Market Reform and Policy Issues for Implementation of Health Reform in North Carolina

In-Person TAG Meeting #6

April 9, 2012

MANATT HEALTH SOLUTIONS

MERCER

OLIVER WYMAN

Agenda

12:30 – 12:40	**Welcome and Introductions**
12:40 – 12:45	Project Timeline, Goals/Objectives of Today's Discussion, and Statement of Values for TAG
12:45 – 1:00	Overview of Essential Health Benefits (EHBs) • ACA Statute • CCIIO Guidance • Stakeholder Perspectives
1:00 – 1:45	Analysis of EHBs in North Carolina • Benchmark Plan Comparison • Outlier Identification & Analysis • TAG Discussion on Analysis
1:45 – 2:15	Discussion of EHBs Selection Process in North Carolina • *Should North Carolina define the benchmark package or defer to the federal selection process?* • *If North Carolina should define the benchmark package, who should provide input into the decision-making process?*
2:15 – 2:30	*Break*
2:30 – 2:45	Review of TAG #5 Meeting Minutes
2:45 – 3:15	Discussion on Most Favored Nation (MFN) Issue • Statement Review and Discussion
3:15 – 3:30	Wrap Up and Next Steps

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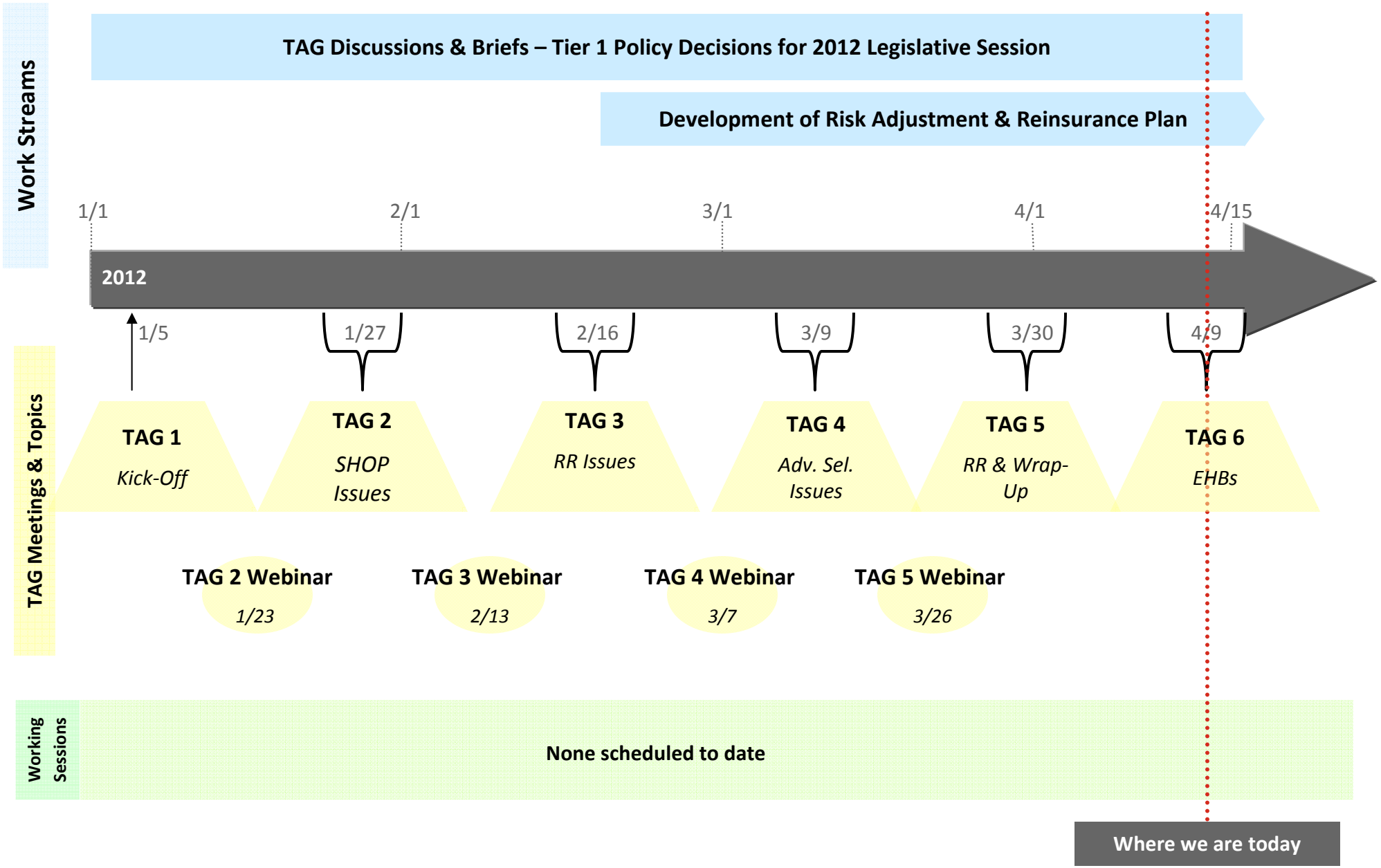
TAG Deliberations – Work Plan for 2012 NCGA Session



Project Goal and Meeting Objectives

Project Purpose: *Develop policy options and considerations and identify areas of consensus to inform the NC DOI recommendations to the NCGA on Exchange-related market reform policies.*

(pursuant to North Carolina Session Law 2011-391)

"It is the intent of the General Assembly to establish and operate a State-based health benefits Exchange that meets the requirements of the [ACA]...The DOI and DHHS may collaborate and plan in furtherance of the requirements of the ACA...The Commissioner of Insurance may also 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. The Commissioner shall submit a report to the...General Assembly containing recommendations resulting from the study."

-- Session Law 2011-391

Goals for Today's Meeting

- Understand the Essential Health Benefit Options for North Carolina
- Validate Analysis Undertaken Related to Essential Health Benefits
- Identify Points of Consensus for Next Steps Related to Essential Health Benefits
- Confirm TAG 5 Meeting Minutes
- Continue Most Favored Nation Discussion and Agree to a Statement

Statement of Values to Guide TAG Deliberations

The TAG will seek to evaluate 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 HBE;
- Empower consumers to make informed choices;
- Support predictability for market stakeholders, competition among plans and long-term sustainability of the HBE;
- 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.

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Overview on Essential Health Benefits (EHBs)

- EHBs include 10 benefit categories which must be covered in all non-grandfathered benefit plans in the individual and small group markets starting in 2014, including Qualified Health Plans (QHPs)
  - EHB also must be in Medicaid benchmark and benchmark-equivalent plans and Basic Health Programs starting in 2014
- EHBs do not apply to self insured and large group plans, but there are some links between EHBs and employer responsibilities
- Scope and duration limits can be included in EHBs (but not dollar limits) if they don't violate other laws (e.g., must comply with mental health parity)
- Cost sharing requirements are separate and apart from definition of EHBs
- Plans can always offer more benefits than the EHBs
  - **For those eligible**, premium and cost-sharing subsidies will only apply against the EHBs

States have to pay for any mandates not included in EHBs for enrollees of QHPs

Ten Categories of EHBs

- Ambulatory Patient Services
- Emergency Services
- Hospitalization
- Maternity and Newborn Care
- Mental Health & Substance Use Disorder Services, Including Behavioral Health Treatment
- Prescription Drugs
- Rehabilitative & Habilitative Services & Devices
- Laboratory Services
- Preventive & Wellness Services & Chronic Disease Management
- Pediatric Services, Including Oral & Vision Care

SOURCE: §1302(b)(1)(A-J)

Relevant ACA Provisions on EHB

- Health insurers offering health insurance coverage in the individual or small group market must have coverage that includes the EHB package. *(PPACA Section 2707(a))*
  - A Qualified Health Plan must offer EHBs, in addition to meeting other requirements. *(PPACA Section 1301(a)(1)(B))*
- The EHB package means any health plan coverage that provides EHBs, limits cost-sharing for coverage in accordance with the ACA and provides catastrophic/bronze/silver/gold/platinum levels of coverage. *(PPACA Section 1302(a))*
  - Cost sharing includes annual limitations on cost sharing (e.g., total value of co-payments, out-of-pocket spending, etc.) and annual limits on deductibles for employer sponsored plans, in addition to other requirements. *(PPACA Section 1302(c)(3))*
  - EHBs include the 10 categories previously noted. *(PPACA Section 1302(b)(1))*
- The Secretary of HHS (Secretary) shall define the EHBs. (*PPACA Section 1302(b))*
- States will defray the cost of any benefits required by State law to be covered by qualified health plans beyond the EHB. *(PPACA Section 1311(d)(3))*

HHS released the EHB Bulletin in December 2011 and Frequently Asked Questions on the EHB Bulletin in February 2012 to guide implementation across 2014 and 2015. HHS "intends" to engage in rulemaking, but it is unclear whether that will happen before the temporary process for 2014 and 2015 is implemented this year.

Overview of EHB Bulletin: States in Driver's Seat

- HHS Bulletin put states in charge of defining EHBs for first two years (2014 and 2015)
- States given up to 10 benchmark plans as options
  - No option to create new plan
- Rationale for deferring to states was that benefits (not cost sharing) are remarkably similar across benchmarks
  - Consistent with general HHS approach of maximizing state flexibility
- State by state approach is temporary, to be revisited for 2016 offerings
- Allows states to choose a benchmark plan that includes all state mandates; if chosen, avoids need to pay for such mandates
  - Mandates enacted after 12/31/2011 cannot be part of EHBs, even if they are added to the state-selected benchmark

Benchmark Plans

States must select one benchmark that will apply to both the individual and small group markets, inside and outside of the Exchange.

- Small group plans (3 choices): largest plan by enrollment in any of the three largest small group insurance products
- State employee plans (3 choices): three largest state employee plans by enrollment
- Federal employee plans (3 choices): three largest federal employee plans by national enrollment
- HMO (1 choice): largest insured commercial HMO in state (non-Medicaid)

Note: Enrollment data for benchmark selection will be based on data from the first quarter, two years prior to the coverage year. For example, enrollment data from HealthCare.gov for the first quarter of calendar year 2012 could be used during the third quarter of 2012 to determine which plans would be potential benchmarks for the coverage year starting on January 1, 2014.

State/Local EHB Process Outlined in Bulletin

State- Level Decision-Making

1 Select Benchmark

- ✓ Pick one from the plans eligible as benchmark plans in the state

2 Supplement Benchmark

- ✓ For categories not covered in benchmark plan, add benefits as found in any other benchmark option
- ✓ Bulletin contains special rules for habilitative services and pediatric oral and vision services where such benefits are not contained in benchmarks

Plan-Level Adjustments with State Oversight

3 Adjust Benefits

- ✓ For specific services covered and/or any quantitative limits
- ✓ Within and potentially across benefit categories
  - Allowing alteration across categories is an option under consideration by HHS subject to comments
- ✓ But, must be actuarial equivalent

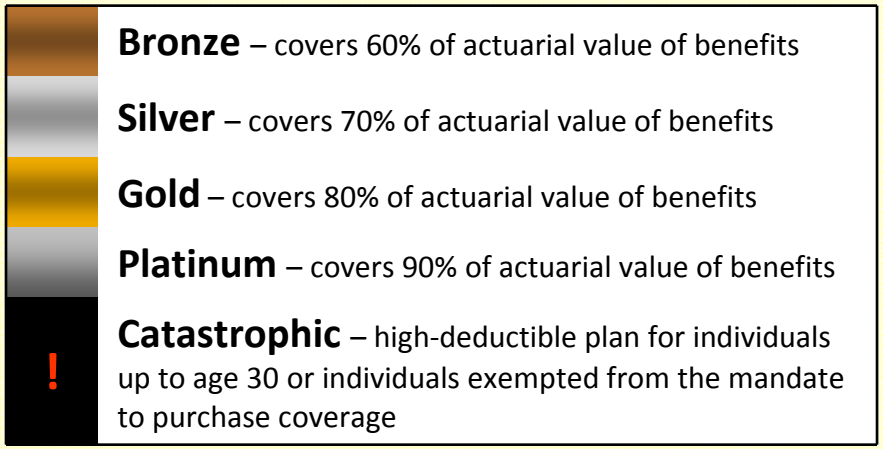
State Option Versus Federal Default Option

	State Option		Federal Default
Select Benchmark	✓ Pick one from the plans eligible as benchmark plans in the state	OR	✓ Default to the largest plan by enrollment by product in the State's small group market
Supplement Benchmark	✓ Add benefits as found in any other benchmark option ✓ Follow federal process for habilitative services and pediatric oral and vision services, if applicable	OR	✓ Benefits supplemented by looking first to the second largest small group market plan, then to the third, then to the FEHBP plan with the highest enrollment ✓ Follow federal process for habilitative services and pediatric and vision services, if applicable

Applicability of EHBs Across Different Plans & Markets

Non-Grandfathered Plans in the Individual and Small Group Markets, Including QHPs

- EHBs must be covered in all plans
- EHB costs are the "100 percent" on which a plan's actuarial value is established for determining if the plan is bronze, silver, etc.
- Plans may not impose lifetime dollar limits on EHBs and must phase out annual dollar limits on EHB benefits by 2014



Self-Insured Plans, Grandfathered Plans in the Individual and Small Group Markets, and Large Group Plans

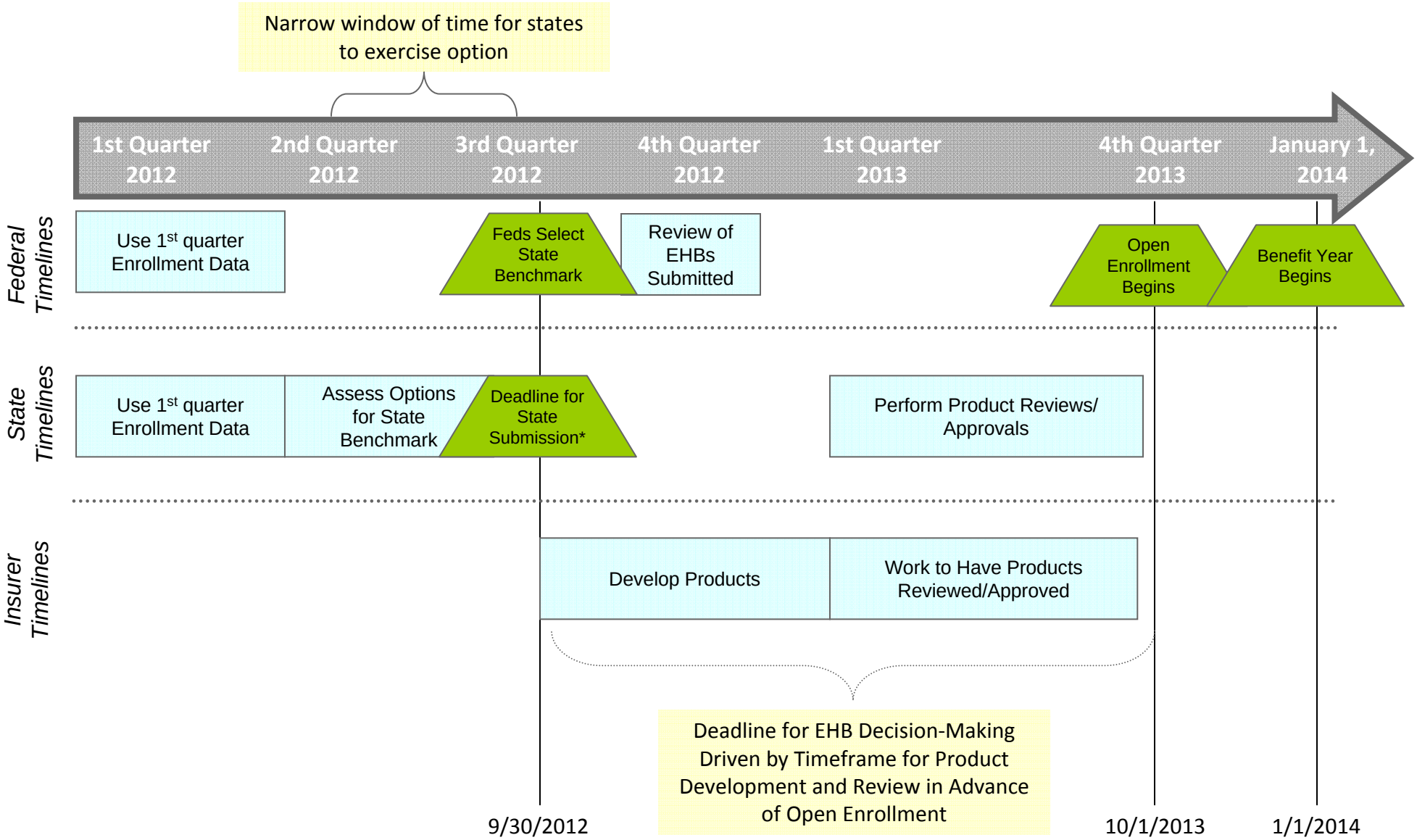
- Plans not required to offer EHBs, but:
  - May not impose lifetime dollar limits on EHBs
  - Must phase out annual dollar limits for any EHB benefit by 2014 (except grandfathered individual health policies)

Medicaid Benchmark, Benchmark-Equivalent and Basic Health Programs*

- EHBs must be covered in the Medicaid benchmark plan for new Medicaid eligibles in 2014
- The Medicaid agency will determine the benchmark and it does not need to be the benchmark used for commercial plans

*The Medicaid Benchmark is not in scope for the TAG, although research and analysis from the TAG effort will be shared with NC DHHS

Timelines and Considerations for Decision-Making Related to EHB



*HHS will specify format for defining and communicating state decision

Responses from Stakeholders

Excerpts of National Dialogue on Essential Health Benefits

- AAA: Flexibility in benefit design could create confusion for consumers; result in situations in which insurers design benefit packages to minimize certain risks; and have a material effect on premium rates, particularly in the individual market... It is important for HHS to differentiate between the scope of benefits, which is related to the essential health benefit coverage, and medical management processes... Clarification of the use of the terms "actuarial equivalence" and "substantially equal" as used in the context of essential health benefits is needed.[1]
- AMA: The AMA agrees that the essential health benefits package, and therefore the benchmark plan selected by each state, should not preclude patients from being offered a range of health plan options from which to choose, or impede private market innovation in product development, benefit packages, and purchasing arrangements.[2]
- EHB Coalition: The Coalition urges HHS to consider an approach that balances reasonably comprehensive benefits with affordability for employers and individuals.[3]
- Consumers Union: HHS must precisely define the scope and services within each of the 10 benefit categories required by the ACA... HHS should provide a complete description of a coverage "safe harbor" for each of the 10 required benefit categories. We strongly urge against allowing insurers to make substitutions within benefit categories or across them.[4]

1 http://www.actuary.org/pdf/health/ISGMTF_comments_EHB_bulletin120131.pdf
2 http://www.ama-assn.org/resources/doc/washington/essential-health-benefits-comment-letter-30jan2012.pdf
3 http://ehbcoalition.org/wp-content/uploads/2012/02/EHBC-Comments.pdf; http://pnhp.org/news/2012/february/beware-the-essential-health-benefits-coalition
4 http://www.healthexchange.ca.gov/Documents/Consumers%20Union%20-%20Comments%20on%20EHB%20Submitted%20to%20Feds%201-31-12.pdf

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Ground Rules for Discussion Related to EHB

The TAG should:

- Weigh in on the analysis conducted to date, including assumptions made during the analysis
- Make recommendations on additional analysis needed, if any, and discuss any considerations stemming from the analysis

The TAG is not being asked:

- To make recommendations on a State-selected benchmark plan
- To discuss or advocate for a specific benefit for inclusion/exclusion in the benchmark package

Plans Included for North Carolina Analysis

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

Note: FEHBP plan selection was based on the top plan enrollment, nationally, based on March 31, 2011 enrollment data. Specific enrollment numbers for FEHBP plans were not released. Enrollment for the state employees health plans was based on October 2011 enrollment, and enrollment is based off of the number of non-Medicare covered lives. Selection of the small group insurance plans and largest non-Medicaid HMO was based on June 30, 2011 enrollment figures submitted to Healthcare.gov. Enrollment in the small group plans and largest non-Medicaid HMO is based on information received from the NC DOI on those plans as of 12/31/2011. **Once 3/31/2012 enrollment data is available, the analysis will be updated, if needed, to reflect any changes in eligible benchmark plans. It is anticipated that the list of eligible benchmark plans will not significantly change.**

Summary of Analysis Conducted to Date

1 Compared Benefits Across Benchmark Plans

- ✓ Compared detailed benefits from each plan against each other to identify differences
- ✓ Supplemented plans to include USPSTF*, women's wellness, mental health parity, state-mandated and EHB benefits
- ✓ Performed holistic pricing to compare high-level cost differences in benchmark plans

2 Selected "Outliers" for Analysis

- ✓ Considered "outliers" which are high cost and/or high frequency benefits to analyze further
- ✓ Requested outlier data from benchmark insurers, as appropriate

3 Analyzed Select "Outliers"

- ✓ Assessed the financial, medical and social impact of including the outliers as a part of the EHB package in the State
- ✓ Review analysis with TAG for further input

*United States Preventive Services Task Force A and B recommendations

Assumptions Made in Analysis

- The state will want to avoid costs associated with covering mandated benefits not in the EHB package
- Cost and frequency were the primary considerations used to narrow the list of outlier benefits for additional analysis
  - Cost was based on an anticipated higher cost PMPM, and frequency was considered in perspective with cost in order to assess the overall impact to the consumer from utilizing the benefit if not covered by insurance

Summary of Comparisons - Benefits Not Consistent Across All Carriers

Selected Benefits	State Employees HP	FEHBP Option #1	FEHBP Option #2	FEHBP Option #3	Small Group Plan #1	Small Group Plan #2	Small Group Plan #3	Largest HMO
Smoking and Tobacco Cessation Rx Drugs	X	X	X	X	X		X	X
Bariatric Surgery	X	X	X	X				
Oral and Maxillofacial Surgery	X*	X**	X**	X**	X*	X*	X*	X*
Cardiac Rehab	Unlim	Unlim	Unlim	Unlim	Unlim	36	Unlim	Unlim
Pulmonary Rehab	Unlim	Unlim	Unlim	Unim	Unlim	20	Unlim	Unlim
Chiropractic Manipulation	30	12	20	12	30	20	30	
Physical Therapy	30	75	50			20		20
Occupational Therapy				60		20		20
Speech Therapy				30	30	20	30	20
Respiratory Therapy	X			X	X	X	X	X
Hyperbaric Oxygen Therapy					X	X	X	X

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

- *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.*

Summary of Comparisons- Continued

Selected Benefits	State Employees HP	FEHBP Option #1	FEHBP Option #2	FEHBP Option #3	Small Group Plan #1	Small Group Plan #2	Small Group Plan #3	Largest HMO
Diagnostic Genetic Testing and Counseling		X	X					X
Infertility Services	X	X	X	X	X		X	
Dental Implants					X	X	X	
Coverage for Needles and Syringes for the Admin. of Covered Meds	X**	X**	X**	X**	X**	X*	X**	X**
Oral Orthotic Devices	X**	X*	X*	X*	X**	X**	X**	X*
Home Health Visit	X***	X*	X*	X**	X***	X**	X***	X*
Private Duty Nursing	X				X		X	
Skilled Nursing Facility	X***	X***	X***	X*	X**	X***	X**	X**
Respite Care	X	X	X					
Acupuncture		X	X	X				
Hypnotherapy	X				X		X	

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Summary of Comparisons- Continued

Selected Benefits	State Employees HP	FEHBP Option #1	FEHBP Option #2	FEHBP Option #3	Small Group Plan #1	Small Group Plan #2	Small Group Plan #3	Largest HMO
Abortion	X	Only if mother in danger	Only if mother in danger	Only if mother in danger	X	X		X
OTC Medications (w/Rx)	X	X	X	X	X	X	X	
Wigs for Hair Loss (Cancer)		X	X					X
Medical Foods		X	X	X				
Routine Vision Exams--Adult				X**	X**	X*	X**	
Eyeglasses and Contact Lens							X	
Eyeglasses Related to an Accident/ Surgery/Med.	X	X	X	X	X		X	X
Routine Dental		X	X	X				
Routine Hearing Exams	X	X	X	X		X		
Hearing Aids	Child -$2500/36	All -$1200/36	All -$1200/36	All	Child -$2500/36	Child -$2500/36	Child-$2500/36	Child -$2500/36
Speech Generating Devices		X			X		X	

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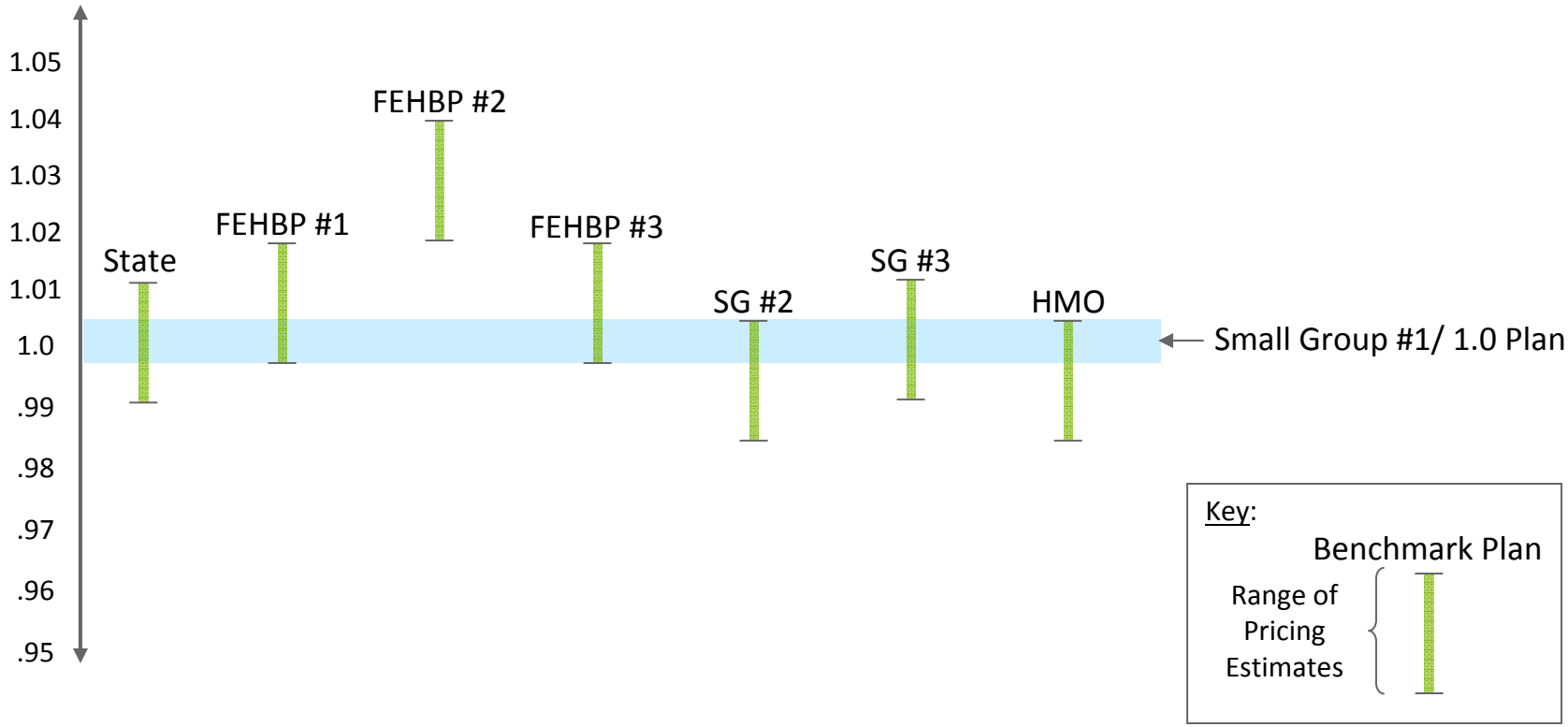
Preliminary Holistic Pricing Analysis



- All plans assessed vis a vis the small group #1 option. The small group plan #1 was selected as the "1.0 plan" from which to gauge the other plans because it is the federal default plan
- Options with values greater than 1.0 would result in a higher cost benefit package than the default option; options less than 1.00 would result in a lower cost package
- Default option is not necessarily representative of the current market average

Outliers Selection - Plan Level Selection

Threshold Question: Do any plans exclude state-mandated benefits from their benefit package?

- Section 1311(d)(3) of the ACA requires States to defray the cost of any benefits required by State law to be covered by QHPs beyond the EHB Package
- FEHBP plans did not include all State mandated benefits
- State-mandated benefits excluded by the plans are:
  - TMJ Joint Dysfunction Coverage
  - Coverage for Post-Mastectomy Care (plans provide only 48 hours of care)
  - Coverage for services provided outside provider networks (covered only in emergencies for BCBS FEHBP plans; GEHABP covered services)
- FEHBP plans were excluded from additional analysis since the State would incur the costs of these benefits for enrollees in QHP plans

Outliers Selection- Benefit Selection

List of Eligible Benefits

- Smoking and Tobacco Cessation Rx Drugs
- Bariatric Surgery
- Oral/Maxillo. Surgery
- Cardiac Rehab
- Pulmonary Rehab
- Chiropractic Manipulation
- PT
- OT
- ST
- Respiratory Therapy
- Hyperbaric Oxygen Therapy
- Diagnostic Genetic Testing
- Infertility Services
- Dental Implants
- Coverage for Needles/Syringes
- Oral Orthotic Devices
- Home Health Visit
- Private Duty Nursing
- Skilled Nursing Facility Care
- Respite Care
- Hypnotherapy
- Abortion
- OTC Medicines (w/ Rx)
- Wigs (Chemo.)
- Routine Vision - Adult
- Eyeglasses/Contacts
- Eyeglasses Related to an Accident, etc.
- Routing Hearing
- Hearing Aids
- Speech Devices

Considerations

Cost

(e.g., "Is the per-use cost of this benefit high?")

Frequency

(e.g., "How many people use this benefit?)

List of Benefits Analyzed

- Adult Routine Vision Exams
- Private Duty Nursing
- Routine Hearing Exams
- Respite Care
- Infertility
- Bariatric Surgery

- *Thirty benefits vary between the remaining benchmark plan options*
- *Of those benefits, many do not appear to reflect either a high cost or high frequency, which means that the impact associated from covering those benefits would be relatively minimal to both consumers and insurers*
- *Six benefits were determined to meet the threshold for more analysis*

TAG Meeting #6 Issues for Discussion

Test Analysis Assumptions

- **Should plans that exclude state-mandated benefits be taken off the table for consideration as a benchmark plan?**
- **Are costs and frequency the appropriate considerations to narrow the list of "outliers"?**

Benefit #1: Adult Routine Vision Examinations

Selected Benefits	State Employees HP	FEHBP Option #1	FEHBP Option #2	FEHBP Option #3	Small Group Plan #1	Small Group Plan #2	Small Group Plan #3	Largest HMO
Routine Visicn Exams--Adult				X**	X**	X*	X**	

Benefit Description & Coverage in Eligible Benchmark Plans

- *Routine examinations, likely at an optometrist's office, to check for common vision issues*
- *FEHBP #3, Small Group #1 and #3 cover one per year and Small Group #2 covers one every two years*
- *Coverage by percent of SG enrollees: 62% covered one per year, 23% covered one every two years, 12% not covered (but could have purchased by rider), 3% unknown*

Medical and Social Impact Findings

Medical

- *Vision problems increase significantly with age*
- *2.5% of North Carolinians age 40 or older are vision impaired (20/40 or worse vision with glasses)[1]*
- *CDC recommends examinations for early detection[2]*

Social

- *48.4% of North Carolinians with moderate to severe visual impairment who did not seek eye care cited cost or lack of coverage as reason[3]*
- *Estimated societal cost of $51.4 billion annually (all ages including 65+, direct and indirect costs)[4]*

Financial Findings

- *$75 - $85 per exam*
- *Roughly ¼ of adults anticipated to use per year (if covered annually)*
- *Estimate $0.60 to $1.50 PMPM to cover one per year*

Sources:
1. Prevent Blindness America, Vision problems in the US, Prevalence of Adult Vision Impairment and Age-Related Eye Disease in America, 2008
2. CDC, Vision Health Initiative, Eye Health tips
3. CDC, Reasons for Not Seeking Eye Care Among Adults Aged ¡Ý40 Years with Moderate-to-Severe Visual Impairment --- 21 States, 2006--2009, MMWR, Weekly May 20, 2011 / 60(19);610-613
4. Prevent Blindness America. The Economic Impact of Vision Problems: The Toll of Major Adult Eye Disorders, Visual Impairment and Blindness on the U.S. Economy, 2007

Benefit #2: Private Duty Nursing

Selected Benefits	State Employees HP	FEHBP Option #1	FEHBP Option #2	FEHBP Option #3	Small Group Plan #1	Small Group Plan #2	Small Group Plan #3	Largest HMO
Private Duty Nursing	X				X		X	

Benefit Description & Coverage in Eligible Benchmark Plans

- *Hourly, skilled nursing care provided in a patient's home; more individual and continuous skilled care than can be provided in a skilled nurse visit through a home health agency[1]*
- *Frequency and duration is **intermittent and temporary** in nature[1]*
- *Covered in SG plans #1 and #3 when medically necessary; State employee plans cover up to 4 hours per day for non-ventilated patients and up to 12 hours per day for ventilated patients*

Medical and Social Impact Findings

- *Nationwide more likely to be covered under Medicaid; most commercial plans do not appear to cover*
- *May serve as an alternative to an institution, allowing the patient to be cared for at home (all plans except FEHBP #1 and #2 cover some amount of skilled nursing facility care and all cover hospitalization)*
- *Some suggest that quality of care is higher than in facilities and results in fewer complications, but evidence is insufficient to be conclusive[1, 3]*

Financial Findings

- *Can be expensive if not well managed or used for long term needs (NC Medicaid paid $155k per patient in fiscal year 2006-2007[2])*
- *If primarily an alternative to short term skilled nursing facility stay, then total cost likely in the range of $0.25 - $1.00 PMPM.*
- *Marginal cost (difference between private duty nursing and alternative care) is less*

Sources:
1. BlueCross BlueShield of North Carolina Corporate Medical Policy, http://www.bcbsnc.com/assets/services/public/pdfs/medicalpolicy/private_duty_nursing_services.pdf
2. Controlling the Cost of Medicaid Private Duty Nursing Services, North Carolina General Assembly, Final Report to the Joint Legislative Program Evaluation Oversight Committee, Report Number 2008-12-05, December 10, 2008
3. Working with Pediatric Hom e Care Agencies, http://www.accuratehomecare.com/resources/0008/7625/8235/PediatricsCouncilArticleFall2010.pdf

Benefit #3: Routine Hearing Exams/Testing

Selected Benefits	State Employees HP	FEHBP Option #1	FEHBP Option #2	FEHBP Option #3	Small Group Plan #1	Small Group Plan #2	Small Group Plan #3	Largest HMO
Routine Hearing Exams	X	X	X	X		X		

Benefit Description & Coverage in Eligible Benchmark Plans

- *A routine hearing exam includes the evaluation of the sensitivity of a person's sense of hearing, and is usually performed by an audiologist*
- *State employee plans cover routine hearing testing; FEHBP plans and SG #2 cover only screenings*

Medical and Social Impact Findings

Medical

- *Studies have found a strong relationship between hearing loss and dementia[1]*
- *Incidence has increased due to an aging population, heavy work equipment, use of "earbuds," and medications proven toxic to the ears*

Social

- *Household income of individuals with untreated hearing loss is negatively impacted up to $12,000 per year[2]*
- *Individuals with hearing loss report a greater incidence of social rejection, loneliness and depression [3]*
- *Hearing loss in children is not always recognized without testing as it mimics certain childhood behavior*

Financial Findings

- *$75 - $150 per test for standard tests; more for special testing*
- *Testing recommended roughly every two to three years for those diagnosed with a hearing problem; once every ten years for others*
- *Estimate $0.50 to $1.50 PMPM*

Sources:
1 Archives of Neurology, "Hearing Loss and Incident Dementia," Vol. 68, No. 2, February 2011
2. Better Hearing Institute, "Impact of Untreated Hearing Loss on Income," May 2007
3. Shield, Bridget, "Evaluation of the Social and Economic Costs of Hearing Impairment," October 2006

Benefit #4: Respite Care (Hospice)

Selected Benefits	State Employees HP	FEHBP Option #1	FEHBP Option #2	FEHBP Option #3	Small Group Plan #1	Small Group Plan #2	Small Group Plan #3	Largest HMO
Respite Care	X	X	X					

Benefit Description & Coverage in Eligible Benchmark Plans

- *Provides Inpatient Hospice Care benefits to patients eligible for home hospice benefits in order to provide relief to a caregiver*
- *FEHBP #1 and #2 cover up to a seven day stay with a 21 day period in traditional home hospice before an additional stay is covered*
- *State employee plan covers without stated restriction on the number of days covered*

Medical and Social Impact Findings

Medical

- *Providing comfort and quality care to terminally ill patients at end of life*

Social

- *Provides stress relief from the demands of caring for a terminally ill loved one*
- *Caregivers providing respite care incur significant out-of-pocket costs, lost wages and productivity and increased medical expenses*

Financial Findings

- *2010 average cost for inpatient hospice services is $210 per day nationwide ($135 per day in NC)*
- *Roughly 0.01% of the population utilize inpatient hospice services*
- *Allowed cost is estimated to be $0.09 PMPM under the FEHBP benefit assuming maximum benefit utilized*

Benefit #5: Infertility

Selected Benefits	State Employees HP	FEHBP Option #1	FEHBP Option #2	FEHBP Option #3	Small Group Plan #1	Small Group Plan #2	Small Group Plan #3	Largest HMO
Infertility Services	X	X	X	X	X		X	

Benefit Description & Coverage in Eligible Benchmark Plans

- *Coverage of diagnosis and treatment of infertility for couples with inability to conceive after a 12 month period*
- *FEHBP #1 and #2 cover but exclude assisted reproductive technology (ART); FEHBP #3 covers up to $3,000 per year but excludes drugs, genetic testing, and ART; State, SG #1 & #3 cover up to $5,000 lifetime w/out specific service exclusions*
- *Unclear how limitations on annual and lifetime dollar maximums may impact required benefit if benchmark plan includes infertility benefit*

Medical and Social Impact Findings

Medical

- *Using ART significantly increases the risk of multiple pregnancies (pregnancies, premature births, and other indirect costs are not included in the financial estimates shown)[4]*
- *Infertility medications put women at risk for ovarian hyperstimulation syndrome*

Social

- *15 states have laws requiring coverage for in vitro fertilization, 9 mandate other infertility service[1]*
- *Inability to conceive may contribute to mental health issues involving stress or depression*

Financial Findings

- *Cost for diagnosis can range from $0.08 to $1.70 PMPM*
- *With a lifetime limit of $5,000, the PMPM cost to diagnose and treat could range from $0.15 to $0.40 (not including any pent up demand in early years for those newly covered)*
- *Roughly 10% of couples have infertility problems[2]*
- *Of those with infertility, less than 25% seek infertility services[3]*

Sources:
1. Council for Affordable Health Insurance, Health Insurance Mandates in the States 2010
2. http://www.cdc.gov/reproductivehealth/Infertility/index.htm#2
3. http://www.iaac.ca/content/why-do-so-few-couples-seek-infertility-treatment
4. http://www.webmd.com/infertility-and-reproduction/tc/infertility-treatment-risks-of-multiple-pregnancy-topic-overview

Benefit #6: Bariatric Surgery

Selected Benefits	State Employees HP	FEHBP Option #1	FEHBP Option #2	FEHBP Option #3	Small Group Plan #1	Small Group Plan #2	Small Group Plan #3	Largest HMO
Bariatric Surgery	X	X	X	X				

Benefit Description & Coverage in Eligible Benchmark Plans

- *Coverage for bariatric surgery to treat morbid obesity, typically a Body Mass Index (BMI) of 40 or more, or BMI of 35 or more with one or more co-morbidities*
- *Coverage provided by State employee plans and all three FEHBP plans*

Medical and Social Impact Findings

Medical

- *There appears to be general agreement that nonsurgical programs should be attempted first*[3]
- *If nonsurgical programs do not work, then surgery is effective in certain patients (typically BMI of 40 or greater, or BMI of 35 or greater with one or more co-morbidities)*[3]

Social

- *7 states mandate coverage for morbid obesity treatment*[1]

Financial Findings

- *28.6% of North Carolinians are obese (BMI 30+)*[4]
- *Cost of surgery estimated to be approximately $20,000 - $30,000*
- *Maryland mandate adds about 0.3% - 0.4% to premium*[2]

Sources:
1. Council for Affordable Health Insurance, Health Insurance Mandates in the States 2010
2. Maryland Health Care Commission, Study of Mandated Health Insurance Services: A Comparative Evaluation
3. Maryland Health Care Commission, Bariatric Surgery: Actuarial Analysis for the Small Group Market, December 2008
4. http://apps.nccd.cdc.gov/brfss/

TAG Meeting #6 Issues for Discussion

Validate Analysis and Considerations for Using Analysis in Benchmark Selection

- **Is the analysis conducted to date sufficient to select the benchmark plan? What further analysis is needed, if any?**
- **How should cost, medical efficacy and social impact be prioritized when assessing the benefit differences between benchmark options? When assessing the benchmark option overall?**

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3:15 – 3:30	Wrap Up and Next Steps

TAG Meeting #6 Issues for Discussion

Recommended Processes Moving Forward

- **Should North Carolina define the benchmark package or defer to the federal selection process?**
- If North Carolina should define the benchmark package, who should provide input into the decision-making process?

Relevant Laws and Regulations

ACA and Federal Guidance on EHB Selection:

- States are permitted to select a single benchmark to serve as the standard for QHPs and plans in the individual and small group markets. If a State does not exercise the option to select a benchmark health plan, the federal govt. will select a default plan in the State, which will be the largest plan by enrollment in the largest product in the State's small group market. *(Essential Health Benefits Bulletin, December 2011)*

North Carolina Statute:

- North Carolina has numerous statutes that reference specific benefit or coverage mandates which are included in the appendix.
- The below statutes reference oversight authority the NC DOI has to enforce and review the benefits offered by select plans in the state:
  - "It is unlawful for any insurance company licensed and admitted to do business in this State to issue, sell, or dispose of any policy, contract, certificate, or certificate of insurance, or use applications in connection therewith, until the forms of the same have been submitted to and approved by the Commissioner, and copies filed in the Department. If a policy form filing is disapproved by the Commissioner, the Commissioner may return the filing to the filer. As used in this section, "policy form" includes endorsements, riders, or amendments to policies that have already been approved by the Commissioner." *NCGS 58-3-150a*
  - Provides that all insurance policies and contracts shall have an index of major provisions which can include the applicable events, occurrences, conditions, losses, or damages covered by the policy. *NCGS 58-38-20(a)(2)*

Considerations

North Carolina can select the benchmark benefits for the state or do nothing and defer to the federal process for selection of benefits for 2014 and 2015. If North Carolina opts to select benefits the State must 1) select the benchmark plan and 2) supplement the plan, as needed, to meet federal requirements. North Carolina must communicate the decision to the federal government on or before September 30, 2012.

Pros of Selecting a Benchmark for the State	Cons of Selecting a Benchmark for the State
▪ More flexibility to select benefits, particularly benefits needed to supplement the plan chosen as the benchmark, that best meet the needs of state residents	▪ Would take time/resources to make selection, thereby distracting from other areas of health reform implementation ▪ Not as easy to comply with federal rules as opposed to deferring

Responses from Other States & Stakeholders

Other States' Approaches to EHB Selection

California

- The Health Benefits Exchange Board has analyzed the potential benchmarks and reviewed public comment at Exchange meetings. A contractor was retained to perform analysis on the benchmarks.
- An Assembly Bill (1453) has been introduced which would require the Exchange Board to submit recommendations to the Assembly and Senate Committees on Health regarding the definition of EHBs.

Maryland

- Maryland's Health Care Reform Coordinating Council is leading the analysis and selection of the state's EHB package. The Legislature may also play a role in the approval process.

Minnesota

- The Health Care Reform Task Force's Access Work Group was charged with making recommendations to the Health Care Reform Task Force concerning EHBs.
- The final decision will likely be made by the Governor, with input from the Health Care Reform Task Force and the Legislature.

Rhode Island

- A joint exchange planning group, appointed by Governor Chafee, is undertaking the decision-making process.

Responses from Other States & Stakeholders

Other States' Approaches to EHB Selection

Mississippi

- The Mississippi Insurance Department (MID) is currently working through the Exchange Advisory Board and Subcommittees to review the eligible plans side-by-side and make a determination of the appropriate EHB benchmark plan.
- MID will need to obtain action from the Governor, perhaps with legislative input, to make the final decision for the state.

Oregon

- Governor Kitzhaber established the EHB Workgroup to provide recommendations for an EHB package and, if needed, review potential legislative language. The Workgroup is jointly chartered by the Oregon Health Policy Board and the Oregon Health Insurance Exchange Board.
- A contractor is conducting a benchmark analysis and comparison. The report is due on May 1, 2012.
- The Workgroup recommendation will be submitted to the Governor for his review.

Washington

- Legislation (HB 2319) directs the Commissioner of Insurance, in consultation with the Exchange Board and Health Care Authority, to select the largest small group plan as the EHB benchmark.
- A contractor released an EHB analysis in February 2012 recommending the state select the most prevalent small group product/plan as the benchmark.

Options and Action Steps

Question: Should North Carolina define the benchmark package or defer to the federal selection process?

Options	Action Steps
Defer to the federal selection process for 2014 and 2015	• Do nothing
North Carolina should define the benchmark package	• Continue to assess analysis • Decide on who should contribute to recommendation process (next question)

TAG Meeting #6 Issues for Discussion

Recommended Processes Moving Forward

- **If North Carolina should define the benchmark package, who should provide input into the decision-making process?**

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Most Favored Nation (MFN) Statement for TAG Review

The TAG supports effective implementation of the Patient Protection and Affordable Care Act (ACA) in North Carolina, which includes anticipating and addressing any potential adverse interactions between ACA and current state law. A significant majority of TAG members expressed serious concerns about strategies utilized in health care provider contracting, known as Most Favored Nation (MFN) clauses. These clauses limit most health insurers' ability to negotiate service rates with certain health care providers in the NC market. Currently, 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. Certain TAG members observed 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 a consensus by the TAG, 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 and other health care provider contract clauses which inhibit insurers' ability to negotiate competitive service rates with health care providers.

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Next Steps

- **Review meeting minutes once released**
  - Minutes reflect points of consensus and considerations discussed during today's meeting, which will be used to develop issue briefs
  - Email comments or thoughts on additional considerations or options to agarcimonde@manatt.com
  - Minutes will be sent for final approval via email for confirmation
- **Review Issue Briefs Once Released Week of 4/9**
  - Issue Brief #1 will include a new excerpt on Employer Participation Rates in SHOP
  - Issue Brief #2 will include a new excerpt on Most Favored Nation, pending outcome of today's meeting
  - Issue Brief #3 will focus on Reinsurance and Risk Adjustment and consist of all new material
- **Review Essential Health Benefits Output, Once Available**
  - Issue Brief #4 under consideration for Essential Health Benefits
  - Analysis will be released shortly

Appendix

- Federal Decision Making Process
- North Carolina Benefit Mandates
- Stakeholder Feedback

Federal Implementation of EHB

- DOL "Survey" reviewed National Compensation Survey (NCS) results previously released, in addition to analysis on select benefits
- HHS requested that IOM issue a report on criteria and methods for defining and updating EHB
  - "What is essential is only what we can afford"
- HHS held 10 EHB "Listening Sessions" around the country to assess key questions, such as how HHS can best meet the dual goals of balancing the comprehensiveness of coverage included in EHBs and affordability

- HHS Released Essential Health Benefits Bulletin – December 16, 2011 and Frequently Asked Questions on EHB Bulletin February 17, 2012
- HHS "intends" to engage in rulemaking but unclear whether that will happen before the temporary process for 2014 and 2015 is implemented this year

Note: HHS also released the EHB Illustrative List of the Largest Three Small Group Products by State – January 25, 2012, which included information on the eligible benchmark plans

Summary of Mandated Benefits

Mandated Benefits	Relevant NC Statute
Mammography for Women Over 40	§58-51-57/ §58-65-92 (BCBS)/ §58-67-76 (HMO)
HPV /Cervical Cancer Screening	§58-51-57/ §58-65-92 (BCBS)/ §58-67-76 (HMO)
Contraception Methods Approved by FDA	§58-3-178
Osteoporosis screening for women over age 60; Bone Mass Measurement	§58-3-174
TMJ Joint Dysfunction Coverage	§58-3-121
Anesthesia and Hospital Charges for Dental Procedures for Children Under Age 9 With Serious Mental, Physical or Behavioral Problems	§58-3-122
Coverage for Post-Mastectomy Inpatient Care (Discharge Decision Made by Patient and Physician)	§58-3-168
Colorectal screening	§58-3-179
Minimum Inpatient Stay Following Delivery of a Baby	§58-3-169
Treat Maternity as any Other Illness (when maternity is provided)	§58-3-170

Mandated Benefits	Relevant NC Statute
Coverage for Emergency Care	§58-3-190
Coverage for services provided outside provider networks	§58-3-200(d)
Mental Illness Minimum Coverage Requirements (Applicable only to group policies)	§58-3-220(b)
Equity in benefits for Mental Health - state requirement	§58-3-220(a)
Equity in benefits for Mental Health consistent with Federal Mental Health Parity	§58-3-220(i)
Access to Non-formulary Drugs	§58-3-221
Coverage for Prescription Drugs During an Emergency or Disaster	§58-3-228
Coverage for Certain Clinical Trials (Phase II, III, and IV Research Studies, Including Prescription Drugs)	§58-3-255
Coverage for Newborn Hearing Screening	§58-3-260
Coverage for Ovarian Cancer Surveillance Tests	§58-3-270

Summary of Mandated Benefits

Mandated Benefits	Relevant NC Statute
Coverage for the Diagnosis and Treatment of Lymphadema	§58-3-280
Coverage for Hearing Aids Up to Age 22 (Up to $2,500 per Ear Every 36 Months)	§58-3-285
Coverage for Losses Sustained or Contracted While Being Intoxicated or Under the Influence of Narcotics	§58-51-16
Coverage for Newborn and Foster Children and Coverage for Congenital Defects and Anomalies	§58-51-30
Minimum benefit offering for Alcoholism/Drug Abuse Treatment (Applicable only to group and blanket policies)	§58-51-50/ §58-65-75 (BCBS)/ §58-67-70 (HMO)
Equity in Benefits for Chemical Dependency/Addiction in Employer Group Health Benefit Plans	§58-51-50/ §58-65-75 (BCBS)/ §58-67-70 (HMO); Covering 51 or More Employees
Coverage for Prostate Screening	§58-51-58/ §58-65-93 (BCBS)/ §58-67-77 (HMO)
Coverage for Certain Off-label Drugs Used for the Treatment of Cancer	§58-51-59/ §58-65-94 (BCBS)/ §58-67-78 (HMO)

Mandated Benefits	Relevant NC Statute
Coverage for Certain Treatment of Diabetes (Training and Educational Services, and Equipment, Supplies, Medications, and Laboratory Procedures Used to Treat Diabetes)	§58-51-61/ §58-65-91 (BCBS)/ §58-67-74 (HMO)
Coverage for Reconstructive Breast Surgery Following a Mastectomy	§58-51-62/ §58-65-96(BCBS)/ §58-67-79 (HMO)
Coverage for Complications of Pregnancy	T11 12.0323
Coverage to Treat HIV/AIDS	T11 12.0324

National Dialogue on TAG #6 Issues

American Academy of Actuaries (AAA)
Comments on Essential Health Benefits
We urge HHS to consider or allow states to consider the following: Defining the age limit for dependents qualifying for pediatric oral and vision services; Defining the standards for "medically necessary orthodontia;" and Recognizing that the current private market typically defines "habilitative" as "developing" function. If the definition is revised to include "maintaining" function, the addition of services could result in increased costs. Also, clarification is needed on whether the benchmark plan would meet the essential health benefits standard if it covers only one service within a given category. While the bulletin states that a plan must cover (or be supplemented to cover) each of the 10 benefit categories, it does not address the range of services that must be covered within each category. It is important for HHS to differentiate between the scope of benefits... For instance, information regarding provider networks, the use of gatekeepers, the use of step therapies, care/medical/disease management programs, quality initiatives, and wellness programs should not be incorporated into EHB requirements. Some of these, however, may be subject to other ACA-related provisions. This will allow innovation in coverage and provider contracting. Clarification is needed, however, on how specific exclusions in the benchmark plan coverage documents will be addressed. If state mandated benefits with dollar limits are part of a benchmark plan, clarification is needed on the treatment of the limits... The concern with dollar limits does not apply to state mandated benefits only... Current pediatric oral and vision plans, for example, commonly use dollar limits to control costs... HHS also may want to consider allowing restrictive benefit limitations by state for those benefits that are not commonplace in employer plans... As a result, starting out with more restrictive limits may allow more flexibility to adapt to changing health care needs and keep costs lower. Clarification of the use of the terms "actuarial equivalence" and "substantially equal" as used in the context of essential health benefits is needed... We recommend HHS modify its proposal so that the CHIP equivalency standard is used exclusive of cost sharing... There are a number of issues that would need to be addressed to make this practicable... Any process that allows substitutions across the 10 categories needs to be clearly defined prior to a plan's acceptance by an exchange to ensure insurers/HMOs cannot design plans to avoid certain risks. http://www.actuary.org/pdf/health/ISGMTF_comments_EHB_bulletin120131.pdf

National Dialogue on TAG #6 Issues

American Medical Association (AMA)
Comments on Essential Health Benefits

AMA policy addressing essential health benefits aims to maximize patient choice of health plans and their respective benefit packages, including strong support for the role of health savings accounts (HSAs). The AMA believes that the interpretation of "essential" in the context of an essential benefit package should align with existing federal guidelines regarding types of health insurance coverage.

While the AMA generally supports the flexibility granted to states to select their own state essential benefits package for adults using the benchmark approach outlined in the Bulletin, we do not support such an approach for children... we urge HHS to use Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program as the model for defining any essential health benefits package for children.

If HHS intends to use the formulary structure of Part D, then we recommend they follow the Part D requirements

We recommend that HHS establish a hotline as well as a website to collect data on problems from patients, physicians, hospitals, and other stakeholders. Surveys of patients, physicians, hospitals, and other stakeholders also would be a useful assessment tool. It will also be important for HHS to enlist the assistance of patient groups such as AARP and Families USA, as well as physician organizations and other stakeholder groups ... to assess the experiences of enrollees regarding the EHB package. For updating the package, HHS should consider convening an advisory committee to be comprised of physicians, patients, and other stakeholders. Significant representation by physicians (especially those in clinical practice) and patients on this committee should be central.

A number of operational issues that will need to be clarified. If each state is going to choose from among the four benchmarks suggested by HHS, what is the process that each state will use in choosing the standard and what will the criteria be? How will HHS review and provide the necessary oversight of ... state- and plan-defined benchmark standards? In order to ensure transparency and appropriate input, consumers, physicians and other providers, and other stakeholders will need to have access to all of the plans under consideration... how will HHS or the Office of Personnel Management, which will be operating the multi-state plan program, determine which states' EHB package will apply?

http://www.ama-assn.org/resources/doc/washington/essential-health-benefits-comment-letter-30jan2012.pdf

National Dialogue on TAG #6 Issues

American Academy of Family Physicians (AAFP)
Comments on Essential Health Benefits
The Academy wasted no time voicing its displeasure with a bulletin recently released by HHS. AAFP wants more specificity than what CMS is offering currently... the Academy wants detailed language, including "establishment of a robust national standard," that would make it clear that the provision of primary care services is essential to keeping patients healthy and keeping health care costs down. "The AAFP hopes that HHS follows up this bulletin quickly with an actual proposed regulation and that HHS specifies that primary care services performed by family physicians are essential." The Academy was disappointed that the recent bulletin did no more than reiterate ideas already clearly outlined in the ACA. With 28 other organizations, AAFP submitted comments to HHS in regards to tobacco cessation: HHS is missing a crucial opportunity to create a minimum federal standard for tobacco cessation, and instead will create yet another patchwork of inadequate coverage.. urge the federal government to enact requirements and policies that provide this tobacco cessation coverage to other populations – particularly low income and/or needy populations like Medicaid enrollees and people buying insurance through state exchanges... We urge HHS to issue regulations requiring state plans to include coverage of all 'A' and 'B' services as the way to fulfill the preventive services requirement for benchmark plans. HHS must track whether plans cover all seven FDA-approved medications for tobacco cessation plus individual, group and phone counseling... urge HHS to help states in this process by publishing on its website which plans are options for benchmark status, and providing detailed and comprehensive information on each plans' coverage. http://www.aafp.org/online/en/home/publications/news/news-now/government-medicine/20120110cmshealthbenefits.html

National Dialogue on TAG #6 Issues

EHB Coalition
Comments on Essential Health Benefits

The Coalition expressed concerns regarding the affordability of coverage for small employers and individuals under the Affordable Care Act ... urge HHS to consider an approach that balances reasonably comprehensive benefits with affordability for employers and individuals.

Recommendations include:

- The EHB package should evaluate benefits, including state benefit mandates, from both a cost and medical effectiveness perspective. The process for updating the EHB package should also be done from a cost and medical effectiveness perspective. These are both recommendations made previously by the Institute of Medicine (IOM) that the coalition strongly supports.
- The EHB package should not limit cost-sharing tools available to employers that enable them to offer, and workers to access, affordable health coverage.
- Only current benefits in effect as of March 1, 2012, should be allowed to be considered for the benchmark EHB package – new state benefit mandates should not be allowed to be added retroactively.
- Just as the December bulletin provided states significant flexibility to design and choose plans, so too should employers be provided flexibility to design and choose health coverage in a competitive marketplace that is most affordable for them and their employees.

http://ehbcoalition.org/wp-content/uploads/2012/02/EHBC-Comments.pdf;
http://pnhp.org/news/2012/february/beware-the-essential-health-benefits-coalition

The Essential Health Benefits Coalition is a broad-based organization representing large and small employers from various sectors of the U.S. economy, pharmacy benefit managers, and health plans operating in every state. The membership of the coalition includes the National Retail Federation, U.S. Chamber of Commerce, National Federation of Independent Business, National Association of Manufacturers, National Association of Wholesaler-Distributors, National Association of Health Underwriters, Blue Cross and Blue Shield Association, Retail Industry Leaders Association, Prime Therapeutics, America's Health Insurance Plans, Express Scripts, Inc., Pharmaceutical Care Management Association, American Osteopathic Association, National Association of Dental Plans, Delta Dental Plans, Council for Affordable Health Insurance, Communicating for Agriculture, and The IHC Group.

National Dialogue on TAG #6 Issues

Academy of Managed Care Pharmacy (AMCP)
Comments on Essential Health Benefits
AMCP proposes that health plans should maintain autonomy over the design of the prescription drug benefit and determination of the specific drugs needed to be covered in order to meet patient needs and to be deemed essential... This would allow a health plan to have the flexibility necessary to meet the needs of the population it serves while ensuring high quality and keeping the benefit affordable. AMCP urged HHS to include both "access to drugs" and "management of medication therapies" under the prescription drugs category of the benefit package. Regulators should not define or require "specific drugs or drug categories for inclusion or exclusion under the essential health benefits provision; instead, health plans should be allowed flexibility in determining appropriate coverage." Likewise, all formulary decisions should be made at the health plan level. The Academy also strongly disagreed with HHS's suggestion in the bulletin that states: "To ensure competition within pharmacy benefits, we intend to propose a standard that reflects the flexibility permitted in Medicare Part D in which plans must cover the categories and classes set forth in the benchmark, but may choose the specific drugs that are covered within categories and classes. If a benchmark plan offers a drug in a certain category or class, all plans must offer at least one drug in that same category or class, even though the specific drugs on the formulary may vary." The Academy supports HHS's statement made in a footnote indicating that it does not intend to adopt the "protected class of drug policy" found in Medicare Part D. http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=14655

National Dialogue on TAG #6 Issues

American Pharmacists Association
Comments on Essential Health Benefits
The Association encouraged HHS to direct the states to include pharmacists' clinical services such as medication therapy management in its upcoming proposed rule. HHS should encourage the states to consider covering pharmacists' services because—based on the USPHS report—pharmacists' cognitive services can apply to most, if not all, of the 10 categories required by the law. http://www.pharmacist.com/AM/Template.cfm?Section=Home2&CONTENTID=27808&TEMPLATE=/CM/HTMLDisplay.cfm

National Dialogue on TAG #6 Issues

National Council for Community Behavioral Healthcare
Comments on Essential Health Benefits
The Council would like to express our concern that the December bulletin does not include sufficient protections to ensure adequate access to mental health and substance use disorder treatment services. We offer recommendations to HHS on strengthening its EHB guidance by: developing and enforce safeguards to ensure that affording state flexibility for development of EHB plans does not undermine access to care; establishing stronger oversight for Parity implementation and adherence; ensuring adequate health insurance coverage for children by requiring states to mirror Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefits when they establish the EHB plans; defining rehabilitation and habilitation benefits so as to explicitly include services to maintain, as well as improve, daily functioning; and more. http://mentalhealthcarereform.org/national-council-submits-comments-to-hhs-on-essential-health-benefits/

National Dialogue on TAG #6 Issues

American Society of Addiction Medicine
Comments on Essential Health Benefits

HHS should develop a detailed, comprehensive essential health benefits (EHB) package that would serve as a "federal floor," similar to the approach used in the Health Insurance Portability and Accountability Act (HIPPA). We continue to believe that a minimum federal EHB that States could go beyond to meet their specific needs is the preferred approach, and ask the Department to develop a minimum federal benefit package. However, if the Department continues to allow States to define their EHBs absent a federal floor, we ask the Department to ensure that each of the ten categories of benefits is consistent with the CHIP benchmark plans in the State and change the default plan from a small employer plan to the BCBS FEHBP plan or another comprehensive benefits package defined by HHS.

HHS should implement a MHPAEA final rule, aggressively enforce MHPAEA on the federal level and provide specific guidance on MHPAEA implementation and enforcement to States to ensure meaningful protection.

HHS should ensure quality, evidence based benefits within the EHB by:

- Requiring that each of the ten EHB categories be medically appropriate and evidence based in the benchmark plan, and if a category is not medically appropriate in the benchmark plan, the Department should require the State to supplement the category using a benchmark option that does provide high-quality, evidence based benefits in that category;
- Including language in the final EHB guidance and the forthcoming actuarial value guidance clearly stating that both the MHPAEA and CHIP flexibility standards preclude downward actuarial adjustment to SUD and MH benefits;
- Developing a federal definition of medical necessity;
- Ensuring robust prescription drug coverage, including medication-assisted addiction treatment; and
- Requiring use by plans in and outside of the exchange of the ASAM Patient Placement Criteria for individuals with substance use disorders. These criteria for placement into defined levels of care (intensities of service) for persons with substance use disorders (SUDs) are currently used in 30 states.

National Dialogue on TAG #6 Issues

American Society of Addiction Medicine (continued)
Comments on Essential Health Benefits
HHS should annually review and update the EHB in all States and assess whether plan enrollees are being well served. Evaluation of the performance of the health insurance marketplace after implementation of the ACA and its various administrative rules is essential—consumers and providers of care should have data on what is working and what is not with respect to access, affordability, and utilization, as well as adherence to rules, especially regarding utilization management. An EHB final rule should require states to take appropriate action when plans fail to provide a comprehensive EHB package consistent with the requirements of the ACA. The Department should also provide annual guidance to States requiring that they update their EHBs to reflect changes in medical evidence, best practices and scientific advancement. HHS should provide benefit data from the specific plans that would be eligible at this point in time to serve as benchmarks in a state, and do so as soon as possible. Prior to 2014, there should be a strong consumer and family education campaign to ensure SUD and MH service consumers understand how to access new coverage benefits and can identify potential violations of their EHB rights. http://www.asam.org/docs/advocacy/asam-ehb-comments-final-letterhead.pdf?sfvrsn=4

National Dialogue on TAG #6 Issues

Consumers Union
Comments on Essential Health Benefits
HHS must precisely define the scope and services within each of the 10 benefit categories required by the ACA... HHS should provide a complete description of a coverage "safe harbor" for each of the 10 required benefit categories. If a state benchmarking process is to be used, a complete description of plan designs that qualify as benchmark plans must be made public on a timely basis, with an opportunity for public comment required. We recommend annual federal review to ensure that state benchmark plans comport with federal law. HHS should carefully consider comments made as part of the state's public review process. These comments and final federal decisions on the benchmark plans' validity must also be made public. Insurer-derived benefits variations should not be part of the rule... Consumers Union strongly opposes both forms of insurer-derived benefits flexibility... The final rule on Essential Health Benefits should include a justification for any benefits flexibility that is included, but greater consumer choice and insurer innovation should not make the list. We strongly urge HHS to take a much more critical look at both of these claims.... Actuarial Equivalence Does Not Provide Adequate Protection for Consumers. We strongly recommend against insurer-derived benefits substitution. We believe that actuarial equivalence is neither workable nor sufficiently protective of consumers. However, if HHS is to rely on actuarial equivalency, the agency must adopt rigorous rules to ensure usable, meaningful results. We recommend a central model must be used to make all actuarial estimates. Alternatively, HHS must require that outside models have been certified to have the capacity to gauge the impact of the fine differences being measured. Under this alternative, HHS must promulgate rules with respect to the benchmarking of costs, definition of the standard population used for the estimate, utilization assumptions and the specificity of benefit categories to be used. Clearly "outpatient services" is too broad a category when it comes to modeling fine substitutions. Sensitivity testing by a reputable independent actuary must be used to test and fine-tune these rules. Whether a central model or a certification process, standards will have to be newly developed to ensure meaningful results. An example of what is included would be a claims distribution that is sufficiently robust to yield meaningful estimates, including visit limits that are dependent upon diagnosis codes. Requiring the analysis be conducted "in accordance with the principles and standards of the Actuarial Standards Board" is welcome, but insufficient.

National Dialogue on TAG #6 Issues

Consumers Union (continued)
Comments on Essential Health Benefits
Anti-discrimination provisions are important, but insufficient... Any deviation from the state benchmark should be decided by states in accordance with federal criteria... States must be allowed to opt-out of benefits flexibility by insurers... Don't let flexibility affect the plan's metal tier designation... Rigorous, ongoing assessment of EHBs over time is critical. We strongly urge against allowing insurers to make substitutions within benefit categories or across them. If, as stated in the Bulletin, the Secretary intends to allow insurer substitutions, any health insurance issuer variance from the benchmark plan should have to be approved by the relevant state regulator using federally defined criteria. Because actuarial estimation is not protective of consumers, we urge different explicit consumer protection safeguards be used. In addition to requiring approval of the state regulator, such substitutions should be limited to those defined by HHS. HHS should develop a list of such substitutions, subject to several tests that are protective of consumers. We urge that states be permitted to opt out of such benefit design flexibility by insurers and be allowed to prohibit health insurance issuers from designing flexible benefit packages that vary from the benchmark plan, without state regulatory approval. http://www.healthexchange.ca.gov/Documents/Consumers%20Union%20-%20Comments%20on%20EHB%20Submitted%20to%20Feds%201-31-12.pdf