January 25, 2018

Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
200 Independence Avenue SW
Washington, DC 20201

***Delivered Electronically***

**RE: Request for Information: Promoting Health Care Choice and Competition Across the United States**

As representatives of state think-tanks, we appreciate the opportunity to comment on the RFI regarding ways to promote choice and competition in health care across the country. We view the Department's efforts in this area as a welcome change, one that can work to slow the skyrocketing growth of health care costs.

While we come from different states, we all agree that the *status quo* in health care has impeded competition, preventing individuals from becoming true consumers and participants in their health care. The Patient Protection and Affordable Care Act (PPACA) imposed myriad new requirements on health insurers, businesses, and individuals, many of which have limited choices and hindered innovation. Moreover, as your Office recently noted, the law's regulations more than doubled health insurance premiums on the individual market from 2013 through 2017, with further double-digit increases hitting this year.[1]

As state-based organizations, we believe that the federal government should cede power and authority wherever possible to the "laboratories of democracy," granting them flexibility to innovate and arrive at customized solutions for their unique needs. The below suggestions would enhance that flexibility, mitigating some of the burdens that Washington has imposed through PPACA, and allowing states to create more effective and efficient health insurance marketplaces.

## 1. Let States Define Their Own Essential Health Benefits

Section 1302 of PPACA sets out parameters for coverage of essential health benefits in qualified health plans. In prior rules, the Department laid out parameters for states to select the essential health benefits in their states from among four benchmark options, with small group coverage serving as the default option should a state not select another benchmark.[2]

---

[1] Department of Health and Human Services Office of Planning and Evaluation, "Individual Market Premium Changes: 2013-2017," *ASPE Data Point* May 23, 2017, https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf; Department of Health and Human Services Office of Planning and Evaluation, "Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange," *ASPE Research Brief* October 30, 2017, https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf.

[2] Department of Health and Human Services, final rule on "Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation," *Federal Register* February 25, 2013, https://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.

However, as the attached document demonstrates, states have often-conflicting definitions of essential health benefits. The states of Idaho, Maryland, and Minnesota have a total of 57 separate mandated benefits offered in one state but not all three—including mandates covering conditions such as acupuncture, port wine stain elimination and bariatric surgery. The conflicting requirements make the "essential" nature of each of these benefits an open question, as these supposedly integral offerings extend within one state's borders, but not others.

Moreover, the linkage of essential health benefits to states' mandated benefits in prior years (e.g., 2017 benefits based on 2014 plan offerings, which were based on states' mandated benefits in 2012) preserves those mandated benefits in perpetuity, even if states have since repealed them. This mechanism functions as a "one-way ratchet," in which states can add new mandates, but not eliminate those already in place. This structure appears contrary to the intent of the statute itself, which requires that states reimburse the higher premium costs associated with additional benefits beyond those deemed essential.[3]

Numerous studies have concluded that essential health benefits raise premiums for consumers.[4] Notwithstanding that fact, the Department's own rule regarding essential benefits admitted that it included categories of services not previously covered by most health insurance plans, such as "rehabilitative and habilitative services and devices."[5] To make coverage more affordable, and increase consumer choices, the Department should expand state flexibility by allowing them to select essential benefits individually, rather than merely choosing from four benchmark plans. Moreover, the Department should set a default standard for a state that does not select its own essential benefit package as that with the fewest mandated benefits, consistent with the "essential" nature of the benefits described in the statute.

## 2. Rescind the December 2015 Guidance Regarding State Innovation Waivers

Section 1332 of PPACA provides states with a process to extricate themselves from some of the regulations and requirements included in the health care law. Specifically, states may apply for State Innovation Waivers that allow them to circumvent some of the law's regulations, waive the mandates on individuals to purchase, and employers to offer, health insurance coverage, and/or receive federal funding as a block grant for their citizens.

---

[3] 42 U.S.C. 13031(d)(3)(B)(ii), as codified by Section 1311(d)(3)(B)(ii) of the Patient Protection and Affordable Care Act, P.L. 111-148.

[4] See for instance testimony of Daniel Durham, Executive Vice President for Policy and Regulatory Affairs, America's Health Insurance Plans, before House Energy and Commerce Subcommittee on Oversight and Investigations Subcommittee hearing on "Health Insurance Premiums Under the Affordable Care Act," May 20, 2013, http://docs.house.gov/meetings/IF/IF02/20130520/100868/HHRG-113-IF02-Wstate-DurhamD-20130520.pdf, p. 8, and Ed Haislmaier and Drew Gonshorowski, "Responding to *King v. Burwell*: Congress' First Step Should Be to Remove Costly Mandates Driving Up Premiums," Heritage Foundation *Issue Brief No. 4400*, May 4, 2015, http://www.heritage.org/research/reports/2015/05/responding-to-king-v-burwell-congresss-first-step-should-be-to-remove-costly-mandates-driving-up-premiums.

[5] Final rule on Essential Health Benefits, pp. 12860-61.

The statute itself imposes restrictions on states wishing to apply for such waivers. States seeking waivers must:

1. "Provide coverage that is at least as comprehensive as the coverage" defined under PPACA;
2. "Provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable" as PPACA;
3. "Provide coverage to at least a comparable number of its residents;" and
4. "Not increase the federal deficit."[6]

These restrictions themselves make it difficult for states to offer alternative forms of coverage—for instance, consumer-oriented plans like those featuring Health Savings Accounts.

However, guidance released by the Department in December 2015 went significantly further than the statutory requirements.[7] For instance, the Department indicated that it would not consider potential savings from a Medicaid section 1115 waiver in conjunction with savings from a 1332 waiver when determining deficit neutrality. Any proposed changes to Medicaid must meet the deficit-neutrality requirements on their own, as must savings from a 1332 waiver; states cannot "combine" savings or spending from the two when complying with the deficit-neutrality requirement.

The December 2015 guidance also contains other cumbersome restrictions on State Innovation Waivers:

- It requires compliance with the four statutory restrictions listed above over every year of a waiver, rather than considering their impact over the entire length of a waiver (for instance, five or ten years).
- It extends the statutory requirements regarding the comprehensiveness of coverage to specific sub-populations, which could effectively prohibit states from offering more innovative types of coverage.
- Because the federal government refused to develop or grant any administrative concessions to states using the federally-run insurance Exchange, it effectively precludes such states from developing any waivers that deviate from current administrative rules and practices.
- It does not guarantee approval to waivers that meet the four statutory criteria.
- It requires states to take administrative costs into consideration when determining deficit-neutrality.

In addition to exceeding the law's existing requirements, these restrictions also undermine the statute's intent. While Section 1332 of PPACA clearly empowered states to waive the essential health benefits requirements in their jurisdiction, the added burden of the Department's guidance will make such a waiver effectively impossible.

---

[6] 42 U.S.C. 18052(b)(1)(A), as codified by Section 1332(b)(1)(A) of PPACA.
[7] Departments of Treasury and Health and Human Services, guidance regarding "Waivers for State Innovation," *Federal Register* December 16, 2015, https://www.gpo.gov/fdsys/pkg/FR-2015-12-16/pdf/2015-31563.pdf.

For these reasons, we believe the Department should revoke the existing December 2015 guidance, and instead develop new guidelines that would provide the states with the flexibility they need to succeed in their waivers:

- Allow states to determine deficit-neutrality, and compliance with the other statutory requirements, over the entire life of the waiver.
- Do not extend the four statutory restrictions to additional sub-populations, allowing states to determine the best solutions for their populations, and judging their success at meeting such restrictions based solely upon statewide average impact.
- Permit states to utilize cost savings from Medicaid and the State Children's Health Insurance Program, as well as potential savings from other federal programs like the Supplemental Nutritional Assistance Program, when determining deficit-neutrality.
- Exempt federal administrative costs from the calculations used to determine deficit-neutrality. The law already requires the federal government to facilitate State Innovation Waivers. As such, the Department should not seek to transfer those costs, based on an existing statutory requirement, to the states in the form of a requirement that states' waivers must account for federal administrative burdens when designing a deficit-neutral waiver.
- Guarantee approval for states that meet the statutory requirements.

### 3. Provide Templates to States Regarding Innovation Waivers

Notwithstanding the restrictions imposed by the statutory restrictions, as highlighted above, the State Innovation Waiver program does allow states to enact reforms to their insurance markets, and generally mitigate some of PPACA's harmful effects. For instance, Alaska received approval for a state-based reinsurance program that has stabilized premium increases in that state. Other states, including Wisconsin, Minnesota, Oklahoma, and others have sought to replicate portions of the Alaska model, and have applied for or are considering submitting waiver applications to HHS.

The Department has already issued a checklist that states can use when applying for waivers designed to lower premiums and stabilize insurance markets. However, to make the process for approval of waivers even clearer for states, HHS should release additional guidance regarding the specific approaches states are considering, factors for states to consider when creating a waiver or stabilization program, and the ways in which HHS will evaluate state waiver applications. Such guidance would replicate similar instruction HHS provided to states regarding Medicaid long-term supports and services waiver proposals in 2013.[8]

Section 2(f) of bipartisan Senate legislation proposed last fall would require HHS to submit such guidance, along with model language states could use for certain types of waivers—including state-based reinsurance or high-risk pools, models to expand insurer participation and access, value-based insurance design, and other issues.[9] Regardless of whether or not that particular legislation passes,

---

[8] Center for Medicare and Medicaid Services, *Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs*, May 20, 2013, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf.

[9] Section 2(f) of the Bipartisan Health Care Stabilization Act of 2017, as proposed by Sens. Lamar Alexander (R-TN) and Patty Murray (D-WA), October 19, 2017, https://www.help.senate.gov/imo/media/doc/THE%20BIPARTISAN%20HEALTH%20CARE%20STABILIZATION%20ACT%20OF%202017-%20TEXT.pdf.

we believe issuing such guidance represents good practice for HHS, and we encourage the Department to do so.

### 4. Provide Faster Approval for Medicaid State Plan Amendments and Waivers That Implement Other States' Successes

To improve the Medicaid partnership between the federal government and the states, states would benefit from additional clarity about the conditions under which the federal government will approve Medicaid waivers. The Department recently helped this process regarding one area of increasing state interest, by issuing guidance about the criteria under which the Department will evaluate waivers seeking to impose a work requirement, or other forms of community engagement, on able-bodied Medicaid recipients.[10]

We believe the Department should go further, and provide for the presumptive approval of already-successful state plan amendments and waivers in additional states, or in cases where multiple states submit waiver requests. Policy-makers on both sides of the aisle have spoken of the regulatory certainty this policy would provide, encouraging more states to apply for waivers by giving them a more efficient process.

We believe that waivers and state plan amendments provide an important vehicle for states to reform their Medicaid programs, by offering incentives for wellness, modernizing benefit offerings, encouraging work and community engagement, improving program integrity, and encouraging individuals to become smart purchasers of health care. Giving states more certainty about the tools they have to reform their Medicaid programs would promote the increases in consumer choice that we seek.

### 5. Allow States to Work with the Federal Government to Facilitate Purchase of Subsidized Health Insurance Through Brokers and Agents

With respect to health insurance Exchanges, current guidance and regulations issued by the Department appear to conflict with the statutory text of PPACA itself. The law states that an Exchange shall "facilitate the purchase of qualified health plans."[11] It further requires that Exchanges "shall make available qualified health plans to qualified individuals and qualified employers."[12] And it includes a list of duties and function for Exchanges that generally fall into this role—helping or assisting with the process of purchasing coverage.[13]

Notably, however, the statute does NOT require state Exchanges to offer or sell qualified health plans themselves—only that they "facilitate" or "make available" such coverage. Despite this significant statutory omission, however, the Department's regulatory structure surrounding Exchanges pre-supposes that these state marketplaces will in fact sell insurance.

---

[10] Centers for Medicare and Medicaid Services, "Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries," State Medicaid Director letter SMD-18-002, January 11, 2018, https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf.
[11] 42 U.S.C. 13031(b)(1)(A), as codified by Section 1311(b)(1)(A) of PPACA.
[12] 42 U.S.C. 13031(d)(2)(A), as codified by Section 1311(d)(2)(A) of PPACA.
[13] 42 U.S.C. 13031(d)(4), as codified by Section 1311(d)(4) of PPACA.

We believe that the Department should provide states with another avenue offering more flexibility—and one arguably more consistent with the text of PPACA itself. Namely, the Department should create a new type of partnership Exchange, one in which the federal government provides only the direct enrollment services offered through the federally-run Exchange. As part of this partnership, states could choose to work with brokers, agents, or other entities to sell qualified health plans—fulfilling the statutory obligation to "facilitate" and "make available" such coverage. Meanwhile, the federal government would fulfill its responsibility to determine eligibility for federal insurance subsidies.

By devolving choice from the state Exchange to other private entities, this arrangement could increase competition within state insurance markets. Moreover, by empowering brokers and agents, it could increase awareness of coverage options among the broader public, increasing the number of individuals with access to affordable coverage.

**6. Increase Employer Flexibility to Offer Defined Contribution Insurance to their Workers**

Immediately after its passage, some observers thought that PPACA might increase the availability of defined contribution health insurance offerings by employers, particularly small employers.[14] The creation of insurance Exchanges could allow employers to provide their workers with a set monthly contribution to fund health insurance coverage selected through the Exchange—giving employers greater predictability in their business costs, and giving employees an avenue to health coverage they may previously have lacked.

However, a rule issued by the Department in 2015 effectively prohibits employers from offering defined contribution arrangements.[15] The rule, which incorporates a 2013 Internal Revenue Service Notice, claims that defined contribution Health Reimbursement Arrangements (HRAs) violate PPACA's prohibition on annual limits and preventive services requirements, purportedly because individual coverage cannot be integrated with group health insurance.[16]

However, PPACA applies its prohibition on annual and lifetime limits, as well as its preventive services requirements, to individual and group plans equally.[17] The stated rationale for the

---

[14] Mark A. Hall and Amy B. Monahan, "Paying for Individual Health Insurance Through Tax-Sheltered Cafeteria Plans," *Inquiry* 259 (2010), p. 259. ("Beginning in 2014, PPACA will remove much of the legal uncertainty about using Section 125 plans for individual insurance because it will eliminate the most troubling aspect of individual insurance: medical underwriting. It is only because individual insurance in most states is not rated and sold like group insurance that using Section 125 plans in this way might be interpreted as violating HIPAA (as interpreted through the tax code). The new federal law, like the 2007 reform law in Massachusetts, eliminates most medical underwriting and requires insurance to be sold in the two market segments under essentially the same rules. Thus, it seems fairly clear that nationally, as in Massachusetts, Section 125 plans could be used for either type of insurance.")

[15] 45 C.F.R. 147.126(d)(4). The preamble to the rule provides: "Although in certain circumstances HRAs and other account-based plans may be integrated with another group health plan to satisfy the annual dollar limit prohibition, these final regulations incorporate the general rule set forth in prior subregulatory guidance clarifying that an HRA and other account-based plans may not be integrated with individual market coverage, and therefore an HRA or other account-based plan used to reimburse premiums for the individual market coverage fails to comply with PHS Act section 2711." Departments of Treasury, Labor, and Health and Human Services, final rule regarding "Grandfathered Plans, Pre-Existing Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections," *Federal Register* November 18, 2015, https://www.gpo.gov/fdsys/pkg/FR-2015-11-18/pdf/2015-29294.pdf, p. 72203.

[16] Internal Revenue Service, Notice 2013-54, September 13, 2013, https://www.irs.gov/pub/irs-drop/n-13-54.pdf.

[17] Sections 2711 and 2713 of the Public Health Service Act, as amended by PPACA Section 1001(5).

Department's action in the 2015 rule thus seems legally dubious. Moreover, the Department's action conflicts with other provisions of PPACA, which demonstrate Congress' intent to allow employers to continue offering individual insurance coverage on a pre-tax basis.[18]

In December 2016, Congress took action to allow small businesses to offer defined contribution health insurance coverage. Provisions in the 21st Century Cures Act permit businesses with under 50 employees to make defined contributions into HRAs that employees can use to purchase individual health insurance.[19] This change will expand access to affordable health coverage, particularly for individuals working for small businesses that did not previously offer group health plans.

Consistent with PPACA's original intent, the bipartisan congressional action in 2016, and the President's recent executive order regarding health care, the Department should revisit the 2015 rule that unduly restricts defined contribution health plans.[20] Doing so would increase consumer choice, expand competition in health care markets, and, by empowering employees to serve as smart purchasers of health insurance, increase incentives to bring down underlying health care costs.

### 7. Establish Special Enrollment Periods for Health Reimbursement Arrangements

While the 21st Century Cures Act provision allows small employers to use HRAs as a vehicle to offer defined contribution health benefits, employers would benefit from additional flexibility regarding the intersection of HRAs and existing statutory guidelines surrounding special enrollment periods. Under current law and guidance, new employees joining small businesses, or small businesses looking to start offering coverage or switch their offerings, may not be able to do so outside the open enrollment period—now limited to six weeks in those states using the federally-run Exchange.

To resolve this potential conflict, the Department should use its regulatory authority either to establish a federal special enrollment period for small business HRAs, or provide guidance for states on ways to go about doing so. [21] Providing such regulatory clarity would help to ensure the success of this new provision, which can increase the availability of defined contribution health coverage among employers nationwide.

### 8. Clarify Whether States Can Impose Fees on Third-Party Administrators of Employer Insurance Plans

States looking to develop a reinsurance or other high-risk mechanism need a broad-based source of funding to do so. In many cases, an assessment on all covered lives within a state would provide an

---

[18] For a full critique of the original guidance, see Peter J. Nelson, *State Strategies to Revive Defined Contribution Health Plan Options in Response to New Federal Obstacles*, Center of the American Experiment Working Paper, December 8, 2015, http://americanexp.wpengine.com/wp-content/uploads/2016/05/DC-Health-Plans-and-Federal-Obstacles.pdf.

[19] Section 18001 of 21st Century Cures Act, P.L. 114-255.

[20] Section 1(b)(iii) of executive order "Promoting Health Care Choice and Competition Across the United States," October 12, 2017, https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/.

[21] For an example, a new law passed in Minnesota in June 2017 creates these two SEPs. Minnesota 2017 Session Laws, 1st Special Session, Chapter 6, Article 13, Sec. 1, https://www.revisor.leg.state.mn.us/laws/?year=2017&type=1&doctype=Chapter&id=6.

appropriate and stable source of funding, given the limited reach of individual insurance markets in many states.

PPACA itself understands that the necessity of imposing a broad-based assessment on all covered lives in a state to fund a reinsurance mechanism. Section 1341(b)(3) of the law specifically granted the Secretary authority to assess group health plans to fund the law's temporary reinsurance program, in operation from 2014 through 2016. However, states themselves lack a similar authority to impose assessments on self-funded employer plans, due to a statutory prohibition included in the Employee Retirement Income Security Act (ERISA).

Current case law provides conflicting guidance to states about whether an assessment on third party administrators (TPAs) of self-insured group health plans (as opposed to the plans themselves) complies with ERISA. While a 1991 ruling by the Fifth Circuit Court of Appeals in *E-Systems v. Pogue* struck down a Texas law assessing TPAs as violating ERISA pre-emption provisions, the Sixth Circuit Court of Appeals more recently upheld a Michigan assessment in *Self-Insurance Institute of America v. Snyder*. While the Sixth Circuit's 2016 ruling appears more consistent with Supreme Court precedents issued since *E-Systems v. Pogue*, states lack the legal certainty they need when designing a successful reinsurance program.

Therefore, we ask that your Department work with the Department of Labor to clarify whether states have the authority to assess TPAs when developing reinsurance or high-risk mechanisms. While we understand the underlying legal issues rest predominantly within the Department of Labor's jurisdiction, the impact of this issue on State Innovation Waivers rests within HHS. Therefore, we hope your Department can encourage the Department of Labor to provide clarity and flexibility to states, allowing them to construct their waivers accordingly.

**Conclusion**

We appreciate the opportunity to comment on this important RFI. Moving in a manner that increases choice and competition within the health care sector can help unlock reforms that will slow the growth of health costs burdening millions of American families. We look forward to working with the Department to explore ways that can expand state flexibility, stabilize health insurance markets, and empower patients and providers towards a system of high-quality coverage and care.

Sincerely,

Bethany Marcum
Executive Director
Alaska Policy Forum

Rea S. Hederman Jr.
Executive Director of the Economic Research Center and Vice President of Policy
The Buckeye Institute (Ohio)

Will Swaim
President
California Policy Center

Chuck Daniel
President
Caesar Rodney Institute (Delaware)

Garrett Ballengee
Executive Director
Cardinal Institute for West Virginia Policy

Kim Crockett, Esq.
Vice President, Senior Fellow and General Counsel
Center of the American Experiment (Minnesota)

Charles Mitchell
President & CEO
Commonwealth Foundation (Pennsylvania)

Robert Roper
President
Ethan Allen Institute (Vermont)

Naomi Lopez Bauman
Director of Healthcare Policy
Goldwater Institute (Arizona)

Jon Caldara
President
Independence Institute (Colorado)

Wayne Hoffman
President
Idaho Freedom Foundation

Sal Nuzzo
Vice President of Policy
The James Madison Institute (Florida)

Brett Healy
President
The John K. MacIver Institute for Public Policy (Wisconsin)

Kory Swanson
President & CEO
John Locke Foundation (North Carolina)

Connor Boyack
President
Libertas Institute (Utah)

Lindsay Boyd Killen
Vice President for Strategic Outreach & Communications
Mackinac Center for Public Policy (Michigan)

Jameson Taylor, Ph.D.
President
Mississippi Center for Public Policy

Brent Mead
CEO
Montana Policy Institute

John Tsarpalas
President
Nevada Policy Research Institute

Jim Vokal
CEO
Platte Institute (Nebraska)

Jim Shaffer
Executive Director
Public Policy Foundation of West Virginia

Mike Stenhouse
CEO
Rhode Island Center for Freedom & Prosperity

Paul Gessing
President
Rio Grande Foundation (New Mexico)

Lynn Taylor
President
Virginia Institute for Public Policy

Jonathan Downing
CEO
Wyoming Liberty Group

**A Comparison of Benefit Differences across Essential Health Benefit Benchmark Plans in Idaho, Maryland, and Minnesota***

| | Benefit | Idaho | Maryland | Minnesota |
|---|---|---|---|---|
| 1. | Hospice Services | Covered ($10,000 limit) | Covered | Covered (30-day limit) |
| 2. | Private-Duty Nursing | *Not Covered* | *Not Covered* | Covered |
| 3. | Routine Eye Exam (Adult) | *Not Covered* | Covered | Covered |
| 4. | Bariatric Surgery | *Not Covered* | Covered | *Not Covered* |
| 5. | Skilled Nursing Facility | Covered (30-day limit) | Covered (100-day limit) | Covered (120-day limit) |
| 6. | Outpatient Rehabilitation Services | Covered (20-visit limit) | Covered (30-visits per condition) | Covered |
| 7. | Habilitation Services | Covered (20-visit limit) | Covered (30-visits per condition) | Covered |
| 8. | Chiropractic Care | Covered ($800 limit) | Covered (20-visits per condition) | Covered |
| 9. | Hearing Aids | *Not Covered* | Covered (1 per 3 years) | Covered (1 per 3 years) |
| 10. | Acupuncture | *Not Covered* | Covered | *Not Covered* |
| 11. | Rehabilitative Speech Therapy | Covered | Covered | *Not Covered* |
| 12. | Rehabilitative Occupational and Rehabilitative Physical Therapy | Covered | Covered | *Not Covered* |
| 13. | Well Baby Visits and Care | Covered | Covered | *Not Covered* |
| 14. | Transplant | Covered | Covered | *Not Covered* |
| 15. | Accidental Dental | Covered | Covered | *Not Covered* |
| 16. | Dialysis | Covered | Covered | *Not Covered* |
| 17. | Allergy Testing | Covered | Covered | *Not Covered* |
| 18. | Chemotherapy | Covered | Covered | *Not Covered* |
| 19. | Radiation | Covered | Covered | *Not Covered* |
| 20. | Diabetes Education | Covered | Covered | *Not Covered* |
| 21. | Prosthetic Devices | Covered | Covered | *Not Covered* |
| 22. | Infusion Therapy | Covered | Covered | *Not Covered* |
| 23. | Treatment for Temporomandibular Joint Disorders | *Not Covered* | Covered | Covered |
| 24. | Nutritional Counseling | Covered | Covered | *Not Covered* |
| 25. | Clinical Trials | *Not Covered* | Covered | *Not Covered* |
| 26. | Diabetes Care Management | *Not Covered* | Covered | Covered |
| 27. | Inherited Metabolic Disorder – PKU | *Not Covered* | Covered | Covered |
| 28. | Off Label Prescription Drugs | *Not Covered* | *Not Covered* | Covered |
| 29. | Dental Anesthesia | *Not Covered* | Covered | Covered |
| 30. | Mental Health Other | *Not Covered* | Covered | Covered |
| 31. | Prescription Drugs Other | *Not Covered* | Covered | Covered |
| 32. | Second Opinion | *Not Covered* | Covered | *Not Covered* |
| 33. | Treatment for Lyme Disease | *Not Covered* | *Not Covered* | Covered |
| 34. | Port-Wine Stain Removal | *Not Covered* | *Not Covered* | Covered |
| 35. | Residential Treatment for Children with Emotional Disabilities | *Not Covered* | *Not Covered* | Covered |
| 36. | Services to Ventilator-Dependent Persons | *Not Covered* | *Not Covered* | Covered |

| | Benefit | Idaho | Maryland | Minnesota |
|---|---|---|---|---|
| 37. | Osteoporosis | *Not Covered* | Covered | *Not Covered* |
| 38. | Blood and Blood Services | *Not Covered* | Covered | *Not Covered* |
| 39. | Family Planning | *Not Covered* | Covered | *Not Covered* |
| Other Benefits | | | | |
| 40. | Respiratory Therapy | Covered | *Not Covered* | *Not Covered* |
| 41. | Enterostomal Therapy | Covered | *Not Covered* | *Not Covered* |
| 42. | Growth Hormone Therapy | Covered | *Not Covered* | *Not Covered* |
| 43. | Nutritional services for the treatment of cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, or kidney disease | *Not Covered* | Covered | *Not Covered* |
| 44. | Medical food for persons with metabolic disorders | *Not Covered* | Covered | *Not Covered* |
| 45. | Medical nutrition therapy to treat a chronic illness or condition | *Not Covered* | Covered | *Not Covered* |
| 46. | Office visits for treatment of childhood obesity | *Not Covered* | Covered | *Not Covered* |
| 47. | Well child care visits for obesity evaluation and management | *Not Covered* | Covered | *Not Covered* |
| 48. | Pulmonary rehabilitation services | *Not Covered* | Covered | *Not Covered* |
| 49. | Increased outpatient rehabilitation (physical therapy, speech therapy, occupational therapy) benefits for cardiac rehabilitation | *Not Covered* | Covered | *Not Covered* |
| 50. | General anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care | *Not Covered* | Covered | *Not Covered* |
| 51. | Any other service approved by the plan's case management program | *Not Covered* | Covered | *Not Covered* |
| 52. | Cost recovery expenses for blood, blood products, derivatives, components, biologics, and serums | *Not Covered* | Covered | *Not Covered* |
| 53. | Coordination of care provided through the Patient-Centered Medical Home Program | *Not Covered* | Covered | *Not Covered* |
| 54. | Abortion services | *Not Covered* | Covered | *Not Covered* |
| 55. | Professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license | *Not Covered* | Covered | *Not Covered* |
| 56. | Diagnostics for mental/behavioral health and substance abuse disorders | *Not Covered* | Covered | *Not Covered* |
| 57. | Online Convenience Care | *Not Covered* | *Not Covered* | Covered |

* This table compares coverage differences across the EHB benchmark plans in Idaho, Maryland, and Minnesota. The table lists only the benefits for which a substantial difference in coverage exists. The list includes 57 benefits, which reveals substantial variation in what these state EHBs deem essential. The states were identified because, prior to the ACA, Idaho is known to have among the fewest state benefit mandates in the country and Maryland and Minnesota are known to have among the most.

Source: The Center for Consumer Information & Insurance Oversight, Centers for Medicare & Medicaid Services, "Information on Essential Health Benefits (EHB) Benchmark Plans," at https://www.cms.gov/cciio/resources/data-resources/ehb.html (accessed on July 6, 2017)