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TO THE HOUSE COMMITTEES ON HEALTH AND
CONSUMER PROTECTION & COMMERCE

TWENTY-SEVENTH LEGISLATURE
Regular Session of 2014

Monday, April 14, 2014
8:30 a.m.

WRITTEN TESTIMONY ONLY

TESTIMONY ON SENATE CONCURRENT RESOLUTION NO. 35, S.D. 1 – REQUESTING THE AUDITOR TO ASSESS THE SOCIAL AND FINANCIAL EFFECTS OF REQUIRING HEALTH INSURERS TO PROVIDE INFERTILITY PROCEDURE COVERAGE.

TO THE HONORABLE DELLA AU BELATTI AND ANGUS L.K. McKELVEY, CHAIRS, AND MEMBERS OF THE COMMITTEES:

My name is Gordon Ito, State Insurance Commissioner, testifying on behalf of the Department of Commerce and Consumer Affairs ("Department"). The Department takes no position on this resolution, and submits the following comments.

The purpose of this resolution is to request that the Auditor conduct an impact assessment report of mandating infertility procedure coverage for all individual and group accident and health or sickness insurance policies that provide pregnancy-related benefits.

Senate Bill No. 2909, S.D.1, mandates a benefit of three in vitro fertilization cycles or a live birth for all outpatient expenses arising from in vitro fertilization procedures performed on the insured or insured's dependent for all individual and group accident and health or sickness insurance policies that provide pregnancy-related benefits. Existing law provides for a one-time benefit.

We thank the Committee for the opportunity to present testimony on this matter.

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Government Relations

Testimony of
John Kirimitsu
Legal and Government Relations Consultant

Before:
House Committee on Health
The Honorable Della Au Bellati, Chair
The Honorable Dee Morikawa, Vice Chair
and
House Committee on Ways and Means
The Honorable Angus L.K. McKelvey, Chair
The Honorable Derek S.K. Kawakami, Vice Chair

April 14, 2014
8:30 am
Conference Room 229

SCR 35, SD1 REQUESTING THE AUDITOR TO ASSESS THE SOCIAL AND FINANCIAL EFFECTS OF REQUIRING HEALTH INSURERS TO PROVIDE INFERTILITY PROCEDURE COVERAGE.

Chairs, Vice-Chairs, and committee members; thank you for this opportunity to provide testimony on this resolution requesting a study by the legislative auditor of mandating health insurance coverage for expanded infertility procedures.

Kaiser Permanente Hawaii supports this resolution.

We support asking the legislative auditor to study the social and financial impacts of this proposed expansion of in vitro fertilization benefits. We offer for your consideration a few additional clauses that may make the auditor's study more useful.

BE IT FURTHER RESOLVED that the Auditor is requested to include in the impact assessment report a survey of other states in the U.S. which have implemented a mandate for expanded infertility in vitro fertilization procedures to examine what the social and financial impact has been in these states; and

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BE IT FURTHER RESOLVED that the Auditor is requested to research if any expansion of infertility in vitro fertilization procedures constitutes benefits that are in excess of the essential health benefits, thus requiring the state to defray such costs; and

BE IT FURTHER RESOLVED that the Auditor is requested to research what is being used as the standard medical definition of "reproductive age" that is best suited for in vitro fertilization procedures, and examine the success rates for the different age groups to determine coverage benefit limitations for this covered benefit. This research should examine whether different standards of infertility treatments are applied to different age groups in need of infertility treatments; and

BE IT FURTHER RESOLVED that the Auditor is requested to examine current medically necessary standards of care used to determine what types of infertility treatment options are available, at a more cost effective savings than in vitro fertilization, which may be best suited for individuals in need of infertility procedures. An examination of the existing technology in in infertility procedures and possible future technology should be examined.

We think this information is important to know when discussing the expansion of infertility services and benefits and whether the state is required to pay for these benefits, if deemed to be in excess of the essential health benefits.

Thank you for your consideration.

TO: COMMITTEE ON HEALTH
The Honorable Della Au Belatti, Chair
The Honorable Dee Morikawa, Vice Chair

COMMITTEE ON CONSUMER PROTECTION & COMMERCE
The Honorable Angus L.K. McKelvey, Chair
The Honorable Derek S.K. Kawakami, Vice Chair

SUBJECT: **SCR 35 SD1 – REQUESTING THE AUDITOR TO ASSESS THE SOCIAL AND FINANCIAL EFFECTS OF REQUIRING HEALTH INSURERS TO PROVIDE INFERTILITY PROCEDURE COVERAGE.**

Hearing: Monday, April 14, 2014
Time: 8:30 a.m.
Place: Conference Room 229

FROM: Na`unanikinau Kamali`i

This testimony in my personal capacity is in **strong support of SCR 35, SD1, with amendments**. SB 2909 SD 1 and SCR 35 SD1 are about the responsibility of the legislature to bring non-compliant laws into compliance and exercising its authority to do so. Health Plans that continue to use non-compliant state laws to justify its unlawful continuation of discriminatory practices is unjust. The audit will assist the legislature in determining what is myth and what is fact and what amounts to unjust enrichment for the health plans. Health Plans have financially benefitted from and perpetuated an IVF coverage law that wrongfully created two classes of members in women and thus discriminated, victimized and demeaned women who were diagnosed with infertility by denying the IVF coverage benefit to women were not married. This practice continues even though it is strictly prohibited under the ACA.

The audit will assist in settling the cost issues to fix a law that has not been in compliance with federal and state laws and must address compliance and discriminatory provisions. The last tactic by health plans is to wrongfully assert that bringing the law in compliance will result in a cost shifted to the state, which health plans say must pay to right the wrong even though for years health plans have benefited greatly financially unjustly from the discriminatory provisions. Clearly, it is health plans that must pay for the discriminatory practices.

This Audit request is a review of the first instance where a discriminatory law is being amended to bring a mandated benefit in compliance under the provisions of the Affordable Care Act. Changes in State mandates to bring them in compliance and remove discriminatory provisions are not an "expansion" or "added essential health benefit" even though such changes may cost more for health plans to cover all women in a non-discriminatory way and are required under prohibition sections of

the ACA. (See 45 CFR §156.125 Prohibition on discrimination and 45 CFR §156.200 (e) *Non-discrimination.* A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, **age, sex**, gender identity or sexual orientation.)

Marital status has no rational relation to the treatment of a medical diagnosis and condition of infertility. The current IVF coverage law wrongfully creates two "classes" of premium paying members and is discriminatory on its face under ERISA, ADA, and ACA. Health plans deliberately upheld discriminatory provisions which called for a member to be married and use her husband`s sperm, reaping a prohibited premium savings from the practice. In application, employed health plan members who are single, divorced, widowed, partnered or otherwise "not married" women pay premiums just like married members diagnosed with infertility yet, ARE NOT eligible for the IVF coverage. The Hawaii legislature has not provided any rational basis for the "marital status" requirement, which rests squarely on moral grounds. In previous testimony, HMSA conceded that the marital status requirement needed to be changed. Kaiser called for an Audit, but sought more questions to be answered by the auditor which changes were part of the recommended changes by the CPN Committee.

The CPN Committee in its report stated the following: *"Your Committee notes that the addition of a new mandated health insurance benefit under Hawaii law may trigger Section 1311(d)(3) of the federal Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), which requires states to defray the additional cost of any benefits in excess of the essential health benefits of the state's qualified health plan."* The 27-year-old IVF benefit Coverage law is currently not in compliance and necessary changes are not an "addition" but rather corrective action to "goes beyond" the existing EHB, which is allowed, and the State does not defray the cost.

Further, Section 1311(d)(3) of the ACA addresses Essential Health Benefits defined in 1302 (b)(1), which as later codified federal regulations on included State Mandates under the allowed Essential Health Benefit Benchmark plan which covers at least the each of the 10 categories. Each state has different HHS approved essential health benefit benchmark plans reflecting these mandates and Hawaii`s approved mandates includes the IVF coverage law. Thus, the Hawaii IVF coverage law is part of the Essential Health Benefit benchmark plan and not "new" or an "additional" benefit that the state must pay for. If that were the case, the state would be paying for it right now, as this all went into effect on January 1. 2014. Final regulations regarding Essential Health Benefits are posted on the CMS website.

Recommended changes to SCR 35 SD1 (added underlined; deleted stricken; notes are commentary)

These are recommended changes to additional requests to the Auditor for inclusion in an impact assessment report beyond what is required by statute:

(2) Whether an expansion of infertility in vitro fertilization procedures to bring it in compliance with the discriminatory and "life time" benefit prohibitions under the Affordable Care Act would constitute benefits that are in excess of the essential health benefits benchmark plan ~~required~~ which includes state mandates approved for health insurance coverage under the federal Patient Protection and Affordable Care Act of 2010, thus requiring the State to defray such costs;

(3) Any other impacts or requirements of the federal Patient Protection and Affordable Care Act of 2010 if a mandate for expanded infertility in vitro fertilization procedures is enacted in Hawaii to address discriminatory , life time benefit , or any other provisions to otherwise bring it incompliance with all federal and state laws;

~~(4) Research on what is being used as the standard medical definition of "reproductive age" that is best suited for in vitro fertilization procedures and the success rates for different age groups to determine coverage benefit limitations for this covered benefit, including whether different standards of infertility treatments are applied to different age groups in need of infertility treatment;~~ *(Note: Age discrimination is prohibited under 45 CFR §156.125 Prohibition on discrimination and 45 CFR §156.200 (e) Non-discrimination. A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability,* ***age, sex,*** *gender identity or sexual orientation.)*

~~(5) An examination of current medically necessary standards of care used to determine what types of infertility treatment options are available at a more cost effective savings than in vitro fertilization, which may be best suited for individuals in need of infertility procedures;~~ *(Note: medical necessity determinations are preempted by federal statue and regulations and also fall within the doctor patient privilege wherein the patients physician and patient and the medical director exchange confidential HIPAA protected information concerning the medical diagnosis, which could include multiple diagnosis contributing to infertility and cannot legislated to establish standards but rather determined on a case by case basis)*

The Audit is long overdue as it relates to the financial impact based on the law and not based on the health plan's bottom line. Any changes to the mandated benefits will be opposed by health plans, even if the change is to bring the IVF benefit coverage law into compliance and end discriminatory practices**. Health plan testimony received thus far as it relates to the IVF coverage legislation has been in support of an audit.** I urge the legislature to pass SCR 35 SD1 and garner the facts it needs to address and bring into compliance the IVF coverage law.

Comments on underlying bills introduced – SB 2909 as amended

Although SCR 35 SD1 does not address substantive changes to the current law, it is required if such changes were made and the legislature still has the power and authority to do so. The underlying bills SB 2909 and its companion HB 2355, as amended, were introduced which addressed the substantive changes to the IVF

coverage laws were held in Ways and Means in the Senate and Finance on the House side. Testimony submitted in **strong support** of both measures recommended amendments: striking "lifetime" in the measure wherever mentioned and ensuring that it passes this session with an effective date of July 1, 2014 to address immediate compliance and discriminatory concerns. The attachments to testimony provided background, which may be informative to this audit.

Both bills SB2909 and HB2355, as amended, provide in vitro fertilization coverage equality for women who are diagnosed with infertility by requiring non-discriminatory coverage and ensuring quality of care in the diagnosis and treatment of infertility. For over 27 years the in vitro fertilization law in Hawaii provided coverage within a discriminatory framework, which must be corrected by the legislature. In vitro fertilization coverage is an Essential Health Benefit (EHB) , which was included in Hawaii`s essential health benefit plan and accepted by Health and Human Services and as of **January 1, 2014** strict federal prohibitions apply to EHB. Foremost, diagnosis and treatment of infertility disease should be brought in alignment with the national standards of the Center for Disease Control and as an EHB in compliance with ERISA, the American Disabilities Act and the Affordable Care Act. (see attached guidelines and Hawaii State mandates approved by HHS)

Summary of changes proffered in underlying bills SB2909 and SB2355:

The measures:

1. Find that infertility is a disease of the reproductive system that impairs and substantially limits an individual's major life activity of reproduction and recognizes infertility as a disability.
2. Require a diagnosis of infertility before treatment.
3. Propose IVF coverage as a "life time" benefit as opposed to a "one time" only benefits, however, the ACA prohibits such lifetime limits with respect to essential health benefits after January 1, 2014 and either old or proposed language must be stricken.
4. Focus on the success of having a child by providing cost effective measurable limitations of three in vitro fertilization cycles or a live birth (see Illinois
5. IVF law).
6. Mandate in vitro fertilization coverage equality for all women diagnosed with a medical condition of infertility by removing discriminatory language based on marital status. EHB may not contain discriminatory provisions.
7. Require a reasonable history of infertility based on national medical standard (ASRM) instead of an arbitrary five-year history.
8. Is consistent with Center for Disease Control national standards of infertility diagnosis categories.
9. Require coverage for other applicable treatments for infertility, unless the individual's physician determines that those treatments are likely to be unsuccessful.

10. Provide the American Society of Reproductive Medicine definition of "infertility".

Expanded Comments expressed in SB2909 and HB2355:

1. A diagnosis of infertility is a disability under the American Disability Act. Courts have held that women suffering from a diagnosis of infertility meet the definition of "disability" set forth in 42 U. S. C. § 12102(2)(A): a physical or mental impairment that substantially limits one or more major life activities. In examining the definition of physical impairment, the Courts have also concluded that women suffering from a diagnosis of infertility suffer from a physical impairment which is defined as "any physiological disorder, or condition, cosmetic disfigurement or anatomical loss affecting one or more of the following body system:….**reproductive** …" 29 C.F.R. §1630.2 (h)(1).

2. The measures provide a "lifetime" limit for the IVF treatment. However, as of January 1, 2014, the restriction of lifetime dollar limits applies to essential health benefits. Because IVF coverage benefit is one of Hawai`i's essential health benefits (EHB) for Hawai`i as reported by CMS, lifetime and annual dollar limits for must be eliminated in 2014. Thus it holds that "lifetime" in the proposed legislation as well as the "one time only" in the current law must be stricken. The prohibition on lifetime dollar limits applies equally to grandfathered and non-grandfathered plans. Further, the plan must give the individual a written notice that the lifetime limit no longer applies and that the individual, if covered, is eligible for benefits. However, nothing in the rule would appear to prohibit the use of visit limits or other treatment limits. Thus, it would appear that the limitation of "three in vitro fertilization cycles or a live birth" is allowed and is measureable to contain cost.

3. The focus of the measures is on ensuring a live birth and not simply that one "try" is afforded the patient. The benefit becomes available when the patient is diagnosed with infertility disease, irrespective of whether she has had other children. The member becomes <u>eligible upon her physician's diagnosis of infertility</u> to treat her disease of infertility. Other states have also enacted language, which focuses the success of a live birth. Illinois IVF coverage law, for example, contains language similar to SB 2909 and HB2355, as amended, which provides coverage for more than one oocyte retrieval and is limited if a live birth follows. Coverage is required subject to the following conditions: … "(B) the covered individual has not undergone 4 completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then 2 more completed oocyte retrievals shall be covered".

4. Marital status has no rational relation to the treatment of a medical diagnosis and condition of infertility. The current IVF coverage law wrongfully creates

two "classes" of premium paying members and is discriminatory on its face under ERISA, ADA, and ACA. Health plans deliberately upheld discriminatory provisions which called for a member to be married and use her husband`s sperm, reaping a prohibited premium savings from the practice. In application, employed health plan members who are single, divorced, widowed, partnered or otherwise "not married" women pay premiums just like married members diagnosed with infertility yet, ARE NOT eligible for the IVF coverage. The Hawaii legislature has not provided any rational basis for the "marital status" requirement, which rests squarely on moral grounds. The purpose of the measures is to provide in vitro fertilization insurance coverage equality for women who are diagnosed with infertility by requiring non-discriminatory coverage and ensuring quality of care in the diagnosis and treatment of infertility. The corrective action by the legislature to eliminate the discriminatory marital status requirement is long overdue. The overriding corrective measure should prevail over any cost consideration to address prohibited discriminatory practices. The focus must again be on a diagnosis of infertility as a determinant on whether coverage will be provided.

5. In its guidance to patients, the American Society of Reproductive Medicine defines infertility as the inability to achieve pregnancy after one year of unprotected intercourse. If the individual has been trying to conceive for a year or more, she should consider an infertility evaluation. However, if she is 35 years or older, she should begin the infertility evaluation after about six months of unprotected intercourse rather than a year, so as not to delay potentially needed treatment.

6. The measures also provide for disease conditions that are consistent with national published guidelines and reporting. The Center for Disease Control reports for year 2011 is attached. (Attachment 2). Any age limitations would violate the ACA. (45 CFR §156.125; 45 CFR §156.200 (e))

Affordable Care Act (ACA) Considerations:

Since the enactment of the Affordable Care Act (ACA), the Department of Health and Human Services has issued several implementing regulations and rules, which have since been codified in Title 45 Code of Federal Regulations. The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act and ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans. Because there are general and specific provisions of the ACA, which apply to States, general and specific preemption considerations also apply.

In consideration of the underlying measures there appear to be ACA considerations as well that are instructive on the bill as well as statements of HHS or CMS concerning Essential Health Benefits.

1. Essential Health Benefits

In Vitro Fertilization Coverage is an Essential Health Benefit (EHB), which imposes no state liability under the ACA. By way of testimony in March 2011, the Hawaii Association of Health Plans ("HARP") raised the concern of the potential liability that the State would be facing by mandating even more extensive infertility treatments because the ACA is still in flux. This assertion is of no consequence and concern at this time post January 1, 2014 since the federal government has since issued two regulations and a final regulation at Federal Register, Vol. 78, No. 37, February 25, 2013 which has been codified in 45 CFR §156 which address these concerns. Also, CMS has published on its web site each States' Essential Health Benefits and IVF coverage is included as an EHB.

Generally the ACA provides that if a State requires issuers to cover benefits in excess of EHB, the Affordable Care Act directs the state to defray the costs of these benefits in Qualified Health Plans. States may include as part of their benchmark plan state benefit requirements, avoiding costs associated with these provisions. Because In Vitro Fertilization is a Hawaii State Required Benefit that is an Essential Health Benefit, there is no State liability. Other general considerations regarding the effect of the ACA on states are provided at the CMS or CCIO website at CMS.gov (Attachment 3)

2. **The ACA prohibitions on discrimination.**

The ACA prohibits discrimination as set forth in Title 45 of Code of Federal Regulations Part 156. Two sections in particular, which prohibit discrimination, are 45 CFR §156.125 and §156.200(e) of the subchapter and also in the Federal Register Vol. 78, No. 37(February 25, 2013). The marital status provision in the current IVF coverage law, which requires that the member be married in order to received treatment creates two classes of members and is in violation of the prohibitions on discrimination. Even if you disagree with its violation with any laws, marriage should not be the defining factor, which prohibits access to this benefit for women who have been diagnosed with infertility disability. Equal Access should be afforded to all.

45 CFR §156.125 Prohibition on discrimination.

(a) 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.

(b) An issuer providing EHB must comply with the requirements of §156.200(e) of this subchapter; and

(c) Nothing in this section shall be construed to prevent an issuer from appropriately utilizing reasonable medical management techniques.

45 CFR §156.200 (e) ***Non-discrimination.*** A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

The Hawaii State legislature is a leader in health care with the historic passage of the Prepaid Health Care Act and should also be the same in the implementation of the Affordable Care Act and provision of this Essential Health Benefit for its citizens. The legislature should not be intimidated or persuaded by insurance companies who will go to any length to make an argument to hold the IVF legislation bills such as: 1) it costs too much, calling for an auditors report to confuse the necessary elimination of discriminatory language, 2) that it needs to be held for further study, when it holds 27 years of claims data on the benefit; or 3) that it would have difficulty administering the benefit even though it is a national health plan or partnered with national health plan networks in states which already administer similar plans or 4) that the State will have to pay for what is an the essential health benefit, which CMS confirms that there is no state liability.

For over 27 years, since the passage of the IVF mandate, the women in Hawaii have been bearing the cost to treat their disease of infertility even with IVF Coverage, the cost financially, the indescribable pain emotionally and left with the lifelong scars that poor legislation creates. For over 27 years the providers of infertility treatment have become leaders in the nation in treatment of assisted reproductive technologies, are highly regulated by CDC and leaders in our state by increasing IVF success rates in Hawaii from about 10% when the IVF coverage law was enacted to over 65% today. It is the legislature`s responsibility to correct discriminatory provisions and treatment provisions for all women diagnosed with infertility. Have the courage to pass out of committee SCR 35 SD1, as an audit is the first step to providing coverage for ALL women suffering from infertility disability equal access to quality affordable treatment.

Hawaii - State Required Benefits

Benefit	Name of Required Benefit	Market Applicability	Citation Number
Hospice Services	Hospice care	Individual, small group, large group, HMO	431:10A-119; 432:1-608; 432D-23
Infertility Treatment	In-vitro fertilization	Individual, small group, large group, HMO	431:10A-116.5 432:1-604 432D-23
Delivery and All Inpatient Services for Maternity Care	Newborn children	Individual, small group, large group, HMO	431:10A-115 432:1-602 432D-23
Mental/Behavioral Health Outpatient Services	Mental illness, alcohol, and drug dependence	Individual, small group, large group, HMO	431M-4 432D-23
Mental/Behavioral Health Inpatient Services	Mental illness, alcohol, and drug dependence	Individual, small group, large group, HMO	431M-4 432D-23
Substance Abuse Disorder Outpatient Services	Mental illness, alcohol, and drug dependence	Individual, small group, large group, HMO	431M-4 432D-23
Substance Abuse Disorder Inpatient Services	Mental illness, alcohol, and drug dependence	Individual, small group, large group, HMO	431M-4 432D-23
Specialty Drugs	Chemotherapy services	Individual, small group, large group, HMO	432:1-616
Preventive Care/Screening/Immunization	Mammography	Individual, small group, large group, HMO	431:10A-116 432:1-605 432D-23
Preventive Care/Screening/Immunization	Contraceptive services	Individual, small group, large group, HMO	431:10A-116.6 431:10A-116.7 432:1-604.5 432D-23
Preventive Care/Screening/Immunization	Child health supervison service	Individual, small group, large group, HMO	431:10A-115.5 432:1-602.5 432D-23
Preventive Care/Screening/Immunization	Colorectal screening	Individual, small group, large group, HMO	431:10A-122

Benefit	Name of Required Benefit	Market Applicability	Citation Number
Diabetes Care Management	Diabetes	Individual, small group, large group, HMO	431:10A-121 432:1-612 432D-23
Inherited Metabolic Disorder - PKU	Medical foods and low protein modified food products	Individual, small group, large group, HMO	431:10A-120 432:1-609 432D-23
Prescription Drugs Other	Chemotherapy services	Individual, small group, large group, HMO	432:1-616

The Center for Consumer Information & Insurance Oversight

Additional Information on Proposed State Essential Health Benefits Benchmark Plans

Background

Beginning in 2014, the Affordable Care Act requires non-grand fathered health plans to cover essential health benefits (EHB), which include items and services in the following ten 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. The essential health benefits should be equal in scope to a typical employer health plan.

In the Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule ("EHB Rule"), HHS defines EHB based on state-specific EHB-benchmark plans. This page contains information on EHB-benchmark plans for each of the 50 states, the District of Columbia (D.C.), and the U.S. territories. Two documents are provided for each EHB-benchmark plan in the 50 states, D.C. and Puerto Rico: (1) a summary of the plan's specific benefits and limits, and list of covered prescription drug categories and classes; and (2) state-required benefits.

The summaries of the covered benefits and limits, and lists of prescription drug categories and classes have been compiled based on the EHB-benchmark plan selection process described in 45 CFR 156.100 and 156.110. These summaries describe the EHB-benchmark plans that have been selected by states, as well as those that have been developed by HHS using the default benchmark plan selection process described in 45 CFR 156.100(c) and the supplementation methodology in 45 CFR 156.110.

Because EHB-benchmark plan benefits are based on 2012 plan designs, and include state-required benefits that were enacted before December 31, 2011, some of the benchmark plan summaries may not reflect requirements effective for plan years starting on or after January 1, 2014. Therefore, when designing plans that are substantially equal to the EHB-benchmark plan, beginning in 2014, issuers may need to conform plan benefits, including coverage and limitations, to comply with these requirements and limitations.

A list of each state's required benefits has also been compiled to help states and issuers determine the state-required benefits in excess of EHB. We consider state-required benefits (or mandates) to include only specific care, treatment, or services that a health plan must cover. We do not consider provider mandates, which require a health plan to reimburse specific health care professionals who render a covered service within their scope of practice, to be state-required benefits for purposes of EHB coverage. Similarly, we do not consider state-required benefits to include dependent mandates, which require a health plan to define dependents in a specific manner or to cover dependents under certain circumstances (e.g., newborn coverage, adopted children, domestic partners, and disabled children). Finally, we do not consider state anti-discrimination requirements, and state requirements relating to service delivery method (e.g., telemedicine) to be state-required benefits.

• **Guide to Reviewing Essential Health Benefits Benchmark Plans**

Essential Health Benefits Benchmark Plans

Alabama | Alaska | American Samoa | Arizona | Arkansas | California | Colorado | Connecticut | Delaware | District of Columbia | Florida | Georgia| Guam |Hawaii | Idaho | Illinois | Indiana | Iowa | Kansas | Kentucky | Louisiana | Maine | Maryland | Massachusetts | Michigan | Minnesota | Mississippi | Missouri | Montana | Nebraska | Nevada | New Hampshire | New Jersey | New Mexico | New York | North Carolina | North Dakota |Northern Mariana Islands | Ohio | Oklahoma | Oregon | Pennsylvania | Puerto Rico | Rhode Island | South Carolina | South Dakota | Tennessee | Texas | Utah | Vermont | Virgin Islands| Virginia | Washington | West Virginia | Wisconsin | Wyoming |

Alabama

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 333 KB)

- State-required benefits (PDF – 65 KB)

Alaska

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 446 KB)
- State-required benefits (PDF – 78 KB)

American Samoa

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF - 333 KB)

Arizona

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 442 KB)
- State-required benefits (PDF – 74 KB)

Arkansas

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 514 KB)
- State-required benefits (PDF – 79 KB)

California

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 364 KB)
- State-required benefits (PDF – 67 KB)

Colorado

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 306 KB)
- State-required benefits (PDF – 74 KB)

Connecticut

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 250 KB)
- State-required benefits (PDF – 77 KB)

Delaware

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 340 KB)
- State-required benefits (PDF – 70 KB)

District of Columbia

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 226 KB)
- State-required benefits (PDF – 68 KB)

Florida

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 397 KB)
- State-required benefits (PDF – 73 KB)

Georgia

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 444 KB)
- State-required benefits (PDF – 74 KB)

Guam

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF - 333 KB)

Hawaii

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 430 KB)
- State-required benefits (PDF – 69 KB)

Idaho

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 341 KB)
- State-required benefits (PDF – 63 KB)

Illinois

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 261 KB)
- State-required benefits (PDF – 78 KB)

Indiana

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 482 KB)
- State-required benefits (PDF – 72 KB)

Iowa

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 448 KB)
- State-required benefits (PDF – 71 KB)

Kansas

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 371 KB)
- State-required benefits (PDF – 69 KB)

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- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 330 KB)
- State-required benefits (PDF – 74 KB)

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Northern Mariana Islands

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Ohio

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- State-required benefits (PDF – 65 KB)

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Utah

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Vermont

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Guide to Reviewing EHB Benchmark Plans

- Printable version (PDF – 128 KB)

Essential health benefits (EHB)-benchmark plans are based on 2012 plan designs, and therefore do not necessarily reflect requirements effective for plan years beginning on or after January 1, 2014. Therefore, when designing plans that are substantially equal to the EHB-benchmark plan beginning January 1, 2014, issuers may need to design plan benefits, including coverage and limitations, to comply with these requirements and limitations, including but not limited to, the following:

Annual and Lifetime Dollar Limits

The EHB-benchmark plans displayed may include annual and/or lifetime dollar limits; however, in accordance with 45 CFR 147.126, these limits cannot be applied to the essential health benefits. Annual and lifetime dollar limits can be converted to actuarially equivalent treatment or service limits.

Excluded Benefits

Pursuant to 45 CFR 156.115, the following benefits are excluded from EHB even though an EHB-benchmark plan may cover them: routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, and/or non-medically necessary orthodontia. Please also note that although the EHB-benchmark plan may cover abortion services, pursuant to section 1303(b)(1)(A) of the Affordable Care Act, a QHP issuer is not required to cover these services. Section 156.115(c) provides that no health plan is required to cover abortion services as part of the requirement to cover EHB. Nothing in this provision impedes an issuer's ability to choose to cover abortion services or limits a state's ability to either prohibit or require these services under state law.

Habilitative Services

If the EHB-benchmark plan does not cover any habilitative services and the state does not define those benefits, then pursuant to 45 CFR 156.115(a)(5), the issuer determines which habilitative services to offer as a part of a two year transitional policy.

Coverage Limits

Pursuant to 45 CFR 156.115(a)(2), with the exception of coverage for pediatric services, a plan may not exclude an enrollee from coverage in an entire EHB category, regardless of whether such limits exist in the EHB-benchmark plan. For example, a plan may not exclude dependent children from the category of maternity and newborn coverage.

State-Required Benefits

For purposes of determining EHB, we consider state-required benefits (or mandates) to include only requirements that a health plan cover specific care, treatment, or services. We do not consider provider mandates, which require a health plan to reimburse specific health care professionals who render a covered service within their scope of practice, to be state-required benefits for purposes of EHB coverage. Similarly, we do not consider state-required benefits to include dependent mandates, which require a health plan to define dependents in a specific manner or to cover dependents under certain circumstances (e.g., newborn coverage, adopted children, domestic partners, and disabled children). Finally, we do not consider state anti-discrimination requirements relating to service delivery method (e.g., telemedicine) as state-required benefits.

Mental Health Parity

The EHB-benchmark plans displayed may not comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). However, as described in 45 CFR 156.115(a)(3), EHB plans must comply with the standards implemented under MHPAEA.

EHB-Benchmark Plan Prescription Drugs by Category and Class

Please note that in some cases a category is listed without a United States Pharmacopeia (USP) class because there are some drugs within the category that have not been assigned to a specific class.

Please also note that where the EHB-benchmark plan does not include coverage in a USP category and/or class, pursuant to 45 CFR 156.122, one drug would have to be offered in that USP category and/or class.

In conjunction with the policy that plans must offer the greater of one drug in every USP category and class or the number of drugs in each USP category and class offered by the EHB-benchmark, HHS is considering developing a drug counting service to assist states and issuers with implementation of the proposed prescription drug policy, as described in the following methodology document:

- EHB Rx Crosswalk Methodology (PDF - 52 KB)

Preventive Services

The EHB-benchmark plans displayed may not offer the preventive services described in 45 CFR 147.130. However, as described in 45 CFR 156.115(a)(4), EHB plans must comply with that section.

Guide to Reviewing Essential Health Benefits Benchmark Plans

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TO: COMMITTEE ON HEALTH
The Honorable Della Au Belatti, Chair
The Honorable Dee Morikawa, Vice Chair

COMMITTEE ON CONSUMER PROTECTION & COMMERCE
The Honorable Angus L.K. McKelvey, Chair
The Honorable Derek S.K. Kawakami, Vice Chair

SUBJECT: **SCR 35 SD1 – REQUESTING THE AUDITOR TO ASSESS THE SOCIAL AND FINANCIAL EFFECTS OF REQUIRING HEALTH INSURERS TO PROVIDE INFERTILITY PROCEDURE COVERAGE.**

Hearing: Monday, April 14, 2014
Time: 8:30 a.m.
Place: Conference Room 229

FROM: Pi`ilani Smith

Chairs, Vice Chairs, and committee members,

Mahalo for the opportunity to provide testimony on SCR 35 SD1, requesting a study by the legislative auditor. This testimony is **in strong support of SCR 35 SD1 with the following amendments** of additional clauses that will make the auditor's study most useful.

BE IT FURTHER RESOLVED that the Auditor is requested to include in the impact assessment report statutory compliance requirements regarding state mandated benefits across Essential Health Benefits Benchmark Plans;

BE IT FURTHER RESOLVED that the Auditor is requested to research the underwriting of the existing Hawaii IVF mandated Essential Health Benefit since its inception, with a look back of 27 years since the passage of the Hawaii IVF mandated benefit; and

BE IT FURTHER RESOLVED that the Auditor is requested to research the existence of at least two classes of employer health plan members paying a premium on the same health plan.

The reason why SCR 35 SD1 was drafted and introduced is because **the present Hawaii IVF mandated Essential Health Benefit is DISCRIMINATORY and NOT IN COMPLIANCE** with Federal law and has not been incompliance since 2010. This resolution with amendments stated above is critical to raising compliance issues regarding the Hawaii Essential Health Benefit Benchmark Plan, specifically ensuring that the IVF coverage benefit is in compliance with the law and administrative

regulations and that quality health care is accessible to all equally diagnosed with infertility.

The audit of infertility procedure coverage is necessary and timely, specifically because **the present Hawaii In Vitro Fertilization (IVF) mandated benefit is a Hawaii Essential Health Benefit (EHB) being discriminatorily applied, creating at least two classes of members, and is not in compliance** with the following laws:

1. Affordable Care Act (ACA);
    a. 45 C.F.R. §156.125. Prohibition on discrimination
    b. 45 C.F.R. §156.200 (e). Non-discrimination
2. Public Health Service Act;
    a. 42 U.S.C. §300gg. No lifetime or annual limits
3. Americans with Disabilities Act; and
    a. 42 U.S.C. § 12102(2)(A): a physical or mental impairment that substantially limits one or more major life activities.
    b. 29 C.F.R. §1630.2 (h)(1). Physical or mental impairment
4. American Indian Religious Freedom Act.
    a. 42 U.S.C. §1996

With approximately 7.3 million women and their partners (husbands, wives and non-married partners) with a medical diagnosis of infertility, I am in good company with a class of people being discriminated against based on marital status. I was diagnosed with infertility and **denied infertility treatment of the IVF mandated Essential Health Benefit by HMSA because I was not married. I am a second class citizen by the State of Hawaii and a second and third class member by the Hawaii Health Plans** who for 27 years have been and continues to impose discriminatory requirements.

- The present Hawaii IVF mandated essential health benefit creates two classes of health plan members paying a premium on a health benefit that they do not qualify for because it is based on marital status with no rational explanation. What is the logic?
    - Marriage is not a requirement for having a medical condition of infertility.
    - Marriage is not a condition for treating a medically diagnosed condition such as infertility.
    - Why are employers paying an employers premium for employees benefits that the employee will not qualify for?
- Unmarried members diagnosed with infertility paying an employees share of an employer's health plan premium, are paying twice by paying a health plan premium. This class of members are not eligible for the IVF health plan benefit based on marital status and must pay out of pocket for infertility treatment, in order to receive services as opposed to married women who are eligible for the IVF health plan benefit covered by the same health plan.

- Only certain conditions of infertility are eligible for the IVF mandated essential health benefit, strictly discriminating against women diagnosed with infertility. Thus, further **creating a discriminatory third class health plan members diagnosed with infertility** who are:
    - Unmarried, single, never been married, divorced, widowed and partnered (with either an opposite or same sex partner) as well as married women unable to use their spouses sperm due to male factor; and
    - Diagnosed with uterine factor, tubal factor, male factor, ovulatory dysfunction and diminished ovarian reserve which conditions are not included in the health benefit coverage requirements.

Because of the discrimination that I experienced regarding IVF health benefit coverage, I have worked diligently this session to bring equality to all women regarding IVF health insurance coverage and compliance with the ACA, ADA and the American Indian Religious Freedom Act by:

- Authoring HB 2355 – Relating to In Vitro Fertilization Health Insurance Coverage
- Authoring SB 2909 – Relating to In Vitro Fertilization Health Insurance Coverage
- Authoring SCR 35 – Requesting the auditor to assess the social and financial effects of requiring health insurers to provide infertility procedure coverage.

The impetus of SCR 35 is to address the outstanding issue before the legislature that the **present Hawaii IVF law is discriminatory and not in compliance with state and federal law**. Within the context of compliance is the concern of cost considerations, and whether the state must incur the costs on changes to the Essential Health Benefits (EHBs) and the states mandated benefits. The answer for the State of Hawaii is simply no.[1] **The State of Hawaii doesn't have to defray the costs where:**

- the Hawaii IVF mandated benefit is part of the state EHB benchmark plan and therefore is automatically included as one of the state's EHBs;
- the Hawaii IVF mandated benefit is one of the in the state's EHBs, and therefore the Hawaii IVF mandated benefit does not go beyond the EHB and thus is not a cost to the state; and
- IVF is a mandated benefit included in the EHB benchmark plan and thus is no cost to the state.

I ask this committee to take particular notice of the following amendment listed below that appear in SCR 35 SD1 proposed by Kaiser Permanente, all of which similarly have been previously analyzed by the State of Hawaii Department of Commerce and Consumer Affairs, Insurance Division – Analysis of Hawaii's Essential

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[1] Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin*, December 16, 2011.

Health Benefit Benchmark Plan Options published in September 19, 2012 and thus should deleted:

- Kaiser SCR 35 SD1 amendment – "Whether an expansion of infertility in vitro fertilization procedures would constitute benefits that are in excess of the essential health benefits required for health insurance coverage under the federal Patient Protection and Affordable Care Act of 2010, thus requiring the State to defray such costs;"
    - Because IVF is a mandated benefit and included in the Hawaii benchmark plan, the ACA requires non-discriminatory compliance. [2] SCR35 SD 1 made reference to S.B. 2909 SD1 (2014) a measure that aims to bring the present discriminatory Hawaii IVF law into compliance. There is no excess of the EHBs, as the Hawaii EHBs specifically IVF is being discriminatorily applied.[3] Therefore, any changes to the present Hawaii EHBs (such as IVF) are no cost to the State because IVF is a mandated benefit included in the benchmark plan of Essential Health Benefits as chosen by the Hawaii Health Plans themselves who included IVF in the benchmark plan.
        - The Hawaii Health Plans resist any changes to the existing IVF mandated Essential Health Benefits benchmark because they know they must incur the cost - a cost the Hawaii Health Plans never intended to incur because they intended on discriminatorily providing the IVF mandated Essential Health Benefit as they always have for the past 27 years. And despite the numerous federal laws that they are required to be incompliance with, the Hawaii Health Plans have blatantly neglected compliance for 4 years (since the passage of ACA in 2010), and continue to wrongfully profit from underwriting of IVF by its discriminatory policies and requirements such as marital status and limiting infertility conditions.

Kaiser Permanente further proposed the following amendment that should be likewise deleted as the question of age is prohibited by the ACA section 1001 (amendment to Public Health Service Act 2711, 42 U.S.C. §300gg-11).

- Amendment - "Research on what is being used as the standard medical definition of "reproductive age" that is best suited for in vitro fertilization procedures and the success rates for different age groups to determine

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[2] State of Hawaii Department of Commerce and Consumer Affairs, *Insurance Division – Analysis of Hawaii's Essential Health Benefit Benchmark Plan Options*, September 19, 2012

[3] 45 C.F.R. §156.125, 45 C.F.R. §156.200 (e), 42 U.S.C. §300gg, 42 U.S.C. § 12102(2)(A), 29 C.F.R. §1630.2 (h)(1), 42 U.S.C. §1996

coverage benefit limitations for this covered benefit, including whether different standards of infertility treatments are applied to different age groups in need of infertility treatment;"

- Lifetime and annual limits for the EHB categories were restricted starting in plan years beginning on or after September 23, 2010 and are prohibited starting January 1, 2014.[4]

I have included in my testimony the State of Hawaii Department of Commerce and Consumer Affairs (DCCA), Insurance Division – Analysis of Hawaii's Essential Health Benefit Benchmark Plan Options published in September 19, 2012, which is the analysis by DCCA on Hawaii's EHB Benchmark Plan options, in which the IVF coverage benefit is a Hawaii Essential Health Benefit, which inclusion is agreed upon by the Hawaii Health Plans. The Hawaii Health Plans have been profiting from the IVF underwriting for 27 years, which doesn't afford all women the infertility health benefit because of marital status. The Health Plans are now prohibited by federal law from discriminating in the administration of health benefits defined in the Hawaii Essential Health Benefit Benchmark Plan and must incur the cost to bring their plans into compliance.

I ask your committees to pass SCR 35 SD1 with the amendments proposed in my testimony to bring light to and best inform this legislative body on issues of infertility.

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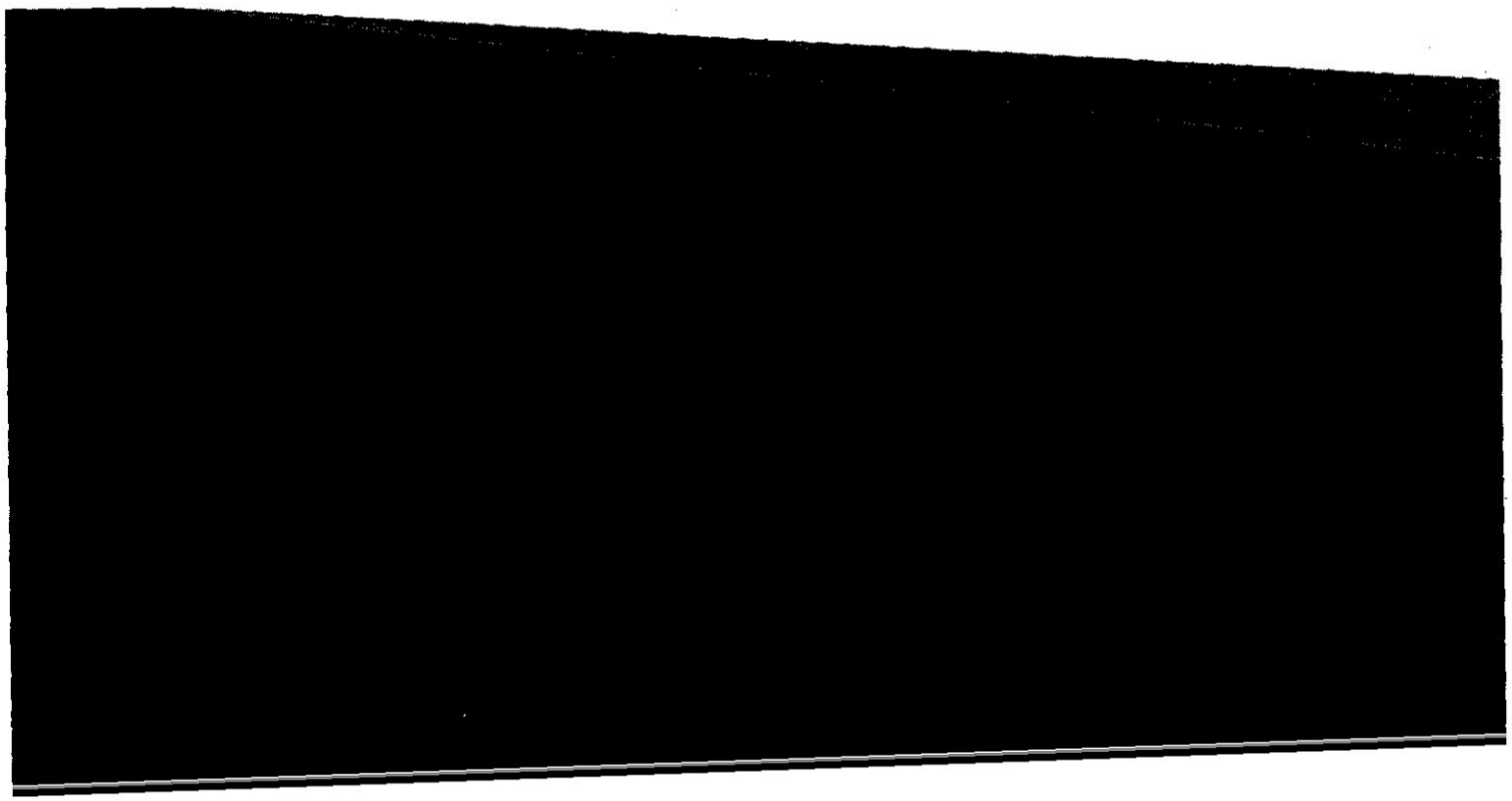
[4] ACA section 1001 (amendment to Public Health Service Act 2711, 42 U.S.C. §300gg-11)

OLIVER WYMAN

SEPTEMBER 19, 2012

ANALYSIS OF HAWAI'I'S ESSENTIAL HEALTH BENEFIT BENCHMARK PLAN OPTIONS

HAWAI'I DEPARTMENT OF COMMERCE & CONSUMER AFFAIRS, INSURANCE DIVISION



MARSH & McLENNAN COMPANIES

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Executive Summary

The Affordable Care Act (ACA) requires all non-grandfathered health insurance plans offered in the small group and individual markets to cover all Essential Health Benefits (EHBs) beginning on January 1, 2014.[1,2] The ACA defines EHBs to include the following ten broad categories of health benefits:

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.

EHBs define a standard set of services that must be covered by applicable plans without regard to cost sharing. Currently, health plans commonly have annual or lifetime limits on certain benefits. For instance, it is common to have an annual maximum for coverage of eyeglasses. EHBs may not be subject to annual or lifetime dollar limits and must not be discriminatory; they may include limits on the duration and scope of covered services. EHBs are the full package of covered benefits to which insurers will apply cost sharing requirements, resulting in levels of coverage (bronze/ silver/ gold/ platinum) and their accordant actuarial values (60/70/80/90) outlined in the ACA.

The ACA charges the Secretary of the U.S. Department of Health and Human Services (HHS) with further defining the EHBs, and instructs the Secretary to ensure that they are equal to the scope of benefits provided under a typical employer plan. In guidance provided by HHS, the approach outlined for 2014 and 2015 allows each state the flexibility to designate a benchmark

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

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

plan to serve as the state's EHBs. States have a choice from among the following ten possible benchmark plans:

- The largest plan in any of the three largest small group products in the state by enrollment;
- The three largest state employee health plans by enrollment;
- The three largest FEHBP[3] options by enrollment; or
- The largest HMO plan offered in the state's commercial market by enrollment.

Due to the same plan of benefits meeting more than one of these ten options, the State of Hawai'i has only seven unique options from which to select. The specific benchmark options for Hawai'i are:

- HMSA State Employees Health Plan Option
- FEHBP Blue Cross Blue Shield Standard Option
- FEHBP Blue Cross Blue Shield Basic Option
- FEHBP Government Employees Health Association Basic Plan Standard Option
- HMSA Small Group PPO Plan
- UHA 3000 Plan
- Kaiser HMO Plan

In designating a benchmark, the State is choosing an entire plan's benefit package from those listed above. To be clear, the State is choosing a market basket of services that will collectively be included in the EHB. The market basket of services will be based on the benefits that are offered in 2012 by one of the plans listed above. The State may not pick and choose the benefits to include, in essence customizing the package. If a benchmark plan does not contain all ten categories of benefits identified in the ACA, the state must supplement the benchmark by selecting the missing benefits from one or more of the other benchmark options for that state. Certain categories, such as habilitative care, may not currently be provided in any benchmark option. In those instances, HHS has outlined special rules for supplementing the benefits. Insurers may be able to substitute the benefits within the ten EHB categories, to the extent such substitutions are actuarially equivalent and consistent with state and federal law. It will be important to ensure that such substitutions are in compliance with the Hawai'i Prepaid Healthcare Act.

States may still mandate that specific benefits be covered in the individual and small group markets. However, states must pay for any mandates not defined as part of the EHB for Qualified Health Plans (QHPs). It is unclear whether this includes QHP enrollees outside of the Exchange, and HHS has not yet provided final guidance on this issue. Thus, by choosing a plan

[3] Federal Employee Health Benefit Program which offers benefits to federal employees.

that covers all current mandates, the State would not have to make the choice between covering benefits with State funds and repealing mandates in the individual and small group markets.

Key Findings

The purpose of this report is to inform the State's selection of a benchmark plan for the EHB package by providing a comparison of each benchmark plan option. The analysis included a comprehensive review of the benchmark plan options in terms of benefits offered and cost differential between these plans, given the benefits provided. Since all QHPs (including plans in the individual market) will be required to offer the EHB starting in 2014, it will be important that the State consider the balance of benefits provided and affordability.

There are several criteria that the State could consider when selecting a benchmark plan for the EHB. They include, but are not limited to:

1. State Mandated Benefits
   - What, if any, State mandated benefits are not covered by each of the benchmark plan options?
   - What are the cost implications to the State if the selected EHB does not include all of the State mandated benefits?
2. Benefits Covered
   - Examine the individual benefits that are covered in one of the benchmark plan options but not another. We refer to these as "outlier benefits." It then becomes a policy decision as to which benefits might be more important to cover.
3. Market Disruption (Benefits)
   - What proportion of the market that would see some change in the benefits that would be covered?
4. Market Disruption (Cost)
   - Selecting a benchmark plan with a more expensive market basket of services would mean mandating a premium increase to those that currently have plans with a leaner market basket.
5. Consumer and Stakeholder Input
   - What is consumer and carrier preference for one benchmark option over another?
6. Ease of Administration by Carriers
   - Is the cost of administering the benefits for one benchmark option more costly than administering the benefits of another, which could impact premiums?

With these criteria in mind, the analysis performed resulted in the following findings for consideration:

- Each of the benchmark plan options cover all State mandated benefits with the exception of in-vitro fertilization (IVF). The FEHBP options do not provide coverage for IVF. If one of these plans were selected as the benchmark plan, the cost of IVF coverage would be required to be defrayed by the State for all individuals enrolled in a QHP. We estimate that

this could cost the State between $4.00 and $4.50 per month for each individual enrolled in a QHP.

- All of the benchmark plan options will need to be supplemented to provide coverage for habilitative services, pediatric vision and oral services. This will increase premiums in the individual and small group markets regardless of the plan selected as the benchmark plan.

- The state employee health plan does not provide coverage for prescription drugs within the base policy and would need to be supplemented to provide this coverage. There will be a significant increase in premium for those individuals and groups that do not elect to purchase prescription drug coverage today.

- Based on the relative value analysis performed, the Kaiser HMO benchmark plan option provides the leanest benefit package. This is driven by the fact that durable medical equipment is offered as an optional rider that is not currently selected by a majority of small groups. In addition, external prosthetic devices are not covered by Kaiser. If the Kaiser HMO plan was selected as the benchmark plan, these benefits would not be required to be covered in the individual and small group markets. These benefits are currently provided by all of the other benchmark plan options.

- Within the Hawai'i market, base policies are offered with optional riders for a number of services. Based on federal regulations pertaining to data collection to support standards related to essential health benefits published on July 20, 2012, the market basket of services within the benchmark options that are considered for the EHB may include "optional benefits available for an additional premium (often referred to as "riders")..., if those benefits are part of the most commonly purchased set of benefits within the product by enrollment."[4] For all benchmark plan options, except the FEHBP options and state employee plan option, prescription drug coverage is offered as an optional rider. Prescription drug coverage is included in the FEHBP plans as part of the base policy and is not offered under the state employee plan option. Since the most commonly purchased set of benefits in Hawai'i include drug coverage, prescription drug coverage that is most often selected will be included in the benchmark option.

[4] http://www.gpo.gov/fdsys/pkg/FR-2012-07-20/pdf/2012-17831.pdf

2

Introduction

The Hawai'i Department of Commerce & Consumer Affairs (DCCA) engaged Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) to assist the State of Hawai'i (the State) by estimating the relative value of the ten plans that could be selected as the benchmark plan for determining the Essential Health Benefits (EHBs) for Hawai'i. Consistent with Paragraph 24 of the General Conditions of the Contract for Professional Services, this report was prepared for the sole use by the State. All decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the State. This report is not intended for general circulation or publication, nor is it to be used or distributed to others for any purpose other than those that may be set forth herein or in the definitive documentation pursuant to which this report has been issued. These estimates were based on regulations issued by the United States Department of Health and Human Services, several of which are still in draft form. Our work may not be used or relied upon by any other party or for any purpose other than for which they were issued by Oliver Wyman. Oliver Wyman is not responsible for the consequences of any unauthorized use.

All projections are based on the information and data available at a point in time, and the projections are not a guarantee of results which might be achieved. The projections are subject to unforeseen and random events and so must be interpreted as having a potentially wide range of variability. We have relied on a wide range of data for our analysis including, but not limited to, information received from commercial carriers offering coverage in the State and various State agencies. We have not independently audited this data, however we have reviewed it for reasonableness and asked clarifying questions where warranted.

Further, the estimates set forth in this report have been prepared before all regulations needed to implement the ACA have been issued, including clarifications and technical corrections, and without guidance on complex financial calculations that may be required. The State is responsible for all financial and design decisions regarding the ACA. Such decisions should be made only after the State's careful consideration of alternative future financial conditions and legislative scenarios, and not solely on the basis of the estimates illustrated within this report.

Finally, the State understands that Oliver Wyman is not engaged in the practice of law and this report, which may include commentary on legal issues and regulations, does not constitute, nor is it a substitute for legal advice. Accordingly, Oliver Wyman recommends that the State secures the advice of competent legal counsel with respect to any legal matters related to this report or otherwise.

This report is intended to be read and used as a whole and not in parts. Separation or alteration of any section or page from the main body of this report is expressly forbidden and invalidates this report.

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

The information contained in this document and in any of the attachments is not intended by Oliver Wyman to be used, nor can it be used, for the purpose of avoiding penalties under the Internal Revenue Code or imposed by any legislative body on the taxpayer or plan sponsor.

3

Background

The Patient Protection and Affordable Care Act and the Health Care and Education Reconcliliation Act of 2010, collectively referred to as the Affordable Care Act (ACA), requires significant changes in how health insurance is purchased, sold and regulated in the states. Among other things, the ACA creates new standards for health benefit plans offered to individuals and small groups, including requirements that all such plans offer a comprehensive package of EHBs.

Beginning on January 1, 2014, the ACA requires all non-grandfathered plans offered in the small group and individual markets to cover all EHBs.[5,6]

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

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

The ACA charges the Secretary of the U.S. Department of Health and Human Services (HHS) with further defining the EHBs, and instructs the Secretary to ensure that they are equal to the scope of benefits provided under a typical employer plan.[7]

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

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

[7] ACA Section 1302(b)(1) and (2)

EHBs define a standard set of services that must be covered by applicable plans without regard to cost sharing provisions. While EHBs may include limits on the duration and scope of covered services, they may not include annual or lifetime dollar limits and must not be discriminatory.[8] The ACA separately regulates cost sharing requirements, including limits on cost sharing and mandates regarding levels of coverage. EHBs are the full package of covered benefits to which insurers will apply cost sharing requirements, resulting in levels of coverage (bronze/ silver/ gold/ platinum) and their corresponding actuarial values (60/70/80/90), as outlined in the ACA.

States may still mandate that specific benefits be covered in the individual and small group markets. However, the cost of any mandates not defined as part of the EHB must be covered by the State, for Qualified Health Plans (QHPs). It is unclear whether this includes individuals enrolled in QHPs outside of the Exchange, and HHS has not provided final guidance on this issue.

On December 16, 2011, HHS issued an EHB Bulletin, outlining an approach for defining EHB packages in plan years 2014 and 2015, and taking into account the need to "balance comprehensiveness, affordability, and state flexibility and to reflect public input received to date."[9] The Bulletin notes that HHS "intends to assess the benchmark process for the year 2016 and beyond based on evaluation and feedback." Therefore, it is unknown at this time what the EHB package might look like in 2016 and beyond.

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

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

If the benchmark plan does not contain all ten categories of benefits identified in the ACA, the state must supplement the benchmark by selecting the missing benefits from one or more of the other benchmark options for that state. Certain categories, such as habilitative care, may not be provided in any benchmark plan option. In those instances, HHS has outlined special rules for supplementing the benefits. In the Hawai'i market, prescription drug coverage is provided as an optional rider. While a majority of small groups purchase prescription drug coverage, individual

[8] Lifetime and annual limits for the EHB categories were restricted starting in plan years beginning on or after September 23, 2010 and are prohibited starting January 1, 2014; ACA Section 1001 (amendment to Public Health Service Act 2711)

[9] http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

and groups that currently do not select prescription drug coverage will realize a significant increase in premium in 2014.

The benchmark health plan option selected will define the market basket of services that will collectively be included in the EHB. States must select a benchmark health plan "in the third quarter of 2012" to establish EHBs for benefit years beginning in 2014 or 2015. If a state does not select a benchmark plan, HHS will designate the small group plan with the largest enrollment as the benchmark, referred to in this report as the "default benchmark plan." In Hawai'i, this would be the HMSA Preferred Provider Plan 2010. Supplemental benefits for the default benchmark plan will be determined by a process dictated by federal guidance that looks first to the second-largest small group market benchmark plan, then to the third and then, if none of the small group plans offer benefits in a missing category, to the FEHBP benchmark plan with the highest enrollment.

HHS has also provided guidance that a state may allow insurers to further modify the benefits offered by the chosen (or default) benchmark plan, as supplemented, to the extent such substitution is otherwise consistent with state and federal law. Health insurers must cover "benefits that are 'substantially equal' to the benefits of the benchmark plan selected by a state and modified as necessary to reflect the ten coverage categories,"[10] however, insurers have "some flexibility to adjust benefits, including both the specific services covered and any quantitative limits provided they continue to offer coverage for all ten statutory EHB categories." Substituted services within each of the ten statutory categories must be actuarially equivalent. If the State allows insurer to make such substitutions, it will be important to verify that such changes are in compliance with the Hawai'i Prepaid Healthcare Act. Plans would also be permitted to impose non-dollar limits (e.g. day or visit limits), consistent with other guidance, that are at least actuarially equivalent to the annual dollar limits. It is important to note, however, that if carriers are permitted to make actuarially-equivalent substitutions within each of the ten EHB categories, the choice of a benchmark plan option will not necessarily determine which specific benefits will be covered by a specific plan, but rather the value of the total package of benefits covered.

If the State allows carriers the flexibility to make actuarially equivalent benefit substitutions, it will be important to verify that such changes comply with the Hawai'i Prepaid Healthcare Act.

Therefore, the three-step process outlined by HHS can be summarized as follows:

1. Select a benchmark plan from one of the plans eligible in the State or default to the largest small group plan.
2. Supplement the benchmark plan selected to ensure it includes all of the required essential health benefits.
3. Adjust the services covered and benefit limits on an actuarially equivalent basis.

[10] http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf, Page 12

The first two items above are decisions to be made by the State. The third item reflects decisions made by insurers with State oversight, if the State decides to make this option available to them.

4

Methodology

Identification of Options and Initial Comparison of Current Benefits

Federal guidance provides Hawai'i the option to select one of ten plans as a benchmark plan for 2014 and 2015. The market basket of services within one of these plans will be collectively selected as the EHB. States may select from the three largest state employee health plans by enrollment. For Hawai'i, two of the options are HMSA plans (562 PPP and 620 PPP) and the benefits covered under both plans are the same. The other state employee plan option is the Kaiser HMO plan. The Kaiser state employee HMO plan is identical to one of the top three small group plans and the largest HMO plan in Hawai'i. Since only the covered benefits are used to determine the EHB package, Hawai'i has only seven total unique options rather than ten.

Hawai'i has only seven unique options from which to select a benchmark plan.

The following table summarizes the ten options Hawai'i has to select from.

Category of Eligible Plan	Hawai'i Plan Options
State employee health plans	[illegible]
[illegible]	[illegible]
Small group market plans	[illegible]

*These plan options are the same plan.

Benefit booklets for each of the benchmark plan options were provided to Oliver Wyman. The benefits were summarized and compared across all plans. The language used in the benefit booklets is not standardized across insurers and, in certain circumstances, is open to interpretation. Thus, the comparison occasionally required interpretation based on our experience of industry practices, particularly in instances where benefits were not specifically listed in the booklets as either a covered or excluded benefit.

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

In an effort to increase accuracy, the full comparisons were provided to the insurers offering each of the plans eligible for benchmark status, with the exception of the FEHBP plans. These entities were asked to review the determinations and provide a revised copy of the summaries making any necessary corrections. A response to this request for verification was received from the three largest small group plans and the state employee plan, and their comments were incorporated within the analysis. A summary of the comparison of current benefits is included in Appendix A. It is important to note that the benefits shown in Appendix A reflect the benefit plan most commonly provided by each carrier. This includes prescription drug coverage, which is offered as an optional rider by all benchmark options, except for the FEHBP plans for which prescription drug coverage is part of the plan or the state employee plan for which prescription drug coverage is not provided.

Categorized and Supplemented Benefits

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

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

- Women's wellness benefits;
- A and B recommendations from the U.S. Preventive Services Task Force (USPSTF);
- Benefits included in the Bright Futures/American Academy of Pediatrics guidelines;

- Habilitative services;
- Pediatric oral and vision services; and
- Parity requirements in MHPAEA[11]

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

Detailed regulations have not yet been promulgated by HHS specifying final rules for supplementing benefits. Additionally, the EHB bulletin is not detailed enough to know with certainty how benefits must be supplemented. For this analysis, it was assumed that MHPAEA parity requirements will not permit limits to be applied to non-biologically based mental illnesses. Such limits are common in the benchmark plan options. HHS guidance provides various options to states when supplementing benchmark options for habilitative and pediatric oral and vision services.

Habilitative Services

The EHB Bulletin indicates that HHS is considering the following two options for supplementing habilitative services when not included in the selected benchmark or any other benchmark options:

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

Under either approach, a plan would be required to offer at least some habilitative benefits. If HHS and future rules allow plans to determine their own habilitative benefit and then report to HHS, the State should consider establishing parameters regarding minimum services or further define "habilitative," thereby ensuring that all habilitative service packages being reported to HHS remain representative of the benefits as defined by the State.

For this analysis, it was assumed that habilitative services would be offered at parity with rehabilitative services, and that the definition of these services would be consistent with the definitions currently used in the commercial market. Specifically, these definitions focus on creating skills and functions, rather than "keeping" or "maintaining" function.

[11] Mental Health Parity and Addiction Equity Act of 2008 requires certain plans to provide benefits, including cost sharing and treatment limits, for mental health and substance use disorder that are no more restrictive than the medical and surgical benefits of the plan.

Pediatric Dental Services

The general absence of pediatric[12] dental services beyond screening and medically related dental repair in most benchmark plan options means that the State will likely need to supplement the benchmark plan. For pediatric dental services, the EHB Bulletin requires the State to supplement benefits from either of the following options:

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

In supplementing benchmark plans for pediatric oral services, this analysis used the estimated costs that are equivalent to the State Child Health Insurance Program (CHIP) program, as published by the National Association of Dental Plans (NADP).[13] The CHIP plan includes preventive and basic dental services as well as advanced dental services. The analysis used the CHIP plan that does not include orthodontia.

Pediatric Vision Services

Plans that do not contain pediatric vision services must be supplemented with benefits covered by the FEDVIP vision plan with the largest enrollment. HHS guidance indicates that the FEDVIP vision plan with the highest enrollment in 2010 covers routine eye exams with refraction, corrective lenses, frames and contact lenses.[14] Further, the 2012 FEDVIP vision plans include both service and dollar limits in its coverage. As an example, the FEDVIP BlueVision plan covers one set of contact lenses per year, up to $130.[15] This combination of both a limit on the frequency with which vision hardware may be replaced, and a dollar limit on the cost of the hardware, could be considered to effectively create an overall annual dollar limit on the vision hardware benefit that is prohibited by the ACA. For this analysis, an assumption was made that a scheduled dollar allowance per set of vision hardware will be allowed to remain, however restrictions on the frequency with which the hardware may be replaced are lifted. The resulting benefit becomes a benefit with a scheduled allowance per service. It is important to note that a scheduled dollar allowance per service with no limitation on the number of services differs from the prohibition on annual dollar limits.

This benchmark option comparison analysis is not impacted by which habilitative services or pediatric oral and vision option is used for supplementing the benchmark package since any

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[12] At present, there is no guidance in the ACA, the Final Rule, the Bulletin or FAQs defining the term "pediatric."

[13] National Association of Dental Plans. "Offering Dental Benefits in Health Exchanges: A Roadmap for Federal and State Policymakers." September 2011

[14] http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

[15] http://cvw1.davisvision.com/forms/StaticFiles/English/FEP2012BenefitSummary.pdf

plan selected as the benchmark would be required to cover these benefits, the additional cost added to each plan is the same.

Hawai'i Mandated Benefit Comparison

Hawai'i law requires certain benefits to be covered by each individual or small group plan offered in the State. Appendix D contains a comparison of the State mandated benefits currently covered by each of the benchmark plan options. The list of mandated benefits was provided by the Hawai'i DCCA Insurance Division and was limited to mandates on covered services, as opposed to requirements related to administration of the plan. All of the benchmark plan options were found to cover every State mandated service, with the exception that in-vitro fertilization (IVF) is not covered by the FEHBP plans. Therefore, if the State selected one of the FEHBP plans as its benchmark plan, IVF would not be included in the EHB and the State would be required to cover the cost of the IVF services for anyone enrolled in a QHP.

For the purposes of this analysis, each of the benchmark plan options was supplemented, resulting in a complete set of benefits that would be required to be covered in the EHB. Should one of the FEHBP benefit packages be selected as the State's EHB IVF would not be included in the EHB. However, IVF would continue to be required to be covered as a mandated benefit, unless repealed by the State, and the cost of IVF coverage would be required to be defrayed by the State for all individuals enrolled in a QHP. We estimate that this could cost the State between $4.00 and $4.50 per month for each individual enrolled in a QHP.. A comparison of these supplemented plans is provided in Appendix E.

Analysis for Benchmark Selection

Using the supplemented benefit packages described above and shown in Appendix E, outlier benefits were identified. Outlier benefits are defined as those where the benefits after supplementation differ among the benchmark plan options. Benefits could be considered outliers because they are covered by one plan but not covered by another. Benefits that are covered by all benchmark plan options could be considered outliers if differences in the level of coverage varies among plans (e.g., number of home health visits covered per year). Benefits that are not outliers – those that are common to all benchmark plans – were priced to estimate the claim cost that is assumed to be common to all benchmark plans. Since benefits not flagged as outliers are common to all benchmark plans, the outlier benefits drive the difference in cost among the benchmark plan options. For the outlier benefits, actuarial analysis of each variation of the benefit was performed separately to determine the estimated cost of the benefit for each benchmark plan option. A comparison of the outlier benefits is provided in Appendix F.

The sum of the common benefit claim cost and the outlier claim cost specific to each plan determined the estimated claim cost for each plan. A relative claim cost was then developed for each plan. The largest small group plan benefit package (HMSA PPO) was selected as a reference benefit package and the cost of each benchmark benefit package was compared to the cost of the reference plan benefit package to determine the relative value. The relative cost compared the total cost of the benefits covered in each benefit package, but did not consider

any cost sharing required under the current benchmark plan options, as cost sharing is not part of the EHB package.

Analysis was based largely on Oliver Wyman's internal pricing model.[16] For benefits that are not commonly covered in today's commercial market, therefore limiting the available data, analysis of publicly available studies was used to supplement the analysis. For plans that contain benefits which currently have annual dollar limits applied, it was assumed those limits apply in our analysis. However, should a plan with any of these limits be selected as the benchmark plan, the annual dollar limit will need to be removed and an actuarially equivalent benefit included. This substitution would have no impact on the overall relative cost between the plans.

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

5

Findings and Pricing Analysis

Several analyses were undertaken to compare Hawai'i's benchmark plan options. These analyses include:

1. Coverage of State mandated benefits
2. Relative cost of benefits covered under the benchmark plan options
3. Benefit variations and outliers across benchmark options

The findings from each of these analyses show variations exist among the benchmark plan options. The detailed findings across each of these analyses are discussed below.

State Mandated Benefits

As previously discussed, under the ACA, states are responsible for the cost of state mandated benefits that are not included in the EHB package for those individuals enrolled in a QHP. Benefit mandates under Hawai'i law currently apply to all of the small group and HMO benchmark options. While mandates in insurance laws generally do not apply to the state employees plan, the state employees plan does contain all mandated benefits in Hawai'i. Thus, selecting a small group, HMO or state employees plan as the benchmark would include the State mandated services in the EHB package with no costs to the State.

In today's market, FEHBP plans are not required to provide coverage for state mandates. The only Hawai'i state mandated benefit that is not covered by the FEHBP plans is coverage for IVF. Hawai'i mandates that a one-time only benefit for all outpatient expenses arising from IVF procedures performed on the insured be provided.[17] Therefore, if one of the FEHBP options were selected as the benchmark plan, these benefits would be required to be covered in the individual and small group markets pursuant to Hawai'i law. However, they would not be part of the EHB package and as a result the cost would be borne by the State for all individuals enrolled in a QHP. However, it is unclear whether Hawai'i would have to pay the cost for only those QHP enrollees who purchase coverage in the Exchange, or for all QHP enrollees both inside and outside the Exchange. HHS has not provided final guidance related to this issue.

The State would be required to cover the cost of IVF services if one of the FEHBP plans were selected as the benchmark plan. Oliver Wyman estimates this could cost the State between $4.00 and $4.50 per member per month for each individual enrolled in a QHP.

[17] Sections 431 :10A-16.5, 432 :1-604 and 432D-23 of the Hawaii Revised Statutes

A complete analysis of the cost to the State of Hawai'i associated with covering this mandate is outside the scope of this report and would require additional data to be collected from carriers in the State, as well as the FEHBP program, to ensure all details of the benefit provisions have been interpreted correctly. Claims experience on the actual cost of providing this benefit in Hawai'i would also need to be gathered. However, based on our research and the level of benefit information we do have available to us, we estimate that the cost to the State of covering this benefit could be between $4.00 and $4.50 per member per month, or approximately 1.25% of claims, for each individual enrolled in a QHP.

Alternatively, the State could repeal the mandate, in which case selecting an FEHBP plan as the benchmark option would result in no additional cost to the State.

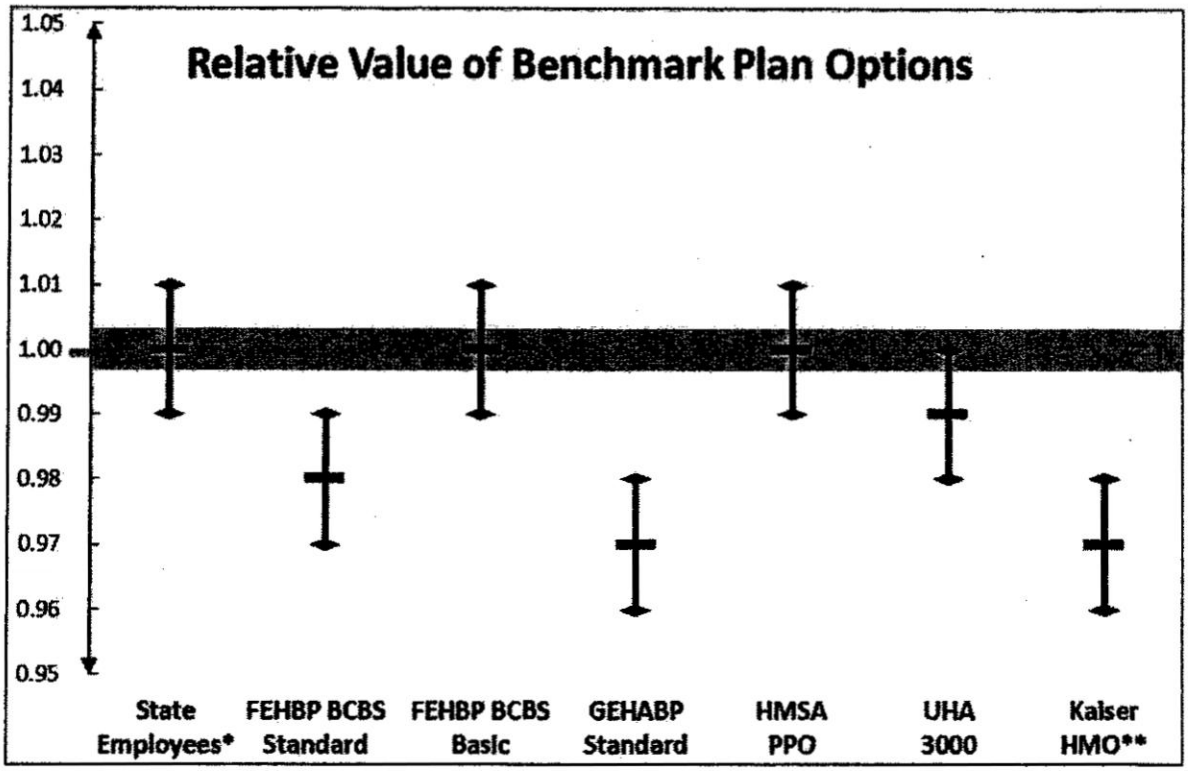
Relative Value of Benchmark Plan Options

A holistic pricing analysis was performed to compare the relative cost, and the rough impact on premiums, of selecting one benchmark benefit plan options over another. Small group option 1 (HMSA PPO) was selected as a reference benefit plan given it is the default option if the State does not proactively select a benchmark plan. Actuarial analysis was then performed to estimate the relative allowed cost of the covered benefits in each plan, once supplemented as previously described.

It is important to note that this analysis does not reflect the impact on current premiums, as such an analysis would require a complete review of all plans currently offered in the market, including an analysis of the underlying costs of each plan.

The results of this relative value analysis are shown graphically on the following page. The graph shows the point estimate of the relative value as well as a +/- 1% margin around the point estimate. This is intended to depict the uncertain nature of the estimates, given a complete review of provider costs and utilization levels in the Hawai'i market was not performed. In addition, different insurers may assign different values to the benefits than are included in our estimates. The value of the plans does not reflect any difference in costs by insurer. Rather, it only is intended to show the estimated difference in the value of benefits, assuming all else, such as network, provider contracts, and utilization management, is equal.

The relative values shown for each plan do not reflect anticipated differences in premiums by insurer, but rather differences in the value of the benefit packages offered by each.



*EUTF benefit plans
**Represents the largest HMO plan, one of the largest State employee plans, and one of the largest small group plans

The graph shows that the seven benchmark plan options that are specific to Hawai'i are similar in their relative value in aggregate, however the differences are not insignificant. The relative value analysis incorporates the supplemental benefits that must be offered as a result of ACA. Consequently this supplementation eliminates any differences in relative value as a result of needing to add coverage for habilitative services, for example. It is not our intention to discount the potential cost impact of being required to add additional services to QHPs, but to aid the State in choosing the benchmark plan for the EHB. Any benchmark plan that is chosen will need to be supplemented and thus the supplementation will have no relative value impact across plans.

Benefits Causing the Difference in Plan Values

It is important to understand which benefits are causing differences in the relative values shown. First, as previously discussed, if a benchmark plan is chosen that does not include Hawai'i mandated benefits, then Hawai'i will have to pay the cost of these additional benefits for QHP enrollees, unless the mandated benefits are repealed prior to 2014. Second, if policymakers

prefer that certain benefits are included for medical efficacy or social reasons, then it is important to know which benefits cause the difference in values. If final rules allow insurers to substitute benefits, however, then this second consideration may become less important.

Below we highlight the differences for each plan relative to the HMSA small group PPO plan.

State Employee Benefit Package Options

As discussed earlier, two of the three largest State employee plans are administered by HMSA (EUTF plans). Both of these plans have the same covered benefits and only differ in member cost sharing. The third largest State employee plan is the Kaiser HMO plan, which will be discussed in more detail later in this section.

The HMSA State employee benefit package and the HMSA PPO benefit package are very similar in all of the benefits provided. The only difference is that the HMSA State employee plans provide coverage for routine vision exams, whereas the HMSA PPO does not provide coverage for this benefit. We estimate the relative value of offering routine vision exams to be less than one percentage point.

FEHBP Benefit Package Options

While the relative value in benefits between these plans and the HMSA small group PPO plan are relatively small, there are several differences in the benefits that are noteworthy. First, the FEHBP plans do not cover IVF which is a State mandated benefit. As previously discussed, if one of the FEHBP benefit packages are selected as the benchmark plan, IVF would not be included in the EHB. However, unless repealed, it would be required to be covered as it is a mandated benefit, and the cost would be borne by the State for individuals enrolled in a QHP. It is estimated that coverage for IVF accounts for roughly 1.25 points of the relative value between plans. Second, none of the FEHBP plans provide coverage for genetic screening, genetic testing, or vision hardware. In the event one of the FEHBP plans were selected as the benchmark plan, these benefits would not be included in the EHB and would not need to be offered by QHPs.

In contrast, the FEHBP plans provide coverage for chiropractic services, acupuncture, and routine adult dental care, whereas the HMSA PPO plan does not provide coverage for these services.

The relative value difference in benefits between the FEHBP Basic plan and the other two FEHBP plans is due to the presence of a comprehensive dental plan. While all three FEHBP plans cover some dental services, the Basic Option has fewer services subject to a scheduled allowance. Since cost sharing is not part of the analysis, the benefit is estimated to have a relatively high value.

UHA 3000 PPO

The relative value of benefits for the UHA 3000 PPO plan is slightly lower than the HMSA small group PPO plan as a result of not providing vision hardware benefits and considerably leaner benefits for physical and occupational therapy services. However, the UHA 3000 PPO plan does provide coverage for chiropractic and acupuncture services, whereas the HMSA small group PPO plan does not. The net impact of these differences in benefits is that the UHA 3000 PPO benefit package relative value is estimated to be one percent lower than that for the HMSA PPO benefit package.

Kaiser HMO

As mentioned previously, the Kaiser HMO plan represents one of the three largest small group plans, the largest HMO plan, and also one of the three largest State employee plans. As you will notice, the benefit package relative value point estimate for Kaiser is 0.97, or three points lower than the HMSA small group PPO benefit package. This difference is driven by the fact that durable medical equipment (DME), external prosthetics, vision hardware, and hearing aid benefits that are provided by the HMSA small group PPO plan and are not provided by the Kaiser HMO plan. We looked into these benefit differences in more detail as it is unusual for a comprehensive benefit plan not to provide coverage for DME and prosthetics. Through discussions with Kaiser, it is our understanding DME services are provided to individuals and small groups as an optional rider, but is not one of the most commonly chosen benefits by members and therefore would not be included in the benchmark plan.

In the event the Kaiser HMO plan is chosen as the EHB, neither DME nor prosthetic devices will be required to be offered by QHPs.

In the following table we provide a high level comparison of the benefit differences between each of the benchmark plans. A more detailed comparison is provided in Appendix F.

Benefit	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Benefit	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
[illegible]							
[illegible]	X		X		X	X	X
[illegible]							
[illegible]					X		
[illegible]							
[illegible]					X	X	
[illegible]	X	X	X	X	X	X	X
[illegible]	X	X	X	X	X	X	X
[illegible]	X	X	X	X	X	X	X

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

6

Policy Considerations in Selecting a Benchmark Plan

Although HHS has not provided a specific list of criteria to be used in selecting the benchmark plan, there are several considerations that could influence the State's choice of a benchmark plan. Several of these items are discussed in more detail below.

State Mandated Benefits

Any state mandated benefits that are not covered by the plan selected as the benchmark must be added to the benchmark benefits and the State must cover the cost of the mandated benefits added for any individual enrolled in a QHP. This assumes the State would not repeal the mandated benefit. The only Hawai'i State mandated benefit that isn't covered by every benchmark plan is IVF, which isn't covered by the FEHBP plans.

Small Group Market Disruption

The State should also consider the market disruption that may be caused by each of the benchmark options. Market disruption can be defined by covered benefits or additional cost. States must consider what benefits will be foregone or added and how these benefits impact the current individual and small group markets. Each benchmark plan option represents a market basket of services that would be required to be covered if selected as the benchmark. If the market basket included in one benchmark is more expensive than another, selecting the plan with the more expensive market basket would mean mandating a premium increase to individuals that currently have plans with a leaner market basket.

Individual Market Disruption

Additionally, since the benchmark selected would also impact the individual market, some states have also performed a detailed analysis of the most common plans in the individual market to gauge the disruption that will occur. In Hawai'i, individual benefit plans are required to provide coverage for State mandated benefits, which will help limit market disruption in the individual market.

Specific Benefits Covered

Specific benefits that are covered in one benchmark plan option but not another can also be considered. We refer to these as "outlier benefits." It then becomes a policy decision as to which benefits might be more important to cover (e.g., private duty nursing vs. wigs for chemotherapy patients). By examining the outlier benefits the State can be sure that the plan selected as the benchmark ensures medical efficacy and coverage of treatments that adequately prevent, ameliorate or cure conditions and diseases as effectively as possible.

Affordability

Given the benchmark plan will serve as a basis for defining the EHB package for Hawai'i, it essentially places a floor on the services that must be covered. While selecting a benchmark option with more comprehensive services may provide broader coverage, it comes with a cost. While selecting the HMSA PPO plan may result in the least amount of disruption in the current small group market, it is also the most expensive of the three largest small group plans and would result in higher premiums as compared to selecting the UHA 3000 or Kaiser HMO plan.

Consumer and Stakeholder Input

The State may wish to seek the input of consumers and other stakeholders. Some states have held consumer focus groups and/or public meetings to gather input and feedback related to the benchmark options available. Other states have solicited comments and feedback via other means, such as mail or email.

Ease of Administration by Carriers

Administration of benefits can vary based on the type of benefit. Selecting a benefit package that requires more manual administration of benefits could lead to higher administrative expenses and in turn higher premiums.

Appendix A

Existing Benefit Comparison Across Benchmark Plans

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
WELLNESS BENEFITS INCLUDING PREVENTIVE SERVICES AND SCREENINGS									
Adult Routine Physical Exam	NO	YES	Not covered	Covered	Covered	Covered	Covered	Covered	Covered
Well-Baby and Well-Child Care	YES	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Immunizations	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Routine Mammography Screening	YES	YES	[illegible]	Covered	Covered	[illegible]	[illegible]	[illegible]	[illegible]
HPV/Cervical Cancer Screening	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Newborn Hearing Screening	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Not Covered
	No	Yes	Covered	Covered	Covered	Covered	Not Covered	Not Covered	Not Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
[illegible]	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered Outpatient Only	Not Covered Outpatient Only	Not Covered
[illegible]	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered [illegible]
[illegible]	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered Outpatient Only	Not Covered Outpatient Only	Not Covered Outpatient Only
[illegible]	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
[illegible]	No	Yes	Covered	Covered Only [illegible]	Covered	Covered	Covered Additional Copayment Only	Covered Additional Copayment Only	Covered
[illegible]	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
OUTPATIENT HOSPITAL SERVICES									
[illegible]	No	Yes	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	No	No	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	Yes	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	Yes	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FFHBP Option 1	FEHBP Option 2	FEHBP Option 3

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	No	No							
	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	No	No	Not covered	Not covered	Not covered	Not covered			
	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	No	No	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
	Yes	Yes	Covered	Covered	Covered	Covered			
	No	No	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
OUTPATIENT HOSPITAL SERVICES									

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
[illegible]	NO	NO	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	NO	NO	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	YES	NO	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	NO	NO	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	NO	NO	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	NO	NO	[illegible]	[illegible]	Not Covered	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	NO	NO	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	NO	NO	[illegible]	[illegible]	Speech only	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	NO	NO	[illegible]	[illegible]	Occupational only	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	NO	NO	[illegible]	[illegible]	Speech only	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	NO	NO	Not Covered	[illegible]	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
[illegible]	NO	NO	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	NO	NO	[illegible]	[illegible]	[illegible]	[illegible]	Not Covered	Not Covered	Not Covered
[illegible]	NO	NO	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	NO	NO	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
Medical/Surgical Supplies	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Oxygen	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Nuclear Medicine	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Injectable Drugs	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Infertility Services	YES	NO	IVF One-Time Only Benefit	IVF One-Time Only Benefit	One-Time Only Benefit	IVF One-Time Only Benefit	Covered – ART Excluded	Covered – ART Excluded	Covered – [illegible] IVF, ART and Prescription Drugs Excluded
Dental Implants	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	[illegible]	Not Covered
Genetic Testing and [illegible]	NO	NO	Covered	Covered – [illegible] only	Covered	Covered	Covered [illegible]	Covered [illegible]	Not Covered
Genetic Counseling	NO	NO	Covered	Covered	Covered	Covered	Not Covered	Not Covered	Not Covered
PHYSICIAN SERVICES									
Inpatient Visits	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Inpatient Surgery	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Outpatient Surgery	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Emergency Room Services	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Urgent Care Visits	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
Physician Office Visits	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered Preferred Provider Only	Covered
Laboratory Services	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Diagnostic Imaging	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Treat Maternity as Any Other Illness	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Prenatal Care	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Minimum Benefit for Mental Illness (30 Office Visits)	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Minimum Benefit for Alcoholism/Drug Abuse Treatment	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
PRESCRIPTION DRUG COVERAGE									
Retail and Mail Order Prescription Drugs	No	No	Covered	Covered	Covered	Not Covered	Covered	Covered	Covered
Prescription Contraceptive	Yes	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Smoking and Tobacco Cessation Prescription Drugs	No	No	Covered	Not Covered	Covered	Covered	Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
OTHER COVERED SERVICES									
Ambulance Service	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Durable Medical Equipment and Supplies	NO	NO	Covered	Covered	Not Covered	Covered	Covered	Covered	Covered
[illegible]	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
[illegible] Equipment and Supplies	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Oxygen	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	NO	NO	Covered	Covered	[illegible]	Covered	Covered	Covered	Covered
Home Health Care	NO	NO	[illegible] Visits per Year	100 Visits per Year	No Limit	[illegible] Visits per Year	25 Visits per Year	[illegible] Visits per Year	[illegible] Visits per Year
Skilled Nursing Facility (SNF)	NO	NO	120 Days per Year	120 Days per Year	60 Days per Year	120 Days per Year	No Limit	No Limit	[illegible]
Custodial/Convalescent Care	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Respite Care	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	[illegible]	[illegible]	Not Covered
Chiropractic Manipulation	NO	NO	Not Covered	$500 limit	Not Covered	Not Covered	12 Visits per Year	12 Visits per Year	[illegible] Visits per Year

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
[illegible]	No	No	[illegible]	[illegible]	Not covered	[illegible]	[illegible]	Covered	[illegible]
[illegible]	No	No	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	No	No	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	Yes	No	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	No	No	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	No	No	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	No	No	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	No	No	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	No	No	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
	No								
	No	No							
	No								
	No	No							
	No	No							
Non-Covered Services									
	No	No							
	No	Yes							

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Appendix B

EHB Categories Across Benchmark Plans

ESSENTIAL HEALTH BENEFIT BENCHMARK PLAN OPTIONS HAWAI'I DEPARTMENT OF COMMERCE & CONSUMER AFFAIRS, INSURANCE DIVISION

EHB Category	Sub-Category	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	YES	[illegible]	[illegible]	YES	[illegible]	[illegible]
	[illegible]	[illegible]	NO	[illegible]	[illegible]	NO	[illegible]	[illegible]
[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	YES	[illegible]
[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	YES	[illegible]	[illegible]	YES	YES	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Routine Vision?	[illegible]	YES	YES	YES	YES	YES	NO
	Vision Hardware	NO	NO	NO	NO	NO	NO	NO

Appendix C

List of Required Supplemented Benefits

USPSTF A and B Recommendations[18]

Benefit	Description

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

Benefit	Description

Benefit	Description

Women's Wellness Benefits[19]

Benefit	Description

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

Bright Futures Recommendations for Pediatric Preventive Health Care[20]

Benefit	Interval

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

Appendix D

State Mandated Benefits Across Benchmark Plans

Legal Reference	Mandate Description	Small Group Option 1	Small Group Option 3	Small Group Option 2	State Employee Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3

Legal Reference	Mandate Description	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employee Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3

Appendix E

Supplemented Benefits Across Benchmark Plans

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
WELLNESS BENEFITS INCLUDING PREVENTIVE SERVICES AND SCREENINGS									
Adult routine physical exam	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Well-baby and well-child care	YES	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Immunizations	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Breast cancer mammography screening	YES	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Cervical cancer screening	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Colorectal cancer screening	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Prostate cancer screening	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Diabetes screening	YES	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Depression screening	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
[illegible]	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Preventive Colonoscopy	YES	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Allergy Testing	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Diabetes Screening	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible] Counseling About Genetic Testing	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Not Covered
	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Yes	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Not Covered
	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	No	No	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Yes	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Yes	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	No	No	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
[illegible] Counseling	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Nutritional Counseling	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
HPV Vaccine	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Flu Vaccine	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Gonorrhea Prophylactic Medication for Newborns	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Iron Supplementation for Children	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Blood Pressure Screening for Adults	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Cholesterol Screening	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Counseling for Sexually Transmitted Infection	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Abdominal Aortic Aneurysm Screening (Men ages 65-75 who have smoked)	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Alcohol Misuse Counseling	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Aspirin to Prevent Cardiovascular Disease	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]									
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
[illegible]	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Complications of Pregnancy	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Medical Supplies	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Durable Medical Equipment	NO	NO	Covered	Covered	Not covered except during hospitalization	Covered	Covered	Covered	Covered
Prosthetics	NO	NO	Covered	Covered	Not covered (internal prosthetic covered only)	Covered	Covered	Covered	Covered
Drugs	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Blood	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Inpatient Rehab Services	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
Mental Health Services	Yes	No	Covered Same as Other Illnesses and Conditions in compliance with federal parity requirements	Covered Same as Other Illnesses and Conditions in compliance with federal parity requirements	Covered Same as Other Illnesses and Conditions in compliance with federal parity requirements	Covered Same as Other Illnesses and Conditions in compliance with federal parity requirements	Covered Same as Other Illnesses and Conditions in compliance with federal parity requirements	Covered Same as Other Illnesses and Conditions in compliance with federal parity requirements	Covered Same as Other Illnesses and Conditions in compliance with federal parity requirements
Alcohol/Substance Abuse	Yes	No	Covered Same as Other Illnesses and Conditions in compliance with federal parity requirements	Covered Same as Other Illnesses and Conditions in compliance with federal parity requirements	Covered Same as Other Illnesses and Conditions in compliance with federal parity requirements	Covered Same as Other Illnesses and Conditions in compliance with federal parity requirements	Covered Same as Other Illnesses and Conditions in compliance with federal parity requirements	Covered Same as Other Illnesses and Conditions in compliance with federal parity requirements	Covered Same as Other Illnesses and Conditions in compliance with federal parity requirements
Transplants	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Reconstructive Breast Surgery Post Mastectomy	Yes	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Surgery to Correct Congenital Anomalies	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Other Reconstructive Surgery	No	No	Illness or injury	Illness or injury	Accident or injury	Illness or injury	Functional Defect or to Restore Mouth due to Pre-cancerous spot	Functional Defect [illegible] Mouth [illegible] cancerous [illegible]	Surgery to correct a condition that produced a Major Effect on the Member's appearance
Bariatric Surgery	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
LASIK Surgery	No	No	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
Tubal Ligation	NO	YES	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Vasectomy	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Reversal of Voluntary Sterilization	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Inpatient Hospice	YES	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered combined Inpatient and Outpatient Maximum of [illegible]
Vision [illegible]	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Anesthesia and Hospital Charges for Dental Procedures for Children Under Age 5 and Persons With Serious Mental, Physical or Behavioral Problems	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]									
[illegible]	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	Yes	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
[illegible]	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Cardiac Rehab	No	No	Not Covered	Not Covered	Not Covered	Not Covered	No Visit Limit	No Visit Limit	No Visit Limit
Pulmonary Rehab	No	No	Covered	Covered	Covered	Covered	No Visit Limit	No Visit Limit	No Visit Limit
Physical Therapy	No	No	[illegible] Days per Year	[illegible]	Short Term Only	[illegible] Days per Year	[illegible] Visits per Year	[illegible] Visits per Year	[illegible] Visits per Year
Occupational Therapy	No	No			Short Term Only				
Speech Therapy	No	No	Covered	Covered	Short Term Only	Covered			[illegible] Visits per Year
Habilitative Services and Devices	No	No	Covered – As Supplemented	Covered – As Supplemented	Covered – As Supplemented	Covered – As Supplemented	Covered – As Supplemented	Covered – As Supplemented	Covered – As Supplemented
Hydrotherapy	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Hyperbaric Oxygen Therapy	No	No	Covered	Covered	Covered	Covered	Not Covered	Not Covered	Not Covered
Dialysis	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Blood and Plasma	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Medical and Surgical Supplies	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Oxygen	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Nuclear Medicine	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Injectable Drugs	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Infertility Services	Yes	No	IVF one time only benefit	IVF one time only benefit	One time only benefit	IVF one time only benefit	Covered – ART Excluded	Covered – ART Excluded	Covered – [illegible] Visits per Year, ART and Prescription Drugs Excluded

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
Dental Implants	No	No	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Covered Screenings for Testing	No	No	Covered	Covered	Covered	Covered	Covered from Different Generic Testing	Covered from Different Generic Testing	Not Covered
Dental Procedures	No	No	Covered	Covered	Covered	Covered	Not Covered	Not Covered	Not Covered
PHYSICIAN SERVICES									
Office Visits	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Inpatient Surgery	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Outpatient Surgery	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Emergency Room Services	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Hospital Stays	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Physician Fees	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Urgent Care	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Mental Health and Other Illness	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Prenatal	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PRESCRIPTION DRUG COVERAGE									
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
OTHER COVERED SERVICES									
Ambulance Services	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
Durable Medical Equipment and Devices	NO	NO	Covered	Covered	Not Covered	Covered	Covered	Covered	Covered
Private Duty Nursing in the Home	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Home Dialysis Equipment and Supplies	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Oxygen	NO	NO	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Prosthetic Devices	NO	NO	Covered	Covered	Not Covered (Internal Prosthetics covered only)	Covered	Covered	Covered	Covered
Home Health Visit	NO	NO	150 Visits per Year	150 Visits per Year	No Limit	150 Visits per Year	25 Visits per Year	[illegible] Visits per Year	[illegible] Visits per Year
Skilled Nursing Facility Care	NO	NO	120 Days per Year	120 Days per Year	60 Days [illegible]	120 Days per Year	No Limit	No Limit	[illegible]
Custodial/Convalescent Care	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Respite Care	NO	NO	Not Covered	Not Covered	Not Covered	Not Covered	[illegible]	[illegible]	Not Covered
Chiropractic Manipulation	NO	NO	Not Covered	$500 limit	Not Covered	Not Covered	[illegible] Visits per Year	[illegible] Visits per Year	[illegible] Visits per Year
Acupuncture	NO	NO	Not Covered		Not Covered	Not Covered	[illegible] Visits per Year	Covered	[illegible] Visits per Year (Medically Necessary)

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
[illegible]	No	No	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
[illegible]	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	No	No	[illegible]	[illegible]	Not covered	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	No	No	Covered	Covered	Limits apply	Covered	[illegible]	[illegible]	[illegible]
[illegible]	No	No	Covered	Covered	Covered	Covered	Covered	Covered	Covered
[illegible]	No	No	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
[illegible]	No	Yes	Covered	Covered	Covered	Covered	Covered	Covered	Covered

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
ANCILLARY BENEFITS									
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employees Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
[illegible]	No	No	Covered	[illegible]	Covered	Covered	Covered	Covered	Covered
Routine Dental	No	No	Not Covered	Not Covered	Not Covered	Not Covered	[illegible]	[illegible]	[illegible]
[illegible]	No	No	Covered	Covered	Covered	Covered	Covered	[illegible]	Covered
Routine Eye Exam	No	No	Covered	Not Covered	Covered	Covered	Not Covered	Not Covered	Not Covered
Hearing Aids	No	No	[illegible]	[illegible]	Not Covered	[illegible]	[illegible]	[illegible]	[illegible]
Speech Generating Devices [illegible]	No	No	Covered	Covered	Covered	Covered	[illegible]	[illegible]	Not Covered

Appendix F

Outlier Analysis

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employee Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
WELLNESS BENEFITS INCLUDING PREVENTIVE SERVICES AND SCREENINGS									
[illegible]	No	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
INPATIENT HOSPITAL SERVICES									
[illegible]	No	No	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	No	No	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	No	No	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	Yes	No	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
OUTPATIENT HOSPITAL SERVICES									
[illegible]	No	No	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	No	No	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	No	No	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	No	No	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employee Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PRESCRIPTION DRUG COVERAGE									
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
OTHER COVERED SERVICES									

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employee Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
Durable Medical Equipment and devices	No	No	Covered if medically necessary; repair/replacement covered if not due to abuse	Covered if medically necessary; repair/replacement covered if not due to abuse	Not Covered (except during hospitalization)	Covered only when prescribed by your treating provider	Covered if medically necessary; repair/replacement covered if not due to abuse (various exclusions apply)	Covered if medically necessary; repair/replacement covered if not due to abuse (various exclusions apply)	Covered if medically necessary; repair/replacement covered if not due to abuse (various exclusions apply)
Prosthetic devices	No	No	Covered	Covered	Not covered (internal prosthetics covered only)	Covered	Covered	Covered	Covered
Home Health Visits	No	No	Covered – limit to 150 visits per year. Only when ordered by a physician and when skilled nursing care is required	Covered – 150 visits; Only ordered by physician and [illegible]	Covered	Covered – limit of 150 visits per year. Only when ordered by a physician and when skilled nursing care is required	Covered – 25 visits; Only when ordered by a physician and when skilled nursing care is required	Covered – 25 visits; Only when ordered by a physician and when skilled nursing care is required	Covered – 50 visits; Only when ordered by a physician and when skilled nursing care is required
Skilled Nursing Facility Care	No	No	Covered – 120 day [illegible]	Covered – 120 day limit	Covered 60 days per year	Covered – 120 days per year	Covered – No day limit [illegible]	Covered – No day limit [illegible]	Covered – Day 1 – $700 [illegible]
Respite Care	No	No	Not Covered	Not Covered	Not Covered	Not Covered	Covered – inpatient hospice for respite care covers up to seven days separated by 21 days discharged	Covered – inpatient hospice for respite care covers up to seven days separated by 21 days discharged	Not Covered
Chiropractic Manipulation	No	No	Not Covered	$500 Limit	Not Covered	Not covered	Covered – 12 visits per year	Covered – 12 visits per year	Covered – 12 visits per year

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employee Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employee Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3
Medical foods (food supplements, formula or special foods)	Yes	No	Covered only for treatment of inborn errors of metabolism	Covered only for treatment of inborn errors of metabolism	Covered only for treatment of inborn errors of metabolism	Covered only for treating inborn errors of metabolism	Covered for children with inborn errors of amino acid metabolism and nutritional supplements administered under [illegible] [illegible] approved foods administered orally that provide [illegible] of nutrition [illegible] children up to age [illegible] per year	Covered for children with inborn errors of amino acid metabolism and nutritional supplements administered under [illegible] approved foods administered orally that provide [illegible] children up to age [illegible] per year	Covered for food supplements [illegible] [illegible]
ANCILLARY BENEFITS									
Routine vision exams – Adult	No	No	Not covered	Not covered	Covered	Covered	Not covered	Not covered	Not covered
Eyeglasses and contact lenses – Adult	No	No	Covered for certain medical conditions and subject to special limits	Not covered	Not covered	Covered for certain medical conditions and subject to special limits/exclusions	Not covered	Not covered	Available through [illegible] vision for no additional premium. Must use [illegible] provider. Discount only for eyeglasses
Routine Dental – Adult	No	No	Not covered	Not covered	Not covered	Not covered	Scheduled allowance for diagnostic and preventive services	Covers [illegible] exams, cleanings, fluoride treatment and $150 in X-rays	Scheduled allowance for diagnostic and preventive services

Benefit	State Mandate	Required Preventive or Women's Wellness	Small Group Option 1	Small Group Option 2	Small Group Option 3	State Employee Health Plan	FEHBP Option 1	FEHBP Option 2	FEHBP Option 3

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TO: COMMITTEE ON HEALTH
The Honorable Della Au Belatti, Chair
The Honorable Dee Morikawa, Vice Chair

COMMITTEE ON CONSUMER PROTECTION & COMMERCE
The Honorable Angus L.K. McKelvey, Chair
The Honorable Derek S.K. Kawakami, Vice Chair

SUBJECT: **SCR 35 SD1 – REQUESTING THE AUDITOR TO ASSESS THE SOCIAL AND FINANCIAL EFFECTS OF REQUIRING HEALTH INSURERS TO PROVIDE INFERTILITY PROCEDURE COVERAGE.**

Hearing: Monday, April 14, 2014
Time: 8:30 a.m.
Place: Conference Room 229

FROM: Na`unanikinau Kamali`i

This testimony in my personal capacity is in **strong support of SCR 35, SD1, with amendments**. SB 2909 SD 1 and SCR 35 SD1 are about the responsibility of the legislature to bring non-compliant laws into compliance and exercising its authority to do so. Health Plans that continue to use non-compliant state laws to justify its unlawful continuation of discriminatory practices is unjust. The audit will assist the legislature in determining what is myth and what is fact and what amounts to unjust enrichment for the health plans. Health Plans have financially benefitted from and perpetuated an IVF coverage law that wrongfully created two classes of members in women and thus discriminated, victimized and demeaned women who were diagnosed with infertility by denying the IVF coverage benefit to women were not married. This practice continues even though it is strictly prohibited under the ACA.

The audit will assist in settling the cost issues to fix a law that has not been in compliance with federal and state laws and must address compliance and discriminatory provisions. The last tactic by health plans is to wrongfully assert that bringing the law in compliance will result in a cost shifted to the state, which health plans say must pay to right the wrong even though for years health plans have benefited greatly financially unjustly from the discriminatory provisions. Clearly, it is health plans that must pay for the discriminatory practices.

This Audit request is a review of the first instance where a discriminatory law is being amended to bring a mandated benefit in compliance under the provisions of the Affordable Care Act. Changes in State mandates to bring them in compliance and remove discriminatory provisions are not an "expansion" or "added essential health benefit" even though such changes may cost more for health plans to cover all women in a non-discriminatory way and are required under prohibition sections of

the ACA. (See 45 CFR §156.125 Prohibition on discrimination and 45 CFR §156.200 (e) *Non-discrimination.* A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, **age, sex**, gender identity or sexual orientation.)

Marital status has no rational relation to the treatment of a medical diagnosis and condition of infertility. The current IVF coverage law wrongfully creates two "classes" of premium paying members and is discriminatory on its face under ERISA, ADA, and ACA. Health plans deliberately upheld discriminatory provisions which called for a member to be married and use her husband`s sperm, reaping a prohibited premium savings from the practice. In application, employed health plan members who are single, divorced, widowed, partnered or otherwise "not married" women pay premiums just like married members diagnosed with infertility yet, ARE NOT eligible for the IVF coverage. The Hawaii legislature has not provided any rational basis for the "marital status" requirement, which rests squarely on moral grounds. In previous testimony, HMSA conceded that the marital status requirement needed to be changed. Kaiser called for an Audit, but sought more questions to be answered by the auditor which changes were part of the recommended changes by the CPN Committee.

The CPN Committee in its report stated the following: *"Your Committee notes that the addition of a new mandated health insurance benefit under Hawaii law may trigger Section 1311(d)(3) of the federal Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), which requires states to defray the additional cost of any benefits in excess of the essential health benefits of the state's qualified health plan."* The 27-year-old IVF benefit Coverage law is currently not in compliance and necessary changes are not an "addition" but rather corrective action to "goes beyond" the existing EHB, which is allowed, and the State does not defray the cost.

Further, Section 1311(d)(3) of the ACA addresses Essential Health Benefits defined in 1302 (b)(1), which as later codified federal regulations on included State Mandates under the allowed Essential Health Benefit Benchmark plan which covers at least the each of the 10 categories. Each state has different HHS approved essential health benefit benchmark plans reflecting these mandates and Hawaii`s approved mandates includes the IVF coverage law. Thus, the Hawaii IVF coverage law is part of the Essential Health Benefit benchmark plan and not "new" or an "additional" benefit that the state must pay for. If that were the case, the state would be paying for it right now, as this all went into effect on January 1. 2014. Final regulations regarding Essential Health Benefits are posted on the CMS website.

Recommended changes to SCR 35 SD1 (added underlined; deleted stricken; notes are commentary)

These are recommended changes to additional requests to the Auditor for inclusion in an impact assessment report beyond what is required by statute:

(2) Whether an expansion of infertility in vitro fertilization procedures to bring it in compliance with the discriminatory and "life time" benefit prohibitions under the Affordable Care Act would constitute benefits that are in excess of the essential health benefits benchmark plan ~~required~~ which includes state mandates approved for health insurance coverage under the federal Patient Protection and Affordable Care Act of 2010, thus requiring the State to defray such costs;

(3) Any other impacts or requirements of the federal Patient Protection and Affordable Care Act of 2010 if a mandate for expanded infertility in vitro fertilization procedures is enacted in Hawaii to address discriminatory, life time benefit, or any other provisions to otherwise bring it incompliance with all federal and state laws;

~~(4) Research on what is being used as the standard medical definition of "reproductive age" that is best suited for in vitro fertilization procedures and the success rates for different age groups to determine coverage benefit limitations for this covered benefit, including whether different standards of infertility treatments are applied to different age groups in need of infertility treatment;~~ *(Note: Age discrimination is prohibited under 45 CFR §156.125 Prohibition on discrimination and 45 CFR §156.200 (e) Non-discrimination. A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability,* ***age, sex,*** *gender identity or sexual orientation.)*

~~(5) An examination of current medically necessary standards of care used to determine what types of infertility treatment options are available at a more cost effective savings than in vitro fertilization, which may be best suited for individuals in need of infertility procedures;~~ *(Note: medical necessity determinations are preempted by federal statue and regulations and also fall within the doctor patient privilege wherein the patients physician and patient and the medical director exchange confidential HIPAA protected information concerning the medical diagnosis, which could include multiple diagnosis contributing to infertility and cannot legislated to establish standards but rather determined on a case by case basis)*

The Audit is long overdue as it relates to the financial impact based on the law and not based on the health plan's bottom line. Any changes to the mandated benefits will be opposed by health plans, even if the change is to bring the IVF benefit coverage law into compliance and end discriminatory practices. **Health plan testimony received thus far as it relates to the IVF coverage legislation has been in support of an audit.** I urge the legislature to pass SCR 35 SD1 and garner the facts it needs to address and bring into compliance the IVF coverage law.

Comments on underlying bills introduced – SB 2909 as amended

Although SCR 35 SD1 does not address substantive changes to the current law, it is required if such changes were made and the legislature still has the power and authority to do so. The underlying bills SB 2909 and its companion HB 2355, as amended, were introduced which addressed the substantive changes to the IVF

coverage laws were held in Ways and Means in the Senate and Finance on the House side. Testimony submitted in **strong support** of both measures recommended amendments: striking "lifetime" in the measure wherever mentioned and ensuring that it passes this session with an effective date of July 1, 2014 to address immediate compliance and discriminatory concerns. The attachments to testimony provided background, which may be informative to this audit.

Both bills SB2909 and HB2355, as amended, provide in vitro fertilization coverage equality for women who are diagnosed with infertility by requiring non-discriminatory coverage and ensuring quality of care in the diagnosis and treatment of infertility. For over 27 years the in vitro fertilization law in Hawaii provided coverage within a discriminatory framework, which must be corrected by the legislature. In vitro fertilization coverage is an Essential Health Benefit (EHB), which was included in Hawaii's essential health benefit plan and accepted by Health and Human Services and as of **January 1, 2014** strict federal prohibitions apply to EHB. Foremost, diagnosis and treatment of infertility disease should be brought in alignment with the national standards of the Center for Disease Control and as an EHB in compliance with ERISA, the American Disabilities Act and the Affordable Care Act. (see attached guidelines and Hawaii State mandates approved by HHS)

Summary of changes proffered in underlying bills SB2909 and SB2355:

The measures:

1. Find that infertility is a disease of the reproductive system that impairs and substantially limits an individual's major life activity of reproduction and recognizes infertility as a disability.
2. Require a diagnosis of infertility before treatment.
3. Propose IVF coverage as a "life time" benefit as opposed to a "one time" only benefits, however, the ACA prohibits such lifetime limits with respect to essential health benefits after January 1, 2014 and either old or proposed language must be stricken.
4. Focus on the success of having a child by providing cost effective measurable limitations of three in vitro fertilization cycles or a live birth (see Illinois
5. IVF law).
6. Mandate in vitro fertilization coverage equality for all women diagnosed with a medical condition of infertility by removing discriminatory language based on marital status. EHB may not contain discriminatory provisions.
7. Require a reasonable history of infertility based on national medical standard (ASRM) instead of an arbitrary five-year history.
8. Is consistent with Center for Disease Control national standards of infertility diagnosis categories.
9. Require coverage for other applicable treatments for infertility, unless the individual's physician determines that those treatments are likely to be unsuccessful.

10. Provide the American Society of Reproductive Medicine definition of "infertility".

Expanded Comments expressed in SB2909 and HB2355:

1. A diagnosis of infertility is a disability under the American Disability Act. Courts have held that women suffering from a diagnosis of infertility meet the definition of "disability" set forth in 42 U. S. C. § 12102(2)(A): a physical or mental impairment that substantially limits one or more major life activities. In examining the definition of physical impairment, the Courts have also concluded that women suffering from a diagnosis of infertility suffer from a physical impairment which is defined as "any physiological disorder, or condition, cosmetic disfigurement or anatomical loss affecting one or more of the following body system:....**reproductive** ..." 29 C.F.R. §1630.2 (h)(1).

2. The measures provide a "lifetime" limit for the IVF treatment. However, as of January 1, 2014, the restriction of lifetime dollar limits applies to essential health benefits. Because IVF coverage benefit is one of Hawai`i's essential health benefits (EHB) for Hawai`i as reported by CMS, lifetime and annual dollar limits for must be eliminated in 2014. Thus it holds that "lifetime" in the proposed legislation as well as the "one time only" in the current law must be stricken. The prohibition on lifetime dollar limits applies equally to grandfathered and non-grandfathered plans. Further, the plan must give the individual a written notice that the lifetime limit no longer applies and that the individual, if covered, is eligible for benefits. However, nothing in the rule would appear to prohibit the use of visit limits or other treatment limits. Thus, it would appear that the limitation of "three in vitro fertilization cycles or a live birth" is allowed and is measureable to contain cost.

3. The focus of the measures is on ensuring a live birth and not simply that one "try" is afforded the patient. The benefit becomes available when the patient is diagnosed with infertility disease, irrespective of whether she has had other children. The member becomes <u>eligible upon her physician's diagnosis of infertility</u> to treat her disease of infertility. Other states have also enacted language, which focuses the success of a live birth. Illinois IVF coverage law, for example, contains language similar to SB 2909 and HB2355, as amended, which provides coverage for more than one oocyte retrieval and is limited if a live birth follows. Coverage is required subject to the following conditions: ... "(B) the covered individual has not undergone 4 completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then 2 more completed oocyte retrievals shall be covered".

4. Marital status has no rational relation to the treatment of a medical diagnosis and condition of infertility. The current IVF coverage law wrongfully creates

two "classes" of premium paying members and is discriminatory on its face under ERISA, ADA, and ACA. Health plans deliberately upheld discriminatory provisions which called for a member to be married and use her husband's sperm, reaping a prohibited premium savings from the practice. In application, employed health plan members who are single, divorced, widowed, partnered or otherwise "not married" women pay premiums just like married members diagnosed with infertility yet, ARE NOT eligible for the IVF coverage. The Hawaii legislature has not provided any rational basis for the "marital status" requirement, which rests squarely on moral grounds. The purpose of the measures is to provide in vitro fertilization insurance coverage equality for women who are diagnosed with infertility by requiring non-discriminatory coverage and ensuring quality of care in the diagnosis and treatment of infertility. The corrective action by the legislature to eliminate the discriminatory marital status requirement is long overdue. The overriding corrective measure should prevail over any cost consideration to address prohibited discriminatory practices. The focus must again be on a diagnosis of infertility as a determinant on whether coverage will be provided.

5. In its guidance to patients, the American Society of Reproductive Medicine defines infertility as the inability to achieve pregnancy after one year of unprotected intercourse. If the individual has been trying to conceive for a year or more, she should consider an infertility evaluation. However, if she is 35 years or older, she should begin the infertility evaluation after about six months of unprotected intercourse rather than a year, so as not to delay potentially needed treatment.

6. The measures also provide for disease conditions that are consistent with national published guidelines and reporting. The Center for Disease Control reports for year 2011 is attached. (Attachment 2). Any age limitations would violate the ACA. (45 CFR §156.125; 45 CFR §156.200 (e))

Affordable Care Act (ACA) Considerations:

Since the enactment of the Affordable Care Act (ACA), the Department of Health and Human Services has issued several implementing regulations and rules, which have since been codified in Title 45 Code of Federal Regulations. The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act and ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans. Because there are general and specific provisions of the ACA, which apply to States, general and specific preemption considerations also apply.

In consideration of the underlying measures there appear to be ACA considerations as well that are instructive on the bill as well as statements of HHS or CMS concerning Essential Health Benefits.

1. Essential Health Benefits

In Vitro Fertilization Coverage is an Essential Health Benefit (EHB), which imposes no state liability under the ACA. By way of testimony in March 2011, the Hawaii Association of Health Plans ("HARP") raised the concern of the potential liability that the State would be facing by mandating even more extensive infertility treatments because the ACA is still in flux. This assertion is of no consequence and concern at this time post January 1, 2014 since the federal government has since issued two regulations and a final regulation at Federal Register, Vol. 78, No. 37, February 25, 2013 which has been codified in 45 CFR §156 which address these concerns. Also, CMS has published on its web site each States' Essential Health Benefits and IVF coverage is included as an EHB.

Generally the ACA provides that if a State requires issuers to cover benefits in excess of EHB, the Affordable Care Act directs the state to defray the costs of these benefits in Qualified Health Plans. States may include as part of their benchmark plan state benefit requirements, avoiding costs associated with these provisions. Because In Vitro Fertilization is a Hawaii State Required Benefit that is an Essential Health Benefit, there is no State liability. Other general considerations regarding the effect of the ACA on states are provided at the CMS or CCIO website at CMS.gov (Attachment 3)

2. **The ACA prohibitions on discrimination.**

The ACA prohibits discrimination as set forth in Title 45 of Code of Federal Regulations Part 156. Two sections in particular, which prohibit discrimination, are 45 CFR §156.125 and §156.200(e) of the subchapter and also in the Federal Register Vol. 78, No. 37(February 25, 2013). The marital status provision in the current IVF coverage law, which requires that the member be married in order to received treatment creates two classes of members and is in violation of the prohibitions on discrimination. Even if you disagree with its violation with any laws, marriage should not be the defining factor, which prohibits access to this benefit for women who have been diagnosed with infertility disability. Equal Access should be afforded to all.

> **45 CFR §156.125 Prohibition on discrimination.**
>
> (a) 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.
>
> (b) An issuer providing EHB must comply with the requirements of §156.200(e) of this subchapter; and

(c) Nothing in this section shall be construed to prevent an issuer from appropriately utilizing reasonable medical management techniques.

45 CFR §156.200 (e) ***Non-discrimination.*** A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

The Hawaii State legislature is a leader in health care with the historic passage of the Prepaid Health Care Act and should also be the same in the implementation of the Affordable Care Act and provision of this Essential Health Benefit for its citizens. The legislature should not be intimidated or persuaded by insurance companies who will go to any length to make an argument to hold the IVF legislation bills such as: 1) it costs too much, calling for an auditors report to confuse the necessary elimination of discriminatory language, 2) that it needs to be held for further study, when it holds 27 years of claims data on the benefit; or 3) that it would have difficulty administering the benefit even though it is a national health plan or partnered with national health plan networks in states which already administer similar plans or 4) that the State will have to pay for what is an the essential health benefit, which CMS confirms that there is no state liability.

For over 27 years, since the passage of the IVF mandate, the women in Hawaii have been bearing the cost to treat their disease of infertility even with IVF Coverage, the cost financially, the indescribable pain emotionally and left with the lifelong scars that poor legislation creates. For over 27 years the providers of infertility treatment have become leaders in the nation in treatment of assisted reproductive technologies, are highly regulated by CDC and leaders in our state by increasing IVF success rates in Hawaii from about 10% when the IVF coverage law was enacted to over 65% today. It is the legislature`s responsibility to correct discriminatory provisions and treatment provisions for all women diagnosed with infertility. Have the courage to pass out of committee SCR 35 SD1, as an audit is the first step to providing coverage for ALL women suffering from infertility disability equal access to quality affordable treatment.

Hawaii - State Required Benefits

Benefit	Name of Required Benefit	Market Applicability	Citation Number
Hospice Services	Hospice care	Individual, small group, large group, HMO	431:10A-119; 432:1-608; 432D-23
Infertility Treatment	In-vitro fertilization	Individual, small group, large group, HMO	431:10A-116.5 432:1-604 432D-23
Delivery and All Inpatient Services for Maternity Care	Newborn children	Individual, small group, large group, HMO	431:10A-115 432:1-602 432D-23
Mental/Behavioral Health Outpatient Services	Mental illness, alcohol, and drug dependence	Individual, small group, large group, HMO	431M-4 432D-23
Mental/Behavioral Health Inpatient Services	Mental illness, alcohol, and drug dependence	Individual, small group, large group, HMO	431M-4 432D-23
Substance Abuse Disorder Outpatient Services	Mental illness, alcohol, and drug dependence	Individual, small group, large group, HMO	431M-4 432D-23
Substance Abuse Disorder Inpatient Services	Mental illness, alcohol, and drug dependence	Individual, small group, large group, HMO	431M-4 432D-23
Specialty Drugs	Chemotherapy services	Individual, small group, large group, HMO	432:1-616
Preventive Care/Screening/Immunization	Mammography	Individual, small group, large group, HMO	431:10A-116 432:1-605 432D-23
Preventive Care/Screening/Immunization	Contraceptive services	Individual, small group, large group, HMO	431:10A-116.6 431:10A-116.7 432:1-604.5 432D-23
Preventive Care/Screening/Immunization	Child health supervison service	Individual, small group, large group, HMO	431:10A-115.5 432:1-602.5 432D-23
Preventive Care/Screening/Immunization	Colorectal screening	Individual, small group, large group, HMO	431:10A-122

Benefit	Name of Required Benefit	Market Applicability	Citation Number
Diabetes Care Management	Diabetes	Individual, small group, large group, HMO	431:10A-121 432:1-612 432D-23
Inherited Metabolic Disorder - PKU	Medical foods and low protein modified food products	Individual, small group, large group, HMO	431:10A-120 432:1-609 432D-23
Prescription Drugs Other	Chemotherapy services	Individual, small group, large group, HMO	432:1-616

The Center for Consumer Information & Insurance Oversight

Additional Information on Proposed State Essential Health Benefits Benchmark Plans

Background

Beginning in 2014, the Affordable Care Act requires non-grand fathered health plans to cover essential health benefits (EHB), which include items and services in the following ten 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. The essential health benefits should be equal in scope to a typical employer health plan.

In the Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule ("EHB Rule"), HHS defines EHB based on state-specific EHB-benchmark plans. This page contains information on EHB-benchmark plans for each of the 50 states, the District of Columbia (D.C.), and the U.S. territories. Two documents are provided for each EHB-benchmark plan in the 50 states, D.C. and Puerto Rico: (1) a summary of the plan's specific benefits and limits, and list of covered prescription drug categories and classes; and (2) state-required benefits.

The summaries of the covered benefits and limits, and lists of prescription drug categories and classes have been compiled based on the EHB-benchmark plan selection process described in 45 CFR 156.100 and 156.110. These summaries describe the EHB-benchmark plans that have been selected by states, as well as those that have been developed by HHS using the default benchmark plan selection process described in 45 CFR 156.100(c) and the supplementation methodology in 45 CFR 156.110.

Because EHB-benchmark plan benefits are based on 2012 plan designs, and include state-required benefits that were enacted before December 31, 2011, some of the benchmark plan summaries may not reflect requirements effective for plan years starting on or after January 1, 2014. Therefore, when designing plans that are substantially equal to the EHB-benchmark plan, beginning in 2014, issuers may need to conform plan benefits, including coverage and limitations, to comply with these requirements and limitations.

A list of each state's required benefits has also been compiled to help states and issuers determine the state-required benefits in excess of EHB. We consider state-required benefits (or mandates) to include only specific care, treatment, or services that a health plan must cover. We do not consider provider mandates, which require a health plan to reimburse specific health care professionals who render a covered service within their scope of practice, to be state-required benefits for purposes of EHB coverage. Similarly, we do not consider state-required benefits to include dependent mandates, which require a health plan to define dependents in a specific manner or to cover dependents under certain circumstances (e.g., newborn coverage, adopted children, domestic partners, and disabled children). Finally, we do not consider state anti-discrimination requirements, and state requirements relating to service delivery method (e.g., telemedicine) to be state-required benefits.

• **Guide to Reviewing Essential Health Benefits Benchmark Plans**

Essential Health Benefits Benchmark Plans

Alabama | Alaska | American Samoa | Arizona | Arkansas | California | Colorado | Connecticut | Delaware | District of Columbia | Florida | Georgia| Guam |Hawaii | Idaho | Illinois | Indiana | Iowa | Kansas | Kentucky | Louisiana | Maine | Maryland | Massachusetts | Michigan | Minnesota | Mississippi | Missouri | Montana | Nebraska | Nevada | New Hampshire | New Jersey | New Mexico | New York | North Carolina | North Dakota |Northern Mariana Islands | Ohio | Oklahoma | Oregon | Pennsylvania | Puerto Rico | Rhode Island | South Carolina | South Dakota | Tennessee | Texas | Utah | Vermont | Virgin Islands| Virginia | Washington | West Virginia | Wisconsin | Wyoming |

Alabama

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 333 KB)

- State-required benefits (PDF – 65 KB)

Alaska

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 446 KB)
- State-required benefits (PDF – 78 KB)

American Samoa

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF - 333 KB)

Arizona

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 442 KB)
- State-required benefits (PDF – 74 KB)

Arkansas

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 514 KB)
- State-required benefits (PDF – 79 KB)

California

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 364 KB)
- State-required benefits (PDF – 67 KB)

Colorado

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 306 KB)
- State-required benefits (PDF – 74 KB)

Connecticut

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 250 KB)
- State-required benefits (PDF – 77 KB)

Delaware

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 340 KB)
- State-required benefits (PDF – 70 KB)

District of Columbia

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 226 KB)
- State-required benefits (PDF – 68 KB)

Florida

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 397 KB)
- State-required benefits (PDF – 73 KB)

Georgia

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 444 KB)
- State-required benefits (PDF – 74 KB)

Guam

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF - 333 KB)

Hawaii

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 430 KB)
- State-required benefits (PDF – 69 KB)

Idaho

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 341 KB)
- State-required benefits (PDF – 63 KB)

Illinois

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 261 KB)
- State-required benefits (PDF – 78 KB)

Indiana

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 482 KB)
- State-required benefits (PDF – 72 KB)

Iowa

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 448 KB)
- State-required benefits (PDF – 71 KB)

Kansas

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 371 KB)
- State-required benefits (PDF – 69 KB)

Kentucky

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 330 KB)
- State-required benefits (PDF – 74 KB)

Louisiana

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 573 KB)
- State-required benefits (PDF – 73 KB)

Maine

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 363 KB)
- State-required benefits (PDF – 79 KB)

Maryland

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 387 KB)
- State-required benefits (PDF – 86 KB)

Massachusetts

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 278 KB)
- State-required benefits (PDF – 80 KB)

Michigan

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 310 KB)
- State-required benefits (PDF – 68 KB)

Minnesota

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 314 KB)
- State-required benefits (PDF – 89 KB)

Mississippi

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 376 KB)
- State-required benefits (PDF – 69 KB)

Missouri

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 432 KB)
- State-required benefits (PDF – 74 KB)

Montana

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 440 KB)
- State-required benefits (PDF – 67 KB)

Nebraska

- Guide to reviewing EHB benchmark materials

- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 370 KB)
- State-required benefits (PDF – 67 KB)

Nevada

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 555 KB)
- State-required benefits (PDF – 74 KB)

New Hampshire

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 492 KB)
- State-required benefits (PDF - 114 KB)

New Jersey

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 400 KB)
- State-required benefits (PDF – 77 KB)

New Mexico

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 272 KB)
- State-required benefits (PDF – 71 KB)

New York

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 364 KB)
- State-required benefits (PDF – 90 KB)

North Carolina

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 341 KB)
- State-required benefits (PDF – 72 KB)

North Dakota

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 376 KB)
- State-required benefits (PDF – 69 KB)

Northern Mariana Islands

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage(PDF - 333 KB)

Ohio

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 262 KB)
- State-required benefits (PDF – 65 KB)

Oklahoma

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 275 KB)
- State-required benefits (PDF – 77 KB)

Oregon

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 462 KB)
- State-required benefits (PDF – 74 KB)

Pennsylvania

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 254 KB)
- State-required benefits (PDF – 69 KB)

Puerto Rico

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF - 333 KB)
- State-required benefits(PDF - 213 KB)

Rhode Island

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 357 KB)
- State-required benefits (PDF – 78 KB)

South Carolina

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 374 KB)
- State-required benefits (PDF – 69 KB)

South Dakota

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 261 KB)
- State-required benefits (PDF – 66 KB)

Tennessee

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 590 KB)
- State-required benefits (PDF – 68 KB)

Texas

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 274 KB)
- State-required benefits (PDF – 80 KB)

Utah

- Guide to reviewing EHB benchmark materials

- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 476 KB)
- State-required benefits (PDF – 64 KB)

Vermont

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 416 KB)
- State-required benefits (PDF – 106 KB)

Virgin Islands

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF - 333 KB

Virginia

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 354 KB)
- State-required benefits (PDF – 78 KB)

Washington

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 356 KB)
- State-required benefits (PDF – 74 KB)

West Virginia

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 403 KB)
- State-required benefits (PDF – 75 KB)

Wisconsin

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 372 KB)
- State-required benefits (PDF – 81 KB)

Wyoming

- Guide to reviewing EHB benchmark materials
- Summary of EHB benefits, limits, and prescription drug coverage (PDF – 391 KB)
- State-required benefits (PDF – 71 KB)

Guide to Reviewing EHB Benchmark Plans

- Printable version (PDF – 128 KB)

Essential health benefits (EHB)-benchmark plans are based on 2012 plan designs, and therefore do not necessarily reflect requirements effective for plan years beginning on or after January 1, 2014. Therefore, when designing plans that are substantially equal to the EHB-benchmark plan beginning January 1, 2014, issuers may need to design plan benefits, including coverage and limitations, to comply with these requirements and limitations, including but not limited to, the following:

Annual and Lifetime Dollar Limits

The EHB-benchmark plans displayed may include annual and/or lifetime dollar limits; however, in accordance with 45 CFR 147.126, these limits cannot be applied to the essential health benefits. Annual and lifetime dollar limits can be converted to actuarially equivalent treatment or service limits.

Excluded Benefits

Pursuant to 45 CFR 156.115, the following benefits are excluded from EHB even though an EHB-benchmark plan may cover them: routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, and/or non-medically necessary orthodontia. Please also note that although the EHB-benchmark plan may cover abortion services, pursuant to section 1303(b)(1)(A) of the Affordable Care Act, a QHP issuer is not required to cover these services. Section 156.115(c) provides that no health plan is required to cover abortion services as part of the requirement to cover EHB. Nothing in this provision impedes an issuer's ability to choose to cover abortion services or limits a state's ability to either prohibit or require these services under state law.

Habilitative Services

If the EHB-benchmark plan does not cover any habilitative services and the state does not define those benefits, then pursuant to 45 CFR 156.115(a)(5), the issuer determines which habilitative services to offer as a part of a two year transitional policy.

Coverage Limits

Pursuant to 45 CFR 156.115(a)(2), with the exception of coverage for pediatric services, a plan may not exclude an enrollee from coverage in an entire EHB category, regardless of whether such limits exist in the EHB-benchmark plan. For example, a plan may not exclude dependent children from the category of maternity and newborn coverage.

State-Required Benefits

For purposes of determining EHB, we consider state-required benefits (or mandates) to include only requirements that a health plan cover specific care, treatment, or services. We do not consider provider mandates, which require a health plan to reimburse specific health care professionals who render a covered service within their scope of practice, to be state-required benefits for purposes of EHB coverage. Similarly, we do not consider state-required benefits to include dependent mandates, which require a health plan to define dependents in a specific manner or to cover dependents under certain circumstances (e.g., newborn coverage, adopted children, domestic partners, and disabled children). Finally, we do not consider state anti-discrimination requirements relating to service delivery method (e.g., telemedicine) as state-required benefits.

Mental Health Parity

The EHB-benchmark plans displayed may not comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). However, as described in 45 CFR 156.115(a)(3), EHB plans must comply with the standards implemented under MHPAEA.

EHB-Benchmark Plan Prescription Drugs by Category and Class

Please note that in some cases a category is listed without a United States Pharmacopeia (USP) class because there are some drugs within the category that have not been assigned to a specific class.

Please also note that where the EHB-benchmark plan does not include coverage in a USP category and/or class, pursuant to 45 CFR 156.122, one drug would have to be offered in that USP category and/or class.

In conjunction with the policy that plans must offer the greater of one drug in every USP category and class or the number of drugs in each USP category and class offered by the EHB-benchmark, HHS is considering developing a drug counting service to assist states and issuers with implementation of the proposed prescription drug policy, as described in the following methodology document:

- EHB Rx Crosswalk Methodology (PDF - 52 KB)

Preventive Services

The EHB-benchmark plans displayed may not offer the preventive services described in 45 CFR 147.130. However, as described in 45 CFR 156.115(a)(4), EHB plans must comply with that section.

Guide to Reviewing Essential Health Benefits Benchmark Plans

Essential health benefits (EHB)-benchmark plans are based on 2012 plan designs, and therefore do not necessarily reflect requirements effective for plan years beginning on or after January 1, 2014. Therefore, when designing plans that are substantially equal to the EHB-benchmark plan beginning January 1, 2014, issuers may need to design plan benefits, including coverage and limitations, to comply with these requirements and limitations, including but not limited to, the following:

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