



**North Dakota
Insurance
Department**

Safeguarding Promises. Fostering Fairness.
Jon Godfread, Commissioner

Review and Evaluation of Proposed Changes to the North Dakota EHB Benchmark Plan

Proposed EHB Cost Impacts

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Executive Summary

North Dakota is interested in reviewing its essential health benefits EHB Benchmark (EHB) plan and has thus received federal funding to conduct same. To facilitate this review the North Dakota Insurance Department (NDID) has hired JWHammer, LLC to provide Program Manager Services and NovaRest to provide actuarial analysis as a Grant Studies Vendor. The vendors have been procured to assist in analyzing potential changes to the current North Dakota EHB Benchmark Plan. This study has been conducted utilizing solely federal grant funding under the State Flexibility to Stabilize the Market Cycle II Grant Program (Funding Opportunity PR-PRP-21-001). The study is intended to enhance and support the role of North Dakota implementing and planning for federal market reforms and consumer protections under Section 2702 (Guarantee Availability of Coverage), Section 2703 (Guarantee Renewability of Coverage) and Section 2707 (Nondiscrimination under Comprehensive Health Insurance Coverage-Essential Health Benefits Package) of Part A of title XXVII of the Public Health Service Act. State funding has not been utilized to conduct this study.

North Dakota's health care market has experienced significant strains in recent years, most notably in rural regions that have seen escalating premiums on individuals and small businesses that must purchase in the individual and small group markets. These forces have prompted significant concern in the State surrounding how best to rein in spending while ensuring access to affordable, high-quality health care services and coverage. NDID is adequately assessing market activities, identifying areas of potential change, and strengthening the market to ensure compliance with plan availability, affordability and renewability. As NDID continues its efforts to promote and strengthen North Dakota's health insurance market, this study is providing vital information necessary to aide in future decision-making and program participation.

The North Dakota EHB Benchmark plan is a set of benefits required to be offered by all individual and small group Affordable Care Act (ACA) plans in the state of North Dakota. Changing the EHB Benchmark plan would change the required ACA benefits to be offered in the individual and small group ACA plans in North Dakota. Approximately 11% of the ND population would be impacted by EHB Benchmark plan changes.¹

¹ PY 2023 Unified Rate Review Template current enrollment compared to 2021 Vintage Population estimates for North Dakota.

Current US Department of Health and Human Services (HHS) rules² concerning state selection of a new EHB Benchmark plan contain 2 important requirements. The requirements for the new EHB Benchmark plan are that the new EHB Benchmark plan must:

- Provide a scope of benefits that is equal to, or greater than, the coverage within each EHB category, of the benefits provided under a typical employer plan, and
- Does not exceed the generosity of the most generous among the plans considered when selecting the current EHB Benchmark plan. This set of comparison plans for purposes of the generosity standard includes the state's new EHB Benchmark plan adopted for the 2017 plan year, and any of the state's options considered for the 2017 plan year.

The most generous plan considered when selecting the EHB Benchmark effective in 2017 was the Federal Employees Health Benefit Plan (FEHBP).

We have determined that the difference between the most generous plan FEHBP and the current EHB Benchmark plan is \$2.42 PMPM.³ Therefore, the value of any additional benefits to the EHB Benchmark plan cannot exceed \$2.42 PMPM.

The benefits that North Dakota is considering adding to the EHB Benchmark plan and their estimated value, including the issuer estimates are:

² <https://www.shvs.org/updating-the-essential-health-benefit-benchmark-plan-an-unexpected-path-to-fill-coverage-gaps/>

³ This does NOT include routine adult dental services (estimated \$3.78 PMPM) and gender reassignment surgery (estimated \$0.21 PMPM). While covered under FEHBP plan covers and specifically excluded by the EHB Benchmark plan, our interpretation of the federal rules indicate they cannot be considered as a difference in value.

Alternative EHBs for Consideration in the Benchmark plan					
		NovaRest Estimate		Issuer PMPM Range	
		PMPM Estimate	% of Premium	Minimum	Maximum
Alternative EHBs for Consideration in the Benchmark plan	Restricted Cost Sharing for Diabetes	\$0.43	0.09%	\$0.00	\$1.49
	Infertility	\$2.38	0.48%	\$1.98	\$24.85
	Hearing Loss/Aids-all ages	\$0.55	0.11%	\$0.00	\$0.50
	Nutritional Counseling and Therapy	\$0.03	0.01%	\$0.00	\$0.50
	Periodontal disease in med plan	\$0.10	0.02%	\$0.00	\$31.35
	Private Duty Home Nursing	\$1.15	0.23%	\$0.00	\$9.00
	PET scans for prostate cancer	\$0.13	0.03%	\$0.00	\$0.50
	Combating opioid epidemic	\$0.05	0.01%	\$0.00	\$0.50
	Medication Optimization	\$0.00	0.00%	\$0.00	\$0.50
Total estimated impact to premium		\$4.82	0.97%		

The North Dakota legislature will determine which of the benefits, if any, to add to the current EHB Benchmark plan. If it is decided to add benefits, an application for the new EHB Benchmark plan for HHS as well as a public comment period will be needed prior to May of 2023 for 2025 implementation.

ACA Benefit Rules

The ACA ten required benefit categories

The Affordable Care Act requires non-grandfathered health plans in the individual and small group markets to cover essential health benefits, which include items and services in the following ten benefit categories:⁴

- (1) ambulatory patient services;
- (2) emergency services;
- (3) hospitalization;
- (4) maternity and newborn care;
- (5) mental health and substance use disorder services including behavioral health treatment;
- (6) prescription drugs;
- (7) rehabilitative and habilitative services and devices;
- (8) laboratory services;
- (9) preventive and wellness services and chronic disease management; and
- (10) pediatric services, including oral and vision care.

The ACA required cost sharing and maximum benefit rules

In adopting the EHB Benchmark approach, the EHB package contained in the EHB Benchmark plan defines the benefits and services that must be covered. In general, the EHB Benchmark plan does not define how specific cost-sharing requirements will be applied by health plans. The EHB package is not intended to define allowed cost-sharing, some of which is mandated in other provisions of the Act. Instead, the actuarial value⁵ requirement for each metal level⁶ will shape how companies design their cost-sharing requirements.

The ACA does include some cost sharing rules. For example, the ACA does not currently allow cost sharing on preventative services like shots and screening tests.

HHS announced the maximum annual limitations on total cost-sharing for the 2023 benefit year for non-grandfathered group health plans under the Affordable Care Act (ACA). The cost-sharing limits for the 2023 benefit year will be \$9,100 for self-only coverage and \$18,200 for other than self-only coverage, up from \$8,700 and \$17,400, respectively, for the 2022 benefit year. In general, cost-sharing includes deductibles, coinsurance, copayments, and any other required

⁴ Described in section 1302(b)(1) of the ACA

⁵ The actuarial value is the percent of premium paid in benefits by the issuer

⁶ The ACA defines four metal levels and a catastrophic plan based on actuarial values

expenditure that is a qualified medical expense with respect to essential health benefits covered under the plan.

Note that under the Act, plans may not establish lifetime or annual limits on the dollar value of a benefit. Any such limits contained in the existing EHB Benchmark plan will not apply in the future. Limits can be made on the number of services.

Excluded benefits that cannot be an EHB

Pursuant to 45 CFR 156.115, the following benefits are excluded from being EHBs even though a new EHB Benchmark plan may cover them:

- Routine non-pediatric dental services,
- Routine non-pediatric eye exam services,
- Long-term/custodial nursing home care benefits,
- Non-medically necessary orthodontia.

Additionally, section 156.115(c) provides that no health plan is required to cover abortion services as part of the requirement to cover EHBs.

Current CMS rules for changing the state EHB

Rules for the revised EHB

Under 45 CFR 156.111 in the Notice of Benefit and Payment Parameters for 2019 Final Rule (2019 Payment Notice) finalized on April 9, 2018, CMS finalized that states may select a new EHB Benchmark plan for plan years beginning on or after January 1, 2020. The Final 2019 Notice of Benefits and Payment Parameters provides States with greater flexibility by establishing standards for states to update their EHB Benchmark plans. CMS is providing states three (3) new options for selection starting in plan year 2020, including:

- Option 1: Selecting the EHB Benchmark plan that another state used for the 2017 plan year.
- Option 2: Replacing one or more categories of EHBs under its EHB Benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB Benchmark plan that another state used for the 2017 plan year.
- Option 3: Otherwise selecting a set of benefits that would become the state's new EHB Benchmark plan.

If a state opts to select a new EHB Benchmark plan utilizing any of the selection options, the state is required⁷ to submit an actuarial certification and associated actuarial report from an actuary, who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies.

This actuarial certification and associated actuarial report must affirm that the state's revised EHB Benchmark plan:

- Provides a scope of benefits that is equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category⁸ the scope of benefits provided under a typical employer plan⁹ and
- Does not exceed the generosity of the most generous among the comparison plans¹⁰ considered. This set of comparison plans for purposes of the generosity standard includes the state's chosen EHB Benchmark plan used for the 2017 plan year, and any of the state's base EHB Benchmark small-group plan options used for the 2017 plan year.¹¹

Non-Discrimination Rules

Any revised EHB Benchmark plan will have to follow the non-discrimination rules¹².

Nondiscrimination based on sexual orientation and gender identity

HHS explicitly prohibit discrimination, by QHP issuers with respect to QHPs, based on sexual orientation and gender identity. HHS is expected to address this policy and respond to comments in future rulemaking, specifically section 1557 rulemaking which is expected to address issues related to prohibited discrimination based on sex.

Refine EHB nondiscrimination policy for health plan designs

An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions; and that a non-discriminatory benefit design that

⁷ Requirements stated under 45 CFR 156.111(e)(2)(i) and (ii)

⁸ 45 CFR 156.110(a) defines the EHB categories

⁹ 45 CFR 156.111(b)(2)(i), defines a typical employer plan

¹⁰ 45 CFR 156.111(b)(2)(ii)(A) and (B) defines the comparison plan

¹¹ These are described in 45 CFR 156.100(a)(1), supplemented as necessary under 45 CFR 156.110

¹² <https://www.federalregister.gov/documents/2022/08/04/2022-16217/nondiscrimination-in-health-programs-and-activities>

provides EHB is one that is clinically based. HHS provided examples of presumptively discriminatory benefit designs.

Benefit Difference Between the Current EHB Benchmark Plan and the Richest Plan

To meet the requirement that the new EHB Benchmark plan does not exceed the generosity of the most generous among the plans considered in 2015, we determined the values of the most generous plan and the current EHB. The total value of any additional EHBs cannot exceed the difference between the most generous plan and the Current EHB Benchmark plan. We determined that the difference between the most generous plan considered in 2015 and the current EHB Benchmark plan is \$2.42 or 0.49% of premium.¹³

Identification of Richest Plan

Based on prior work done to select the current state EHB Benchmark plan, we believe the Federal Employee Health Benefits Plan (FEHBP) administered by Blue Cross Blue Shield of North Dakota remains the highest actuarial value plan among the 10 plans considered. In order to assess the impact to premium of potential new EHBs, we identified benefits included in the FEHBP that are not in the EHB Benchmark plan that would need to be adjusted out to have comparable sets of benefits.

To develop claim estimates and percent of premium, each benefit was analyzed using either prior studies of mandated benefits or EHBs in other states or built cost estimates from first principles. The estimated impact of these benefit adjustments is as follows:

- 0.63% of premium
- \$3.11 Premium impact

The richest plan premium impact excludes routine adult dental services, which cannot be an EHB, and gender reassignment surgery which may be a required benefit due to new CMS discrimination guidance.

¹³ This does NOT include routine adult dental services (estimated \$3.78 PMPM) and gender reassignment surgery (estimated \$0.21 PMPM). While covered under FEHBP plan covers and specifically excluded by the EHB Benchmark plan, our interpretation of the federal rules indicate they cannot be considered as a difference in value.

Covered Benefits in EHB Benchmark Plan not Included in Richest Plan

In order to assess the impact to premium of potential new EHBs, we identified benefits included in the EHB Benchmark plan that are not in the FEHBP (richest) that would need to be adjusted out to have comparable sets of benefits.

To develop claim estimates and percent of premium, each benefit was analyzed using either prior studies of mandated benefits or EHBs in other states or built cost estimates from first principles. The estimated benefit adjustments are as follows:

- 0.14% of premium
- \$0.69 premium impact

Residential treatment for mental health and substance abuse and habilitative therapies for autism services were originally identified as non-covered services in the FEHBP comparative plan. However, further research suggests that these are both covered, and no adjustment is necessary.

Current EHBs to Consider for removal from EHB Benchmark Plan

If benefits in the current EHB Benchmark plan were dropped it would increase the difference between the FEHBP and the current EHB Benchmark plan. We asked issuers if there were any coverages that they believed could be eliminated. All the issuers replied that they could not identify any coverages that should be eliminated.

Available Premium Dollars for Additional EHB Benefits

When we consider the total value to the benefits in the FEHBP and not in the current EHB Benchmark plan we see that there is approximately \$3.11 more benefit in the FEHBP. Then we have to consider the benefits in the EHB that are not in the FEHBP of \$0.69. The difference shows that the value of the FEHBP is \$2.42 more PMPM than the current Benchmark plan.

Plan values

Benefit comparison grid for benefits from richest plan and current EHB

Appendix A – Benefit Comparison Between the Current EHB Benchmark plan and the Richest Plan Considered (FEHBP), compares the current EHB Benchmark plan benefits to the richest plan benefits.

Value of proposed additional benefits

Alternative EHBs for Consideration in the Benchmark plan					
		NovaRest Estimate		Issuer PMPM Range	
		PMPM Estimate	% of Premium	Minimum	Maximum
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	Hearing Loss/Aids-all ages	\$0.55	0.11%	\$0.00	\$0.50
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	Private Duty Home Nursing	\$1.15	0.23%	\$0.00	\$9.00
	PET scans for prostate cancer	\$0.13	0.03%	\$0.00	\$0.50
	Combating opioid epidemic	\$0.05	0.01%	\$0.00	\$0.50
	Medication Optimization	\$0.00	0.00%	\$0.00	\$0.50
	Total estimated impact to premium		\$4.82	0.97%	

Proposed Additional Essential Health Benefits for 2025 EHB Benchmark Plan

For all estimates, we relied on public information, interviews with medical providers, plan year 2023 ND carrier rate filing information and 2021 ND carrier financials. We did not have access to actual carrier claims data. For demographic information, we use information from the US Census Bureau, including Vintage Population Estimates and the American Community Survey. We

assume a 5.5% annual cost medical trend¹⁴ and 75% carrier cost sharing¹⁵. For dental services, we assume a 2.5% trend, as dental trend estimates are lower than medical trends.¹⁶ We note our estimates do not vary significantly between the individual and small group markets as the membership and the current premiums in the markets are within 5% of each other. Please note our estimates represent a market average, the impact to each carrier will vary based on numerous factors such as coverage level, population, and covered benefits.

The original list of proposed EHB's included expanded coverage for repairs or replacements of prosthetic devices as determined by the enrollee's provider. After further review of the issuers' replies to our data request and certificates of coverage (COC) which provides detailed covered benefits and exclusions, it was determined that all issuers in the ACA market were already meeting the minimum benefit consideration under this proposal.

Restricted Cost Sharing for Diabetes

1. Description of proposed benefit

Cost sharing for 30-day supply of:

- a. Prescribed insulin drugs which may not exceed twenty-five (\$25) dollars per pharmacy or distributor, regardless of the quantity or type of insulin drug used to fill the covered individual's prescription needs, where insulin includes the following categories:
 - i. Rapid-acting insulin
 - ii. Short-acting insulin
 - iii. Intermediate-acting insulin
 - iv. Long-acting insulin
 - v. Premixed insulin product
 - vi. Premixed insulin/GLP-1 RA product
 - vii. Concentrated human regular insulin
- b. Prescribed medical supplies for insulin dosing and administration, the total of which may not exceed twenty-five (\$25) dollars per pharmacy or distributor, regardless of the quantity or manufacturer of supplies used to fill the covered individual's prescription needs.
 - i. Blood glucose meters
 - ii. Blood glucose test strips

¹⁴ Projected Private Health Insurance Spending Per Enrollee 2021. National Health Care Expenditures: Table 17 Health Insurance Enrollment and Enrollment Growth Rates. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected>

¹⁵ 2021 incurred to allowed from combined ND carriers plan year 2023 rate filing URRTs was 76%.

¹⁶ <https://www.segalco.com/consulting-insights/2022-health-plan-cost-trend-survey>

- iii. Lancing devices and lancets
 - iv. Ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone strips
 - v. Glocagon, injectable or nasal forms
 - vi. Insulin pen needles
 - vii. Insulin syringes
2. Comparison of proposed benefit to the current benefit coverage
The proposed benefit would not add new benefits or services, but instead would limit the member cost sharing for the insulin and supplies specified above.
 3. Demand for benefit – extent and how many impacted
There are approximately 54,372 people in North Dakota with diagnosed diabetes, many of which use insulin.¹⁷ While there are some cases of non-diabetic insulin use, we only considered Type 1, Type 2, and Gestational Diabetes. We used a CDC to estimate the age distribution of those with diabetes in North Dakota¹⁸ as we assume those over 65 would be covered by Medicare. Additionally, 15% of the under 65 population would be impacted by the EHB Benchmark plan change.¹⁹ 31% of diabetes patients are treated with insulin.²⁰ In addition, 2% to 10% of pregnancies result in gestational diabetes²¹, where 20% of those²² or approximately 40 more people²³ would use insulin for an extended period. We estimate approximately 1,740 insulin users covered by individual and small group ACA products.
 4. Cost estimate for proposed benefit
 - a. Methodology
There is not much information on the distributions on the type(s) of insulin used and the dosage(s), as it is prescribed on an individualized basis. We found the cost per unit for the various types of insulin covered by the proposed

¹⁷ https://diabetes.org/sites/default/files/2021-10/ADV_2021_State_Fact_sheets_North%20Dakota.pdf

¹⁸ <https://www.cdc.gov/diabetes/data/statistics-report/diagnosed-undiagnosed-diabetes.html>

¹⁹ 2021 SHCE covered lives for health, life and P&C individual and small group business compared to 2021 Vintage population estimates in North Dakota.

²⁰ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4714726/>

²¹ <https://www.cdc.gov/diabetes/basics/gestational.html>

²² <https://www.tommys.org/pregnancy-information/pregnancy-complications/gestational-diabetes/taking-medication-and-insulin-gestational-diabetes>

²³ Pregnancies based on American Community Survey data in North Dakota.

benefit^{24,25} and insulin supplies for a 30-day supply^{26,27,28}. For insulin, we assumed 62 units of insulin per day.²⁹

We used 25% as the current member cost sharing on insulin and insulin products. We used the difference between 25% of insulin cost and \$25 cap as the cost shifted to issuers with the proposed EHB Benchmark plan change. We performed the same analysis for insulin supplies.

We note some issuers have implemented cost sharing caps on insulin³⁰ or have moved certain insulin to preferred tiers where member cost sharing is as low as \$5 for a monthly supply.

b. Cost

We estimate the gross cost of adding the proposed insulin cap to be \$0.66 PMPM or about 0.13% of premium, however, some issuers have already implemented member cost sharing which are lower than the proposed \$25 monthly cap. Therefore, we find the net cost of implementing the insulin cap to be \$0.43 PMPM or about 0.09% of premium.

The issuers estimated between \$0.00 to \$1.49 PMPM or 0.00% to 0.30% of premium.

Infertility Coverage

1. Description of proposed benefit

We are analyzing the impact of North Dakota House Bill No. 1147. (HB 1147) on the individual and small group ACA compliant market. The previous House Bill originally only applied to the Public Employee plan (NDPERS). HB 1147 would provide for diagnosis, preservation, storage, and infertility treatment where medically necessary up to a maximum \$50,000 per covered individual. The definition of medically necessary is (1) consistent with findings and recommendations of a licensed physician or (2) consistent with generally accepted standards of medical practice as set forth by a professional medical

²⁴ <https://www.goodrx.com/healthcare-access/research/how-much-does-insulin-cost-compare-brands>

²⁵ <https://cardiab.biomedcentral.com/articles/10.1186/s12933-020-01211-4>

²⁶ <https://health.costhelper.com/glucose-meter.html#:~:text=Typical%20costs%3A,on%20the%20meter's%20extra%20features.>

²⁷ https://www.goodrx.com/glucagon?dosage=amphastar-of-1mg&form=kit&label_override=glucagon&quantity=1&sort_type=popularity

²⁸ <https://www.healthline.com/health/type-2-diabetes/insulin-prices-pumps-pens-syringes#insulin-vials-and-syringes>

²⁹ <https://www.americanactionforum.org/research/insulin-cost-and-pricing-trends/>

³⁰ <https://www.medica.com/newsroom/news-releases/2021/06/medica-introduces-insulin-cost-relief-program-in-north-dakota>

organization with a specialization in any aspect of reproductive health, such as the American society for Reproductive Medicine or the American College of Obstetricians and Gynecologists; or (3) clinically appropriate in terms of type frequency, extent, site, and duration.

2. Comparison of proposed benefit to the current benefit coverage

The EHB Benchmark plan does not discuss any fertility benefits, except what is explicitly excluded. The EHB Benchmark plan excludes “Services related to infertility, Including Assisted Conception, donor eggs including any donor treatment and retrieval costs, donor sperm, cryopreservation or storage of unfertilized sperm or eggs, Surrogate pregnancy and delivery, Gestational Issuer pregnancy and delivery, and preimplantation genetic diagnosis testing.” We therefore believe none of the proposed benefit is currently covered by the EHB Benchmark plan.

3. Demand for benefit – extent and how many impacted

According to a National Health Statistics Report analysis, approximately 11% of women between ages 15-44 and 9% of men between ages 15-44 will experience non-surgical infertility¹⁵ or approximately 32,000 people in North Dakota. Additionally, some North Dakotans will experience iatrogenic infertility, which is infertility as a result of a treatment for a disease, typically cancer treatment. We estimate the proposed benefit would provide fertility benefits for 4,700 current members in the individual and small group ACA market. Not all benefits will use advanced fertility treatment such as IVF, in fact we expect most will only use diagnostic testing benefits or fertility medications.

4. Cost estimate for proposed benefit

a. Methodology

We see this benefit as 4 separate benefits with 5 sources of cost. The benefit would provide coverage for diagnosis of infertility, fertility preservation, gamete storage, and fertility treatment where medically necessary. As a result of these benefits, we also estimate the cost of additional live births.

Fertility Diagnosis

The benefit would include diagnosis of infertility. “Diagnosis of infertility” means the services, procedures, testing, or medications recommended by a licensed physician which are consistent with established, published, or approved best practices or professional standards or guidelines, such as the

American Society of Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American society of Clinical Oncology for diagnosing and treating infertility. "Infertility" means a disease or condition characterized by: (1) The failure to conceive a pregnancy or to carry a pregnancy to live birth after unprotected sexual intercourse; (2) An individual's inability to cause pregnancy and live birth either as a covered individual or with the covered individual's partner; or (3) A licensed health care provider's findings and statement based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

- We assume the population who would pursue fertility diagnosis would include married or cohabitating couple households.³¹ We did not include any impact from same-sex couples who would reflect less than 1% of the households in North Dakota, and we believe same-sex couples are more likely to move directly to fertility treatment services.
- We assume fertility diagnosis would be restricted to ages 20-44,³² where clinics above age 45 will recommend donor eggs or embryos.³³
- Infertility would be diagnosed by a medical professional, however, we considered consider 12-months of inability to conceive, which is approximately 12%-15% of couples³⁴ and CDC conditions where they would consider pursuing fertility diagnosis prior to 12 months³⁵ which includes Endometriosis, Pelvic inflammatory disease, very painful periods, more than one miscarriage, and suspected male factors. Incidence rates for these conditions are from a variety of sources including WHO, CDC, NIH, and Mayo Clinic. Inability to conceive and demonstrable conditions produce about 4% of the indiv/sm grp ACA population, or 32% of the indiv/sm grp ACA population ages 20-44 who would pursue testing over the 25-year period.
- We assume couples pursuing testing in a year is uniform over the 25-year period.
- Male diagnostic testing is primarily a semen analysis, which is typically one round according to a medical professional interview, which is approximately \$175.³⁶ We included an 85% estimate on the percentage of males who would only require the semen analysis. Other more invasive

³¹ 2019 ACS 1-Year Estimates North Dakota

³² 2020 Vintage Population Estimates for demographic breakdown in North Dakota

³³ based on discussions we have had with providers

³⁴ How common is infertility? | NICHD - Eunice Kennedy Shriver National Institute of Child Health and Human Development (nih.gov)

³⁵ Infertility | Reproductive Health | CDC

³⁶ <https://advancedfertility.com/fertility-treatment/affording-care/fertility-treatment-costs/>

tests include ultrasounds, biopsies, and other specialized tests which could cost up to \$1,500³⁷. We use approximately \$1,050 for more advanced testing which would represent the other 25% of tests.

- Female diagnostics is primarily a basic panel, which a provider indicated would be about 75% of cases and reflect about \$950.³⁸ More intensive tests could cost up to \$3,500 for genetic testing.³⁹ We assume more advanced testing would cost \$2,700 and would represent the other 25% of tests.

Fertility Preservation

The benefit covers "Standard fertility preservation services" means services, procedures, testing, medications, treatments, cryopreservation of eggs, sperm, embryos, and products consistent with established best medical practices or professional guidelines such as those published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology for an individual who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment recognized by medical professionals to result in, or increase the risk of, impaired fertility.

- We assume medically necessary fertility preservation is primarily driven by cancer treatments.
- We used nationwide incidence rates of all cancer for age 15-44 by sex.⁴⁰ Females were reduced by 9.8%⁴¹ for leukemia, lymphoma, and myeloma which required immediate treatment which would not allow for fertility preservation services.⁴²
- We assume fertility preservation would be restricted to ages 15-44,⁴³ where below age 15 clinics would not likely perform fertility preservation services and above age 45 clinics will recommend donor eggs or embryos.⁴⁴
- We assumed 50% of eligible members would use fertility preservation benefits.
- We used \$1,055 as the cost to bank sperm⁴⁵ and \$12,660 to bank eggs/embryos⁴⁶

³⁷ <https://www.ajronline.org/doi/pdf/10.2214/AJR.16.17322>

³⁸ <https://advancedfertility.com/fertility-treatment/affording-care/fertility-treatment-costs/>

³⁹ <https://advancedfertility.com/fertility-treatment/affording-care/pgd-cost/>

⁴⁰ Cancer Tomorrow (iarc.fr)

⁴¹ Lymphoma Survival Rate | Blood Cancer Survival Rates | LLS

⁴² According to discussions with a medical provider

⁴³ 2020 Vintage Population Estimates for demographic breakdown in North Dakota

⁴⁴ Based on discussions we have had with providers

⁴⁵ Sperm Banking | Alliance for Fertility Preservation

⁴⁶ <https://www.businessinsider.com/how-much-does-it-cost-to-freeze-your-eggs-2020-1>

- Stored gametes would need to be used prior to age 50 when clinics would not likely perform fertility treatment services for over age 50.⁴⁷
- Using ND demographics, the average age for 15 to 44 is 29⁴⁸, so approximately 21 years to use samples at a storage cost of \$633 per year.⁴⁹
- We used a durational analysis to determine the ultimate expected number of members with storage costs, with an average duration of use at 10.5 years.

Fertility Treatment

"Fertility treatment" means health care services, procedures, testing, medications, monitoring, treatments, or products, including genetic testing and assisted reproductive technologies such as oocyte retrievals, in vitro fertilization, and fresh and frozen embryo transfers, provided with the intent to achieve a pregnancy that results in a live birth with healthy outcomes. It must cover 3 completed cycles of IUI and must be in accordance with the guidelines of the American Society for Reproductive Medicine.

- For the number of couples, we used the couples pursuing fertility treatment, number of couples using their stored samples, and added same-sex couples who would pursue fertility services based on ACS data on married and unmarried same-sex couple's households with children.⁵⁰
- Fertility treatment services used, and probabilities of use are based on an NIH study, which provided ultimate probabilities of using the various treatments.⁵¹ We used this information to create scenarios of when treatment would be used, with members using less expensive treatments before moving up. Treatments include no-cycle treatment, medication only, IUI with two types of medications, and IVF. The study also includes IVF with donor egg, although as the donor egg would not be covered by the proposed benefit we considered consistent with IVF without donor egg but did not adjust the effectiveness probabilities.
- Costs are based on a mix of discussions with medical providers and the Fertility Within Reach® July 2021 Policymaker's Guide.
- EHB Benchmark plan benefits cannot have dollar limits, so instead of using the \$50,000 limit included in the bill, we substitute to service limits that would be less than \$50,000 for a member. This would include at least 3

⁴⁷ Based on discussions we have had with providers

⁴⁸ 2020 Vintage Population Estimates for demographic breakdown in North Dakota

⁴⁹ <https://www.businessinsider.com/how-much-does-it-cost-to-freeze-your-eggs-2020-1>

⁵⁰ Same-Sex Couple Households: 2019 (census.gov)

⁵¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3043157/>

rounds of IUI using either drug but would only include up to 2 rounds of IVF.

Additional Births

The purpose of the bill is to produce more births, which would have a cost impact.

- We use an estimate of annual couples pursuing fertility treatment from the prior analysis against the NIH study⁵² of effectiveness of fertility treatment to determine the expected number of successful pregnancies.
- We use 20% to represent the couples who would not seek fertility treatment due to cost if there was no coverage.⁵³
- The difference between the success of 100% of couples pursuing treatment and the 70% who would not have pursued treatment due to cost prior to coverage reflects the additional births expected.
- IVF has a higher percentage of multiple births.⁵⁴ We assumed fewer multiple births if infertility coverage was added.⁵⁵ The cost of multiple births is significantly higher than single births.⁵⁶

b. Cost

We estimate the gross cost of adding the proposed infertility benefits to be \$2.38 PMPM or about 0.48% of premium. We do not believe any carriers currently cover these services and do not find significant cost savings from implementing the benefit, so assume the net cost is the same as the gross cost, or \$2.38 PMPM or about 0.48% of premium.

The issuers estimated between \$1.98 and \$24.85 PMPM. Removing the outlier estimate produces the issuer estimate of \$1.98 to \$2.50 PMPM or 0.4% to 0.5% of premium.

Hearing Loss and Hearing Aid Coverage-All Ages

1. Description of proposed benefit

This benefit would include coverage for all insured individuals. Health plans would be required to provide coverage for one hearing aid per hearing-impaired ear every 36 months unless there is a significant change in the insured's hearing

⁵² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3043157/>

⁵³ Based on a discussion with a medical professional

⁵⁴ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3043157/>

⁵⁵ <https://corporate.dukehealth.org/news/state-mandated-coverage-ivf-may-lower-chances-multiple-births>

⁵⁶ 2013 study, needed to trend to 2025 [https://www.ajog.org/article/S0002-9378\(13\)01043-0/pdfSummary](https://www.ajog.org/article/S0002-9378(13)01043-0/pdfSummary)

status. (Average cost of a hearing aid was assumed to be \$2,500). A dollar limit would not be allowed when a benefit is an EHB. Issuers may impose pre-authorization or other limits to provide a benefit commensurate with this limit.

- The hearing loss must be documented by a licensed physician or audiologist
- Devices must be purchased from licensed audiologists

Hearing loss is diagnosed based on the patient history, behavior, and the result of medical and audiological examinations. The degree of hearing loss is measured as: mild, moderate, severe or profound. In adults, the most common causes of hearing loss are noise and aging. Hearing loss can occur suddenly or there may be a gradual decrease in hearing ability over time. There is a strong relationship between age and reported hearing loss.

2. Comparison of proposed benefit to the current benefit coverage

Coverage for hearing aids is not an EHB in the state of North Dakota and therefore, are not covered within the EHB Benchmark plan.

3. Demand for benefit – extent and how many impacted

According to a CDC report from 2014 to 2016, 20.9% of North Dakotans aged 18 and over suffered some level of hearing loss.⁵⁷ Further, the CDC cites 14.9% of children aged 6-19 experienced some level of Low- or High-frequency loss of at least 16-decibel hearing level in one or both ears. Men are nearly twice as likely to have hearing loss than women.⁵⁸

4. Cost estimate for proposed benefit

a. Methodology

NovaRest performed a hearing aid and hearing loss study in 2014 for the state of Maine. This prior work and the estimated issuer costs were considered when looking at a possible hearing EHB in North Dakota. Adjustments were made to account for hearing loss prevalence between the two states (21.9% for Maine vs 20% for ND). Additionally, the average cost of a hearing aid in the 2 states (2014 in Maine, 2022 estimate in North Dakota) along with the demographic difference under 65 were accounted for in the development of the PMPM estimate. The estimate also considers the availability of audiologists and hearing aid providers within a reasonable proximity to the member. North Dakota is among the top 5 states in the US in per capita audiology services. As a potentially new EHB, there could be pent up demand in the first year. Cost estimate assumes a multi-year impact.

⁵⁷ https://www.cdc.gov/nchs/data/health_policy/hearing_loss_table_SEs.pdf

⁵⁸ <https://www.nidcd.nih.gov/health/statistics/quick-statistics-hearing>

b. Cost

The 2014 cost estimate in the state of Maine was developed assuming no dollar limit on the hearing aid purchase. Trending costs forward and applying an adjustment for prevalence of hearing loss in Maine versus North Dakota, we estimate a cost of adding this EHB from \$0.55 PMPM. This represents an impact to premium of 0.11%.

Additional cost impacts may be associated with adding coverage for the audiologist visit and testing if those are included as part of this benefit consideration.

The issuers estimates were between \$0.20 and \$0.50 PMPM or 0.04% to 0.10% of premium.

Nutritional Counseling and Therapy Coverage

1. Description of proposed benefit

Coverage and reimbursement for dietary or nutritional screening, counseling and/or therapy for obesity, diabetes-related diagnosis or a chronic illness or condition that could be managed through nutritional or weight loss programs up to twelve sessions every policy year, if prescribed by the patient's physician.

2. Comparison of proposed benefit to the current benefit coverage

The current EHB Benchmark plan⁵⁹ covered in-network nutritional counseling up to 4 visits per member per benefit period for hyperlipidemia, gestational diabetes, diabetes mellitus, obesity, and outpatient nutritional care services for Phenylketonuria (PKU). In-network nutritional counseling for hypertension covered up to 2 visits per member per benefit period.

Outpatient nutritional care services is covered when provided by a Licensed Registered Dietician when ordered by a Professional Health Care Provider for assessment of food practices and dietary/nutritional status, and diet counseling for preventive and therapeutic needs for the diagnosed medical conditions.

Nutritional counseling for control of dental disease, oral hygiene instruction and personal hygiene and convenience items are specifically excluded.

⁵⁹ Certificate of Insurance for BlueCare 90 500 Group Benefit Plan

In addition to the EHB Benchmark plan, under the ACA services that have an “A” or “B” recommendation rating from the United States Preventive Service Task Force (USPSTF) must be covered at no cost sharing.⁶⁰ As of the time of this report nutritional screening is recommended with a B rating for obesity, Dyslipidemia, Diabetes, Hypertension or elevated blood pressure, or Mixed or multiple risk factors such as metabolic syndrome or an estimated 10-year CVD risk of $\geq 7.5\%$.^{61,62} As of the time of this report nutritional counseling is recommended with a B rating for obesity, Dyslipidemia, Hypertension or elevated blood pressure, or Mixed or multiple risk factors such as metabolic syndrome or an estimated 10-year CVD risk of $\geq 7.5\%$ with a median of 12 contacts.^{63,64}

We note the USPSTF recommendations are subject to change. For example, diabetes was removed from the nutritional counseling B recommendation to a separate C recommendation which reflects including all non-cardiovascular disease risk factors.⁶⁵

3. Demand for benefit – extent and how many impacted

The proposed language requires, providing for “dietary or nutritional screening, counseling and/or therapy for obesity, diabetes-related diagnosis or a chronic illness or condition that could be managed through nutritional or weight loss programs.”

We were unable to find a definitive list of all chronic illnesses or condition that could be managed through nutritional or weight loss programs, however, there are approximately 410,000 people in North Dakota that have at least 1 chronic disease⁶⁶, or about 53% of the population. We estimate 85% of those age 65 and older have at least 1 chronic disease,⁶⁷ leaving approximately 47% of the

⁶⁰

<https://www.cdc.gov/nchhstp/highqualitycare/preventiveservices/index.html#:~:text=Medicare%20%E2%80%93%20Under%20the%20ACA%2C%20USPSTF,under%20part%20A%20or%20enrolled>

⁶¹ <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/healthy-diet-and-physical-activity-counseling-adults-with-high-risk-of-cvd>

⁶² <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes>

⁶³ <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/healthy-diet-and-physical-activity-counseling-adults-with-high-risk-of-cvd>

⁶⁴ <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/obesity-in-adults-interventions>

⁶⁵ <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/healthy-lifestyle-and-physical-activity-for-cvd-prevention-adults-without-known-risk-factors-behavioral-counseling>

⁶⁶ https://www.fightchronicdisease.org/sites/default/files/download/PFCND_ND_FactSheet_FINAL1.pdf

⁶⁷ <https://www.nia.nih.gov/health/supporting-older-patients-chronic-conditions>

under-age 65 population with chronic disease, or about 41,000 members who would be eligible for benefits.

4. Cost estimate for proposed benefit

a. Methodology

While we assume 47% of the population are eligible for benefits as described above, we expect low usage of the benefit. AARP found usage rates for nutritional counseling under 1% for eligible Medicare enrollees.⁶⁸ Additionally, while individuals may use the benefit, we find it unlikely that individuals will use all 12 sessions or will continue to use the service every year.

We assumed an annual cost of \$950 for nutritional counseling and \$80 for screening.⁶⁹

To determine the net cost as described above, we assume nutritional screening is fully covered for obesity, Dyslipidemia, Diabetes, Hypertension or elevated blood pressure, and CVD currently. We believe nutritional counseling is fully covered for all except diabetes which is covered up to 4 visits. We assume obesity, dyslipidemia, Hypertension or elevated blood pressure, and CVD represent 30% of the population and 9% of the population reflects diabetes.⁷⁰ Additionally, we assumed an annual savings ranging from \$3-\$4 based on the USPSTF study,⁷¹ which provided the expected 25-year cost savings from interventions.

b. Cost

- Gross cost before cost savings: \$0.04 PMPM or 0.01% of premium
- Net cost after cost savings: \$0.03 PMPM or 0.01% of premium

Two issuers estimated \$0.00 PMPM, and one estimated \$0.50 PMPM or a range of 0% to 0.10% of premium.

Periodontal Disease (medical) Coverage

1. Description of proposed benefit

The proposed benefits would require all health issuers to provide coverage for diagnosis and treatment of periodontal disease when recommended by a

⁶⁸ <https://www.aarp.org/health/medicare-insurance/info-2019/medicare-nutrition-counseling-benefit.html>

⁶⁹ <https://diabetesjournals.org/care/article/40/5/640/36827/Cost-effectiveness-of-the-2014-U-S-Preventive>

⁷⁰ http://www.ndhealth.gov/phsp/documents/health_status_assessment_report_for_north_dakota.pdf

⁷¹ <https://diabetesjournals.org/care/article/40/5/640/36827/Cost-effectiveness-of-the-2014-U-S-Preventive>

board-certified medical practitioner based on health-related impacts or further deterioration in existing acute or chronic disease state due to gum disease. This would apply to all ages.

2. Comparison of proposed benefit to the current benefit coverage

Current coverage only includes that for children (under 19 years of age) or for people who have dental policies.

3. Demand for benefit – extent and how many impacted

The proposed benefit would only provide coverage if deterioration in existing acute or chronic disease state. Periodontitis can include minor or moderate which would require cleanings or minor procedures, which we assume would not be covered under the proposed language. We assume only severe cases would be covered, as those cases are likely to worsen acute or chronic disease states. We also assume members who have dental policies would also use dental coverage to cover mild or moderate cases. Considering prevalence rates by age,⁷² and members who would already have dental coverage, we estimate the proposed benefit would impact approximately 2,500 members in North Dakota.

4. Cost estimate for proposed benefit

a. Methodology

We began by grouping CPT codes together that relate to each type of treatment in order to determine a range of costs. Costs were obtained from a 2016 dental fee survey done by the American Dental Association and the Health Policy Institute.⁷³ Specifically, costs from the West North Central Division were used. This area includes Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota. Where information for a certain code or procedure was not available, the general practitioner and periodontist national averages were used.

We assumed that services would only be utilized by adults aged 30 to 64 for severe periodontitis and those with dental insurance would use dental benefits rather than medical.

b. Cost

⁷² <https://www.nidcr.nih.gov/research/data-statistics/periodontal-disease/adults>

⁷³ <https://ebusiness.ada.org/Assets/docs/32418.pdf>

We estimate the cost of treating severe periodontal disease to be \$0.10 PMPM, or 0.02% of premium.

The issuers estimated between \$0.00 and \$31.35 PMPM. Removing the outlier \$31.35 PMPM estimate produces an issuer range of \$0.00 to \$0.50 PMPM or 0% to 0.10% of premium.

Private Duty Nursing Coverage

1. Description of proposed benefit

The proposed benefits would require all health issuers to offer coverage for in-home private duty nursing services provided by a registered nurse (RN) or licensed practical nurse (LPN) licensed to provide individualized and continuous nursing care, as ordered by a physician who is involved in the patient's care, when such care is medically necessary and is a viable alternative to an inpatient facility. Services may be provided on a per hour or per diem basis.

2. Comparison of proposed benefit to the current benefit coverage

The current EHB Benchmark plan excludes private duty nursing. At least one ACA issuer in North Dakota covers private duty nursing subject to prior authorization. Other issuers cover skilled nursing but do not include private duty nursing.

3. Demand for benefit – extent and how many impacted

There continues to be a shift to in-home care across the country. Estimates from CMS suggest a growth of in-home expenditures of 73% from 2020 to 2028, moving to whole person care.⁷⁴

4. Cost estimate for proposed benefit

a. Methodology

We looked at the types of services that a nurse would perform within the home and researched prevalence rates of those conditions. These include conditions such as wound care, drain management, medication management, ostomy (all forms), chronic condition care (CSF, ALS, Huntington's, etc.), administering medication, hospice care and ventilator care.⁷⁵

⁷⁴ <https://healthpayerintelligence.com/news/how-home-health-will-evolve-in-the-year-ahead>

⁷⁵ <https://www.maximhealthcare.com/healthcare-blog/what-is-private-duty-nursing/>

After identifying prevalence rates for these conditions, we spoke with a provider to understand the average amount of time spent with the patient and the length of time that in-home care would need to be delivered. The provider also gave us hourly rates and estimated monthly rates for Medicaid patients they are treating, which was the majority of care they administered. A dampening factor was applied which is an estimate today of how much care is referred to home care agencies. We would expect that factor to increase given the expected transition of facility-based care to in-home care noted by CMS. An adjustment was also applied to account for the percent of market share the issuer that covers private duty nursing represents, since overall market premiums are used to calculate the impact.

b. Cost

Transferring care out of inpatient/outpatient facilities or skilled nursing facilities will need to be accounted for in estimating the net impact to premium. Johns Hopkins developed a hospital-at-home program for elderly care and estimated at-home care was 32% less than hospital care and also experienced a 1/3 lesser length of stay.⁷⁶ It is possible that the overall net impact could be a reduction in claim costs and negative impact to premium. Final cost estimates were based on external data that showed comparable costs (PMPM) for SNF and in-home PDN. Assuming a shift of care from skilled nursing, primarily, to in-home care requiring private duty nursing, we have estimated a net increase overall if PDN were to be covered, which reflects the reduction in skilled nursing facility costs.

We estimate a gross premium impact of \$1.46 or 0.29% of premium.

After considering reduced SNF costs, we estimated a net impact of \$1.15 or 0.23% of premium

The issuers estimated between \$0.00 and \$9.00 PMPM or 0% to 1.80% of premium.

PET Scan Coverage for Prostate Cancer

1. Description of proposed benefit

The proposed benefit would cover PET scans for any member who has received a prostate cancer diagnosis including those in remission or who have been cured. The coverage would include at least two different types of PET scans (FDG, PSMA, Choline, etc.) upon initial diagnosis if requested by a physician, and one PET scan every six months for the life of the member.

⁷⁶ <https://commhealthcare.com/cost-of-home-healthcare-vs-cost-of-hospital-stay/>

2. Comparison of proposed benefit to the current benefit coverage

Coverage for prostate cancer is not discussed in the EHB Benchmark plan, other than prostate cancer screenings. Our understanding from discussions with medical providers is that issuers will cover CT scans and bone scans as part of prostate cancer treatment. It is unclear what scans are covered after prostate cancer treatment and it is unclear under which situation PET scans and what types of PET scan agents are currently covered. Providers report that issuers may cover one PET scan, but if a PET scan with another agent is recommended after the first scan, the second may be denied. The carriers' responses indicate PET scans would be covered with no limitations if medically necessary, although the definition of medically necessary is not clear. No carriers reported denied claims for PET scans.

3. Demand for benefit – extent and how many impacted

The Cancer Statistics Center estimates 600 new cases of prostate cancer per year in North Dakota, which is more than any other type of cancer.⁷⁷ The Prostate Cancer Foundation indicates 60% of prostate cancers are diagnosed in men over the age of 65.⁷⁸ According to medical providers we've interviewed, Medicare does include some coverage for PET scans. However, 290 cases of prostate cancer for the under 65 population still makes it among the most common cancer types. We estimate 33 new cases per year would be impacted by the proposed benefit.

4. Cost estimate for proposed benefit

a. Methodology

Using the information described in the demand for this benefit we are able to determine the estimated new prostate cancer cases for those who would be covered by the EHB Benchmark plan changes. We use the Prostate Cancer Foundation to allocate these expected cases into age ranges⁷⁹ although we do not include any cases for under age 40.⁸⁰ We then perform a durational analysis using a 98% 5-year survival rate for people with prostate cancer⁸¹ to determine the ultimate number of members who would be eligible for 2 PET scans per year if prescribed by their doctor, removing members when we estimate they would turn age 65 and be eligible for Medicare coverage.

⁷⁷ [North%20Dakota Cancer Statistics | American Cancer Society - Cancer Facts & Statistics](#)

⁷⁸ [Prostate Cancer Survival Rates | Prostate Cancer Foundation \(pcf.org\)](#)

⁷⁹ [Prostate Cancer Survival Rates | Prostate Cancer Foundation \(pcf.org\)](#)

⁸⁰ [Key Statistics for Prostate Cancer | Prostate Cancer Facts](#)

⁸¹ [Prostate Cancer: Statistics | Cancer.Net](#)

While the medical professional we interviewed recommended 1 PET scan every six months for the life of the member, we expect lower utilization, for those who have been cured or are in remission. Additionally, typical prostate screenings are much less expensive than PET scans.

The cost of a PET scan is variable, and we were not able to find a definitive answer even during our interviews with medical providers. Our research produces estimates from less than \$2,000 to \$12,000 per scan based on the type and if it covers the whole body. We used a cost of \$5,750.⁸²

According to our carrier survey, all carriers will cover PET scans when medically necessary, while the definition of medically necessary is unclear. We interpret this to mean one PET scan per new case and assume 50% of follow-up scans would be considered medically necessary.

We found two sources of cost savings for implementing this benefit.

- The first is the PET scans would replace the bone scans/CT scans that are currently used. According to our discussions with medical providers, bone scans/CT scans would not be required if 2 types of PET scans were used. We estimate \$685 per CT scan and \$180 per bone scan.⁸³
- Second is a cost avoidance that comes from the effectiveness of the PET scans compared to conventional scans which is in the form of less complications from the cancer and less surgeries. We found two studies which show cost savings^{84,85}, when converted to US dollars we use a cost savings estimate of \$977 per new case.

b. Cost

- Gross cost before cost saving: \$0.55 PMPM or 0.11% of premium
- Net cost after cost savings: \$0.13 PMPM or 0.03% of premium

The issuers estimated \$0.00 to \$0.50 PMPM or 0% to 0.10% of premium.

⁸² <https://www.newchoicehealth.com/pet-scan/cost>

⁸³ [Bismarck, ND CT Scan Cost Average \(newchoicehealth.com\)](https://www.newchoicehealth.com)

⁸⁴ [PET Scanning: Worth the Cost in Cancer? Not Only Worth the Cost, but Sometimes a Cost-Cutter! \(cancernetwork.com\)](https://www.cancernetwork.com)

⁸⁵ [The Cost-Effectiveness of PSMA-PET/CT When Compared with Conventional Imaging. An Analysis Informed by the proPSMA Trial - Journal Club - Christopher Wallis & Zachary Klaassen \(urotoday.com\)](https://www.urotoday.com)

Expanded Opioid Use Disorder Treatment

1. Description of proposed benefit

- An intranasal spray opioid reversal agent would be prescribed when prescriptions of opioids are 50 MME and higher.
- Removal of any prior authorization requirements for Buprenorphine and similar opioid replacement drugs

2. Comparison of proposed benefit to the current benefit coverage

We do not know the current coverage of these benefits.

3. Demand for benefit – extent and how many impacted

The ND Board of Pharmacy indicated 70,417 member months in 2021 or about 5,900 patients with over 50 MME in opioids.

The ND Board of Pharmacy also indicated 28,220 scripts for Buprenorphine and equivalents in 2021. We estimate approximately 92% of these scripts were for generic Buprenorphine which we expect will not have prior authorization. However, there are still over 2,000 brand scripts that may have prior authorization requirements to help members avoid or get off opioids.

About 15% of those under the age of 65 would be covered by proposed changes to the EHB Benchmark plan.⁸⁶

4. Cost estimate for proposed benefit

a. Methodology

Intranasal Opioid

We began with the member months of patients receiving over 50 MME from the ND Board of Pharmacy. We then used the opioid prescription counts by age⁸⁷ to distribute these member months into age groups. Older age groups tend to use more prescriptions, we assume over age 65 would be covered by Medicare.

We do not expect every eligible prescription would be filled. We assume 9% will fill the prescription based on a study of prescriptions made to new users,⁸⁸ who we believe would likely fill the prescription and considered twice that amount in other cases. We used a cost per script of \$145.⁸⁹

⁸⁶ 2021 SHCE covered lives in the individual and small group market compared to 2021 vintage population estimates in North Dakota.

⁸⁷ [Opioid | Department of Health \(nd.gov\)](#)

⁸⁸ [Changes in Initial Opioid Prescribing Practices After the 2016 Release of the CDC Guideline for Prescribing Opioids for Chronic Pain | Addiction Medicine | JAMA Network Open | JAMA Network](#)

⁸⁹ [Narcan Nasal Spray Prices, Coupons & Patient Assistance Programs - Drugs.com](#)

Some carriers already cover intranasal when prescribed, but do not influence provider prescribing patterns.

Removal of Prior Authorization for Buprenorphine and Equivalents

We started with the count of Buprenorphine scripts in 2021 provided by the ND Pharmacy Board, by type and categorized the scripts into generic and brand, which was approximately 92% generic. We then used the opioid prescription counts by age⁹⁰ to distribute these member months into age groups.

We assumed there would be shifting from the generic to brand Buprenorphine equivalents as a result of removing the prior authorization. For the brand, which we calculate as 8% of scripts, we assume an increase in utilization of 4% (50% of the 8% current usage) to 8% (100% of the 8% current usage) as a result of removing prior authorization. The brand drugs have a higher cost than generic. We estimate \$367 per brand script versus \$91 per generic script, so an increase in \$276 per script.⁹¹

b. Cost

- Intranasal spray opioid reversal: Gross \$0.07 PMPM or 0.01% of premium. Net \$0.02 PMPM or 0.00% of premium
- Removal of prior authorization of Buprenorphine and equivalents: \$0.03 PMPM, or 0.01% of premium.

Gross total cost before savings \$0.10 PMPM or 0.02% of premium

Net cost estimate after savings \$0.05 PMPM or 0.01% of premium

The issuers estimated \$0.00 - \$0.50 PMPM or 0.0% to 0.1% of premium

Medication Optimization

1. Description of proposed benefit

Medication optimization, also known as Comprehensive Medication Management (CMM) would not be a benefit change or increase in benefit to the EHB Benchmark plan but rather would be a programmatic change among issuers to implement CMM for eligible disease states to ensure members have access to doctors and pharmacists to review their medication mix and have medications adjusted to reduce possible side effects or adverse drug interactions. Health plans already provide for benefits to access primary care

⁹⁰ [Opioid | Department of Health \(nd.gov\)](#)

⁹¹ [Drugs.com | Prescription Drug Information, Interactions & Side Effects](#)

doctors and this would be extended to apply to pharmacists participating in the CMM program.

2. Comparison of proposed benefit to the current benefit coverage
North Dakota does not currently legislate the practice of optimizing medication prescribing, including use of pharmacists to work with the patient. However, it does appear most issuers in the fully insured markets in North Dakota have implemented a form of Medication therapy management (MTM) or CCM for their members to engage and opt in. This includes outreach by prescribing physicians and pharmacists to work with the member on medication adherence and monitoring drug interactions.
3. Demand for benefit – extent and how many impacted
Fairview Health noted that pre-/post-engagement of their diabetic population into a CCM program doubled (21.5% before, 45.5% after).⁹² They saw similar results in their asthma patients. The patient conditions, and prevalence rates in North Dakota, for which an optimization program should be considered are:
 - Diabetes (9.1% diagnosed, 2.8% undiagnosed, 32% pre-diabetes)
 - Hypertension (24%)
 - Hyperlipidemia (29%)
 - Smoking cessation
 - COPD (4.7%)
 - Heart Failure
 - Asthma (8.6%)
 - Transplants
 - HIV (0.9%)
 - Mental Health
4. Cost estimate for proposed benefit
 - a. Methodology
For issuers already applying a form of MTM or CCM, we would not expect there to be a meaningful cost impact to hire or contract more pharmacists to build out a more robust program. Issuers without an integrated approach to medication optimization would likely need to contract with or hire internal pharmacy resources to review high risk member drug mix and possible adverse interaction. Since this would be more of a

[92 Medication Optimization Use Case – Minnesota Health Fairview: Minneapolis-St. Paul, Minnesota - Get The Medications Right \(gtmr.org\)](#)

staffing/expense issue, we have attempted to estimate expenses impacts and resulting premium change.

b. Cost

The M Health Fairview use case indicated an increased number of members with diabetes and asthma who were being optimally managed and a resulting cost savings associated with these members' overall healthcare costs. This savings was net of increased in-person, phone consults and video chats between doctor/pharmacist and the member. Issuers providing this program to their members have likely already built in the savings to their premiums. For issuers that have not, we would expect a net reduction in total cost of care for engaged members.

The issuers estimated between \$0.00 and \$0.01 PMPM or 0% of premium.

Limitations

NovaRest has prepared this report in conformity with its intended use by persons technically competent to evaluate our estimate of the proposed benefits. Any judgments as to the data contained in the report or conclusions about the ramifications of that data should be made only after reviewing the report in its entirety, as the conclusions reached by review of a section or sections on an isolated basis may be incorrect. Appropriate staff is available to explain and/or clarify any matter presented herein. It is assumed that any user of this report will seek such explanations as to any matter in question.

NovaRest has developed projections in conformity with what we believe to be the current and proposed operating environments and are based on best estimates of future experience within such environments. It should be recognized that actual future results may vary from those projected in this report. Factors that may cause the actual results to vary from the projected include new insurance regulations, differences in implementation of the required coverage by carrier, accounting practices, changes in federal and/or local taxation, external economic factors such as inflation rates, investment yields and ratings and inherent potential for normal random fluctuations in experience.

Reliance and Qualifications

We are providing this report to you solely to communicate our findings and analysis of the proposed benefit changes. The reliance of parties other than the North Dakota Insurance Department on any aspect of our work is not authorized by us and is done at their own risk.

To arrive at our estimate, we made use of public information, information provided by carriers included in the data call, the carrier's statutory financials, and the carrier's rate filing information. We also made assumptions based on information gained from interviews with medical professionals and interested parties. We did not perform an independent investigation or verification. If this information was in any way inaccurate, incomplete, or out of date, the findings and conclusions in this report may require revision. While we have relied on information without independent investigation or verification, the medical professionals we spoke to are fully qualified and knowledgeable in their field.

This memorandum has been prepared in conformity with the applicable Actuarial Standards of Practice. We have no conflicts of interest in performing this review and providing this report.

We are members of the American Academy of Actuaries and meet that body's Qualification Standards to render this opinion. We meet the Qualification Standards promulgated by these professional organizations to perform the analyses and opine upon the results presented in this Actuarial Report.

Appendix A – Benefit Comparison Between the Current EHB Benchmark Plan and the Richest Plan Considered (FEHBP)

An "X" indicates that the benefit is covered and NC indicates that it is not covered.

1) Ambulatory

Benefit Subcategories	EHB Benchmark Plan	FEHBP - Richest Plan
Primary Care Office Visits	X	X
Specialist Office Visits	X	X
Acupressure	NC	NC
Acupuncture	NC	X
Allergy Services	X	X
Biofeedback	NC	NC
Chemotherapy	X	X
Chiropractor Services	X	X
Preventive dental services (exams, cleaning)	NC	X
Basic dental services (fillings, periodontal disease, etc.)	NC	X
Dental Services Related to Accident	X	X
Oral Surgery – removal of impacted teeth	NC	X
Oral Surgery for Cleft Lip/Palate	X	X
Orthognathic Surgery (correcting deformities of the jaw)	X	X
Diagnostic Services	X	X
Hearing Exams	X	X
Home Health Care	X	X
Home Infusion Therapy	X	X
Hospice	X	X
Private Duty Nursing	NC	NC
Infertility	NC	NC
Artificial insemination	NC	NC
Donor eggs, sperm	NC	NC
In vitro fertilization	NC	NC
Services to diagnose infertility	X	X
Services to treat underlying cause of infertility	NC	X
Preimplantation genetic diagnosis testing	NC	NC
Surrogacy	NC	NC
Nutritional Supplements (other than to sustain life)	NC	NC

Benefit Subcategories	EHB Benchmark Plan	FEHBP - Richest Plan
Outpatient Infusion Therapy	X	X
Outpatient Surgery	X	X
Radiation Therapy	X	X
Reconstructive/Restorative Surgery (non-cosmetic)	X	X
Renal Dialysis	X	X
Second opinion (surgery)	X	X
Sterilization - Voluntary		
Men	X	X
Women	X	X
Reversal of Sterilization	NC	NC
Treatment of Temporomandibular Joint (TMJ) & Craniomandibular Disorders - #6	X	X
Urgent Care Services	X	X
Vision Services (Adult)		
Routine Eye Exams	NC	NC
Eyeglasses or contact lenses	NC	NC
Eyeglasses or contact lenses following a covered cataract surgery	NC	X
Nutritional Counseling		
Anorexia	X	X
Bulimia	X	X
Chronic Renal Failure	X	X
Diabetes	X	X
Gestational Diabetes	X	X
Hyperlipidemia	X	X
Hypertension	X	X
Obesity	X	X
Phenylketonuria (PKU)	X	X

2) Emergency Services

Benefit Subcategories	EHB Benchmark Plan	FEHBP - Richest Plan
Physician Charges	X	X
Facility Charges (Room, Imaging, Testing and Supplies)	X	X
Ambulance		
Ground	X	X
Air	X	X

3) Hospitalization

Benefit Subcategories	EHB Benchmark Plan	FEHBP - Richest Plan
Inpatient Hospital (includes anesthesia, bed, board, general nursing, diagnostic services and surgery)	X	X
Inpatient Medical	X	X
Bariatric/Obesity Surgery	X	X
Medical services related to suicide	X	X
Medical services related to intoxication	X	X
Reconstructive Breast Surgery - #11	X	X
Skilled Nursing	X	X
Organ Transplants		
Surgery	X	X
Delivery of donor organ	X	X
Removal of donor organ	X	X
Transportation of recipient	NC	NC
Lodging	NC	NC

4) Maternity & Newborn Care

Benefit Subcategories	EHB Benchmark Plan	FEHBP - Richest Plan
Medically necessary abortion	X	X
Elective abortion	NC	NC
Birthing centers	X	X
Delivery by Mid-wife in home	NC	NC
Circumcision	X	X
Complications of pregnancy - #5	X	X
Delivery	X	X
Post-delivery (mothers & newborn) - #9	X	X
Neonatal Intensive Care	X	X
Newborn Child Coverage	X	X
Normal pregnancy, newborn nursery & care	X	X
Post-Partum Care	X	X
Prenatal Care	X	X
Contraceptives		
Implanted	X	X
Injectable	X	X
Oral	X	X

5) Mental Health & Substance Use Disorder Services including Behavioral Health Treatment

Benefit Subcategories	EHB Benchmark Plan	FEHBP - Richest Plan
Inpatient Mental Health - #3	X	X
Outpatient Mental Health - #3	X	X
Inpatient Substance Abuse - #2	X	X
Outpatient Substance Abuse - #2	X	X
Partial Day Hospitalization - #2, #3	X	X
Residential Treatment - #3	X	NC
Supervised Living	NC	NC
Applied Behavior Analysis	NC	NC
Group therapy	X	X
Learning Disorders/Behavioral Issues	NC	NC
Psychiatric services	X	X
Psychological Testing	X	X
Detoxification	X	X
Autism Services		
Habilitative Therapies	X	NC
Rehabilitative Therapies	NC	NC

6) Prescription Drugs

Benefit Subcategories	EHB Benchmark Plan	FEHBP - Richest Plan
Generic Drugs	X	X
Preferred Brand Drugs	X	X
Non-Preferred Brand Drugs	X	X
Specialty Drugs	X	X
Off Label Drugs	X	X
Growth Hormones	X	X
Infertility Drugs	NC	NC
Medical Foods – PKU - #8	X	X
Prenatal Vitamins	X	X
Sexual Dysfunction Drugs	NC	X
Smoking/Tobacco Cessation Drugs	X	X

7) Laboratory Services

Benefit Subcategories	EHB Benchmark Plan	FEHBP - Richest Plan
Diagnostic (Lab, X-ray, Imaging, etc.)	X	X
Genetic Testing	X	X

8) Rehabilitative & Habilitative Services & Devices

Benefit Subcategories	EHB Benchmark Plan	FEHBP - Richest Plan
Cardiac Rehabilitation	X	X
Habilitation for congenital or birth defect	X	X
Rehab/Habilitation for disability from medical condition	X	X
Occupational Therapy due to surgery, injury, or illness	X	X
Outpatient Physical Therapy	X	X
Pulmonary Rehabilitation	X	X
Respiratory Therapy Services	X	X
Speech Therapy due to surgery, injury, or illness	X	X
Speech Therapy to correct speech impediments	X	X
Medical Equipment & Supplies		
Breast Prosthesis	X	X
Cochlear implants	X	X
Diabetes (blood glucose monitors, testing, etc.)	X	X
Hearing Aids (less than age 18)	NC	X
Hearing aids (18 +)	NC	X
Orthotics & special footwear (medically appropriate & necessary)	X	X
Ostomy Supplies	X	X
Oxygen	X	X
Prosthetics	X	X
Replacement or repair of DME (durable medical equipment)	X	X
Wigs & Scalp Prosthetics for hair loss due to chemotherapy	NC	X

9) Preventive & Wellness Services & Chronic Disease Management

Benefit Subcategories	EHB Benchmark Plan	FEHBP - Richest Plan
Colorectal Cancer Screening	X	X
Diabetic Education	X	X
Mammography - # 4	X	X
Osteoporosis screening	X	X
Preventive Health Mandated by ACA (immunizations, well child and adult care)	X	X
Prostate Specific Antigen (PSA) -#7	X	X
Smoking/Tobacco Cessation Services	X	X
Preventive Care for Women (8/1/2012)		
Minimum one well-woman preventive visit (gynecological exam) annually	X	X
Screening for gestational diabetes between 24 and 28 weeks	X	X
Screening for gestational diabetes at 1st prenatal visit at high risk for diabetes	X	X
HPV testing > 29 y/o every 3 years if normal pap	X	X
Annual counseling on sexually transmitted infections for all sexually active women	X	X
Annual screening for HIV for sexually active women	X	X
Contraceptive methods and counseling	X	X
Lactation support and counseling by a trained provider	X	X
Rental of Lactation Equipment	X	X
Screening & counseling for interpersonal and domestic violence	X	X

10) Pediatric Services, including Oral and Vision Care

Benefit Subcategories	EHB Benchmark Plan	FEHBP - Richest Plan
Pediatric Oral Services	X	X
Preventive dental services (exams, cleaning)	X	X
Basic dental services (fillings, periodontal disease, etc.)	X	X
Dental Services Related to Accidental Injury	X	X
Dental anesthesia and hospitalization for dental care to children under age 9, children who are severely disabled or children who have a medical condition that requires hospitalization or general anesthesia.- #10	X	X
Pediatric Vision Care		
Routine Eye Exams	X	X
Eyeglasses or contact lenses	X	NC
Refraction and glaucoma screening	X	NC
Dilated eye exam for diabetes related diagnosis	X	NC
Post-operative refractive examination	X	NC
Visual training services, including orthoptics and pleoptic training, provided to children under age 10 for the treatment of amblyopia	X	X

Appendix B - State and Federal Regulations

Original Rules for choosing an EHB Benchmark plan

All ten (10) statutory categories must be included as a part of the EHB Benchmark Plan; therefore, if the selected or default EHB Benchmark Plan does not initially cover a category, the EHB Benchmark plan must be supplemented in accordance with 45 CFR 156.110(b).⁹³

The Department of Health and Human Services (HHS) gave the states the freedom to model their EHB Benchmark plan (i.e., the plan that serves as a minimum standard on which all new plans are modeled, including the specifics in terms of how essential health benefits are covered) for individuals and businesses on either:

- One of the three small group plans in their state that boast the largest enrollment, or
- One of the three most popular state employee plans, or
- One of the three federal employee health plan options with the largest enrollment in the state, or
- The most popular HMO plan in the state's commercial market.

State Mandated Benefits

This report addresses changes that can be made to the EHB Benchmark plan. However, states may also require benefits or services be offered through legislation, which we call mandated benefits. By mandating benefits, states may also require benefits be offered in markets beyond just the individual and small group ACA markets which would be affected by the EHB Benchmark plan change. For example, the large group market (employers with more than 50 employees) provide insurance to approximately 150,000 members, which is more than the combined individual and small group ACA market. The large group market would not be impacted by an EHB Benchmark plan change but could be impacted by a mandated benefit if specified in the legislation.

It is important to note, however, that (1) mandating a benefit will likely have a premium impact and (2) mandating a benefit may require the state pay for or “defray” the cost of benefits mandated in addition to the EHB Benchmark plan in the individual and small group ACA market. A benefit required by North Dakota

⁹³ The Essential Health Benefits: List of the Largest Three Small Group Products by State for 2017 is available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Top3ListFinal-5-19-2015.pdf>. States' EHB Benchmark plans used for the 2017 plan year are available at https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Final-List-of-BMPs_4816.pdf.

prior to December 31, 2011, is considered an EHB. A benefit mandated by North Dakota taking place after January 1, 2012, would be considered an “addition to the EHB”, which would require North Dakota to defray the cost of the benefit in the individual and small group ACA market. If the mandated benefit is an expansion of existing services already required by the EHB Benchmark plan, it may not be considered an “addition to the EHB.”

The following eleven benefits were mandated to be covered by North Dakota. All of these were enacted before 2012. Therefore, they are considered EHBs, and North Dakota is not required to defray any costs for these benefits.⁹⁴

1. §26.1-36-06.1 - coverage for off-label uses of prescription drugs cannot be denied if the drug is recognized for the particular treatment in standard medical reference materials or literature
2. §26.1-36-08 - substance abuse coverage (Applies pursuant to Mental Health Parity Act)
3. §26.1-36-09 -mental disorder coverage (Applies pursuant to Mental Health Parity Act)
4. §26.1-36-09.1 - Mammogram examination coverage. One baseline mammogram examination for each woman who is at least thirty-five but less than forty years of age. One mammogram examination every year, or more frequently if ordered by a physician, for each woman who is at least forty years of age.
5. §26.1-36-09.2 – coverage for involuntary complications of pregnancy
6. §26.1-36-09.3 – TMJ mandate. FEHBP does not have dollar limits.
7. §26.1-36-09.6 - Annual digital rectal examination and prostate-specific antigen test coverage. Male aged fifty and over, a black male aged forty and over, and a male aged forty or over with a family history of prostate cancer.
8. §26.1-36-09.7 - coverage for medical foods and low-protein modified food products determined by a physician to be medically necessary for the therapeutic treatment of an inherited metabolic disease (e.g., maple syrup urine disease or phenylketonuria) (FEHBP does not have a dollar limit).
9. §26.1-36-09.8 - post-delivery coverage for mothers and newborns (e.g., 48 hours following normal vaginal delivery and 96 hours following caesarean section) that requires dental anesthesia and hospitalization.

⁹⁴ https://downloads.cms.gov/ccio/State%20Required%20Benefits_ND.PDF

10. §26.1-36-09.9 - coverage for anesthesia and hospitalization for dental care for covered individual who is under age nine, is severely disabled or has a medical condition and FEHBP covers to age 22.

11. §26.1-36-09.11 - breast reconstruction surgery coverage

Mental Health Parity Requirements

The Mental Health Parity and Addiction Equity Act (MHPAEA) amended the Public Health Service Act (PHS Act), the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code (the Code) to provide increased parity between mental health and substance use disorder benefits and medical/surgical benefits. In general, MHPAEA requires that the financial requirements (such as coinsurance) and treatment limitations (such as visit limits) imposed on mental health and substance use disorder benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits.

The Affordable Care Act amended the PHS Act to apply MHPAEA to health insurance issuers offering individual health insurance coverage (both through the Health Insurance Marketplaces, also known as Exchanges, and outside the Marketplaces). These changes are effective for policy years beginning on or after January 1, 2014. The final rules apply to individual health insurance coverage for policy years beginning on or after July 1, 2014 and apply to both grandfathered and non-grandfathered plans.

Appendix C – North Dakota EHB Selection History

Original EHB Benchmark Plan Selection

Original EHB Benchmark Plan and EHB Options considered by ND

Note there are ten possible EHB Benchmark plan choices among the four plan types identified by HHS. Based on information supplied by the NDID to INS⁹⁵, the following plans comprise the ten possible EHB Benchmark plan choices:

1. Largest non-grandfathered small group insurance products in North Dakota's small group market:
 - a) Medica Insurance Company. Medica Choice Passport (PPO).
 - b) Blue Cross Blue Shield of North Dakota. Classic Blue (PPO).
 - c) Blue Cross Blue Shield of North Dakota. CompChoice 80 (PPO).
2. Largest three state employee health benefit plans by enrollment:
 - a) North Dakota Public Employees Retirement System (NDPERS). Health Care Coverage (grandfathered). Plans are issued by Blue Cross Blue Shield of North Dakota.
 - b) North Dakota Public Employees Retirement System. Health Care Coverage (non-grandfathered). Plans are issued by Blue Cross Blue Shield of North Dakota.
 - c) North Dakota Public Employees Retirement System. High deductible health plan. This benefit plan is a high deductible health plan designed to comply with Section 223 of the U.S. Internal Revenue Code and is intended for use with a Health Savings Account (HSA). Plans are issued by Blue Cross Blue Shield of North Dakota.
3. Largest three national Federal Employees Health Benefits Plans (FEHBP).
 - a) Blue Cross Blue Shield Standard Option (PPO).
 - b) Blue Cross Blue Shield Basic Option (PPO). Note that covered services are generally the same for BCBS Standard Option and BCBS Basic Option.
 - c) Government Employees Health Association, Inc. Benefit Plan. Sponsored and administered by the Government Employees Health Association, Inc.

⁹⁵ INS Consultants, Inc performed original EHB analysis summarized in Analysis of Essential Health Benefits Under the Patient Protection and Affordable Care Act dated Aust 31, 2012.

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

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

Original EHB Benchmark Plan and EHB Option chosen by ND

Plan chosen for EHB Benchmark plan was the Largest HMO plan, a Sanford Health Plan. The plan included 2 supplemented categories: Pediatric Oral and Pediatric Vision.

EHB Reconsideration in 2015

Options Considered by North Dakota

North Dakota reviewed the same 10 plan options that were part of the original EHB Benchmark Plan study in 2012 and are noted above. The plan benefits were again compared across all plans as issuers may have added, modified or removed benefits from the original plan studied in 2012.

Options Chosen by North Dakota

North Dakota adopted the Blue Cross Blue Shield of North Dakota small group exchange plan, BlueCare Gold 90 500 as the EHB Benchmark plan beginning 2017. There were no additional supplemental categories.⁹⁶

The following are the EHB benefit changes moving from the original EHB Benchmark plan (Sanford plan) to the current EHB Benchmark plan (BCBS-ND small group plan) effective in 2017:

- Private Duty Nursing was removed
- Benefits for transportation and lodging associated with organ transplants were removed
- Birthing centers for maternity and newborn care were included
- Group therapy and detoxification services for mental health and substance abuse were included
- Rehabilitative therapy for autism was removed
- Speech therapy to correct speech impediment was included

⁹⁶ [Final-List-of-BMPs_4816.pdf \(cms.gov\)](#)

Appendix D – Carrier Responses to NovaRest Narrative Questions

In this appendix we have summarized the carrier answers to our narrative questions on the proposed potential new EHB benefits. We have edited the answers so that confidentiality is maintained. We have not included any of the medicine optimization replies due to confidentiality concerns.

General Questions

When thinking about changing the EHB plan

1. Do you believe that there are any coverages that should be eliminated?

Current EHB coverage is expansive and not burdensome to the Plan.

2. Do you believe that there are any coverages that should be revised?

Current EHB benchmark requires coverage for eyeglass or contacts with a diagnosis of aphakia. One issuer would like to see coverage expanded for eyeglasses or contacts to include these benefits within 6 months of cataract surgery.

3. Do you believe that there are any coverages that should be added that would provide wellness and improved health outcomes?

Diabetes Prevention Program services for Members age 18 and older meeting certain medical criteria of having a high risk of developing type 2 diabetes when enrolled through a Diabetes Prevention Provider. Coverage is limited to one enrollment in a Diabetes Prevention Program per year, regardless of whether the Member completes the Diabetes Prevention Program. Coverage for the Diabetes Prevention Program for Members age 18 and older would be at 100% of Allowed Charge. Deductible Amount waived.

Diabetes

1. Are there any technology barriers for providers to providing expanded diabetes coverage?

The need for balancing the need to adhering to HIPPA standards, and security protocols that come with that, with making sure security software does not hinder a patient's ability to have a good connection during their meeting.

At this time, one issuer was not able to identify barriers on behalf of providers as it relates to expanded diabetes coverage. However, the issuer acknowledged the evolving technology/ innovation landscape for chronic care management, specifically diabetes, which over time, could influence coverage.

2. Are there alternatives to expanded diabetes coverage? Please describe any alternatives to expanded diabetes coverage in as much detail as possible.

Incentive pricing that waves deductible. For a preferred drugs, the deductible could be waived and have a \$5 copay/month for all drugs on the lists.

Invested in alternate care delivery services including digital partners, which decreases the cost of diabetic supplies, decreases barriers to care and makes it easier for members to proactively manage their condition.

An additional option may be to expand coverage of diabetes prevention programs (DPP), according to the CDC more than 96 million America adults (more than 1 in 3) have prediabetes, and of those 8 in 10 do not know they have it. Promoting lifestyle changes and management through DPP programs could reduce the need for medication management and potentially also reduce other health risks.

[National Diabetes Prevention Program | Diabetes | CDC](#)

3. Are there any technology barriers if expanded diabetes coverage was added to the North Dakota EHB? Please describe any technology barriers to this benefit in as much detail as possible.

None identified

4. Please identify any comparative research studies documenting the cost or potential savings in health care cost from expanded diabetes coverage.

Academy of Managed Care Pharmacy (AMCP) 2017 Press release. [Lowering Cost Share May Improve Rates of Home Glucose Monitoring Among Patients with Diabetes Using Insulin | AMCP.org](#)

According to the CDC, the National Diabetes Prevention Program (DPP) which focuses on healthy eating and physical activity demonstrated that people with prediabetes who take part in a structured lifestyle change program reduce their risk of developing type 2 diabetes by 58% and 71% for people who are over 60 years old.

[National Diabetes Prevention Program | Diabetes | CDC](#)

5. Please provide an inventory of denied claims for insulin and diabetic devices or supplies. Please include the item denials and the reason for denial. If it is easier a count of the number for a specific denial reason is sufficient.

Answers were supplied in separate files.

Infertility Treatment

1. Are there any technology barriers for providers to providing infertility treatment?

The need for balancing the need to adhering to HIPPA standards, and security protocols that come with that, with making sure security software does not hinder a patient's ability to have a good connection during their meeting.

2. Are there alternatives to expanded treatment of infertility coverage? Please describe any alternatives to expanded treatment of infertility coverage in as much detail as possible.

Alternative options could include coverage for surrogacy or adoption fees. The proposal already encompasses all infertility treatment options that one issuer was aware of.

3. Are there any technology barriers if expanded treatment of infertility coverage was added to the North Dakota EHB? Please describe any technology barriers to this benefit in as much detail as possible.

If there is limited availability of providers, then there could be technological barriers in administering this benefit.

4. Please identify any comparative research studies documenting the cost or potential savings in health care cost from expanded treatment of infertility coverage.

None identified

5. Please provide an inventory of denied claims for treatment of infertility. If it is easier a count of the number for a specific denial reason is sufficient.

Answers were supplied in separate files.

Hearing Loss/Aids for All Ages

1. Are there any technology barriers for providers to providing hearing loss/aids for all ages?

The need for balancing the need to adhering to HIPPA standards, and security protocols that come with that, with making sure security software does not hinder a patient's ability to have a good connection during their meeting.

2. Are there alternatives to expanded hearing loss/aids for all ages coverage? Please describe any alternatives to expanded hearing loss/aids for all ages coverage in as much detail as possible.

Recently, the Federal government (FDA) proposed rules to facilitate the marketing/sales/use of lower cost, OTC hearing aids. OTC hearing devices may serve as an alternative for those who do not have coverage.

3. Are there any technology barriers if expanded hearing loss/aids for all ages coverage was added to the North Dakota EHB? Please describe any technology barriers to this benefit in as much detail as possible.

If there is limited availability of providers, then there could be technological barriers in administering this benefit.

4. Please identify any comparative research studies documenting the cost or potential savings in health care cost from expanded hearing loss/aids coverage.

None identified

5. Please provide an inventory of denied claims for hearing loss/aids. If it is easier a count of the number for a specific denial reason is sufficient.

Answers were supplied in separate files.

Nutritional Counseling

1. Are there any technology barriers for providers to providing nutritional counseling?

The need for balancing the need to adhering to HIPPA standards, and security protocols that come with that, with making sure security software does not hinder a patient's ability to have a good connection during their meeting.

One issuer currently provides coverage for nutritional counseling to its members; however, states that this benefit is underutilized by members.

2. Are there alternatives to expanded nutritional counseling coverage? Please describe any alternatives to expanded nutritional counseling coverage in as much detail as possible.

Increased information, education, and reinforcement of this benefit (to members) may be an alternate step prior to mandating expansion of coverage.

3. Are there any technology barriers if expanded nutritional counseling coverage was added to the North Dakota EHB? Please describe any technology barriers to this benefit in as much detail as possible.

Should the proposed expanded EHB contain a virtual care component, one issuer assumes that current telehealth barriers such as level of and/or limited broadband access could influence member use of this benefit.

4. Please identify any comparative research studies documenting the cost or potential savings in health care cost from expanded nutritional counseling coverage.

None identified

5. Please provide an inventory of denied claims for nutritional counseling coverage. If it is easier a count of the number for a specific denial reason is sufficient.

Answers were supplied in separate files.

Periodontal Disease

Concerning periodontal disease, please answer the following

1. Are there any technology barriers for providers to providing periodontal disease treatment?

Any front-line dental provider, general dentist, or periodontal specialist should be able to manage periodontal disease treatment.

The need for balancing the need to adhering to HIPPA standards, and security protocols that come with that, with making sure security software does not hinder a patient's ability to have a good connection during their meeting.

We currently cover the diagnosis of periodontal disease, some treatment, and stabilizing services--subject to a handful of exclusions depending on policy language. One issuer offers major med coverage but not dental plans.

2. Are there alternatives? Please describe any alternatives in as much detail as possible.

There may be opportunities through other covered benefits, such as nutritional counseling to better inform and educate patients on prevention.

3. Are there any technology barriers if periodontal disease treatment was added to the North Dakota EHB? Please describe any technology barriers to this benefit in as much detail as possible.

The use of virtual/telehealth for dental is evolving and may be appropriate for diagnosis.

4. Please identify any comparative research studies documenting the cost or potential savings in health care cost.

Diabetes is currently the only medical disease that is well-researched and studied related to periodontal disease. There is ongoing research for other conditions such as pregnancy and cardiovascular disease. Treating periodontal disease for the diabetic population could provide cost savings and prevent additional complications.

5. Please provide an inventory of denied claims. If it is easier a count of the number for a specific denial reason is sufficient.

Answers were supplied in separate files.

Private Duty Nursing

Concerning Private Duty Nursing, please answer the following

1. Are there any technology barriers for providers to providing Private Duty Nursing?

The need for balancing the need to adhering to HIPPA standards, and security protocols that come with that, with making sure security software does not hinder a patient's ability to have a good connection during their meeting.

2. Are there alternatives? Please describe any alternatives in as much detail as possible.

Each care plan and care coordination is unique to a specific member.

3. Are there any technology barriers if Private Duty Nursing was added to the North Dakota EHB? Please describe any technology barriers to this benefit in as much detail as possible.

None identified

4. Please identify any comparative research studies documenting the cost or potential savings in health care cost.

None identified

5. Please provide an inventory of denied claims. If it is easier a count of the number for a specific denial reason is sufficient.

Answers were supplied in separate files.

PET scans for prostate cancer

Concerning PET scans for prostate cancer, please answer the following

1. Would Pluvicto be covered with a gallium PSMA-11 (i.e., Locametz) expression in tumors? What other PSMA agents (i.e., Pylarify) would allow selection for Pluvicto?

Pluvicto is FDA approved for metastatic castration-resistant prostate cancer, Prostate-specific membrane antigen (PSMA) positive after treatment with androgen receptor pathway inhibition and taxane-based chemotherapy. The Pluvicto policy requires that the patient has prostate-specific membrane antigen (PSMA)-positive disease defined as having at least one tumor lesion with gallium Ga-68 gozetotide uptake greater than normal liver as one of the required criteria elements. Please refer to the attached policy criteria for all of the criteria details.

What other PSMA agents (i.e., Pylarify) would allow selection for Pluvicto? Per the Pluvicto policy, the patient must meet certain criteria. Pylarify would not meet one issuer's policy criteria.

Yes, Pluvicto would likely be covered with the correct medical guidance. Given approval (for Pluvicto) was just granted in the spring of 2022 and the medical complexities – it is difficult to answer what other agents would allow for selection for Pluvicto.

2. Are there any technology barriers for providers to providing PET scans for prostate cancer?

The need for balancing the need to adhering to HIPPA standards, and security protocols that come with that, with making sure security software does not hinder a patient's ability to have a good connection during their meeting.

PET technology may not be available or readily accessible to members/patients living in rural areas. These operations require specialist training/staffing and expensive equipment which could be barriers to access.

3. Are there alternatives? Please describe any alternatives in as much detail as possible.

Bone scanning is the current standard of care and could be performed every 6-12 months. If you get a result or a routine diagnostic PET scan, could do a more targeted exam as compared to more conventional scanning such as CT and MRI. Course of care will depend on the disease state of the member.

4. Are there any technology barriers if PET scans for prostate cancer was added to the North Dakota EHB? Please describe any technology barriers to this benefit in as much detail as possible.

There could be technology barriers related to expanded PET coverage for residents of rural areas-- the availability of equipment, trained and certified staffing, and financial investment may present barriers in rural communities.

5. Please describe potential benefit or savings from adding 2 PET scans a year for each member with a prostate cancer diagnosis (including those in remission) to the EHBs.

One issuer already covers PET scans as ordered by a physician for medical necessity; therefore, does not anticipate any cost changes.

6. Please identify any comparative research studies documenting the cost or potential savings in health care cost.

None identified

7. Please provide an inventory of denied claims. If it is easier a count of the number for a specific denial reason is sufficient.

Answers were supplied in separate files.

Combating the Opioid Epidemic

For the recommended opioid treatment

1. Are there any technology barriers for providers to providing the recommended treatment?

The need for balancing the need to adhering to HIPPA standards, and security protocols that come with that, with making sure security software does not hinder a patient's ability to have a good connection during their meeting.

2. Are there alternatives? Please describe any alternatives in as much detail as possible.

Formulary quantity limits, retrospective review program, and provider engagement are methods of combating the opioid epidemic.

Other alternatives include:

- Formulary Limits used to limit higher doses and to ensure that patients receiving higher doses are monitored appropriately
- Further review from retrospective review programs
- Oversight of a member's Opiate utilization follows the opiate prescribing guidelines published by the CDC.
- Use of appropriate caution, limiting initial supply, and avoiding long-acting opiates as initial therapy.

3. Are there any technology barriers if the recommended opioid treatment was added to the North Dakota EHB? Please describe any technology barriers to this benefit in as much detail as possible.

If the intent of "At least one intranasal spray opioid reversal agent when prescriptions of opioids are dosages of 50 MME or higher", is to require a fill of a reversal agent for prescriptions higher than 50 MME, there is not a way to require the member to purchase one drug prior to receiving another.

4. Please identify any comparative research studies documenting the cost or potential savings in health care cost.

None identified

5. Please provide an inventory of denied claims. If it is easier a count of the number for a specific denial reason is sufficient.

Answers were supplied in separate files.



**North Dakota
Insurance
Department**

Safeguarding Promises. Fostering Fairness.
Jon Godfread, Commissioner



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