Public Comments on Essential Health Benefits And
Recognition of Entities for Accreditation of Qualified Health Plans

June 22, 2012

Catholic Health Association of Minnesota
Minnesota Hospital Association
Minnesota Psychiatric Society
Minnesota Society of Orthotists, Prosthetists & Pedorthists

Sue Delaney
June 19, 2012

Re: Essential Health Benefits

To Whom it May Concern:

On behalf of the Catholic Health Association of Minnesota (CHA MN), I am responding to the Department of Health and Human Services request for rulemaking in the above referenced matter.

CHA MN is the state leadership organization for the Catholic health ministry, consisting of Catholic health care sponsors, systems, hospitals, long-term care facilities, and related organizations. One in every six patients in the United States is cared for in a Catholic hospital each year.

CHA MN has long insisted on and worked for the right of everyone to affordable, accessible health care. We welcomed the enactment of the Patient Protection and Affordable Care Act (ACA), and support the ACA’s ability to allow states to create their own state level exchanges with Essential Health Benefits.

We remain deeply concerned, however, that the current approach to determining the essential health benefits in a state level exchange, and the establishment of benchmark plans and accreditation process, may not recognize the personal conscience of individuals. Specifically, the lack of direction the current proposal has taken with respect to contraceptive services, especially abortifacient drugs and sterilization.

The establishment of the exchange benchmark plan products and the establishment of essential health benefits, should allow for the opportunity for an individual to purchase a product that does not include coverage for these services, if they are a violation of that individual or families beliefs.

In conclusion, for the reasons stated above we urge you at the very least to reexamine the evaluation of the benchmark plans and the essential health benefits selection to allow for a benchmark plan and essential health benefits that would allow individuals to honor their religious beliefs and not include coverage for morally objectionable services such as abortifacients and contraceptives.

Sincerely,

Toby Pearson
Executive Director of Catholic Health Association of Minnesota

1 Among the drugs approved by the FDA for use as a contraceptive is ulipristal acetate, commonly known as “ella.” Studies of ulipristal’s mechanism of action have indicated that the drug can interfere with implantation of a fertilized egg. The Catholic Church considers a drug which interferes with the implantation of a fertilized egg to be abortifacient, based upon the known science of reproduction and the Church’s belief that human life begins at the moment of fertilization.
Toby Pearson
Executive Director
CHA-Minnesota
651-503-2163
June 21, 2012

Submitted electronically

Ralonda Mason, Chair
Members of the Access Work Group of the Minnesota Health Care Reform Task Force
Healthreform.mn@state.mn.us

RE: Essential Health Benefits and affordability within Minnesota’s health insurance exchange

Dear Ms. Mason and members of the Access Work Group of the Minnesota Health Care Reform Task Force:

On behalf of our 145 member hospitals and 17 member health systems, the Minnesota Hospital Association (MHA) appreciates the opportunity to reiterate our commitment to a robust set of essential health benefits (EHB) as well as affordability of coverage for Minnesotans utilizing the Health Insurance Exchange.

MHA supports the broad range of benefits that are to be included in the EHB. In addition to primary, preventive and hospital services, it is important that the mandatory categories include meaningful mental health and chemical dependency, as well as all pediatric services. However, there is some concern that the EHB will not be as comprehensive as what is currently available to many Minnesotans.

MHA hopes that the state will adopt a comprehensive benefit set. Of the available options, the association has previously recommended the state use either SEGIP or the state’s largest small group insurance plan for the benchmark plan. MHA has recommended these two options over others because both plans incorporate state mandates and robust coverage for mental health, among other important services. Ideally, any benefit set would include Minnesota’s model mental health benefit set that is part of Minnesota’s Medicaid benefit package, including the mid-level interventions that many Minnesotans currently receive when in a crisis to prevent further escalation. Otherwise, hospitals will see a dramatic increase in uncompensated care due to emergency room visits, transfers and inpatient admissions resulting from patients in a mental health crisis with nowhere else to turn. Minnesota’s “intermediate” level of care for people in this situation should be part of the EHB.
MHA continues to support efforts to provide affordable, quality, comprehensive health care and coverage to all Minnesotans. MHA remains concerned that the Actuarial Value and Cost-Sharing Reductions Bulletin (AV/CSR) published by the Center for Consumer Information and Insurance Oversight (CCIIOO) on February 24, 2012, lowered eligibility for cost-sharing reductions within silver plans for individuals in households with incomes between 250% and 400% of the Federal poverty level (FPL). MHA is also concerned that out-of-pocket limits may collide with service limits, creating an unexpected expense for individuals who need services beyond those covered in their benefit package. In short, these caps in eligibility for cost-sharing reductions and the false security of out-of-pocket limits might make comprehensive insurance coverage unaffordable, from a practical perspective, for the very people we are trying to assist.

MHA continues to support access to affordable, quality, comprehensive coverage for adults without children in the 138%-200% FPL population. Coverage for these individuals should not be a step backwards from the Medicaid benefit set, nor should coverage be priced in a way that encourages individuals to enroll in high deductible plans that financially preclude them from getting needed care, on one hand, or forgo coverage altogether on the other. Increasing the premiums for people who are currently on MinnesotaCare, for example, could be a barrier to them enrolling in coverage. Hospitals already shoulder the increasing costs of uncompensated care that result from uninsured individuals and those who carry insurance but cannot afford their high deductibles.

Minnesota should not encourage the growth of uncompensated care through plans in the Exchange. Instead, the Exchange should be a tool to expand coverage that is affordable to purchase (premium cost) and affordable to use (co-pays and deductibles). Addressing one without the other will serve only to increase the number of uninsured, underinsured or both.

Thank you again for the opportunity to comment. If you have any questions, please feel free to contact me at (651) 659-1405 or jmcnertney@mnhospitals.org.

Sincerely,

Jennifer McNertney
Policy Analyst
June 22, 2012

Submitted electronically

Commissioner Mike Rothman, Minnesota Department of Commerce
Commissioner Ed Ehlinger, Minnesota Department of Health
Commissioner Cindy Jesson, Minnesota Department of Human Services
Healthreform.mn@state.mn.us

RE: Standards related to essential health benefits and recognition of entities for the accreditation of qualified health plans

Dear Commissioners:

On behalf of our 145 member hospitals and 17 member health systems, the Minnesota Hospital Association (MHA) appreciates the opportunity to comment on proposed rule CMS-9965-P, Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans.

MHA supports the proposed rule for collecting data from the identified health plans for defining essential health benefits. Under the proposed language, section 156.20 (2), each plan will be required to submit all health benefits in the plan, treatment limitations, drug coverage, and enrollment. MHA agrees with this list.

MHA generally agrees with the proposed approach in certifying qualified health plans to operate in the Health Insurance Exchange. The preamble of the proposed rule identifies those categories required by the Affordable Care Act: clinical quality measures such as the Healthcare Effectiveness Data and Information Set (HEDIS); patient experience ratings on a standardized Consumer Assessment of Health Care Providers and Systems (CAHPS) survey; consumer access; utilization management; quality assurance; provider credentialing; complaints and appeals; network adequacy and access; and patient information programs. MHA supports using these criteria, and particularly stresses the importance of ensuring provider network adequacy in certifying qualified health plans for the Exchange.

MHA also agrees with the proposed additional clinical quality measures in section 156.275(2)(ii), particularly the proposal to include a measure set that “spans a breadth of
conditions and domains,” including mental health and substance abuse disorders. MHA also supports B-E of the proposed clinical quality measures.

While MHA agrees with these measures for accrediting qualified health plans, the association also suggests the next phase of accreditation include clinical measures such as those from Minnesota Community Measurement, which measure the health of patients, not just what care patients have received. Consumers will find that sort of information more helpful as they use the Exchange to compare cost and quality data for health plans and providers.

Thank you again for the opportunity to comment. If you have any questions, please feel free to contact me at (651) 659-1405 or jmcnertney@mnhospitals.org.

Sincerely,

Jennifer McNertney
Policy Analyst
We are writing today to relay mental health priorities and recommendations pertaining to Minnesota’s essential benefit set. The Minnesota Psychiatric Society and the Minnesota Society of Child and Adolescent Psychiatry represent the state’s professional community of psychiatrists, and bring to bear the cumulative knowledge and expertise of the psychiatric profession. Using recognized guidelines established by the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP) which have been recognized as the preeminent authorities to set the standards of care and have subsequently been incorporated into Minnesota statute, we support and recommend the following.

MPS supports adoption of an essential benefit set (EBS) with full service mental health and substance use (mental conditions) coverage in Healthcare Exchanges. Importantly, once the ESB is chosen, it is imperative that payment for mental condition services be the same as payment for medical services, e.g., coding and billing procedures, administration, etc., so that mental condition services are available with other medical services in both the medical and mental health settings without hassle to patients or mental health providers. Specifically, independently managed behavioral health payment procedures, whether from an external vendor or segregated claims adjudication procedures within a health plan, should be phased out.

MPS supports EBS implementation based on medical necessity and best practices including evidence-based medical and non-medical therapies, as defined by APA and the AACAP. The APA began developing practice guidelines in 1991. Practice guidelines are defined as systematically developed documents in a standardized format that present patient care strategies to assist psychiatrists in clinical decision making. The APA guidelines are available online at http://psychiatryonline.org/guidelines.aspx. AACAP Practice Parameters are clinical practice guidelines developed by the AACAP Committee on Quality Issues to encourage best practices in child mental health. AACAP Practice parameters are available online at http://www.aacap.org/page.ww?section=Practice+Parameters&name=Practice+Parameters. The Minnesota EBS should allow uniform application of APA and AACAP guidelines.

Longitudinal data shows that early identification and coordination of medical and mental condition services and care delivery reduces overall health-related expenses, e.g., claims costs, disability costs, public program costs, by improving total health outcomes of patients. This should be captured as a part of benefit set decisions and application of claims adjudication business practices as Exchanges in Minnesota are developed.

Sincerely,

Eric Brown, MD
MPS President
Joel Obestar, MD
MSCAP President

Linda Vukelich
Executive Director
Minnesota Psychiatric Society
4707 Highway 61, #232
St Paul, MN 55110
office 651-407-1873
fax 651-407-1754
cell 651-278-4241
lvukelich@comcast.net
www.mnpsychsoc.org
May 12, 2012

Commissioner Michael Rothman  
Minnesota Commerce Department  
85 Seventh Place East  
St Paul, MN  55101

Dear Commissioner Rothman,

We are writing today to relay mental health priorities and recommendations pertaining to Minnesota’s essential benefit set. The Minnesota Psychiatric Society and the Minnesota Society of Child and Adolescent Psychiatry represent the state’s professional community of psychiatrists, and bring to bear the cumulative knowledge and expertise of the psychiatric profession. Using recognized guidelines established by the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACP) which have been recognized as the preeminent authorities to set the standards of care and have subsequently been incorporated into Minnesota statute, we support and recommend the following.

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disability costs, public program costs, by improving total health outcomes of patients. This should be captured as a part of benefit set decisions and application of claims adjudication business practices as Exchanges in Minnesota are developed.

Thank you for your consideration. The members and leadership of the MPS and MSCAP are available to you for further consultation and discussion. Please contact us through our offices at 651-407-1873 to schedule a meeting, to answer questions, or for additional information.

Sincerely,

Eric Brown, MD
MPS President

Joel Obestar, MD
MSCAP President
Minnesota Society of Orthotists, Prosthetists & Pedorthists

June 20, 2012

Minnesota Department of Commerce
Minnesota Department of Human Services
Minnesota Department of Health

Re: Essential Health Benefits – Orthotics and Prosthetics

To Whom It May Concern,

The intention of this letter is to respond to the Request for Comment Regarding Standards Related to Essential Health Benefits and Recognition of Entities for the Accreditation of Qualified Health Plans. Specifically, orthotics and prosthetics must be included in the essential health benefits package.

People who need prosthetic and orthotic services and devices are those who have suffered limb loss or limb impairment. Their medical needs are essential in that the services and devices they require assist them in functioning at normal levels in their activities of daily living. For example, the use of a prosthetic leg enables an individual to walk, to work and to be a contributing member of society.

In support of these assertions, please find the attached documentation:

1. Orthotics and Prosthetics Must Be Included in the Essential Health Benefits Package (American Orthotic & Prosthetic Association White Paper);
2. Colorado Study Executive Summary, Prosthetic and Orthotic Adult Benefit;
3. Colorado Study Full Report, Prosthetic and Orthotic Adult Benefit; and

The above documents clearly support the two criteria for determining essential health benefits as established by the Affordable Care Act. They describe orthotic and prosthetic services as essential benefits that are (1) prevalent in private employer health plans and (2) reasonable in cost. The white paper provides the requisite background information and references specific studies. The Colorado Study shows that when cost savings from avoidance of co-morbid conditions were factored in, the state saved more money providing orthotic and prosthetic coverage than the costs it incurred. And finally, the HHS Bulletin, laying out the benchmark approach, grouped orthotic and prosthetic services among “physician visits” and benefits that “are consistently covered” by employer health plans.

Please review the attached documentation and contact me at the address below should you have any questions or need additional information. Please know the prosthetic and orthotic community in the State of Minnesota, both people living with limb loss or limb impairment and those of us privileged to work with them, thank you for your time and attention to these matters.

Kind regards,

Kevin L. Hines, CPO
President
Minnesota Society of Orthotists, Prosthetists & Pedorthists
11855 Ulysses St, NE #230
Blaine, MN 55434
Prosthetic and Orthotic Adult Benefit
Summary

In Fiscal Year 1998-99 the Medicaid Prosthetic Program for adults was funded in the amount of $978,994. The Joint Budget Committee requested information regarding the anticipated expenditures for the first and second fiscal years which is the reason for this report.

An advisory committee was set up through the provider community in order to assist with additional protocols for review. The advisory committee would also assist in training regarding prostheses and orthoses. Providers received questionnaires to help reviewers conduct a comprehensive review of each request for prior authorization. The Department also developed two questionnaires, which assisted in determining the degree to which each request meets the Medicare criteria, to be submitted with the prior authorization request.

For the first year, expenditures were a total of $373,964.50, serving 381 clients. The expected figures for fiscal year 1999-2000 is a 30% increase for a total of $485,426. The anticipated increase is due to the fact that not all providers and clients seem to be fully aware of the benefit and will request the services during the second year.

For some types of medical services there have been increased expenditures, while there have been decreased expenditures for others. Net savings documented for one-half of the benefit’s first fiscal year are $195,482. Across the balance of the population, the net savings would result in an estimated amount of $448,666 for the entire year in other medical services because of the prosthetic and orthotic benefit.
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING MEDICAL POLICY AND BENEFITS
PROSTHETIC AND ORTHOTIC ADULT BENEFIT

The following status report is submitted in response to Footnote 49, of the Fiscal Year 1999-2000 Long Bill, as indicated immediately below.

"Department of Health Care Policy and Financing, Medical Service Premiums - It is the intent of the General Assembly to track the costs of providing services under Section 26-4-302 (l)(f), C.R.S. Accordingly, the Department is requested to (1) provide an estimate of the costs for FY 1998-99; (2) provide an estimate of the anticipated changes in the second year of implementation; and (3) provide estimates of savings in other Medicaid areas attributable to funding of this program. This report is requested to be submitted to the Joint Budget Committee by December 1, 1999."

PROGRAM HISTORICAL OVERVIEW

Since the inception of the Medicaid Program in 1969, Colorado Revised Statutes have stated that Medicaid provides benefit for prostheses when they are "surgically implanted." Federal OBRA '89 required state Medicaid Programs to provide medically necessary services under the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) whether or not the requested service is a benefit of the Medicaid Program. As a consequence, Colorado and other states began providing prostheses and orthoses to eligible Medicaid clients under the age of 21 years, when determined to be medically necessary. However, because of statutory requirements, adults needing external prostheses and orthoses continued to be ineligible for receipt of such devices.

During the 1997 Legislative session, HB 97-1063, the 1997 Medicaid Omnibus Bill, provided for the addition of a new optional service under Section 26-4-302(1)(f), C.R.S. The authorized service would provide prosthetic devices, including medically necessary augmentative communication devices, to eligible adult Medicaid clients. HB 97-1063 amended the statute to read as follows:

26-4-302. Basic Services for the categorically needy - optional services. (1) The following are services for which federal financial participation is available and which Colorado has selected to provide as optional services under the medical assistance program:

... (f) Prosthetic devices, including medically necessary augmentative communication devices; except that non-surgically implanted prosthetic devices shall be included only after July 1, 1998, and only if the general assembly approves appropriations for these devices as new benefit.

Funding, in the amount of $978, 994, of which $481,469 was General Funds, was appropriated in the Fiscal Year 1998-99 Long Bill to implement the statute effective with the first day of Fiscal Year 1999.

The Medical Services Board passed amended regulations, effective July 1, 1998, and a change to the Colorado Medicaid State Plan was submitted to the Health Care financing Administration on September 30, 1998, effective July 1, 1998. It was approved by HCFA on December 9, 1998.
PROGRAM DESCRIPTION

Prosthetic Devices are defined in Department regulations as "replacement, corrective, or supportive devices prescribed by a doctor of medicine or a doctor of osteopathy to:

1. Artificially replace a missing portion of the body;
2. Prevent or correct physical deformity or malfunction; or
3. Support a weak or deformed portion of the body."

This definition, which is identical to the Federal statutory definition, covers the medically accepted definitions for both prostheses and orthoses. By medical definition, a prosthesis replaces a missing body part, and an orthoses corrects a physical deformity or malfunction, or supports a weak or deformed portion of the body. Prostheses would include artificial limbs and augmentative communication devices. Orthoses would include braces, specially constructed shoes, splints, and medically necessary specialized eating utensils or other medically necessary activities-of-daily living aids.

The Colorado Department of Health Care Policy and Financing Staff Manual Volume 8, in Section 8.593.01 Q, indicates that prosthetic and orthotic devices, including but not limited to the following, are a benefit for clients of all ages:

1. Artificial limbs;
2. Facial prosthetics;
3. Ankle-foot/knee-ankle-foot orthotics;
4. Recumbent ankle positioning splints;
5. Thoracic-lumbar-sacral orthoses (TLSO);
6. Lumbar-sacral orthoses (LSO);
7. Rigid and semi-rigid braces;
8. Therapeutic shoes for diabetics;
9. Orthopedic footwear, including shoes, related modifications, inserts, and heel/sole replacements when a medically necessary and integral part of a leg or ankle brace;
10. Specialized eating utensils and other medically necessary activities of daily living aids; and augmentative communication devices and communication boards.
Determinations of appropriate benefit are being made through the utilization of guidelines and criteria developed by Medicare for use in its prosthetic and orthotic program. The Department determined that utilization of such guidelines was advisable due to the limited amount of experience staff has in dealing with prostheses and orthoses for adults. Medicare guidelines are specific regarding devices which are appropriate and allowable for particular medical and health conditions. For example, using Medicare guidelines, benefit would be allowed for coverage of a lower limb prosthesis when the client:
- Will reach or maintain a defined functional state within a reasonable period of time; and
- Is motivated to ambulate.

A determination of the medical necessity for certain components/additions to the prosthesis is based on the client's functional abilities. Potential functional ability is based on the reasonable expectations of the prosthetist, and ordering physician, considering factors including, but not limited to:
- The client's past history, including prior prosthetic use, if applicable;
- The client's current condition including the status of the residual limb and the nature of other medical problems; and
- The client's desire to ambulate.

Clinical assessments of a client's rehabilitation potential, or his/her functional ability, are used in the determination of medical necessity and the potential for successful use of a prosthesis, are based on the following classification levels:

**Level 0:** Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.

**Level 1:** Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.

**Level 2:** Has the ability or potential for ambulation with the ability to traverse low-level environmental barriers such as curbs, stairs, or uneven surfaces. Typical of the limited community ambulator.

**Level 3:** Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

**Level 4:** Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.
PRIOR AUTHORIZATION PROCESS

Prior authorization is required for all prosthetic and orthotic benefits. The Department has contracted with the Colorado Foundation for Medical Care (CFMC) to provide medically professional review of adult prior authorization requests. Reviewers use the Medicare guidelines in their review process.

In addition to the Medicare guidelines, the Department developed two questionnaires to be submitted with the Request for Prior Authorization. One must be submitted with requests for prostheses or orthoses, and another is requested to be submitted with requests for augmentative communication devices. The questionnaires were developed to assist the reviewers with determining the degree to which each request meets the Medicare criteria. They are also used to provide an estimation of the medical impact, both before and after receipt of the requested device. However, the questionnaires have evolved during the first year of the new benefit, with occasional changes needed as staff developed more experience and understanding of the complexities of the adult program. The current questionnaires requests less information about anticipated fiscal impact than did the original, as reviewers found that neither the physicians nor the providers of the requested services, were able to assign a fiscal value to previous medical services, or to potential future services. Copies of the two questionnaires are attached to this report as "Attachment B" and "Attachment C."

ADVISORY COMMITTEE

The Department has solicited the help of an advisory committee to assist with the implementation of this new adult benefit. The Prosthetic and Orthotic Advisory Committee is comprised of certified prosthetists and orthotists, augmentative communication specialists, CFMC staff, fiscal agent claims processors, and Department staff. It is anticipated that staff from the Department of Human Services, Division of Rehabilitation, will participate in the Advisory Committee in the future.

The Committee began by meeting at approximately two-month intervals. Beginning with the October, 1999 meeting, the Advisory Committee plans to meet at a standing quarterly meeting to allow members to schedule meeting dates, rather than attempting to find a date meeting everyone's needs.

Committee members not employed by the Department or its contractors have provided the Program with information regarding devices, which are unnecessarily high in cost, ineffective, duplicative, etc. Consultation has also been provided regarding the process of amputation and the development of an appropriate prosthesis.

The Department has utilized the Advisory Committee to review limited and selected Requests for Prior Authorization, which are questionable. Such requests (without client or provider identified) have been submitted to three of the providers serving on the Committee. The committee members have provided
recommendations regarding additional information needed and other devices that

**STATE FISCAL YEAR 1998-1999 UTILIZATION AND EXPENDITURES**

The Colorado Medicaid Adult Prosthetic and Orthotic Program has been operational since July 1, 1998. It was slow in its start up phase, while word of the new benefit was circulated among both providers and clients. However, the pace of implementation picked up following both the passage of time and the production of an official Medicaid Bulletin announcing the new benefit.

A review of claims paid for services provided since July 1, 1998, indicates the following claims breakdown. Claims include those paid for dates of service between July 1, 1998, and June 30, 1999; claims submitted between July 1, 1998, and October 30, 1999 (the last date for which a claim for a date of service within fiscal year 1998-1999 could be billed).

**Prostheses**

- Distinct count of clients: 52
- Total Payments: $241,310.63
- Single client high cost: $13,229.59
- Average cost per client: $4,640.59
- Average units per client: 16.85
- Total numbers of prosthetic units: 876
- Number of diagnoses represented: 15

As indicated in the table below, 49.2% of the prosthetic units, and 44.5% of expenditures were utilized by female clients. Males utilized 50.8% of units and 55.5% of expenditures.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number of Prosthetic Units</th>
<th>Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>431</td>
<td>$107,489.67</td>
</tr>
<tr>
<td>Male</td>
<td>445</td>
<td>$133,820.96</td>
</tr>
<tr>
<td>TOTAL</td>
<td>876</td>
<td>$241,310.63</td>
</tr>
</tbody>
</table>

The table below itemizes utilization by aid category. Clients in the Aid to the Needy Disabled (AND) category utilized the majority of services with 71.9% of units and 76.7% of expenditures.

<table>
<thead>
<tr>
<th>Aid Category</th>
<th>Number of Prosthetic Units</th>
<th>Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Old Age Pension - Class A</td>
<td>91</td>
<td>$27,023.82</td>
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<tr>
<td>Old Age Pension - Class B</td>
<td>101</td>
<td>$18,422.14</td>
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<tr>
<td>Aid to Needy Disabled, SSI Medicaid</td>
<td>630</td>
<td>$185,086.85</td>
</tr>
<tr>
<td>Aid to Needy Disabled, State Only</td>
<td>54</td>
<td>$10,777.82</td>
</tr>
<tr>
<td>TOTAL</td>
<td>876</td>
<td>$241,310.63</td>
</tr>
</tbody>
</table>
The most common diagnoses indicating the need for a prosthesis were those relating to traumatic amputation of some limb. Traumatic amputation accounted for 80% of all units utilized, and for 84% of prosthetic expenditures. A complete itemized list of all diagnoses indicated on claims for prosthetic services can be found in Attachment A.

**TOTAL EXPENDITURES FOR NEW ADULT BENEFIT**

<table>
<thead>
<tr>
<th>Distinct count of clients</th>
<th>381</th>
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<tr>
<td>Total Payments</td>
<td>$373,964.50</td>
</tr>
<tr>
<td>Single client high cost</td>
<td>$13,229.59</td>
</tr>
<tr>
<td>Average cost percent</td>
<td>$981.53</td>
</tr>
<tr>
<td>Average units per client</td>
<td>4.06</td>
</tr>
<tr>
<td>Total numbers of units</td>
<td>1545</td>
</tr>
<tr>
<td>Number of diagnoses</td>
<td>195</td>
</tr>
<tr>
<td>Single client low cost</td>
<td>$4.58</td>
</tr>
<tr>
<td>Average cost per unit</td>
<td>$245.34</td>
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</table>

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Number of Units</th>
<th>Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostheses</td>
<td>876</td>
<td>$241,310.63</td>
</tr>
<tr>
<td>Prosthetic eyes</td>
<td>8</td>
<td>$10,540.90</td>
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<tr>
<td>Augmentative Communication</td>
<td>24</td>
<td>$23,658.63</td>
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<tr>
<td>Orthoses</td>
<td>638</td>
<td>$98,454.34</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1,546</strong></td>
<td><strong>$373,964.50</strong></td>
</tr>
</tbody>
</table>

**FISCAL YEAR 1999-2000 ESTIMATED UTILIZATION AND EXPENDITURES**

Although a Medicaid Bulletin was published, announcing the new benefit for adults, the Department continues to receive requests for confirmation that prostheses and orthoses are now considered a regular benefit of the Medicaid program. Both clients and providers do not fully understand that a service not offered for 30 years is now available as a regular benefit. Because of that lack of understanding, and a continuing increase in the number of prior authorization requests for prosthetic and orthotic services, staff of the Department believes that growth in utilization for previously unmet needs will continue into the new fiscal year. Consequently, based upon experience of the prior authorization reviewers and the advisory committee membership, it is estimated that expenditures for Prostheses during state fiscal year 1999-2000 will be approximately $485,669. This amount reflects an estimated utilization growth factor of 30%.

The 30% growth in utilization has been applied evenly across all prosthetic and orthotic services, particularly since it is an estimate. Anticipated utilization therefore appears to be as follows:
<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Units</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostheses</td>
<td>1139</td>
<td>$313,760.00</td>
</tr>
<tr>
<td>Prosthetic Eyes</td>
<td>10</td>
<td>$13,176.00</td>
</tr>
<tr>
<td>Augmentative Communication</td>
<td>31</td>
<td>$30,427.00</td>
</tr>
<tr>
<td>Devices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthoses</td>
<td>829</td>
<td>$127,931.00</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>2,009</strong></td>
<td><strong>$485,294.00</strong></td>
</tr>
</tbody>
</table>

**POTENTIAL SAVINGS**

The provision of prostheses and orthoses to adult Medicaid clients results in a variety of benefits, some of which are fiscal in nature; some of which are more related to quality of life issues, which are less measurable.

It had been the intent of the Department to identify and quantify some of the areas of potential client improvements anticipated or experienced by clients newly able to obtain medically necessary prostheses and orthoses. The information was to be provided by the two questionnaires used as part of the prior authorization process. However, although experience with the questionnaires proved to be useful in determining medical necessity, those portions of the questionnaires which asked physicians to speculate on the physical and/or quality-of-life improvements to be anticipated were often incomplete, and therefore invalid for quantifying such improvements. Physicians, in completing the forms, were unwilling or unable to forecast such anticipated outcomes.

While not able to quantify anticipated physical/quality-of-life changes, it is believed that the long-term effects of newly available prostheses and orthoses will be a reduction in pain, decreased dependence on caretakers, and reduced chance of diabetic-related infection leading to limb amputation. Savings in overall medical costs experienced by clients utilizing the new adult prosthetic and orthotic benefit were identified. Clients were selected who had utilized the new adult benefit, and who had a full six months of potential medical services available to them, and billed, following receipt of their prosthetic or orthotic. Further, clients were selected who had also received medical services during a comparable six-month period in the previous year.

Medical expenses for each of the 166 clients meeting the above criteria were examined for dates of service occurring during the 7th through the 12th month preceding the month in which the client received a prosthetic or orthotic. The costs of medical care received during and in the five months following receipt of the prosthetic or orthotic were also examined and compared to those previous costs. For example, if a client received a prosthetic in October, 1998, the client's medical expenses were examined for the period October, 1997 through March, 1998, and for the period October, 1998 through March, 1999. For the subject group of clients, information...
provided does not include a comparison of medical equipment costs. Expenditures for durable medical equipment increased for the subject study group by virtue of the fact that the cost of the prosthetic or orthotic was included in the costs expended for the month of service, and was not an expenditure for the corresponding period, 12-months earlier.

Changes in the medical expenditures for the study group of 166 clients are indicated below.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Prior Costs</th>
<th>Subsequent Costs</th>
<th>Difference</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO1500 (medical)</td>
<td>$399,598</td>
<td>$417,392</td>
<td>$17,794</td>
<td>+ 4.45%</td>
</tr>
<tr>
<td>Med Equipment (not including Prosth &amp; Ortho)</td>
<td>$85,551</td>
<td>$60,315</td>
<td>($25,236)</td>
<td>-29.50%</td>
</tr>
<tr>
<td>UB-92 (Hosp, Nursing Fac, and Home Health)</td>
<td>$1,353,013</td>
<td>$824,228</td>
<td>($528,785)</td>
<td>-39.08%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$152,564</td>
<td>$169,551</td>
<td>$16,987</td>
<td>+11.13%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,990,726</strong></td>
<td><strong>$1,633,365</strong></td>
<td><strong>($357,361)</strong></td>
<td><strong>-17.95%</strong></td>
</tr>
</tbody>
</table>

It should be noted that the study group of 166 clients had expenditures in the amount of $161,879 not included in the above table. This amount was for the purchase of a prosthetic, orthotic, or augmentative communication device.

Consequently, as indicated by the table, there were gross savings in the amount of $357,361. However, discounting the expenditures for the new adult benefit services, there was a net savings realized of $195,482, or $1,177.60 per client.

If the per client average were to be applied to the 215 prosthetic and orthotic clients not included in the study group, there would be an additional estimated savings for the fiscal year of $253,184. Consequently, the estimated net savings for fiscal year 1998-1999, would be $448,666 ($195,482 + $253,184).
Summary

The Medicaid Prosthetic Program for adults was funded in the amount of $978,994 for Fiscal Year 1998-99. The Joint Budget Committee requested information regarding the anticipated expenditures for the first and second fiscal years.

As part of the implementation of this new benefit, the Department has selected medical criteria for use during reviews of requests for prior authorization. Staff has worked with the provider community to establish an advisory committee to assist with additional protocols for review, in addition to training regarding the complex issue of adult prostheses and orthoses. Questionnaires have been designed and made available to providers to help reviewers conduct a comprehensive review of each request for prior authorization.

Expenditures for the first year have been a total of $373,964.50, with 381 clients being served. It is anticipated for fiscal year 1999-2000, that expenditures will increase approximately 30% for a total of $485,426. The increase is anticipated due to the fact that not all providers and clients seem to be fully aware of the new adult benefit availability, and will therefore be presenting for services during year two, rather than the first year as originally anticipated.

There have been increased expenditures experienced for some types of medical services following provision of a prosthetic to an adult client, and decreased expenditures for others. Net savings documented for one-half of the benefit's first fiscal year are $195,482. Projecting average savings across the balance of the population would result in an estimated net savings of $448,666.

In addition to the estimated savings realized, the Department feels that a valuable service is being offered to Medicaid adult clients, that will provide a more pain free, less dependent life for them.
Utilization by Diagnosis

### Prostheses:

<table>
<thead>
<tr>
<th>Principal Diagnosis</th>
<th>Number of Prosthetic Units</th>
<th>Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant Neoplasm of the Larynx</td>
<td>3</td>
<td>$75.00</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>21</td>
<td>$3,426.97</td>
</tr>
<tr>
<td>Diabetes with peripheral circulatory disorders</td>
<td>17</td>
<td>$0.00</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>3</td>
<td>$135.00</td>
</tr>
<tr>
<td>Peripheral vascular disease, unspecified</td>
<td>18</td>
<td>$2,600.98</td>
</tr>
<tr>
<td>Chronic airway obstruction, not elsewhere classified</td>
<td>1</td>
<td>$26.00</td>
</tr>
<tr>
<td>Impotence of organic origin</td>
<td>1</td>
<td>$335.57</td>
</tr>
<tr>
<td>Other ill-defined and unknown causes of morbidity and mortality</td>
<td>2</td>
<td>$90.00</td>
</tr>
<tr>
<td>Fracture of facial bones, other facial bones, open</td>
<td>1</td>
<td>$2,500</td>
</tr>
<tr>
<td>Traumatic amputation of arm and hand, bilateral, complicated</td>
<td>13</td>
<td>$5,677.35</td>
</tr>
<tr>
<td>Traumatic amputation of foot, bilateral without mention of complication</td>
<td>10</td>
<td>$8,901.18</td>
</tr>
<tr>
<td>Traumatic amputation of leg(s)</td>
<td>54</td>
<td>$8,812.48</td>
</tr>
<tr>
<td>Traumatic amputation of leg(s), unilateral, below knee, without mention of complication</td>
<td>454</td>
<td>$106,640.29</td>
</tr>
<tr>
<td>Traumatic amputation of leg(s), unilateral, at or above knee, without mention of complication</td>
<td>137</td>
<td>$66,074.53</td>
</tr>
<tr>
<td>Traumatic amputation of leg(s), bilateral without mention of complication</td>
<td>34</td>
<td>$6,033.32</td>
</tr>
<tr>
<td>Unknown</td>
<td>107</td>
<td>$29,921.96</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>876</strong></td>
<td><strong>$241,310.63</strong></td>
</tr>
</tbody>
</table>
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ESSENTIAL HEALTH BENEFITS BULLETIN

Purpose

The purpose of this bulletin is to provide information and solicit comments on the regulatory approach that the Department of Health and Human Services (HHS) plans to propose to define essential health benefits (EHB) under section 1302 of the Affordable Care Act. This bulletin begins with an overview of the relevant statutory provisions and other background information, reviews research on health care services covered by employers today, and then describes the approach HHS plans to propose. This bulletin only relates to covered services. Plan cost sharing and the calculation of actuarial value are not addressed in this bulletin. We plan to release guidance on calculating actuarial value and the provision of minimum value by employer-sponsored coverage in the near future. In addition, we plan to issue future guidance on essential health benefit implementation in the Medicaid program.

The intended regulatory approach utilizes a reference plan based on employer-sponsored coverage in the marketplace today, supplemented as necessary to ensure that plans cover each of the 10 statutory categories of EHB. In developing this intended approach, HHS sought to balance comprehensiveness, affordability, and State flexibility and to reflect public input received to date.

Public input is welcome on this intended approach. Please send comments on the bulletin by January 31, 2012 to: EssentialHealthBenefits@cms.hhs.gov.

Defining Essential Health Benefits

A. Introduction and Background

Statutory Provisions

Section 1302(b) of the Affordable Care Act directs the Secretary of Health and Human Services (the Secretary) to define essential health benefits (EHB). Non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent, and Basic Health Programs must cover the EHB beginning in 2014.1 Section 1302(b)(1) provides that EHB include items and services within the following 10 benefit categories: (1) ambulatory patient services, (2) emergency services (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.

1 Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to cover the essential health benefits.
Section 1302(b)(2) of the Affordable Care Act instructs the Secretary that the scope of EHB shall equal the scope of benefits provided under a typical employer plan. In defining EHB, section 1302(b)(4) directs the Secretary to establish an appropriate balance among the benefit categories. Further, under this provision, the Secretary must not make coverage decisions, determine reimbursement rates, or establish incentive programs. Benefits must not be designed in ways that discriminate based on age, disability, or expected length of life, but must consider the health care needs of diverse segments of the population. The Secretary must submit a report to the appropriate committees of Congress along with a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the scope of the EHB is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary.

In addition, section 1311(d)(3) of the Affordable Care Act requires States to defray the cost of any benefits required by State law to be covered by qualified health plans beyond the EHB.

The statute distinguishes between a plan’s covered services and the plan’s cost-sharing features, such as deductibles, copayments, and coinsurance. The cost-sharing features will determine the level of actuarial value of the plan, expressed as a “metal level” as specified in statute: bronze at 60 percent actuarial value, silver at 70 percent actuarial value, gold at 80 percent actuarial value, and platinum at 90 percent actuarial value.2

Public and Other Input

To inform the Department’s understanding of the benefits provided by employer plans, HHS has considered a report on employer plans submitted by the Department of Labor (DOL), recommendations on the process for defining and updating EHB from the Institute of Medicine (IOM), and input from the public and other interested stakeholders during a series of public listening sessions detailed below.

Section 1302(b)(2)(A) requires the Secretary of Labor to inform the determination of EHB with a survey of employer-sponsored plans. On April 15, 2011, the DOL issued its report, in satisfaction of section 1302(b)(2)(A) of the Affordable Care Act, providing results on the scope of benefits offered under employer-sponsored insurance to HHS.3 The DOL survey provided a broad overview of benefits available to employees enrolled in employer sponsored plans. The report drew on data from the 2008 and 2009 National Compensation Survey (which includes large and small employers), as well as DOL’s supplemental review of health plan Summary Plan Documents, and provided information on the extent to which employees have coverage for approximately 25 services within the 10 categories of EHB outlined in the Affordable Care Act (e.g., a certain percentage of plan participants have coverage for a certain benefit).

In order to receive independent guidance, HHS also commissioned the IOM to recommend a process that would help HHS define the benefits that should be included in the EHB and update the benefits to take into account advances in science, gaps in access, etc.

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2 As noted, these will be the subject of forthcoming guidance.

3 Available at http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf
and the effect of any benefit changes on cost. The IOM submitted its consensus recommendations in a report entitled “Essential Health Benefits: Balancing Coverage and Cost” on October 7, 2011. In order to balance the cost and comprehensiveness of EHB, the IOM recommended that EHB reflect plans in the small employer market and that the establishment of an EHB package should be guided by a national premium target. The IOM also recommended the development of a framework for updating EHB that would take into account new evidence about effective interventions and changes in provider and consumer preferences while ensuring that the cost of the revised package of benefits remains within predetermined limits as the benefit standards become more specific. The IOM recommended flexibility across States and suggested that States operating their own Exchanges be allowed to substitute a plan that is actuarially equivalent to the national EHB package. The IOM also recommended continued public input throughout the process.

Following the release of the IOM’s recommendations, HHS held a series of sessions with stakeholders, including consumers, providers, employers, plans, and State representatives, in both Washington, D.C. and around the nation to gather public input. Several key themes emerged. Consumer groups and some provider groups expressed concern at the IOM’s emphasis on cost over the comprehensiveness of benefits. Some consumer groups expressed a belief that small group plans may not represent the typical employer plan envisioned by the statute, while employers and health insurance issuers generally supported the IOM conclusion that EHB should be based on small employer plans. Consumer and provider groups commented that specific benefits should be spelled out by the Secretary, while health insurance issuers and employers commented that they prefer more general guidance, allowing for greater flexibility. Both provider and consumer groups expressed concern about discrimination against individuals with particular conditions. Employers and health insurance issuers stressed concern about resources and urged the Secretary to adopt a more moderate benefit package. Consumers generally favored a uniform benefits package, and many consumers requested that State mandates be included in the benefits package. Some requested a uniform benefit package so that consumer choice of plan could focus on other plan features such as premium, provider network, and quality improvement. Some employer, health insurance issuer, and State representatives focused on the need for flexibility across the country to reflect local preferences and practices. States, health insurance issuers, and employers emphasized the need for timely guidance in preparing for implementation around EHB.

B. Summary of Research on Employer Sponsored Plan Benefits and State Benefit Mandates

While the Affordable Care Act directs the Secretary to define the scope of EHB as being equal to a typical employer plan, the statute does not provide a definition of “typical.” Therefore, HHS gathered benefit information on large employer plans (which account for

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the majority of employer plan enrollees), small employer products (which account for the majority of employer plans), and plans offered to public employees.5

There is not yet a national standard for plan reporting of benefits.6 While the DOL collects information on benefits offered by employer plans, no single data set includes comprehensive data on coverage of each of the 10 statutory essential health benefit categories. Consequently, to supplement information available from the DOL, Mercer,7 and Kaiser Family Foundation/Health Research & Educational Trust (KFF/HRET)8 surveys of employer plans, HHS gathered information on employer plan benefits from the IOM’s survey of three small group issuers and supplemented this information with an internal analysis of publicly available information on State employee plans and Federal employee plans,9 and information on benefits submitted to HealthCare.gov by small group health insurance issuers. To inform our understanding of the category of pediatric oral and vision care, HHS staff also analyzed dental and vision plans in the Federal Employees Dental/Vision Insurance Program (FEDVIP).10 The FEDVIP program is a standalone vision and dental program where eligible Federal enrollees pay the full cost of their coverage.

Similarities and Differences in Benefit Coverage Across Markets

Generally, according to this analysis, products in the small group market, State employee plans, and the Federal Employees Health Benefits Program (FEHBP) Blue Cross Blue Shield (BCBS) Standard Option and Government Employees Health Association (GEHA) plans do not differ significantly in the range of services they cover. They differ mainly in cost-sharing provisions, but cost-sharing is not taken into account in determining EHB. Similarly, these plans and products and the small group issuers surveyed by the IOM appear to generally cover health care services in virtually all of the 10 statutory categories.

For example, across the markets and plans examined, it appears that the following benefits are consistently covered: physician and specialist office visits, inpatient and

5 Nomenclature used in HealthCare.gov describes “products” as the services covered as a package by an issuer, which may have several cost-sharing options and riders as options. A “plan” refers to the specific benefits and cost-sharing provisions available to an enrolled consumer. For example, multiple plans with different cost-sharing structures and rider options may derive from a single product.


8 Available at http://ehbs.kff.org

9 HHS staff analyzed the Federal Employees Health Benefits Program (FEHBP) Blue Cross Blue Shield (BCBS) Standard Option and Government Employees Health Association Benefit plan booklets.

10 Further information is available at https://www.benefeds.com/Portal/jsp/LoginPage.jsp
outpatient surgery, hospitalization, organ transplants, emergency services, maternity care, inpatient and outpatient mental health and substance use disorder services, generic and brand prescription drugs, physical, occupational and speech therapy, durable medical equipment, prosthetics and orthotics, laboratory and imaging services, preventive care and nutritional counseling services for patients with diabetes, and well child and pediatric services such as immunizations. As noted in a previous HHS analysis, variation appears to be much greater for cost-sharing than for covered services.11

While the plans and products in all the markets studied appear to cover a similar general scope of services, there was some variation in coverage of a few specific services among markets and among plans and products within markets, although there is no systematic difference noted in the breadth of services among these markets. For example, the FEHBP BCBS Standard Option plan covers preventive and basic dental care, acupuncture, bariatric surgery, hearing aids, and smoking cessation programs and medications. These benefits are not all consistently covered by small employer health plans. Coverage of these benefits in State employee plans varies between States. However, in some cases, small group products cover some benefits that are not included in the FEHBP plans examined and may not be included in State employee plans, especially in States for which benefits such as in-vitro fertilization or applied behavior analysis (ABA) for children with autism are mandated by State law.12 Finally, there is a subset of benefits including mental health and substance use disorder services, pediatric oral and vision services, and habilitative services – where there is variation in coverage among plans, products, and markets. These service categories are examined in more detail below.

Mental Health and Substance Use Disorder Services

In general, the plans and products studied appear to cover inpatient and outpatient mental health and substance use disorder services; however, coverage in the small group market often has limits. As discussed later in this document, coverage will have to be consistent with the Mental Health Parity and Addiction Equity Act (MHPAEA).13

The extent to which plans and products cover behavioral health treatment, a component of the mental health and substance use disorder EHB category, is unclear. In general, plans do not mention behavioral health treatment as a category of services in summary


12 In addition to mandated benefits, it appears that the small group issuers the IOM surveyed also generally cover residential treatment centers, which the FEHBP BCBS Standard Option plan excludes. However, as this analysis compares three small group issuers to one FEHBP plan, it is unclear if this finding can be generalized to other plans.

plan documents. The exception is behavioral treatment for autism, which small group issuers in the IOM survey indicated is usually covered only when mandated by States.

Pediatric Oral and Vision Care

Coverage of dental and vision care services are provided through a mix of comprehensive health coverage plans and stand-alone coverage separate from the major medical coverage, which may be excepted benefits under PHS Act section 2722.14 The FEDVIP vision plan with the highest enrollment in 2010 covers routine eye examinations with refraction, corrective lenses and contact lenses, and the FEDVIP dental plan covers preventive and basic dental services such as cleanings and fillings, as well as advanced dental services such as root canals, crowns and medically necessary orthodontia. In some cases, dental or vision services may be covered by a medical plan. For example, the FEHBP BCBS Standard Option plan covers basic and preventive dental services.

Habilitative Services

There is no generally accepted definition of habilitative services among health plans, and in general, health insurance plans do not identify habilitative services as a distinct group of services. However, many States, consumer groups, and other organizations have suggested definitions of habilitative services which focus on: learning new skills or functions – as distinguished from rehabilitation which focuses on relearning existing skills or functions, or defining “habilitative services” as the term is used in the Medicaid program.15,16,17 An example of habilitative services is speech therapy for a child who is not talking at the expected age.

Two of the three small group issuers surveyed by the IOM indicated that they do not cover habilitative services. However, data submitted by small group issuers for display on HealthCare.gov indicates that about 70 percent of small group products offer at least limited coverage of habilitative services.18 Physical therapy (PT), occupational therapy (OT), and speech therapy (ST) for habilitative purposes may be covered under the rehabilitation benefit of health insurance plans, which often includes visit limits. All three issuers reporting to the IOM covered PT, OT, and ST, though one issuer did not cover these services for patients with an autism diagnosis. The FEHBP BCBS Standard Option plan also covers PT, OT, and ST. State employee plans examined appear to generally cover PT, OT, and ST.

14 When dental or vision coverage is provided in plan that is separate from or otherwise not an integral part of a major medical plan, that separate coverage is not subject to the insurance market reforms in title XXVII of the PHS Act. See PHS Act §§ 2722(c)(1), 2791(c)(2).
15 For State definitions, see Md. Code Ins. § 15-835(a)(3); D.C. Code § 31-3271(3); 215 Ill. Comp. Stat. 5/356z.14(i).
17 For Medicaid definition, see Social Security Act, § 1915(c)(5)(A).
18 Data submitted in October 2011.
Comparison to Other Employer Plan Surveys

These findings are generally consistent with other surveys of employer sponsored health coverage conducted by DOL, Mercer, and KFF/HRET. The Department of Labor survey found that employees had widespread coverage for medical services such as inpatient hospital services, hospital room and board, emergency room visits, ambulance service, maternity, durable medical equipment, and physical therapy. Similarly, Mercer found employers provided widespread coverage for medical services such as durable medical equipment, outpatient facility charges, and physical, occupational, and speech therapy. The KFF/HRET survey also found widespread coverage of prescription drugs among employees with employer-sponsored coverage.

State Benefit Mandates

State laws regarding required coverage of benefits vary widely in number, scope, and topic, so that generalizing about mandates and their impact on typical employer plans is difficult. All States have adopted at least one health insurance mandate, and there are more than 1,600 specific service and provider coverage requirements across the 50 States and the District of Columbia.19

Almost all State mandated services are typically included in benefit packages in States without the mandate – such as immunizations and emergency services. In order to better understand the variation in State mandates, their impact on the benefits covered by plans, and their cost, HHS analyzed 150 categories of benefit and provider mandates across all 50 States and the District of Columbia. The FEHBP BCBS Standard and Basic Options are not subject to any State mandates, but our analysis indicates that they cover nearly all of the benefit and provider mandate categories required under State mandates. The FEHBP BCBS Standard Option is not subject to any State mandates, but our analysis indicates that it covers about 95 percent of the benefit and provider mandate categories required under State mandates. The primary exceptions are mandates requiring coverage of in-vitro fertilization and ABA therapy for autism, which are not covered by the FEHBP BCBS Standard Option plan but are required in 8 and 29 States, respectively.

These two mandates commonly permit annual dollar limits, annual lifetime or frequency limits, and/or age limits. Research by States with these two mandates indicates that the cost of covering in-vitro fertilization benefits raises average premiums by about one percent20,21 and the cost of covering ABA therapy for autism raises average premiums by approximately 0.3 percent.22 Approximately 10 percent of people covered by small

19 Of these 1,600 mandates, about 1,150 are benefit mandates and 450 are provider mandates.


group policies live in a State requiring coverage of in-vitro fertilization, and approximately 50 percent live in a State requiring coverage of ABA.

The small group issuers surveyed by the IOM indicated they cover ABA only when required by State benefit mandates. The FEHBP BCBS Standard Option does not cover ABA. The extent to which these services are covered by State employee plans is unclear, as there is variation between States in whether benefit mandates apply (either by statute or voluntarily) to State employee plans.

C. Intended Regulatory Approach

As noted in the introduction, the Affordable Care Act authorizes the Secretary to define EHB. In response to the research and recommendations described above, as a general matter, our goal is to pursue an approach that will:

- Encompass the 10 categories of services identified in the statute;
- Reflect typical employer health benefit plans;
- Reflect balance among the categories;
- Account for diverse health needs across many populations;
- Ensure there are no incentives for coverage decisions, cost sharing or reimbursement rates to discriminate impermissibly against individuals because of their age, disability, or expected length of life;
- Ensure compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);
- Provide States a role in defining EHB; and
- Balance comprehensiveness and affordability for those purchasing coverage.

As recommended by the IOM, HHS aims to balance comprehensiveness, affordability, and State flexibility while taking into account public input throughout the process of establishing and implementing EHB. Our intended approach to EHB incorporates plans typically offered by small employers and benefits that are covered across the current employer marketplace.

We intend to propose that EHB be defined by a benchmark plan selected by each State. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a “typical employer plan” in that State as required by section 1302(b)(2)(A) of the Affordable Care Act. This approach is based on the approach established by Congress for the Children’s Health Insurance Program (CHIP), created in 1997, and for certain Medicaid populations. A major advantage of the benchmark approach is that it recognizes that issuers make a holistic decision in constructing a package of benefits and adopt packages they believe balance consumers’ needs for comprehensiveness and affordability. As described below, health insurance


24 Balanced Budget Act of 1997; Public Law 105-33

25 Section 42 CFR 457.410 and 457.420
issuers could adopt the scope of services and limits of the State benchmark, or vary it within the parameters described below.

Four Benchmark Plan Types

Our analysis of offerings that exist today suggests that the following four benchmark plan types for 2014 and 2015 best reflect the statutory standards for EHB in the Affordable Care Act:

1. the largest plan by enrollment in any of the three largest small group insurance products in the State’s small group market;26
2. any of the largest three State employee health benefit plans by enrollment;
3. any of the largest three national FEHBP plan options by enrollment; or
4. the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

HHS intends to assess the benchmark process for the year 2016 and beyond based on evaluation and feedback.

To reflect the State flexibility recommended by the IOM, under our intended approach, States are permitted to select a single benchmark to serve as the standard for qualified health plans inside the Exchange operating in their State and plans offered in the individual and small group markets in their State. To determine enrollment in plans for specifying the benchmark options, we intend to propose to use enrollment data from the first quarter two years prior to the coverage year and that States select a benchmark in the third quarter two years prior to the coverage year. For example, enrollment data from HealthCare.gov for the first quarter of calendar year 2012 could be used to determine which plans would be potential benchmarks for State selection and the benchmark plan specified during the third quarter of 2012 for coverage year 2014. If a State does not exercise the option to select a benchmark health plan, we intend to propose that the default benchmark plan for that State would be the largest plan by enrollment in the largest product in the State’s small group market.

Defraying the Cost of Additional Benefits

Section 1311(d)(3)(B) of the Affordable Care Act requires States to defray the costs of State-mandated benefits in excess of EHB for individuals enrolled in any qualified health plan either in the individual market or in the small group market. Similar to other Exchange decisions, the State may select the benchmark plan. The approach for 2014 and 2015 would provide a transition period for States to coordinate their benefit mandates while minimizing the likelihood the State would be required to defray the costs of these mandates in excess of EHB. In the transitional years of 2014 and 2015, if a State chooses a benchmark subject to State mandates – such as a small group market plan – that benchmark would include those mandates in the State EHB package. Alternatively,

26 Nomenclature used in HealthCare.gov describes “products” as the services covered as a package by an issuer, which may have several cost-sharing options and riders as options. A “plan” refers to the specific benefits and cost-sharing provisions available to an enrolled consumer. For example, multiple plans with different cost-sharing structures and rider options may derive from a single product.
under our intended approach a State could also select a benchmark such as an FEHBP plan that may not include some or all of the State’s benefit mandates, and therefore under Section 1311(d)(3)(B), the State would be required to cover the cost of those mandates outside the State EHB package. HHS intends to evaluate the benchmark approach for the calendar year 2016 and will develop an approach that may exclude some State benefit mandates from inclusion in the State EHB package.

**Benchmark Plan Approach and the 10 Benefit Categories**

One of the challenges with the described benchmark plan approach to defining EHB is meeting both the test of a “typical employer plan” and ensuring coverage of all 10 categories of services set forth in section 1302(b)(1) of the Affordable Care Act. Not every benchmark plan includes coverage of all 10 categories of benefits identified in the Affordable Care Act (e.g., some of the benchmark plans do not routinely cover habilitative services or pediatric oral or vision services). The Affordable Care Act requires all issuers subject to the EHB standard in section 1302(a) to cover each of the 10 benefit categories.\(^27\) If a category is missing in the benchmark plan, it must nevertheless be covered by health plans required to offer EHB. In selecting a benchmark plan, a State may need to supplement the benchmark plan to cover each of the 10 categories. We are considering policy options for how a State supplements its benchmark benefits if the selected benchmark is missing a category of benefits. The most commonly non-covered categories of benefits among typical employer plans are habilitative services, pediatric oral services, and pediatric vision services.

Below, we discuss several specific options for habilitative services, pediatric oral care and pediatric vision care. Generally, we intend to propose that if a benchmark is missing other categories of benefits, the State must supplement the missing categories using the benefits from any other benchmark option. In a State with a default benchmark with missing categories, the benchmark plan would be supplemented using the largest plan in the benchmark type (e.g. small group plans or State employee plans or FEHBP) by enrollment offering the benefit. If none of the benchmark options in that benchmark type offer the benefit, the benefit will be supplemented using the FEHBP plan with the largest enrollment. For example, in a State where the default benchmark is in place but that default plan did not offer prescription drug benefits, the benchmark would be supplemented using the prescription drug benefits offered in the largest small group benchmark plan option with coverage for prescription drugs. If none of the three small group market benchmark options offer prescription drug benefits, that category would be based on the largest plan offering prescription drug benefits in FEHBP. We are continuing to consider options for supplementing missing categories such as habilitative care, pediatric oral care and pediatric vision care if States do not select one of the options discussed below.

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\(^{27}\) A qualified health plan may choose to not offer coverage for pediatric oral services provided that a standalone dental benefit plan which covers pediatric oral services as defined by EHB is offered through the same Exchange.
Habilitation

Because habilitative services are a less well defined area of care, there is uncertainty on what is included in it. The NAIC has proposed a definition of habilitation in materials transmitted to the Department as required under Section 2715 of the PHSA, and Medicaid has also adopted a definition of habilitative services. These definitions include the concept of “keeping” or “maintaining” function, but this concept is virtually unknown in commercial insurance, which focuses on creating skills and functions (in habilitation) or restoring skills and function (for rehabilitation). Private insurance and Medicare may use different definitions when relating to coverage of these services. We seek comment on the advantages and disadvantages of including maintenance of function as part of the definition of habilitative services. We are considering two options if a benchmark plan does not include coverage for habilitative services:

1) Habilitative services would be offered at parity with rehabilitative services -- a plan covering services such as PT, OT, and ST for rehabilitation must also cover those services in similar scope, amount, and duration for habilitation; or
2) As a transitional approach, plans would decide which habilitative services to cover, and would report on that coverage to HHS. HHS would evaluate those decisions, and further define habilitative services in the future.

Pediatric Oral and Vision

For pediatric oral services, we are considering two options for supplementing benchmarks that do not include these categories. The State may select supplemental benefits from either:

1) The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment; or
2) The State’s separate CHIP program.

We intend to propose the EHB definition would not include non-medically necessary orthodontic benefits.

For pediatric vision services we intend to propose the plan must supplement with the benefits covered by the FEDVIP vision plan with the largest enrollment. The rationale for a different treatment of this category is that CHIP does not require vision services. As with habilitative services, we also seek comment on an approach that lets plans define the pediatric oral and vision services with required reporting as a transition policy.

29 For Medicaid definition, see Social Security Act, Section 1915(c)(5)(A).
30 See section 220.2(c) and (d) in the Medicare Benefits Policy Manual available here: http://www.cms.gov/manuals/Downloads/bp102c15.pdf
31 If a State does not have a separate CHIP program, it may establish a benchmark that is consistent with the applicable CHIP standards. http://www.cms.gov/SMDL/downloads/CHIPRA%20Dental%20SHO%20Final%20100709revised.pdf
Mental Health and Substance Use Disorder Services and Parity

The MHPAEA expanded on previous Federal parity legislation addressing the potential for discrimination in mental health and substance use disorder benefits to occur by generally requiring that the financial requirements or treatment limitations for mental health and substance use disorder benefits be no more restrictive than those for medical and surgical benefits. However, although parity was applied for covered mental health and substance use disorder benefits, there was no requirement to offer such a benefit in the first instance. Also, prior to the Affordable Care Act, MHPAEA parity requirements did not apply to the individual market or group health coverage sponsored by employers with 50 or fewer employees.

The Affordable Care Act identifies coverage of mental health and substance use disorder benefits as one of the 10 categories and therefore as an EHB in both the individual and small group markets. The Affordable Care Act also specifically extends MHPAEA to the individual market. Because the Affordable Care Act requires any issuer that must meet the coverage standard set in section 1302(a) to cover each of the 10 categories, all such plans must include coverage for mental health and substance use disorder services, including behavioral health treatment. Consistent with Congressional intent, we intend to propose that parity applies in the context of EHB.

Benefit Design Flexibility

To meet the EHB coverage standard, HHS intends to require that a health plan offer benefits that are “substantially equal” to the benefits of the benchmark plan selected by the State and modified as necessary to reflect the 10 coverage categories. This is the same equivalency standard that applies to plans under CHIP.32 Similar to CHIP, we intend to propose that a health insurance issuer have some flexibility to adjust benefits, including both the specific services covered and any quantitative limits provided they continue to offer coverage for all 10 statutory EHB categories. Any flexibility provided would be subject to a baseline set of relevant benefits, reflected in the benchmark plan as modified. Permitting flexibility would provide greater choice to consumers, promoting plan innovation through coverage and design options, while ensuring that plans providing EHB offer a certain level of benefits. We are considering permitting substitutions that may occur only within each of the 10 categories specified by the Affordable Care Act. However, we are also considering whether to allow substitution across the benefit categories. If such flexibility is permitted, we seek input on whether substitution across categories should be subject to a higher level of scrutiny in order to mitigate the potential for eliminating important services or benefits in particular categories. In addition, we intend to require that the substitution be actuarially equivalent, using the same measures defined in CHIP.33

To ensure competition within pharmacy benefits, we intend to propose a standard that reflects the flexibility permitted in Medicare Part D in which plans must cover the

32 42 CFR 457.420.
33 42 CFR 457.431
categories and classes set forth in the benchmark, but may choose the specific drugs that
are covered within categories and classes.\textsuperscript{34} If a benchmark plan offers a drug in a certain
category or class, all plans must offer at least one drug in that same category or class,
even though the specific drugs on the formulary may vary.

The Affordable Care Act also directs the Secretary to consider balance in defining
benefits and to ensure that health insurance issuers do not discriminate against enrollees
or applicants with health conditions. Providing guidelines for substitution will ensure
that health insurance issuers meet these standards.

\textit{Updating Essential Health Benefits}

Section 1302(b)(4)(G) and (H) direct the Secretary to periodically review and update
EHB. As required by the Affordable Care Act, we will assess whether enrollees have
difficulties with access for reasons of coverage or cost, changes in medical evidence or
scientific advancement, market changes not reflected in the benchmarks and the
affordability of coverage as it relates to EHB. We invite comment on approaches to
gathering information and making this assessment. Under the benchmark framework, we
note that the provision of a “substantially equal” standard would allow health insurance
issuers to update their benefits on an annual basis and they would be expected on an
ongoing basis to reflect improvements in the quality and practice of medicine. We also
intend to propose a process to evaluate the benchmark approach.

\textsuperscript{34} Drug category and class lists would be provided by the U.S. Pharmacopoeia, AHMS, or through a similar
standard. Note: we do not intend to adopt the protected class of drug policy in Part D.
Orthotics and Prosthetics Must Be Included in the Essential Health Benefits Package

**Background**

The legislative process used to enact the PPACA was not ideal, and so has left important ambiguities. Most notable among these in the O&P field is whether these services to help restore mobility for patients with limb loss or chronic limb impairment will be included when HHS issues regulations defining the essential health benefits. The House bill was very clear, enumerating eleven benefits categories, including orthotics and prosthetics by name. The Senate bill, which is the one which survived, largely for reasons of political realities, was less clear, referencing rehabilitative and habilitative services and devices, without specifically reciting the terms orthotics and prosthetics.

The criteria for inclusion in the essential health benefits references two criteria: (1) is the benefit prevalent in private employer health plans; and (2) are costs of the benefit reasonable. It seems pretty clear that a very significant majority of major employer health insurance plans do currently provide coverage for orthotic and prosthetic (O&P) services needed by the plan’s beneficiaries. And a slightly smaller, but still significant majority of smaller, individual health insurance plans also provide some type of coverage for O&P services. Bottom line answer, on the threshold question is that most health plans (both major employer and smaller/individual plans) do provide some coverage for orthotics and prosthetics, even if the precise components of some of those plans could certainly be improved.

Three separate studies have concluded that O&P services are indeed prevalent in private employer health plans. In September, 2010 AOPA looked to two sources for data to try to substantiate this prevailing disposition in the field. We took a modest sample from O&P patient care providers in different portions of the country, asking them based on plans they encountered in their daily practices to estimate the percentage of (i) major employer health plans, and (ii) small, individual coverage health plans in your area include SOME benefit for orthotics and prosthetics. Two-thirds of respondents said that major employer health insurance plans cover O&P services over 80% of the time, with the composite national average being at least 75% for these employer plans. The corresponding composite number as to smaller employer health plans works out that between 67-70% of smaller/individual health insurance plans across the country offer and O&P benefit.

By far, the most robust and compelling data on this topic comes from a second source independent of the O&P field. The Society of Human Resource Management (SHRM),
the world’s largest HR organization with over 250,000 members conducted a survey relating to employer plan availability of O&P services, securing responses from a subset of its membership falling into two categories: (a) large employers with 5,000 or more employees, and (b) smaller organizations with between 100 and 499 employees. Based on 1116 responses they received, at least 75% of large private employer plans, and 70% of the smaller private employer plans offer coverage for artificial limbs and customized bracing, i.e., prosthetic and orthotics, with a margin of error for this sample of +/- 3%.

Finally, a survey of O&P facilities in major metropolitan areas where the presence of corporate headquarters assured a major concentration of employees from specific major employers revealed that two-thirds of respondents of large employers surveyed in seven large cities said that major employer health insurance plans cover O&P services over 80% of the time, with the composite national average being at least 75% for these employer plans.

What is the Magnitude of Cost of this Coverage?

On this issue, we have some very solid, independent data. Approximately 20 states have now enacted state-level orthotic and prosthetic parity laws. Most of these laws state that if an insurer offers O&P coverage, that it must be on the same terms as the policy’s general medical and surgical coverage (N.B.: these bills typically are not mandates of coverage, but rather set a minimum standard of what must be offered if the insurer is to present its plan as including O&P benefits). Obviously, one of the first questions that arises at a state legislature when such a parity bill is introduced is—how much would it cost insurers (and thereby, in beneficiary premiums) if we enact this bill? A significant number of legislatures commissioned studies, some by government personnel, and others by outside entities hired and managed by government, to render this information.

One of these independent state-commissioned studies, in Colorado State study, concluded that when O&P coverage is provided, savings are actually generated to the state, with these savings actually exceeding the costs of providing the O&P coverage, because several co-morbid conditions among patients who suffer serious mobility loss or impairment are eliminated. In other words, this Colorado study says the insurers (and the state in terms of its own Medicaid plan) will actually save money if O&P coverage is as widely available as possible. When about a dozen of these independent, state commissioned analyses on the costs of O&P coverage are compiled in aggregate terms these several states reflect a composite viewpoint that O&P coverage would add about 5 cents per beneficiary per month, i.e. no more than 60 cents per beneficiary/per year—a very nominal cost. The results from Colorado and the results from these other states are comparable and consistent when you recognize that several of the state studies recognize that there are certain savings related to reduced diabetes, obesity, depression and other conditions which often accompany a person who has lost most if not all mobility.

All of this data confirms in numeric terms what already appears to have face validity from the intuitive responses of average citizens. Most are certain that their health insurance plan would definitely cover artificial limb(s) if someone in their family had an amputation and that this same insurance plan would cover customized bracing if, for instance, a
family member was born with spina bifida, and developed cerebral palsy or multiple sclerosis.

Finally, the legislative history supports the interpretation that Congress indeed did intend to assure that these needed orthotics and prosthetics would be provided in the essential health benefits package. Here is what Rep. George Miller (D-CA) said:

“I am pleased that the essential benefits in the Patient Protection and Affordable Care Act include rehabilitative and habilitative services and devices, as these benefits are of particular importance to people with disabilities and chronic conditions...The term “rehabilitative and habilitative devices” includes durable medical equipment, prosthetics, orthotics, and related supplies. It is my understanding that the Patient Protection and Affordable Care Act requires the Secretary of Health and Human Services to develop, through regulation, standard definitions of many terms for purposes of comparing benefit categories from one private health plan to another. It is my expectation “prosthetics, orthotics and related supplies” will be defined separately from “durable medical equipment.”

Toward this same end, here is an excerpt from Rep. Rob Andrews letter to Secretary Sebelius on this topic:

“I am writing to urge that in developing regulations and implementing provisions of the Patient Protection and Affordable Care Act (PPACA) that you ensure protections for those who need prosthetics and custom orthotics and related services. This would include making clear that the term “rehabilitative and habilitative services and devices” in Section 1302 of the new law includes coverage of orthotics and prosthetics in the essential benefit package and that insurance policies can no longer impose arbitrary limits on coverage. These services and devices are critical for those who have lost a limb or have sustained significant limb impairment and need orthotics to assist in mobility.”

**Recommendation**

Patients with limb loss or limb impairment, as well as those of us who have the privileged calling of providing services to these patients, would welcome and appreciate any efforts which you can expend to assure that, in the end, O&P is indeed included in the essential health benefits package.

For more information contact the American Orthotic & Prosthetic Association (AOPA) at (571) 431-0876 or www.AOPAnet.org.
Essential Health Benefits

I would like Minnesota state law to require of insurance companies (regardless of whether the Federal ACA stands or not) the following:

Coverage of preventive care in all policies  
No lifetime coverage caps  
Coverage even for those with pre-existing conditions  
Coverage of children until age 26

An insurance marketplace to make shopping for health insurance easy and affordable.

My husband and I have been self employed since 1993 and have been purchasing high deductible health plans with an attached HSA since that time. The reason for purchasing the high deductible plan is that is the only plan we can afford, being on the individual market and not part of a group to lower our risk. We have noticed the high deductible has forced us to become more careful health care consumes and we routinely compare costs before deciding on when and where to get health care.

If insurance were not tied to employment and everyone had to purchase insurance individually it would level the playing field tremendously in my opinion. Other benefits would include employees having their choice of insurance plans plus not have to worry about a drop in coverage if they changed jobs. And the employer would benefit by not having to pay health insurance premiums, which would not only enable them to pay their workers more in straight wages, but lessen their paperwork burden.

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