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TO THE SENATE COMMITTEE ON WAYS AND MEANS

TWENTY-SEVENTH LEGISLATURE
Regular Session of 2014

Tuesday, April 1, 2014
9:00 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 DAVID Y. IGE, CHAIR, AND MEMBERS OF THE COMMITTEE:

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:
Senate Committee on Ways and Means
The Honorable David Y. Ige, Chair
The Honorable Michelle N. Kidani, Vice Chair

April 1, 2014
9:00 am
Conference Room 211

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

Chair, Vice-Chair, 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

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

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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 WAYS AND MEANS
The Honorable David Y. Ige, Chair
The Honorable Michelle N. Kidani, 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: Tuesday, April 01, 2014
Time: 9:00 a.m.
Place: Conference Room 211

FROM: Na`unanikinau Kamali`i

This testimony is in **strong support of SCR 35, SD1, with amendments**. 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.

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 need to 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.

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 in 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. I submitted testimony in **strong support** of both measures with 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<u>, reaping a prohibited premium savings from the practice</u>. In application, <u>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</u>. 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 this SCR 35 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

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:

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.

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
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- 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

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

Michigan

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- 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
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- State-required benefits (PDF – 90 KB)

North Carolina

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- State-required benefits (PDF – 72 KB)

North Dakota

- Guide to reviewing EHB benchmark materials
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- State-required benefits (PDF – 69 KB)

Northern Mariana Islands

- Guide to reviewing EHB benchmark materials
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Ohio

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- 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
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- State-required benefits (PDF – 78 KB)

South Carolina

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- State-required benefits (PDF – 69 KB)

South Dakota

- Guide to reviewing EHB benchmark materials
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- 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

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- 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.