

# Essential Health Benefits stakeholder comments

In response to draft report sent August 22, 2012

## Fonkert, Andrea L.

---

**From:** Joan Connell [jmconnellmd@msn.com]  
**Sent:** Monday, August 27, 2012 4:13 PM  
**To:** Fonkert, Andrea L.; Gallup-Millner, Tammy L.; kcoebele@ndmed.com; chris tiongson; Joan  
**Subject:** North Dakota American Academy of Pediatrics response to consultative report

Dear Ms. Fonkert,

My name is Joan Connell. I am a pediatrician in Bismarck, ND. I currently serve as the vice president for the North Dakota Academy of Pediatrics. I appreciate you requesting feedback with regard to the consultative report that was provided regarding our state's options for choosing a health care benefit plan and what we value as essential health benefits. I appreciated the latter portion of this document which compared and contrasted the various options. I would like to reinforce some of the essential items relevant to children's health care benefits. Please note that the cost of the first 5 areas mentioned is really trivial in the grand scheme of the health care budget.

1. Provision for well child care using AAP endorsed Bright Futures criteria/recommendations for frequency of well checks. Essentially, this recommends well checks frequently in the first year of life, less frequently between ages 1 and 2 years, then annually thereafter. With well checks comes the necessity for coverage of CDC recommended immunizations. This too needs to be a part of essential health benefits. It was not clear that the plans described will cover all recommended well checks, particularly those annual well checks occurring after age 2. These visits provide opportunities for a healthcare provider to monitor for signs of chronic disease, suboptimal development, discuss parenting and discipline issues, as well as establish a relationship with the child that will grow into an adolescent who may have needs related to risky behaviors and/or depression. Remember, the ND High School Activities Assn mandates a sports physical annually for all participants. This is one additional reason why annual well checks should be considered an essential health benefit in children >2 years of age. Also, given the broad scope of material that needs to be covered and the time required to do that in a comprehensive way, provision of these services must be associated with fair reimbursement.
2. Provision of habilitative and rehabilitative services. There are many studies that document the cost savings of early intervention services that can be utilized to optimize children's development. If we want to provide care in the most cost effective way, we need to take opportunities to intervene and fix small problems before they become large problems. Optimizing children's outcomes will optimize their future productivity as citizens. It appears that rehabilitative services will be included as part of essential health benefits. The particulars of these benefits must be customized for children and their needs as when it comes to meeting the healthcare needs of children, they cannot be considered "little adults". Children grow and develop, frequently with good responses to therapy. They therefore need to have items such as hearing aids and many pieces of durable medical equipment modified to account for their growing and changing bodies. Their therapy needs are also unique. This too may make their needs different from the adult population.
3. Provision for pharmaceuticals. I noticed that this was included in most/all of the plans. This provision should include medical food for patients with inborn errors of metabolism, including PKU. Our state currently mandates that formula be provided to all children and some adults with phenylketonuria and maple syrup urine disease, two diseases resulting from inborn errors of metabolism. Since the 1960s when this legislation was introduced, additional inborn errors of metabolism have been discovered. Those diseases often require specialty formula to optimize patient outcomes. Optimizing patient outcomes often times leads to overall less financial expenditure and superior patient outcomes, many times resulting in a more productive citizen. Currently ND Medicaid does not provide for specialty formula for these other disease states. This is illogical and needs to be made a part of essential health benefits.
4. Provision for treatment of mental illness. I noticed that not all plans included benefits for detoxification and residential treatment. I recently heard that North Dakota is currently the #1 binge drinking state in the nation. The experimental and risk taking behaviors typical of adolescence requires that detoxification be a component of health plans. I also believe that significant interventions, including residential treatment programs, may be most beneficial in the adolescent who is still somewhat capable of change and modification of bad behaviors. Furthermore, relocation of these particular children away from their dysfunctional environments to a setting that role models a healthier lifestyle may be imperative for successful long lasting changes in behavior to occur. We must stop thinking about short term costs and start thinking about investing in optimizing long term outcomes that will be overall financially efficient and result in a more productive citizen.
5. Vision and dental care. I understand that this is a new frontier. Children must be able to see the chalk/smart board, their books, etc to learn. Eyeglasses may be necessary. They must have good dentition to eat a standard healthy diet. These provisions, again, allow them to grow into healthy productive adults. I must say that refusing to pay for a dilated eye exam in a diabetic pediatric patient seems illogical. I would defer to the Children's Diabetes specialists/optometrists/ophthalmologists for recommendations on what is necessary for an appropriate annual eye exam in a child with diabetes.

6. Children with special health care needs. These children do account for the majority of pediatric health care expense. Determining health care benefits that will optimize their outcomes in a cost effective way is important. This applies to children with physical disabilities as well as mental/behavioral/developmental disabilities, including autism. Helping the families of these children avoid personal financial ruin due to holes in their children's health care coverage is also important and needs to be considered when determining a benefit plan. Keep in mind that one of the main goals of the Affordability Care Act is to prevent patients from "falling through the cracks". This is clearly an underinsured population.

Again, thank you for considering my comments. I would like to participate in the meeting September 6. However, I am in clinic that morning, which cannot be rescheduled. If it is possible to discuss issues relevant to the pediatric population later in the afternoon or if I may be of service to you at some other time, I would love to participate in this process. Thanks again for your time and consideration... Joan Connell, MD/Professor of Pediatrics, UND School of Medicine/  
Pediatrician-UND Center for Family Medicine/Medical Director Children's Special Health Services

## Fonkert, Andrea L.

---

**From:** Rod St. Aubyn [Rod.St.Aubyn@bcbsnd.com]  
**Sent:** Monday, August 27, 2012 4:36 PM  
**To:** Fonkert, Andrea L.  
**Cc:** Dan Ulmer  
**Subject:** RE: Essential health benefits analysis

Thank you for the opportunity to comment. Our staff noted the following:

- The report references Basic Dental Services. It is unclear if that reference is for adults or the pediatric Basic Dental Services. Nowhere in the ACA or the Bulletin does HHS infer that dental services for adults are to be included - only pediatric dental and vision services.
- On page 12 the report references that Medica pays for elective abortion services. That may be incorrect in that state law prohibits insurers paying for elective abortions unless provided as a separate rider (NDCC 14-02.3-03) or it should be clarified that the option is by purchase of a rider.
- Is it appropriate or permissible to use the "grandfathered" PERS plan for a benchmark option, since HHS did not consider grandfathered plans in the total enrollment numbers when calculating the top 3 small group plans? We recognize that a "grandfathered" plan would have to supplement all the ACA near term requirements in addition to any other missing benefits from the 10 categories, but just questioned if a "grandfathered" plan could or should be considered as an option.
- The report never addressed the prohibition of lifetime or annual dollar limits for Essential Health Benefits - ie TMJ mandate (NDCC 26.1-36-09.3)
- . On page 14, Category 9 ii) the consultant report indicates the NDPERS GF plan doesn't offer Preventive Care for Women. It does go on to clarify on page 23 paragraph 4 preventive care for women "as promulgated by the Act", which we presume to mean the Women's Preventive Care benefits scheduled to go into effect on 8/1/12 for NGF plans. The NDPERS GF plan does pay for basic women's preventive care such as one annual visit, one pap smear with associated office visit, mammograms. The statement on page 14 appeared to be a little misleading

Thanks again for the opportunity to comment on the analysis report.

Rod St. Aubyn  
Manager - Government Relations  
4510 13th Avenue S.  
Fargo, ND 58121-0001  
701-282-1847

---

**From:** Fonkert, Andrea L. [<mailto:afonkert@nd.gov>]  
**Sent:** Wednesday, August 22, 2012 4:46 PM  
**To:** Fonkert, Andrea L.  
**Subject:** Essential health benefits analysis  
**Importance:** High

**To:** North Dakota Insurance Department

**From:** Constance Hofland & Amy Davis, Public Policy Representatives of North Dakota Academy of Nutrition and Dietetics

**Date:** August 27, 2012

**Subject:** Comments on Essential Health Benefits Analysis

Thank you for the opportunity to comment on the analysis on Essential Health Benefits (“EHB”) conducted by INS Consultants, Inc., dated August 2012.

The North Dakota Academy of Nutrition and Dietetics (formerly the North Dakota Dietetics Association) is committed to improving the health of North Dakotans. As the EHB package is being designed, we believe it should include access to nutrition services in the form of medical nutrition therapy (“MNT”) provided by registered dietitians (“RDs”).

#### **Coverage of the EHB of Nutrition Counseling in the Ten Benchmark Choices**

INS provided a comparison of the nutrition counseling covered by the 10 plans that are candidates for the benchmark plan for North Dakota. As outlined on page 47 of the draft report, nutrition counseling is covered similarly for the three Small Group Insurance Plans. This is consistent our prior analysis of these three plans. However, the reference on the bottom of page 11, paragraph(ix) regarding the Medica plan is misleading. It states that Medica covers nutrition counseling in general but only mentions diabetes, but we understand that this does not mean that only diabetes is covered. Rather, we understand the Medica plan covers any individual nutrition therapy sessions, not limited to a specific diagnosis when referred by a physician. It is also important to note that group nutrition therapy sessions are not covered in the Medica plan and that group sessions are covered in the other benchmark plans.

Similarly, we would like to clarify the chart on page 56 on limits on the number of annual visits for nutrition counseling. The Medica Choice plan is listed as not explicitly specifying the number of visits. We understand the number of nutrition counseling sessions allowed in the Medica plan is determined by physician referrals. We want to be sure this “NS” not interpreted to mean that no visits are covered, when there is no set limit on the number of annual visits with an RD for nutrition counseling in the Medica plan .

Looking at all 10 benchmark plan candidates, we favor a plan that covers nutrition therapy for a minimum of the following medical conditions: anorexia, bulimia, chronic renal failure, diabetes, gestational diabetes, hyperlipidemia, hypertension, obesity, and phenylketonuria. Because of the effectiveness of nutrition counseling in disease prevention, additional coverage for other diagnoses; such pre-diabetes, could result in a cost savings for health care in North Dakota.

### **Registered Dietitians are uniquely qualified to provide cost effective nutrition therapy and preventive and wellness services**

The role of nutrition in health promotion, disease prevention and disease management has become a progressively more significant public health issue. Overweight and obesity runs rampant in the United States. In fact, it is considered to be one of the leading causes of deaths of adults. In preventing chronic diseases, nutrition and diet must be incorporated into a daily regimen. The importance of nutrition is underscored by the role of nutrition in the prevention of the leading causes of death including cardiovascular disease, type 2 diabetes, hypertension, osteoporosis, and some forms of cancer. Four of the top six leading causes of death, diseases of the heart, cancer, cerebrovascular disease and diabetes can be influenced by diet and nutrition.

RDs are the most cost-effective, qualified health care professional to provide MNT. MNT is distinctly different than nutrition education and requires advanced skills beyond those of other professionals. According to the Institute of Medicine, “the registered dietitian is currently the single identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy.”

MNT provided by RDs for prevention, wellness and disease management can improve a consumer’s health and increase productivity and satisfaction levels through decreased doctor visits, hospitalizations and reduced prescription drug costs. Also, MNT provided by RDs impacts productivity. For example, the RD-led lifestyle intervention provided to patients with diabetes and obesity reduced the risk of having lost work days by 64.3% and disability days by 87.2%, compared with those receiving usual medical care without the RD-led lifestyle intervention. (Diabetes Care. 2004; 27:1570-6).

RDs are the most qualified practitioners to provide such services and by utilizing RDs to provide nutrition services there will be a significant impact on chronic disease and will result in cost savings.

For questions or more information, please contact Constance Hofland, MS, RD, LRD, JD at [chofland@zkslaw.com](mailto:chofland@zkslaw.com) or Amy Davis, RD, LRD at [adavis@mohs.org](mailto:adavis@mohs.org).

**Deb Knuth** | Director of Government Relations

Great West Division | American Cancer Society Cancer Action Network, Inc.

## Benchmark Plan/EHB Comments

### North Dakota

#### Prescription Drugs

- Although the analysis states that all plans cover brand drugs, generic drugs and off-label use, it lacks specifics on information about:
  - Prior Authorization requirements
  - Step Therapy requirements
  - Tiered Drug Benefits
- Drug benefits are extremely important to cancer patients and limitations on drug access can be detrimental to a cancer patient's health outcome. Do any of the benchmark plan options have the above three components as part of their drug benefit? If so will the prior authorization, step therapy or tiered benefit be applied to all plans offered in the exchange?
- The analysis also indicates that the BCBSND PPO plan does not cover smoking/tobacco cessation drugs. This coverage gap is of obvious concern for cancer prevention purposes.
- Although the analysis indicates "coverage" for tobacco cessation drugs, often this benefit is very limited. Do the other benchmark plan options limit coverage for tobacco cessation drugs (ex. Cap on number of prescriptions per plan year; cap on number of "quit attempts" per year)

#### Hair Loss Supplies

- Only two of the Federal Employee Health Plans (BCBS Standard and Basic) cover wigs and scalp prosthetics for chemotherapy related hair loss. Although this benefit is not our highest coverage priority compared to other prevention and treatment services, this benefit can often contribute greatly to a cancer patient's quality of life and should be noted.

#### Genetic Testing

- ACS CAN is still looking into the issue of genetic testing as a form of prevention and early detection for those with a strong family history of cancer. Although we don't have a formal policy position on whether cancer related genetic testing should be a priority covered benefit, it is worth noting instances of non-coverage.
- Coverage for Genetic testing is not covered at all by the FEHBP- GEHA plan.
- Genetic testing is listed as a covered benefit for all other benchmark plan options. Are there limits on this coverage? Is the benefit subject to a high risk determination by the insurer? Is the coverage limited to genetic testing for certain disease/condition areas?

## Smoking/Tobacco Cessation Services

- See “prescription drugs” section for concerns related to cessation drugs.
- Smoking/Tobacco cessation services are listed as NOT COVERED by the ND State Employee Plan (PPO). This is of concern from a cancer prevention perspective. Although the USPSTF includes “tobacco cessation treatment” as an “A” recommendation (and is therefore a required benefit under ACA) the language of the recommendation is quite vague so it is important for the selected benchmark plan to not only cover these services but cover these services, but to define and adequately cover these services.
- For the benchmark plans that do cover “smoking/tobacco cessation services”, four plans (Small group BCBS Classic Blue and Comp Choice, State Employee Health Plans BCBSND NDPERS NGF and BCBSND HDHGP NGF) only cover two “quit attempts” per year. What is actually covered for a “quit attempt”? How long is the duration of covered services for one attempt?
- The Sanford HMO plan only covers one “quit attempt” per lifetime. This is a very inadequate benefit as most smoking do not quit successfully after one attempt.

September 4, 2012

MEDICA®

North Dakota Insurance Department  
Attention: Andrea Fonkert, Public Information Officer  
600 E. Boulevard Ave., Dept. 401  
Bismarck, ND 58505-0320

**Re: Analysis of Essential Health Benefits Under the Patient Protection and Affordable Care Act**

Dear Ms. Fonkert:

Thank you for the opportunity to provide comments to the North Dakota Insurance Department (“the Department”) with respect to the Analysis of Essential Health Benefits Under the Patient Protection and Affordable Care Act (“Analysis”), which was prepared for the Department by INS Consultants, Inc. (“INS”). Medica Insurance Company and Medica Health Plans (collectively referred to as “we,” “our,” and “Medica”) respectfully submit the following comments to the Department.

Generally, Medica supports the selection of an Essential Health Benefits (“EHB”) benchmark plan that meets the minimum requirements of the EHB set, including providing coverage for all state-mandated benefits. This would be the most cost-effective approach for the State and will ensure that less expensive products are available to consumers. It will also maximize flexibility for carriers as they determine when and how it makes the most sense to modify their product offerings, including by adding additional benefits.

As a more specific point of feedback, Medica disagrees with what we understand (from a recent conversation with the Department) to be the underlying assumption in Item No. 2 of the Analysis that the final EHB regulations will outline specific benefits that must be covered within each of the ten statutory EHB categories, and therefore that specific benefits will need to be added to the EHB benchmark plan. This interpretation appears to conflict with HHS’ regulatory approach as set forth in its December 16, 2011 bulletin, in which it states that it “[intends] to propose that EHB be defined by a benchmark plan selected by each State. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a ‘typical employer plan’ in that State as required by section 1302(b)(2)(A) of the Affordable Care Act” and “[g]enerally, we intend to propose that if a benchmark is missing other categories of benefits, the State must supplement the missing categories using the benefits from any other benchmark option.”

By instructing states to select an EHB benchmark plan from a list of already-existing plan options instead of outlining a detailed list of benefits that must be covered as part of any EHB set, it appears as though HHS’ intention is to use what is already available in the marketplace,



Medica Comments re Analysis of Essential Health Benefits Under the Patient Protection and Affordable Care Act  
September 4, 2012  
Page 2 of 2

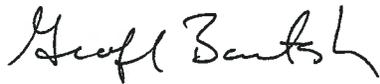
instead of prescribing a new set of benefit criteria that a plan must comply with in order to meet the requirements of the EHB set.

In addition, the bulletin discusses supplementing missing *categories*, not missing *benefits* within each category. We believe it is premature to assume that the final EHB regulation will go further than this broad standard by requiring that categories be supplemented with specific benefits.

For these reasons, we do not believe that this assumption should be a factor in the selection of a benchmark plan. In fact, if the State requires additional benefits to be added to the benchmark, we believe that this could be construed as a benefit mandate and generate additional cost to the State.

Thank you once again for the opportunity to provide these comments. Please do not hesitate to contact me if you have any questions or would like to discuss Medica's comments in more detail. I can be reached directly via telephone at: (952) 992-2461; via email at: [geoffrey.bartsh@medica.com](mailto:geoffrey.bartsh@medica.com); or at the following address: Medica Health Plans, Inc., 401 Carlson Parkway, Mail Route CP250, Minnetonka, MN 55305.

Sincerely,



Geoff Bartsh  
Vice President, Public Policy & Government Relations  
Medica