition of infertility, which determines eligibility for services, was estimated to add $0.60 PMPM in claim costs in 2012 dollars.[105] However, the Massachusetts mandate includes coverage for ART treatments, so it may be considered a high estimate of what an unlimited infertility benefit might cost.

[104] http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/mandates/comp-rev-mand-benefits.pdf.
[105] http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/09/infertility-report.pdf.

Medical and Social Impact

In examining the medical and social impact of providing coverage for infertility, there are several questions that can be addressed.

a. Are the services safe and effective?

Women with infertility often suffer from depression, anger, and anxiety.[106] Relationships may also suffer with the spouse or partner, as well as friends and family members. It is possible, however, that treatments for infertility may heighten stress and anxiety.[107]

Infertility treatments increase the risk of having multiple pregnancies. The risk of multiple pregnancies is 5% - 8% with Clomid and superovulatoin which can be triggered by both oral and injectable drugs. Multiple pregnancies increase the risk of complications during pregnancy and increase the risk of birth defects. Women are also at risk for ovarian hyperstimulation syndrome (OHS) when using fertility medications. In some cases OHS can cause liver failure, stroke, or heart damage.[108]

Diagnosis is effective in about 70% to 85% of couples. The remaining causes of infertility remain unexplained. Clomid results in pregnancy for roughly half of the women that take it. About half of those taking injectable drugs get pregnant as well.[109]

b. Is the benefit used by a significant portion of the population?

As previously discussed, about 10% of the population is infertile. Not all of these couples seek diagnosis and treatment even when covered by insurance.

c. Does lack of coverage lead to avoiding necessary treatment?

A study performed for the State of Maryland found that, "In general, infertility treatment is not considered medically necessary. Although there may be health effects associated with infertility, and the lack of access to infertility treatment may contribute to mental health issues involving stress or depression, infertility treatment may be considered a choice, rather than a necessity, as there are no direct medical consequences for people who do not seek infertility treatments."[110]

Lack of coverage could make treatment cost prohibitive for some couples. As previously noted, injectable drugs cost about $1,500 to $3,000 per cycle in addition

[106] http://voices.yahoo.com/the-social-implications-womans-infertility-642566.html.
[107] http://www.health.harvard.edu/press_releases/Psychological-impact-of-infertility.
[108] http://www.webmd.com/hw-popup/ovarian-hyperstimulation-syndrome.
[109] http://www.webmd.com/infertility-and-reproduction/guide/fertility-drugs?page=2.
[110] http://mhcc.maryland.gov/health_insurance/annualmandaterpt2008.pdf.

to the necessary monitoring during their use. The most expensive treatments involving ART were not covered under any of the plans studied.

d. What is the level of demand from the public or providers?

Currently only 15 states have laws requiring coverage for infertility treatment.[111]

[111] http://www.fertilitylifelines.com/payingfortreatment/state-mandatedinsurancelist.jsp.

Routine Adult Vision Exams

Background info

An eye examination is a series of tests that measure a person's ocular health and visual status to detect abnormalities in the components of the visual system, and to determine how well the person can see.[112] Examinations are typically performed by an optometrist or ophthalmologist and are more extensive than a vision screening that uses an eye chart and may be done by a primary care physician.

Current Coverage

Figure G.6 Benchmark Plan Coverage for Routine Adult Vision Exams

Plan	Current Coverage
FEHBP Option 1	Not covered
FEHBP Option 2	Not covered
FEHBP Option 3	Not covered
State Employees Option	Not covered
SG Option 1	Covered one per year
SG Option 2	Covered one every two years
SG Option 3	Covered one per year
HMO Option	Not covered (riders covering one per year or one every two years are available)

In the individual market, neither BCBSNC or WellPath cover routine adult vision exams.

The largest insurers in North Carolina were asked to respond to a survey providing coverage, cost, and utilization information for several benefits, including routine adult vision exams. Using the survey responses and small group enrollment provided by the North Carolina Department of Insurance (DOI), it is estimated that: 62% of small group enrollees have coverage for annual vision examinations; 24% have coverage for vision examinations every two years; 12% do not have coverage in their base plans, however some of these enrollees may have coverage under a rider which could provide for examinations every year or two years; and the remaining 2% are unknown because they have coverage with smaller insurers that were not asked to complete the survey.

[112] http://medical-dictionary.thefreedictionary.com/Eye+Examination.

Financial Impact

The cost of a routine adult vision exam for most North Carolina insurers ranges from $75 to $85 per examination.

The overall financial impact of a routine vision examination depends upon the frequency at which exams are covered. As previously shown, among plans that cover the exams, some cover one per year while others cover one every two years. Some insurers cover the exams for all enrolled groups, while others offer the benefit as a separate rider. This will affect the utilization of services and the total annual costs.

Since insurers provide varying levels of coverage, utilization and the resulting per member per month (PMPM) costs are more difficult to compare. The benefits covering one exam per year cost approximately $0.60 to $1.40 PMPM, or 0.17% to 0.40% of premium, assuming the benefit is a standard benefit for all groups and not a separate rider.

Medical and Social Impact

In examining the medical and social impact of providing coverage for routine eye examinations for adults, there are several questions that can be addressed.

a. Are the services safe and effective?

There is little in the way of evidence-based research related to routine adult vision examinations. More information is available regarding routine vision exams for children, perhaps due to the importance of vision to learning and the prevalence of amblyopia, or lazy eye, for which early detection is important. The U.S. Preventive Services Task Force recommends vision screening for children. Pediatric routine vision exams are required to be part of the EHBs.

While the volume of evidence for routine vision exams may not be large, particularly in adults under age 65, the CDC does recommend routine vision examinations. In its "Fast Facts," the CDC states that "Early detection and timely treatment of eye conditions such as diabetic retinopathy has been found to be efficacious and cost effective." In the CDC's "Eye Health Tips" it is suggested that people have a comprehensive dilated eye exam, since it is the only way to be sure the eyes are healthy and to detect diseases such as glaucoma, diabetic eye disease and age-related macular degeneration in their early stages.

Recommended Frequency

There does not appear to be a common standard for the frequency at which vision exams should be performed. The American Optometric Association recommends eye

examinations at least every two years for adults aged 19 to 60. [113, 114] Starting at age 61, annual eye exams are recommended.[115] The Mayo Clinic, however, recommends eye exams every five to ten years from age 20 to 39, and every two years from age 40 to 65[116].

b. Is the benefit used by a significant portion of the population?

In adults, vision problems increase significantly with age. According to the CDC, "Of the 3.3 million Americans with impaired vision, 2.9 million are 65 years or older."[117] People aged 65 and older are often covered by Medicare, rather than commercially purchased individual or group coverage to which the EHBs will apply.

Estimated prevalence of vision impairment, defined as having 20/40 or worse vision in the better eye even with eyeglasses, is 2.5% in North Carolina and 2.8% nationwide in adults age 40 or older, as of 2004.[118] The 2008 Update to the Fourth Edition of "Vision Problems in the U.S." shows the prevalence of vision impairment by age group for ages 40 and older. At ages 40-49, the prevalence is essentially 0% and remains less than 1% through age 64, then increases more rapidly to roughly 2% at ages 75-79 and about 6% at ages 80 and older.

As mentioned previously, insurers' reported utilization cannot be directly compared since coverage varies by insurer. Using the estimated PMPM cost for a benefit of one exam per year and the reported cost per exam, it is estimated that roughly 10% to 25% of covered members will have an exam each year. Since roughly 30% of members are estimated to be children, this translates to an anticipated utilization among adults of about 14% to 36% in a given year. A survey of adults from 1997 to 2005 found that 38.9% of adults with health insurance received eye care within the prior year.[119] The survey found 37.3% utilization among insured adults with no visual impairment, 54.1% among those with some visual impairment, and 60.3% among those with severe visual impairment.[120] A California study reported 125 optometry and 104 ophthalmology vision exam visits per 1,000 commercial members, which appears to include all visits and not only routine visits.[121]

c. Does lack of coverage lead to avoiding necessary treatment?

The CDC analyzed survey data to determine why adults age 40 or older with

[113] http://www.aoa.org/x9452.xml.
[114] http://www.aoa.org/x9453.xml.
[115] http://www.aoa.org/x9454.xml.
[116] http://www.mayoclinic.com/health/eye-exam/MY00245/DSECTION=why-its-done.
[117] http://www.cdc.gov/Features/HealthyVision/.
[118] http://www.preventblindness.net/site/DocServer/VPUS_2008_update.pdf.
[119] http://archopht.ama-assn.org/cgi/reprint/127/3/303.
[120] Survey respondents were asked, "Do you have any trouble seeing, even when wearing glasses or contact lenses?" Those that answered yes were considered to have some visual impairment. Participants who answered yes to, "Are you blind or unable to see at all?" were considered to have severe visual impairment.
[121] http://www.chbrp.org/documents/ab_1084anal.pdf.

moderate to severe visual impairment did not seek eye care. Cost or lack of insurance was cited by 48.4% of North Carolina adults aged 40 to 64 years.[122]

d. What is the level of demand from the public or providers?

Only one state mandates vision care services.

e. What is the cost to society?

In 2007 Prevent Blindness America published a study estimating the economic impact of vision problems to be about $51.4 billion annually.[123] The table below summarizes the results:

Figure G.7. Costs Associated with Lack of Access to Routine Vision Exams

Type of Cost	Definition	Estimated Cost in Billions
Direct medical costs	Inpatient, outpatient, and prescription drug services, vitamins and other medications used by people with age-related macular degeneration (AMD), cataract, diabetic retinopathy, glaucoma or refractive error	$16.2
Other direct costs	Nursing home care due to visual impairment, government programs for people who are visually impaired and guide dogs	$11.2
Lost productivity	Cost of lower labor force participation and lower wages among people who are visually impaired or blind compared to those in the same age group who have normal vision	$8.0
Medical care expenditures	Costs associated with events such as outpatient doctor visits, emergency room visits, hospital stays, dental visits, home care and also medical supplies and prescription drugs	$5.1
Informal care costs	Value of time related to unpaid care provided by friends and family members	$0.4
Health utility loss	Measure for evaluating quality of life in chronic medical conditions where there is little or no impact on mortality in the short term	$10.5

The costs in the table above include costs for all ages, including people age 65 and older. Of the $16.2 billion direct medical costs, slightly more than half of the costs ($8.3 billion) are related to people age 65 and older. It is unknown whether some of the costs, including those for people

[122] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6019a3.htm.
[123] http://www.preventblindness.net/site/DocServer/Impact_of_Vision_Problems.pdf?docID=1321.

age 65 and older, might have been avoided with additional routine examinations prior to age 65.

Private Duty Nursing

Background Info

Private duty nursing is defined generally as nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of a hospital or skilled nursing facility. The services are provided by a registered nurse or licensed practical nurse under the direction of a physician. Services may be provided in a hospital, skilled nursing facility or in the home.[124] In this report, private duty nursing refers only to services provided in the home, since the benchmark plan options under review do not cover inpatient private duty nursing. Private duty nursing is not used to treat specific conditions but rather as part of transitional care from a more acute setting to home, and is not intended for managing chronic conditions. It is often used by patients dependent on technology, such as a ventilator.

Current Coverage

Coverage of private duty nursing in the home within the benchmark plan options is depicted in the figure below.

Figure G.8: Benchmark Plan Coverage for Private Duty Nursing

Plan	Current Coverage
FEHBP Option 1	Not covered
FEHBP Option 2	Not covered
FEHBP Option 3	Not covered
State Employees Option	Covered up to four hours per day for non-ventilated patients and 12 hours per day for ventilated patients.
SG Option 1	If medically necessary and ordered by a doctor
SG Option 2	Not covered
SG Option 3	If medically necessary and ordered by a doctor
HMO Option	Not covered

Only the SG Options 1 and 3 and the State Employees Option provide coverage for private duty nursing. In the individual market, BCBSNC provides coverage if medically necessary and WellPath does not provide coverage.

[124] http://law.justia.com/cfr/title42/42-3.0.1.1.9.1.109.10.html.

The SG Option 1 and 3 medical policy states the following:[125]

> *Private duty nursing (PDN) is hourly, skilled nursing care provided in a patient's home. Private duty nursing provides more individual and continuous skilled care than can be provided in a skilled nurse visit through a home health agency. The intent of private duty nursing is to assist the patient with complex direct skilled nursing care, to develop caregiver competencies through training and education, and to optimize patient health status and outcomes. Private duty nursing is medically necessary continuous, substantial and complex hourly nursing services provided by a licensed nurse in the patient's home. (The nursing tasks must be done so frequently that the need is continuous.) The frequency and duration of private duty nursing services is intermittent and temporary in nature and is not intended to be provided on a permanent ongoing basis.*

Private duty nursing in the home appears to be infrequently covered in commercial insurance. Therefore, data on its commercial use is limited.

Financial Impact

In Medicaid, private duty nursing is optional for adults, but is a mandatory part of Early and Periodic Screening, Diagnostic, and Treatment (EPDST) services for children under age 21.[126] North Carolina's Medicaid program covered home-based private duty nursing for both children and adults, prior to the passage of Session Law 2010-31 which limited coverage to recipients under age 21.[127] The change in law appears to have been a result of a report to the Joint Legislature dated December 10, 2008 related to cost control of private duty nursing services.[128] At the time the report was written, the Medicaid program provided unlimited service hours per day, did not require a willing and capable unpaid caregiver, did not limit coverage to technology dependence, and did not require an independent assessment of the continuous need for services. As a result of the unlimited, long-term benefits and lack of independent assessment of need, Medicaid spent an average of $155,343 on private duty nursing per recipient of private duty nursing services in fiscal year 2006-07.

Since the benefit in the benchmark plan options is specifically intended to be intermittent and temporary, it is assumed for purposes of this report that necessary restrictions and verification will be done in the commercial market to control costs should the benefit be included in the EHB. Some of the findings from the report that could inform the care that is provided in the commercial market are:

- "Recipients choose private duty nursing services over nursing facility services because they prefer to be cared for at home…."

[125] http://www.bcbsnc.com/assets/services/public/pdfs/medicalpolicy/private_duty_nursing_services.pdf.
[126] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html.
[127] http://www.ncleg.net/Sessions/2009/Bills/Senate/PDF/S897v8.pdf.
[128] http://www.ncleg.net/PED/Reports/documents/PDN/PDN_Report.pdf.

- "Recipients and family members believe patients have a higher quality of life at home than in an institution."
- "Recipients and family members believe patients receive a higher quality of care from private duty nurses than they would receive in nursing facilities."
- "In essence, recipients have a choice between two covered benefits: nursing home care or an amount of private duty nursing that does not exceed the cost of nursing home care."

These quotations suggest that private duty nursing in the home setting is used as an alternative to institutional care. In addition, a large commercial insurer operating outside of North Carolina has a medical policy that states that private duty nursing in the home setting includes caregiver training "to assist with transition of care from a more acute setting to home." The SG Option 1 and 3 medical policy indicates one use as developing "caregiver competencies through training and education."

Although private duty nursing is rarely covered, all of the benchmark plan options cover skilled nursing facilities. The number of days covered in skilled nursing are limited to 60 to 100 days per year or per cause, depending on the insurer. Based on insurer surveys, PMPM spending on skilled nursing facilities ranged from $0.02 to $0.84 which could be used as a proxy for the cost of private duty nursing. In Medicaid, private duty nursing costs often exceeded skilled nursing facility costs on a per-day basis depending upon the number of nursing hours provided per day.[129] Not all skilled nursing facility days could be replaced by private duty nursing, but it is possible the private duty costs per day could be higher.

As with skilled nursing facility costs, the home health costs in the market were reviewed as a proxy for private duty nursing costs. Home health PMPM costs ranged from $0.04 to $1.42. While home health visits would cost less than private duty nursing which requires more skilled care, their frequency is likely greater than private duty nursing which is often used by technology-dependent patients.

Given the lack of commercial data on private duty nursing in the home, and using the skilled nursing facility and home health PMPMs as proxies, spending on private duty nursing would likely range from $0.25 to $1.00 PMPM, or 0.07% to 0.29% of premium. However, since it is used as a replacement for institutional care, the incremental cost if added to plans as a new benefit would be lower.

Medical and Social Impact

In examining the medical and social impact of providing coverage for private duty nursing in the home, there are several questions that can be addressed.

[129] http://www.ncleg.net/PED/Reports/documents/PDN/PDN_Report.pdf.

a. Are the services safe and effective?

No evidence was found to suggest that private duty nursing is not a safe or effective treatment. As mentioned earlier, Medicaid recipients and their families believe that the care is higher quality than that of nursing facilities. They cited beliefs that private duty nursing results in avoided hospitalizations, catching complications more quickly, and exposure to fewer germs. However, we note that this is based on interviews of 10 recipients and families and does not represent a statistically credible sample. There is insufficient evidence to draw reliable conclusions regarding the quality of private duty nursing relative to institutional care.

b. Is there a social benefit associated with providing coverage for private duty nursing?

Socially there may be a benefit to allowing people to be cared for in the home. They may be more comfortable or feel more independent at home and are more easily able to interact with family in the home setting.

c. Is the benefit used by a significant portion of the population?

Another measure of the social impact is the number of people who would use the benefit. Utilization from the insurer survey was reviewed, again using the skilled nursing facility usage as a proxy. After removing one apparent outlier response that indicated utilization more than ten times the next highest response, the range of utilization was 0.02 to 7.60 days per thousand covered members, with most responses indicating less than 1 day per thousand covered members. Even if each person stayed for only one day, the percent of people using the services would remain quite low as a percent of the overall population.

Bariatric Surgery

Background Info

Bariatric surgery is a surgical treatment for morbid obesity. It is defined as "surgery on the stomach and/or intestines to help a person with extreme obesity lose weight."[130]

Current Coverage

Figure G.9 Benchmark Plan Coverage for Bariatric Surgery

Plan	Current Coverage
FEHBP Option 1	Covered for body mass index (BMI) of 40+ or 35+ with one or more co-morbidities for 2 years prior to surgery and 3 months of weight loss program with nutritional counseling, attempts at weight loss ineffective for 1 year, psychological clearance, no evidence of substance abuse in prior year (must be at least 18 years)
FEHBP Option 2	Covered for BMI of 40+ or 35+ with one or more co-morbidities for 2 years prior to surgery and 3 months of weight loss program with nutritional counseling, attempts at weight loss ineffective for 1 year, psychological clearance, no evidence of substance abuse in prior year (must be at least 18 years)
FEHBP Option 3	Covered for BMI of 40+ or 35+ with one or more co-morbidities for 6 months prior to surgery, failure to lower BMI by medically supervised program within last 12 months of diet and exercise of at least 6 months (must be at least 18 years)
State Employees Option	Covered (criteria not found in benefit booklet)
SG Option 1	Covered (criteria not found in benefit booklet)
SG Option 2	Not covered
SG Option 3	Covered (criteria not found in benefit booklet)
HMO Option	Not covered

In the individual market, BCBSNC provides coverage while WellPath does not.

[130] http://www.medterms.com/script/main/art.asp?articlekey=23436.

Financial Impact

Based on published studies and a proprietary database of claims, the cost of the surgery is estimated between $20,000 to $30,000.[131] One study estimates that the cost of open surgery is returned within four years, and may be returned in as little as two years for laparoscopic surgery. These savings result from decreased co-morbidities.[132]

In 2010, 28.6% of North Carolinians were obese, defined as having a BMI of 30 or greater.[133] About 10% of the national population has a BMI of 35 or greater, and therefore may meet the criteria for the treatment.[134] Alternatively, the 2004 Consensus Conference estimated that 20% of obese adults are morbidly obese.[135] Using this estimate, roughly 6% of North Carolinians would meet the criteria for treatment. The prevalence is estimated, therefore, to be in the range of 6% to 10%.

Despite the prevalence of morbid obesity, it is assumed that not all morbidly obese individuals will have the surgery due to not meeting the necessary criteria of the insurer or a desire not to undergo surgery. The FEHBP Options 1 and 2 contain specific criteria under which a second surgery may be performed on a given person, suggesting that some do pursue more than one in a lifetime. Using these assumptions, the estimate of the cost of coverage is between $0.50 to $3.00 PMPM, or 0.14% to 0.86% of premium.

Figure G.11. Costs Ranges for Bariatric Surgery

Scenario	Prevalence	Number who Pursue Surgery	Number of Sugeries per Lifetime	Cost	PMPM
Low	6%	33%	1.00	$20,000	$0.51
Middle	8%	50%	1.05	$25,000	$1.35
High	10%	67%	1.10	$30,000	$2.83

The prevalence of obesity in North Carolina increased from 21.8% in 2000 to 28.6% in 2010.[136] With the increasing prevalence of obesity, it is possible the cost will increase over time at a rate faster than the rate of increase in general health care costs. The estimated cost does not include the cost of any complications of the surgery, nor does it include any savings from improved overall health.

[131] http://mhcc.maryland.gov/smallgroup/bariatricsurgery.pdf.
[132] http://www.ajmc.com/files/articlefiles/AJMC_08sep_Cremieux589to596.pdf.
[133] http://apps.nccd.cdc.gov/brfss/.
[134] Durden, Emily D., PhD; Dan Huse, MA; Rami Ben-Joseph, PhD; Bong-Chul Chu, PhD. "Economic Costs of Obesity to Self-Insured Employers." (2008).
[135] http://www.asbs.org/html/pdf/2004_ASBS_Consensus_Conference_Statement.pdf.
[136] http://apps.nccd.cdc.gov/brfss/.

Medical and Social Impact

In examining the medical and social impact of providing coverage for bariatric surgery, there are several questions that can be addressed.

a. Are the services safe and effective?

Bariatric surgery is considered to be an effective treatment for morbid obesity, defined as having a BMI of 40 or greater, or having a BMI of 35 or greater with one or more co-morbidities. In 1991, the National Institutes of Health (NIH) developed a consensus including the following recommendations:[137]

1. Patients seeking therapy for severe obesity for the first time should be considered for treatment in a nonsurgical program with integrated components of a dietary regimen, appropriate exercise, and behavioral modification and support.
2. Gastric restrictive or bypass procedures could be considered for well-informed and motivated patients with acceptable operative risks.
3. Patients who are candidates for surgical procedures should be selected carefully after evaluation by a multidisciplinary team with medical, surgical, psychiatric, and nutritional expertise.
4. The operation should be performed by a surgeon substantially experienced with the appropriate procedures and working in a clinical setting with adequate support for all aspects of management and assessment.

Numerous studies have found the treatment to be effective. For example, the Betsy Lehman Center for Patient Safety and Medical Error Reduction identified over 3,000 abstracts on this subject and reviewed 104 of them in detail.[138] The Center's recommendation was consistent with the 1991 NIH consensus. Furthermore, a 2005 meta-analysis reviewed 167 previously published studies and found that surgery is more effective than nonsurgical treatment in the morbidly obese population.[139]

There are a number of bariatric surgery centers of excellence in North Carolina as designated by the American Society for Metabolic and Bariatric Surgery.[140]

Health risks associated with untreated obesity include:[141, 142]

a. Coronary heart disease
b. Type 2 diabetes

[137] http://consensus.nih.gov/1991/1991GISurgeryObesity084.html.htm.
[138] http://www.mass.gov/eohhs/docs/dph/patient-safety/weight-loss-executive-report.pdf.
[139] www.annals.org/cgi/content/full/142/7/547.
[140] The Blue Cross Blue Shield of North Carolina requires this designation for inclusion in their bariatric network (http://asmbs.org/wp-content/uploads/asmbs_bscoe_benefits1.pdf); BCBSNC network providers can be found at http://www.bcbsnc.com/bdc/bariatric.htm.
[141] http://www.cdc.gov/obesity/causes/health.html.
[142] http://www.webmd.com/diet/tc/obesity-health-risks-of-obesity.

c. Cancers (endometrial, breast, and colon)
d. Hypertension
e. Stroke
f. Liver and gallbladder disease
g. Sleep apnea and respiratory problems

b. Is the benefit used by a significant portion of the population?

Prevalence of morbid obesity is estimated to be in the range of 6% to 10%.

c. Does a lack of coverage lead to avoiding necessary treatment?

As previously mentioned, the cost of the surgery is estimated to be in the range of $20,000 to $30,000[143] and may be cost prohibitive for many people.

d. What is the level of demand from the public or providers?

In 2010, seven states mandated coverage for morbid obesity treatment.[144] A Maryland study found that "most" self-funded employers surveyed, defined as 61% to 89% of employers, choose to cover treatment of morbid obesity.[145]

It is estimated that 220,000 people in the United States had bariatric surgery in 2008.[146] The United States population in 2008 was roughly 304 million people.[147] Therefore, less than 0.1% of the population had the surgery in that year.

e. What are the societal costs of obesity?

A Duke University study found that obese women with a BMI over 40 miss on average nearly 23 workdays per year and cost society $73 billion in lost productivity.[148] By way of comparison, women with a BMI between 30 and 34.9, still obese, averaged about 6.3 days of lost work time.

f. What are the personal costs of being obese?

A 2010 study found that the annual cost of being obese is $4,879 for women and $2,646 for men.[149] These costs are related to, among other things, medical expenses, adaptation of homes, clothing, and lower wages resulting from lower productivity. Other non-financial costs include lower education, lower socioeconomic achievement, and earlier morbidity.[150]

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[143] http://mhcc.maryland.gov/smallgroup/bariatricsurgery.pdf.
[144] Council for Affordable Health Insurance, Health Insurance Mandates in the States 2010.
[145] Maryland Health Care Commission, Study of Mandated Health Insurance Services: A Comparative Evaluation.
[146] http://win.niddk.nih.gov/publications/labs.htm#howmany.
[147] http://www.census.gov/popest/data/historical/2000s/vintage_2008/.
[148] http://www.naturalnews.com/030000_obesity_productivity.html.
[149] http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_35308C47-5056-9D20-3DB157B39AC53093.pdf.
[150] http://www.ncbi.nlm.nih.gov/pubmed/10147251.

Routine Hearing Exams

Background info

A routine hearing exam includes the testing and evaluation of a person's sense of hearing sensitivity, and is usually performed by an audiologist. It is more extensive than a hearing screening which only provides an indication of whether there is a possibility of hearing loss and need for further testing. Hearing tests typically involve four steps: Audiologic (hearing) evaluation by a hearing professional, different types of tests, a hearing case history, and an audiogram.[151] Common tests include pure tone testing measuring air or bone conduction response, sound field testing, and speech recognition tests.

Hearing loss is defined as the total or partial inability to hear sound in one or both ears. Mild hearing loss is commonly defined as the inability to hear frequencies associated with speech processing that are less than 25 decibels (dB), with moderate hearing loss defined as inability to hear those frequencies under 40 dB.[152]

Hearing loss can result from a variety of causes, ranging from the build up of fluid or wax in the ear to infections, injuries, congenital causes, tumors, working around loud noises or presbycusis (aging).[153] Diagnosis of hearing loss, including determination of the cause and whether it is temporary or permanent, is important to inform the appropriate course of treatment. For example, most hearing loss caused by infections can be treated with simple antibiotics; however more serious infections that lead to hearing loss such as bacterial meningitis could lead to brain damage if untreated. Unidentified hearing loss in children can often be mistaken as Attention-Deficit Disorder (ADD), behavioral problems, rudeness or inattentiveness.[154]

[151] http://www.harrishearing.com/hearing-tests.
[152] http://www.uspreventiveservicestaskforce.org/uspstf11/adulthearing/adultheares.pdf.
[153] http://www.nlm.nih.gov/medlineplus/ency/article/003044.htm.
[154] http://www.cchdwi.org/resources.php.

Current Coverage

Figure G.12 Benchmark Plan Coverage for Routine Hearing Exams

Plan	Current Coverage
FEHBP Option 1	Not Covered
FEHBP Option 2	Not Covered
FEHBP Option 3	Not Covered
State Employees Option	Cover annual routine hearing exams and testing
SG Option 1	Not Covered
SG Option 2	Not Covered
SG Option 3	Not Covered
HMO Option	Covered, except for hearing aid fittings

In the individual market, neither BCBSNC or WellPath cover routine hearing exams.

The insurer survey previously mentioned also requested coverage, cost, and utilization information for routine hearing exams. Using the survey responses and small group enrollment provided by the North Carolina DOI, it is estimated that 89% of small group enrollees do not currently have coverage for routine hearing examinations, and 9% have coverage but only if medically necessary due to a hearing condition. The remaining 2% are unknown because they have coverage with smaller insurers that were not asked to complete the survey.

Financial Impact

None of the small group insurers surveyed provide coverage for routine hearing exams, which means that the estimates of cost for this section are based on external research, rather than North Carolina specific experience. The research shows that the cost of a routine hearing exam typically ranges from $75 to $150, depending on the type and level of testing performed.

The incidence of hearing loss increases significantly with age. When combining a 2008 study by the CDC with population estimates from the U.S. Census Bureau, the result shows the incidence of hearing loss among North Carolinians was 11.6% among those ages 18-64 and increased to 42.6% among those ages 75 and older.[155] However, people age 65 and older are often covered by Medicare, rather than commercially purchased individual or group coverage to which the EHBs will apply.

The overall financial impact of covering routine hearing examinations depends on the frequency with which exams are performed. As previously shown, the State Employees Option

[155] http://www.ncdhhs.gov/dsdhh/facts/hearing_loss_by_age_2010.pdf.

is the only benchmark option that covers routine hearing exams and testing, and coverage is provided for one exam annually. The American Speech-Language-Hearing Association recommends hearing tests every ten years for adults up to the age of 50, and every three years thereafter.[156] It is recommended among audiologists that those with diagnosed hearing loss be tested every year, however re-testing often occurs at a lower rate. Many times individuals assume that if their symptoms go away their ears have returned to normal. Others simply deny that they have a hearing problem or cannot afford the test costs.

Figure G.13. Cost Ranges for Hearing Exams/Tests

Scenario	% Age 18-64 Diagnosed with Hearing Problem	% Diagnosed that are Retested Each Year	% Age 18-64 Without Hearing Problem Tested Each Year	% of Total Age 18-64 Population Tested Each Year	Cost Per Exam/Test
Low	11.6%	33.0%	5.0%	8.3%	$ 75
Mid	11.6%	50.0%	10.0%	14.6%	$ 100
High	11.6%	66.0%	15.0%	20.9%	$ 150

The benefits covering one routine hearing exam per year are estimated to cost approximately $0.25 to $2.00 PMPM, or 0.07% to 0.57% of premium, depending on the frequency of testing sought by consumers and the type of tests performed.

Medical and Social Impact

In examining the medical and social impact of providing coverage for routine hearing examinations, there are several questions that can be addressed.

a. Are the services safe and effective?

There is little in the way of evidence-based research related to routine hearing examinations. More information is available regarding routine hearing screenings for newborns. The U.S. Preventive Services Task Force recommends hearing screening for children and Bright Futures recommends screenings continue through age 21.

Hearing exams have been shown to be more effective at detecting hearing loss than simple hearing screenings. A pure-tone air conduction test, which includes the use of earphones so that information can be obtained from both ears, increases the chances of detecting hearing loss that occurs in only one ear.[157] Tests of the middle ear provide information on the type of hearing loss which assists the audiologist in recommending the most appropriate treatment.[158]

[156] http://www.caring.com/articles/skin-cancer-screening-tests.
[157] http://www.asha.org/public/hearing/Pure-Tone-Testing/.
[158] http://www.asha.org/public/hearing/Tests-of-the-Middle-Ear/.

b. Is the benefit used by a significant portion of the population?

While hearing loss has historically and continues to impact older adults at greater rates than younger individuals, there has been a sharp increase in the number of younger individuals with hearing difficulties over the past couple of decades. From 1971 to 1990, hearing difficulties jumped 26% among those age 45 to 64, and 17% among those age 18 to 44.[159] Among other reasons, this growth in incidence among these age groups can be linked to societal changes such as a greater use of heavy work equipment and a frequent use of "earbuds."

Men are more likely than women to suffer from hearing loss. While men comprise roughly 50% of the population, 60% of people with hearing loss are men. This is likely correlated by the fact that workers with hearing loss are more likely to list their occupation as farming, craft and repair, machine operator or transportation which are occupations traditionally held by men. Unemployment is also higher among individuals with hearing loss.[160]

c. What are the personal effects of untreated hearing loss?

Untreated hearing loss can have a profound impact on one's quality of life. In particular, individuals with hearing loss report a greater incidence of social rejection, loneliness and depression.[161] People with hearing loss also express greater dissatisfaction with their friendships, family life, health and financial situation than people without hearing loss.[162]

Research has demonstrated considerable adverse health effects from hearing loss. According to the National Academy on an Aging Society, 39% of people who suffer from hearing loss say they are in excellent or very good health, compared to 68% of those without hearing loss.[163] Studies have linked untreated hearing loss to fatigue, tension, stress and depression.[164] A John Hopkins study found a strong link between the degree of hearing loss and risk of developing dementia. However, the study could not definitively conclude that early treatment of hearing loss would reduce the risk of dementia.[165] A more recent John Hopkins study found that untreated mild hearing loss increases the chances of falling by three times, and more significant hearing loss increases the risk further.[166]

[159] Reis, Peter, W. (1994). Prevalence and Characteristics of Persons with Hearing Trouble: United States, 1990-91 National Center for Health Statistics, Vital and Health Statistics, Series 10, No. 188.
[160] http://ihcrp.georgetown.edu/agingsociety/pdfs/hearing.pdf.
[161] Shield, Bridget, "Evaluation of the Social and Economic Costs of Hearing Impairment," October 2006
[162] http://ihcrp.georgetown.edu/agingsociety/pdfs/hearing.pdf.
[163] http://ihcrp.georgetown.edu/agingsociety/pdfs/hearing.pdf.
[164] http://www.betterhearing.org/press/articles/pr_UntreatedConseq.cfm.
[165] http://www.asha.org/Aud/Articles/Untreated-Hearing-Loss-in-Adults/.
[166] http://gazette.jhu.edu/2012/03/05/hearing-loss-linked-to-threefold-risk-of-falling/.

d. What is the cost to society?

Hearing loss also has a significant direct fiscal impact on society. A 2007 study by the Better Hearing Institute estimates that untreated hearing loss leads to underachievement in terms of job performance and negatively impacts incomes on-average up to $12,000 per year depending on the degree of hearing loss. This translates into total lost income for people in the U.S. with untreated hearing loss at $122 billion, thereby creating an unrealized $18 billion in Federal taxes.[167]

[167] http://www.betterhearing.org/pdfs/marketrak_income.pdf.