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ESSENTIAL HEALTH BENEFIT REQUIREMENTS AND IMPLICATIONS FOR BENCHMARK PLAN SELECTION

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CSG Government Solutions

180 N. Stetson
Suite 3200
Chicago, IL 60601

Phone: 312.444.2760
Fax: 312.938.2191
www.CSGdelivers.com

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1. SUMMARY

Beginning in 2014, the Patient Protection and Affordable Care Act (ACA) requires all health insurance plans sold to individuals and small businesses to meet minimum benefit requirements. The law establishes a benefit package of Essential Health Benefits (EHB) that must include coverage of 10 broad categories of care. The Secretary of the federal Health and Human Services (HHS) is required to further refine the benefit package, and will oversee states' compliance with the requirements.

While HHS has not yet published regulations on EHB, late last year the Department released a bulletin describing the approach it intends to take. Partly in response to requests from states, rather than establishing a single national standard benchmark plan, HHS plans to allow each state to choose its own specific benchmark. Following this approach, a state will select an EHB benchmark from one of the following 10 options:

- the largest commercial Health Maintenance Organization (HMO) plan in the state based on enrollment;
- the three largest small group insurance products in the state based on enrollment;
- the three largest state employee benefit plans in the state based on enrollment; and
- the three largest Federal Employee Health Benefit Program (FEHBP) plans based on enrollment.

As requested by the State of Iowa, Health Management Associates completed a review of all ten potential benchmark benefit plans to identify which services are included in the plans. We also identified whether the plans included Iowa's mandated insurance benefits, since the state may be responsible for paying the cost of mandated benefits that exceed the EHB requirements. This report includes the results of our analysis. Following is a summary of the key findings and conclusions.

- Our review confirmed that all of the potential benchmark plans include benefits in each of the 10 required categories of coverage, but the level of benefits varied among each of the plans. Consistent with federal findings, most plans do not cover some services, including habilitative care, dental and vision benefits.

- Exclusions and limitations were common and could have a significant impact on the services enrollees have access to, particularly for therapy services, and preventive health and wellness services. Some revisions will likely be necessary among the benchmark options in order to satisfy minimum EHB requirements.

- Because the ACA requires mental health parity benefits consistent with the Federal Mental Health Parity and Addiction Equity Act, any benchmark plan will be required to meet this minimum standard.

- The lack of detail in many of the documents we reviewed made it impossible to clearly determine whether some benefits were covered or to what extent they were covered. For this reason, we recommend that Iowa follow up with health plans to confirm the inclusion of specific benefits. This analysis should be completed prior to selection of a benchmark plan to ensure the state understands which benefits would require the selection of a supplemental benchmark.

- Selection of one of the three largest small group market plans as Iowa's benchmark is the most logical decision and would provide continuity for small businesses and enrollees during a time of significant change as the Exchange is implemented in 2014. The small group plans are likely to be a more cost-effective selection as the benefits are less comprehensive and, therefore, less costly, than those included in the state and federal employee benefit plans. The small group benefits also more closely resemble benefits offered in the individual market, which also must comply with the EHB benchmark requirements.

- Under the proposed HHS approach described in the EHB bulletin, the state will not be required to defray the cost of mandated benefits that are included in the benchmark plan during the first two years. However, any new mandated benefits that may be added during the current Iowa legislative session would require payment by the state to the extent the mandate would not otherwise be included in the plan.

- The state should develop a plan for collecting information on the cost of mandated benefits for future reference and evaluation. HHS intends to reevaluate its benchmark approach and policy regarding the cost of mandated benefits after the initial transition period, and Iowa may need a more accurate assessment of the costs associated specifically with Iowa-mandated benefits.

- The HHS bulletin on EHB is a preliminary document and is intended to serve as guidance for states until the official regulations are issued. The state will need to carefully review the future regulations which may contain requirements that vary from the approach described in the bulletin.

2. INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) establishes minimum benefits standards for individual and small group health benefit plans sold within and outside the exchange, beginning January 1, 2014. Referred to as the essential health benefits (EHB), the law establishes 10 broad categories of benefits that must be included, and requires the Secretary of the Department of Health and Human Services (HHS) to define and periodically update the benefit requirements through rulemaking as described under Section 1302 (c)(b)(3) of the ACA. The ACA also applies the EHB definition to Medicaid benchmark plans and Basic Health Programs, which will be discussed in a separate report.

To assist the HHS Secretary in development of EHB regulations, the ACA requires the Secretary of Labor to conduct a survey of employer-sponsored plans to identify the benefits commonly included. The results of the survey were provided to the HHS last year and are briefly summarized in this report. To further inform the options for defining EHB requirements, HHS asked the Institute of Medicine (IOM) to recommend a process that would help HHS define the benefits and make subsequent updates that take into account advances in science, gaps in coverage, and the effect of any benefit changes on the cost of health care and coverage in order to evaluate affordability of coverage. The significant findings of the IOM study are also summarized in this report.

In an effort to provide preliminary guidance and obtain input from interested stakeholders, on December 16, 2012, HHS published a bulletin on the EHB describing the approach it intends to take in future rulemaking.[1] Comments on the proposal were requested no later than January 31, 2012. Additional clarification was subsequently published in a release of "Frequently Asked Questions on Essential Health Benefits Bulletin."[2] The Bulletin describes a fairly broad approach and provides ten potential benchmark plans options from which states will select a single benchmark that serves as the standard for EHB requirements.

The purpose of this report is to provide an overview of the EHB requirements as described in the ACA and the EHB Bulletin, and an analysis of the potential benchmark plans for the State of Iowa. Our analysis is based on the most recent information available from HHS and health plan documents provided by the State of Iowa. The report includes information on Iowa's mandated health insurance benefits and how the regulatory proposal may impact the state's decision related to the inclusion or exclusion of state mandates in the EHB plan requirements. Following the discussion of EHB requirements, the report provides an overview of ACA provisions related to mandated health insurance benefits and how the Secretary intends to address the inclusion of mandated benefits in EHB requirements. Included is information on Iowa's mandated benefits, how those benefits align with the EHB benefit categories, and estimated costs of those benefits

[1] Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, "Essential Health Benefits Bulletin," December 16, 2011. Available at: http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

[2] Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, "Frequently Asked Questions on Essential Health Benefits Bulletin." Available at: http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf.

based on a variety of published reports. The final section of the report provides a discussion of key findings and conclusions.

3. ESSENTIAL HEALTH BENEFIT REQUIREMENTS

3.1 Federal Essential Health Benefit Plan Requirements

With a few exceptions, the federal government has generally refrained from imposing specific benefit requirements on commercial benefit plans, leaving the minimum requirements up to states to determine.[3] The ACA represents a significant departure from that practice with the inclusion of a minimum standard of coverage that must be met by all plans sold in the Exchange and in markets outside the Exchange. Beginning January 1, 2014, all individual and small group plans must cover the EHB.[4] Plans that retain their grandfathered status are exempt from the requirement, as are self-insured plans and plans offered to large groups with more than 100 employees.[5]

The ACA identifies 10 broad categories[6], or classes, of benefits that must be included, and requires the Secretary of HHS to define the specific coverage that will be required within those categories. The 10 EHB categories include:

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

The ACA further specified that the scope of the EHB must be equal to those typically included in employer and multiple employer plans sold today, and required the Secretary of Labor to conduct a survey of employer-sponsored coverage to identify the benefits that are typically included.[7]

The Secretary also is required to comply with several other provisions in defining the EHB:

- Benefits must reflect an appropriate balance among all 10 categories of coverage;
- The Secretary may not make coverage decisions, determine reimbursement rates, or establish incentive programs;
- Benefits may not be established in a way that discriminates against individuals based on age, disability, or expected length of life and must consider the health care needs of diverse

[3] Notable exceptions include requirements for minimum maternity stays for mothers and newborns, coverage for treatments related to mastectomies, mental health parity benefits, and non-discrimination and access to coverage provisions in the Health Insurance Portability and Accountability Act of 1996.
[4] ACA §1301(a)
[5] ACA §1563
[6] ACA §1302(b)(1)
[7] ACA§1302(b)(2)

segments of the population including women, children, and individuals with disabilities; and

- Benefits for emergency care services must be provided without requiring pre-authorization of services and may not limit services based on whether treatment is provided by a network or non-network provider.[8]

The ACA also addresses the inclusion of certain "mandated benefits" required by state law or regulations by clarifying that, while states are not prohibited from imposing such benefit requirements, states (not enrollees or health plans) will be required to pay the costs associated with the additional benefit requirements (i.e., those that exceed EHB requirements) for plans sold within the Exchange. For plans sold outside the Exchange, the cost of those additional mandates may be included in the premium.

3.1.1 Department of Labor Report – "Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services"

As noted, the ACA required the U.S. Department of Labor (DOL) to conduct a survey of employer-sponsored coverage to identify the benefits typically covered by employers and report the findings to the Secretary of HHS to inform the development of EHB requirements. On April 15, 2011, the DOL Bureau of Labor Statistics (BLS) released its findings based on a survey of approximately 3,900 employers.[9] In addition to the survey results, BLS also reviewed "summary plan descriptions" of benefit plans.

A major challenge for the BLS study was the fact that many of the survey responses and summary documents included only a very general overview of benefits and did not provide the type of coverage details that are available in a health plan benefit contract or master plan document. In many cases, the documents made no mention of specific benefits, such as dialysis, maternity benefits, or transplants. The absence of such information limited the extent to which BLS was able to evaluate the availability of benefits, which is reflected in the following summary information:

- The majority of employees (79%) were covered under a fee-for-service plan (typically utilizing a preferred provider organization) while 21% were enrolled in HMO plans.
- Virtually all plans included comprehensive benefits for certain benefit categories, including inpatient hospital services, inpatient and outpatient surgery, and physician office care. Plan benefits varied among other EHB categories of coverage: 73% of plan enrollees had benefits for home health services; 80% had coverage for adult physical exams; 77% for pediatric/well-child care; and 56% for adult immunizations.
- Benefits varied widely for mental health and behavioral health services, both in the level of coverage, exclusions, eligibility requirements, coverage limitations and cost-sharing requirements. Virtually all plans covered inpatient mental health care at some level, while only 85% of enrollees had coverage for outpatient mental health care services. Inpatient substance abuse detoxification was included for 98% of plan enrollees, but only 78% had benefits for inpatient and outpatient substance abuse rehabilitation.

[8] ACA§1302(b)(4)

[9] U.S. Department of Labor, Bureau of Labor Statistics, "Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services," April 15, 2011. Available at: http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf.

- Coverage also varied significantly for 12 other specific benefits, but in many cases, the data was very limited due to lack of available information:
    - Emergency room visits – 91% of enrollees covered; no information was available in documents covering 9% of enrollees.
    - Ambulance transportation – 64% of enrollees covered; no information was available in documents covering 35% of enrollees.
    - Diabetes care management – 27% of enrollees covered; no information was available in documents covering 73% of enrollees.
    - Kidney dialysis –27% of enrollees covered; no information was available in documents covering 73% of enrollees.
    - Physical Therapy – 70% of enrollees covered, most with limitations; no information was available in documents covering 30% of enrollees.
    - Durable Medical Equipment – 67% of enrollees covered, most with limitations; no information was available in documents covering 33% of enrollees.
    - Prosthetics – 46% of enrollees covered, most with limitations; no information was available in documents covering 54% of enrollees.
    - Maternity benefits – 66% of enrollees covered, with wide variations in coverage; no information was available in documents covering 33% of enrollees.
    - Infertility – 27% of enrollees covered, most with limitations; no coverage was available for 20% of enrollees; no information was available in documents covering 53% of enrollees.
    - Voluntary Sterilization – 26% of enrollees covered; 2% of enrollees not covered; no information was available in documents covering 73% of enrollees.
    - Gynecological Examinations – 60% of enrollees covered; no information was available in documents covering 40% of enrollees.
    - Organ Transplants – 45% of enrollees covered; no information was available in documents covering 55% of enrollees.

3.1.2 Institute of Medicine EHB Report

Last year, the Secretary of HHS asked the Institute of Medicine (IOM) to assist in identifying a process that could be used to define and periodically update the specific benefits that should be included in the definition of the EHB. The IOM was asked to take into account how to ensure the required benefits reflect advances in science and gaps in access to coverage, and the potential impact of any benefit changes on the cost of care. The IOM was directed not to decide what should be covered in the EHB, but to propose a set of criteria and methodology for identifying which benefits to include.

In its report, issued in October 2011, the IOM noted that the committee that developed the report envisioned its primary task as finding the right balance between providing a sufficient scope of coverage to ensure people had access to necessary services with the ongoing challenge of ensuring coverage is affordable. [10] To maximize the number of people covered, the committee suggested that HHS develop a framework for the entire EHB package that would:

- "consider the population's health needs as a whole;

[10] Institute of Medicine, "Essential Health Benefits: Balancing Coverage and Cost," October 7, 2011. Available at: http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx.

- encourage better care by ensuring good science is used to inform coverage decisions;
- emphasize the judicious use of resources; and
- carefully use economic tools to improve value and performance."

The committee identified several conclusions to resolve what they felt are key ambiguities in the law:

- The EHB package should be considered as a basic plan that "will meet the statutory requirements of a typical employer plan and its expansion to the 10 categories before considering any other additions."
- The Secretary should not interpret the ACA to require inclusion of all items and services that are included within the 10 broad categories, even if those benefits are typically included in employer plans.
- Benefits that are not specifically excluded in a health plan should be considered covered if medically necessary. Silence on treatments or benefits should not be interpreted to mean the benefit is not covered unless the health plans make that specification. Insurers also should be allowed to exclude benefits that serve a "primarily educational or social" function, with appropriate oversight by state and federal regulators.
- Current state mandated benefit requirements should not automatically be included in the EHB package, but should be reviewed in the same way as other potential benefits.

Key recommendations included in the report include:

- The process for defining and updating the EHB should be highly visible and allow for input from current and future enrollees to help define priorities.
- Only medically necessary services should be covered, and insurers should be allowed flexibility to determine what is necessary based on the circumstances of an individual case.
- States should be provided flexibility to design a benefit package that is equivalent in value to the EHB, to encourage innovation at the state level.
- HHS should update the EHB benefit package annually to ensure the benefits promote better health outcomes and are based on proven effectiveness. The IOM recommends creation of a National Benefits Advisory Council to monitor and evaluate benefits on an ongoing basis, with states providing necessary data as identified by HHS.
- HHS should work with stakeholders to develop a strategy to reduce the rate of growth in health care spending to help preserve the coverage provided in the EHB package.
- Benefits included in small employer benefit plans should be considered the criteria for identifying "typical" benefits.
- The Secretary should provide specific, detailed guidance on what benefits must be included to ensure a "consistent national benefit package." Such guidance should also include information on what is specifically excluded.
- Benefit limits and medical necessity decisions should be "strongly rooted in evidence," and any guidance on medical necessity by the Secretary should guard against "inflexibility in the application of medical necessity, clinical policies, medical management, and limits without consideration of the circumstances of an individual's case." Doing otherwise would, in the committee's opinion, be "undesirable and potentially discriminatory."

3.1.3 Center for Medicare & Medicaid Services (CMS) Essential Health Benefits Bulletin

On December 16, 2011, the CMS Center for Consumer Information and Insurance Oversight (CCIIO) published a bulletin outlining the approach it intends to take in future rulemaking to define the EHB.[11] The proposed policy was released to "give consumers, states, employers and issuers timely information as they work toward establishing Exchanges and making decisions for 2014."[12] HHS states in its news release that the approach is designed to provide an inclusive, affordable and flexible approach that protects consumers and provides states the flexibility to adopt coverage requirements that meet the unique needs of their residents.

The Bulletin describes HHS' intent to take a broad approach that will:

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

Rather than take a prescriptive approach to defining the EHB for all states, CCIIO intends to follow an approach used to identify benefits for the Children's Health Insurance Program (CHIP) in 1997. The bulletin proposes to allow each state to select a benchmark plan that reflects the benefits and limitations offered by a "typical employer plan" in that state. CCIIO identifies four potential benchmark categories based on the plans with the largest enrollment:

- One of the three largest small group plans in the state;
- One of the three largest state employee health plans;
- One of the three largest federal employee health plan options; or
- The largest non-Medicaid HMO plan in the state based on enrollment.

The benchmark plan options are based on enrollment data from the first quarter of 2012. States are required to select their benchmark in the third quarter of 2012 to provide health plans sufficient notice regarding benefit requirements starting January 1, 2014. If a state fails to select a plan, CCIIO will select the largest plan in the small group market to serve as the benchmark.

Other important issues discussed in the bulletin are summarized below.

3.1.3.1 State Mandated Benefits

CCIIO intends to establish a "transition period" during 2014 and 2015. The bulletin acknowledges that the proposed benchmark plans in the small group market, the state's employee health plans,

[11] Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight "Essential Health Benefits Bulletin", December 16, 2011.
[12] U.S. Department of Health and Human Services, News Release, "HHS to give states more flexibility to implement health reform," December 16, 2011.

and the largest HMO are all likely to include state mandated benefits. CCIIO notes that if the state selects a benchmark subject to state mandates, then the benchmark would include those mandates in the state EHB definition, and the state would not be required to defray the cost of mandates included in the benchmark. However, if a state selects a benchmark that does not include some or all of the mandates, the state would be required to cover the cost of those mandates outside the state's selected EHB benchmark package. CCIIO will re-evaluate the benchmark approach for 2016 and notes that it may adopt an approach that will exclude some state benefit mandates.

3.1.3.2 Coverage of all EHB Benefit Categories

States will be required to ensure all 10 EHB benefit categories are included in health plans offered, even if the benchmark plan does not include some benefits. The bulletin notes that CCIIO is considering options for how a state may supplement its benchmark plan for missing categories and indicates that states will be expected to use other benchmarks to fill in coverage gaps. For example, if a benchmark plan does not cover maternity services, the state must select another benchmark plan to supplement for maternity services. If a state fails to identify a benchmark, the default plan is to supplement the benchmark plan using the largest plan in the benchmark type (small group, state employee plan, or FEHBP) offering the category.

3.1.3.3 Benefits Typically not included in Any Benchmark - Pediatric Oral and Vision Care, and Habilitative Care

HHS notes that the proposed benchmark options often do not include benefits for pediatric oral and vision care, or habilitative care and is considering options for supplementing these missing categories. For habilitation services, CCIIO is considering two alternatives:

1) The benchmark plan would be required to offer parity between rehabilitation and habilitation services (including occupational therapy, physical therapy, and speech therapy), with benefits included for maintaining or keeping an individual patient's existing functions. The bulletin suggests using the National Association of Insurance Commissioners' (NAIC) definition of habilitation, which is "health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physician and occupational therapy, speech language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings."[13]
2) Under a transitional plan, CCIIO would allow health plans to determine which services they would cover and report on that coverage to the Secretary. CCIIO would review those decisions and issue a definition of covered benefits in the future.

For pediatric oral services, HHS is also considering allowing the states to select supplemental benefits from either the Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest enrollment, or from the state's CHIP program. CCIIO also notes that it intends to propose that the EHB definition would ***not*** include non-medically necessary orthodontic benefits.

For pediatric vision services, CCIIO intends to propose that plans include benefits covered by the FEDVIP vision plan with the largest enrollment.

[13] 76 Federal Register 52,529; August 22, 2011.

3.1.3.4 Benefit Flexibility Among Health Plans

While CCIIO intends to require that a health plan offer benefits that are substantially equal to the benchmark plan, plans will have flexibility to adjust benefits. Plans will be allowed to vary the benefits for both the specific services covered and any quantitative limits, as long as they cover all 10 categories and the coverage has the same value. Flexibility would be subject to a baseline set of relevant benefits, reflected in the benchmark plan. CCIIO is considering whether to restrict benefit substitutions only within each of the 10 EHB benefit categories, or whether they also would allow substitution across the benefit categories subject to a higher level of scrutiny to mitigate the potential for eliminating important benefits. All substitutions must be actuarially equivalent, using the same measures as the equivalency standard that applies to plans under CHIP. [14]

3.1.3.5 Prescription Drug Benefit Flexibility

CCIIO also intends to promote pharmacy benefit competition by proposing a standard that reflects flexibility similar to that allowed in Medicare Part D, which requires plans to cover the categories and classes included in the benchmark, but allows individual plans to choose the specific drugs that are covered. If a benchmark plan offers a drug in a specific category or class, all plans must include at least one drug in that same category or class, though the specific drugs covered may vary by formulary.

3.1.3.6 Cost-Sharing Requirements

An important issue ***not*** addressed in the EHB bulletin is the impact of cost-sharing provisions on the actuarial value of plans. The ACA requires plans sold in the Exchange to meet minimum actuarial value, which reflects the amount of expected health care expenses the health benefit plan would pay for a typical beneficiary. Richer, more comprehensive benefits and variable cost-sharing requirements will have a direct impact on the actuarial value. While the bulletin does not address cost-sharing provisions, including deductibles, copayments, and coinsurance, CCIIO notes that future bulletins and/or rules will address cost-sharing requirements and actuarial value determinations.

3.2 Benchmark Plan Options and Analysis

As described above, the December 16, 2011 bulletin on the EHB identifies 10 potential benefit plans from which states may select the most suitable benchmark for their population and market. Consistent with that guidance, HMA worked with Iowa to identify the following benefit plans for analysis:

- the three largest plans by enrollment in Iowa's small group market:
  - Medical Associates Community Plan
  - United Healthcare Select Advantage HMO
  - Wellmark Alliant Select;
- the three largest state employee benefit plans available, based on enrollment:
  - Blue Access
  - Blue Advantage

[14] 42 CFR 457.420 and 42 CFR 457.431

- Program 3 Plus;

- the three largest FEHBP options based on enrollment:
  - FEHBP Blue Cross Blue Shield Standard Option
  - FEHBP Blue Cross Blue Shield Basic Option
  - Government Employees Health Association (GHEA); and
- the largest commercial HMO in Iowa:
  - Wellmark HMO.

The identification of the three largest small group market plans was based on a document provided by HHS on January 25, 2012, which included a list of these products in each state based on enrollment data collected by HealthCare.gov.[15] We also relied on this document for identification of the three largest FEHBP plans. The largest commercial HMO and the three largest state employee benefit plans were identified by Iowa.

3.2.1 Methodology of Analysis and Data Limitations

To perform our review of the potential benchmark plans, HMA relied primarily on documents provided by the state for the three largest small group plans and the largest commercial HMO, and various websites with summary of coverage documents for information on the state and federal employee benefit plans. These summary descriptions varied significantly in the level of detail provided on specific benefits and policy exclusions, with some documents providing fairly detailed information and others providing more limited summaries. To the extent the information was available, our review included an analysis of benefits described in the summary of coverage, the policy description of covered benefits, the definitions of benefits and covered providers, and the list of exclusions and services not covered by the plan.

Based on our review of the documents listed above, we developed a summary table of the benefits we identified as most likely to be included within the 10 broad categories of coverage required in EHB benchmark plans. The table is attached in Appendix A. If the plan documents clearly indicated that a benefit is provided, the table notes that the benefit is included. If we identified limitations or exclusions for that benefit, we included a footnote that describes the limitations. If the documents identified a specific exclusion that shows a benefit is not included, the table shows that no coverage is available for the benefit. In cases where the plan documents note that coverage is restricted but do not identify the specific limitations, we were unable to include the limitations in our summary table.

Similar to the challenges encountered by DOL in its analysis of employer plans as described earlier in this report, our analysis also is limited because the summary documents often were silent with regard to certain benefits. If we were unable to find any reference to a specific benefit in the summary of benefits or in the exclusions and limitations, we noted on the table that the status of the benefit coverage is "unknown." For example, plan descriptions commonly stated maternity benefits were included but failed to identify whether coverage is available for childbirth classes. Likewise, health benefit plan documents described the inclusion of cancer screenings, but did not specify which types of screenings are covered.

[15] Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, "Essential Health Benefits: Illustrative List of the Largest Three Small Group Products by State." Available at: http://cciio.cms.gov/resources/files/Files2/01272012/top_three_plans_by_enrollment_508_20120125.pdf.

Plans also use "bracketed options" to indicate that some benefits may be limited within a range that varies based on a specific policy form, or the purchaser (employer or individual) selects the specific benefit limit within that range. For example, a plan may offer 25 to 75 visits a year for a particular service, but the purchaser selects the benefit limitation and the premium is adjusted to reflect that specific level of coverage. In some cases, the policy form does not specify the range of services so that insurers have flexibility to adjust those ranges without filing new forms with the Iowa Insurance Department (IID); rather, they simply indicate a bracket with "xxx – xxx" inside to indicate a range is available. It is up to the agent or insurer to work with the purchaser to complete those brackets when the plan is purchased. Where bracketed options are provided, we were unable to identify specific limitations in our summary table.

As is noted in the EHB bulletin, insurers commonly offer plan riders to allow purchasers (employers or individuals) to enhance the standard benefit plan with additional benefits. Dental and vision services are examples of benefits that are commonly excluded in benefit plans but available through riders. The use of benefit riders, while a common practice, was not a part of our analysis. HHS has clarified that, for purposes of identifying the benchmark plan, benefits provided by rider are excluded. HHS intends to propose that if benefits within a specific EHB category are offered only through the purchase of riders in a benchmark plan, the state would have to select another benchmark to supplement those benefits.[16]

3.2.2 Analysis of Findings

HMA's analysis of the 10 potential benchmark plans revealed the following key findings:

- All of the plans cover some level of services within each of the 10 EHB categories. While the specific benefits varied, there were also many similarities. As might be expected based on other reports (e.g., the DOL review of employer benefit plans), most plans do not appear to cover habilitative therapies, telehealth, pediatric dental, or vision services for children or adults. Iowa will most likely have to supplement the selected benchmark with these required services.

- Exclusions and limitations were prevalent among all plans, but varied significantly. Limitations were consistently applicable to therapy services (including physical, occupational and speech), mental health benefits, skilled nursing coverage, and preventive health and wellness services.

- None of the three largest small group plans cover dental services, except for services required as a result of accidental injury. Only one plan appears to include prescription drug benefits. All of the plans, however appear to offer dental services and prescription drugs as a rider. Consistent with the HHS guidelines, our summary table reflects that benefits are not included if the purchaser is required to separately purchase those benefits as a rider or under a separate policy form.

[16] "Frequently Asked Questions on Essential Health Benefits Bulletin," Department of Health and Human Services, available at: http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf

- All of the small group plans and most of the other benchmark options appear to exclude coverage of habilitative services, though it is possible the policy forms are simply silent on this issue. The state should follow-up with the insurers to determine what, if any, coverage is provided for habilitative services. For both of these services, the federal bulletin notes that supplemental coverage likely will be required.

- Abortion coverage was not clearly addressed in most policy documents. HHS does not address this benefit in the EHB bulletin, but the state should review the final regulations to determine any limitations or requirements for this specific benefit, as well as other benefits that are not clearly addressed in the bulletin's description of EHB requirements.

- The lack of detail in many of the plan documents we reviewed limited the extent to which we could evaluate the benefits. This fact is reflected in the numerous "unknown" items for which we were unable to identify whether services were included, excluded, or included with limitations.

4. Mandated Benefits – Costs, Coverages and Impact on EHB Benchmark Plan Selection

4.1 Federal Provisions Related to State Mandated Benefits

The ACA includes language clarifying that a state may require individual and group health plans sold within and outside the Exchange to include mandated benefits that exceed the EHB requirements. However, if the requirements apply to Qualified Health Plans (QHPs) sold inside the Exchange, the ACA requires the state to pay the costs associated with the additional requirements.[17] For plans sold by insurers in the non-Exchange markets, the cost of additional state benefit mandates may be added to the premium cost, consistent with the current practice.

The ACA provisions do not address mandated benefits that fall within an EHB category. For example, if a state law requires coverage of maternity care in individual and small group policies, the ACA does not specifically state whether this requirement would be considered a mandated benefit that requires payment by the state, or whether the state would be exempted from its obligation to pay for the benefits since they are a required EHB category.

In the December 16, 2011 EHB bulletin, CCIIO advises that the intended approach for 2014 and 2015 is to provide a transitional period for states to "coordinate their benefit mandates while minimizing the likelihood the state would be required to defray the costs of these mandates in excess of EHB." During the transitional period, any state mandated benefits that are included in the state's EHB benchmark plan are considered part of the EHB benchmark requirements, and the state would not be required to cover the cost of those services. However, if the state selects a plan that does not include mandates and then adds those mandated benefit requirements to the benchmark, the state would be required to cover the cost of those benefits included in plans sold inside the Exchange. The costs of those benefits in plans sold outside the Exchange would be included in the premium paid by the consumer. CCIIO notes that, regardless of what approach it decides to take when regulations are promulgated later this year, it intends to revisit this issue in 2016.

It is important to note that the intentions described in the CCIIO bulletin are not final regulations and may be revised in forthcoming regulatory guidance. The CCIIO bulletin also does not address how a state would calculate the cost of mandated benefits.

4.2 Mandated Benefit Costs and Selection of Benchmark Plan

Based on information provided by the state and a listing of benefits published by the Council for Affordable Health Insurance (CAHI),[18] HMA identified the following mandated benefits currently required in plans sold in Iowa:

- Autism;
- Contraceptives;

[17] ACA §1311(d)(3)(B)

[18] For our review, Iowa initially provided a list of state mandates which were identified by the Council for Affordable Health Insurance in a publication entitled "Health Insurance Mandates in the States, 2010". After closer review of the list, the state provided a supplemental document that included additional benefits for inclusion in this report.

- Dental Anesthesia;
- Diabetes Self-Management;
- Diabetic Supplies;
- Emergency Room Services;
- HPV Vaccine;
- Mammography Screening;
- Breast Reconstruction following a Mastectomy;
- Minimum Maternity Stay;
- Mental Health Parity;
- Prosthetics;
- Well-Child Care;
- Continuity of Care for Pregnant Women;
- Continuity of Care for Terminally-Ill Patients;
- Oral Chemotherapy;
- Continued Coverage of Individuals Participating in Cancer Clinical Trials;
- Mental Illness Treatment for Veterans; and
- Skilled Nursing Care in a Hospital if Services are Not Otherwise Available.

Though HHS has not identified the specific benefits within each of the EHB categories, Iowa's state mandates appear to most likely fall within the categories listed in the following table:

Iowa Mandated Benefit	EHB Benefit Category in Which Mandate is Likely to be Included
Autism	Mental Health and Substance Abuse
Breast Reconstruction	Hospitalization and Ambulatory Patient Services
Contraceptives	Prescription Drugs; Preventive and Wellness Services and Chronic Disease Management
Dental Anesthesia	Hospitalization; Pediatric Services
Diabetes Self-Management	Preventive and Wellness Services and Chronic Disease Management; Ambulatory Patient Services
Diabetic Supplies	Preventive and Wellness Services and Chronic Disease Management; Ambulatory Patient Services
Emergency Room Services	Emergency Services
HPV Vaccine	Preventive and Wellness Services and Chronic Disease Management; Pediatric Services
Mammography Screening	Preventive and Wellness Services and Chronic Disease Management
Minimum Maternity Stay	Maternity and Newborn Care
Mental Health Parity	Mental Health and Substance Use Disorder Services and Devices
Orthotics and/or Prosthetics	Rehabilitative and Habilitative Services and Devices
Well Child Care	Pediatric Services
Continuity of Care for Pregnant Women	Maternity and Newborn Care

Continuity of Care for Terminally Ill Patients	Preventive and Wellness Services and Chronic Disease Management; Ambulatory Patient Services, Hospitalization
Oral Chemotherapy	Prescription Drugs
Continued Coverage of Individuals Participating in Cancer Clinical Trials	Preventive and Wellness Services and Chronic Disease Management; Ambulatory Patient Services, Hospitalization
Mental Illness Treatment of Veterans	Mental Health and Substance Abuse
Skilled Nursing Care in a Hospital	Ambulatory Patient Services, Hospitalization

Of the benefits identified above, several are certain to be benefits HHS will require to be included under the 10 EHB categories, including emergency room coverage, breast reconstruction benefits, mental health parity, mental illness treatment of veterans and minimum maternity stays. Breast reconstruction following a mastectomy and minimum maternity stays are already required benefits under federal law, and emergency services are a specific required coverage category. Mental health parity will be a required benefit in both small group and individual plans in compliance with the ACA requirement to comply with the federal Mental Health Parity and Addiction Equity Act. Mental illness treatment of veterans is likely to be required under mental health and substance abuse disorders.

In addition to the list of benefits identified by AHIP, Iowa identified several benefits that may or may not be classified by HHS as a "mandated benefit." Iowa, like all other states, requires health plans to include a variety of provisions in their insurance plans, some of which are widely recognized as a mandated benefit. Others, however, do not clearly mandate a specific benefit, but may address administrative processes, claims payment requirements, or provide consumer protections. The CCIIO EHB bulletin does not define "mandated benefits," but, depending on future regulations, the following requirements in Iowa may or may not be classified as a mandated benefit:

- Disclosures Relating to Dental Coverage Reimbursement Rates;
- Prohibition of Dental Fee Restriction for Non-Covered Services;
- Prescription Drug Benefit Restrictions;
- Coordination of Health Care Benefits with State Medical Assistance;
- Payment of Licensed Physician Assistants and Licensed Advanced Registered Nurse Practitioners for Covered Services;
- Group Managed Health Care Plans Requirements Attached to Limited Provider Network Plan Offers;
- Prohibition Against Penalizing or Prohibiting Providers from Discussing Treatment Options with Patients; and
- Payment Requirements for Immunizations that Include Trace Amounts of Mercury.

The state also identified several statutory provisions that require health plans to extend coverage to certain people, including adopted children, newborn children, and children for whom a parent is required to provide coverage under a court-issued medical support order. A separate statute prohibits plans from denying or canceling coverage for individuals based on a diagnosis of fibrocystic breast disease. These requirements are all likely to be addressed under other ACA provisions related to guaranteed issue and prohibitions against denying coverage to individuals

based on pre-existing conditions. However, the state should continue to be mindful of these provisions and how they may affect future decisions based on whether they are classified as mandated benefits.

While the December 2011 CCIIO bulletin clarified that the state will not be responsible for defraying the cost of mandated benefits **included** in the selected benchmark plan in 2014 or 2015, HHS intends to revisit this approach for 2016 and beyond. Thus, it is important for Iowa to understand the potential costs of mandated benefits to accurately assess the financial impact on the state if required to pay those costs.

Because Iowa does not have data on mandated benefit costs, we reviewed several other mandated benefit cost studies that evaluate similar benefits in other states. While this is not a perfect process, studies have shown that most benefit mandates experience similar costs and utilization experience, with the exception of mandate requirements that vary significantly from state to state, which is common for some mandated benefits (e.g., those requiring mental health and autism coverage). For a more exact estimate of Iowa's costs, the state should consider collecting specific cost and utilization data from existing health plans before 2016.

To identify approximate cost estimates for each of Iowa's mandated benefits, we relied on several published reports, described below. However, note that we were not able to locate cost estimates for all of the state's mandated benefits.

Texas Mandated Benefit Cost and Utilization Report
http://www.tdi.texas.gov/reports/life/documents/lhlmanbenrept09.pdf

The Texas report provides information on four mandates similar to Iowa's requirements:

- Diabetes Education and Supplies – The Texas mandated benefit requirement includes coverage for both diabetes education and supplies. In 2009, the annual estimated premium cost for these services was $22.20 for a benefit plan covering a single individual and $53.53 for family coverage.

- Mammography Screening – The Texas mandated benefit requirement includes coverage for an annual mammography screening for all women age 35 and over. In 2009, the annual estimated premium cost for the screening was $12.68 for single coverage and $30.41 for family coverage.

- Contraception – The Texas mandated benefit requirement includes coverage of prescription oral contraceptive drugs, devices, and related services. In 2009, the annual estimated premium cost for the benefit was $4.75 for individual coverage and $11.41 for family coverage.

- Breast Reconstruction Following Mastectomy – The Texas mandated benefit is consistent with the federal requirement, which requires coverage of reconstructive surgery after a mastectomy in plans that cover the mastectomy service. In 2009, the annual estimated premium cost for the benefit was $10.80 for individual coverage and $28.14 for family coverage.

Actuarial Cost Estimate – Virginia House Bill No. 303 and Senate Bill No. 464
http://www.autismvotes.org/atf/cf/%7B2A179B73-96E2-44C3-8816-1B1C0BE5334B%7D/VA%20HB%20303%20and%20SB%20464%20Actuarial%20Cost%20Analysis%201%2015%202010%20Final.pdf

- This report provides an estimate of the impact of mandated coverage of autism spectrum disorder in Virginia. The report provides a low, medium and high estimate of the average annual premium cost per person. The lowest cost is $9.60, middle cost is $15.10, and high cost is $24.70.

Connecticut Mandated Health Insurance Benefits Reviews 2010; University of Connecticut

- This report includes estimates of Connecticut mandated benefits, including the following:
  - Diabetes Testing and Treatment – Group plans, 1.5% of premium; individual plans, 0.3% of premiums;
  - Diabetes Self-Management – Group and individual plans, 0.0% of premium;
  - Mammography – Group plans, 0.8% of premium; individual plans, 0.9%;
  - Contraception – Group and individual plans, 0.4% of premium;
  - Autism – Group plans, 1.7% of premium; and
  - Well Child care – Group plans, 0.6% of premium.

Maryland Annual Mandated Health Insurance Services Evaluation, December 31, 2008
http://mhcc.dhmh.maryland.gov/healthinsurance/Documents/sp.mhcc.maryland.gov/healthinsurance/annualmandaterpt2008.pdf

- This report provides a review of proposed autism spectrum disorder mandate legislation in Maryland and includes information on the estimated costs of other states' autism mandates, including:
  - Pennsylvania – 1 to 1.5 percent annual premium increase;
  - South Carolina - $48 annual premium cost per enrollee;
  - Wisconsin - $41.30 to $49.20 annual premium cost per enrollee; and
  - New Jersey - $122.04 annual premium cost per family policy.

Study of Mandated Health Insurance Services: A Comparative Evaluation; January 1, 2012
http://mhcc.dhmh.maryland.gov/healthinsurance/Documents/sp.mhcc.maryland.gov/healthinsurance/mandated_2012_20120106.pdf

- This report provides an estimate of the annual cost of Maryland's mandated benefits for small group and individual plans, and includes the following:
  - Mammography – small group, 0.8% of premium; individual, 0.7% of premium;
  - Reconstructive breast surgery – small group and individual, 0.2% of premium;
  - Diabetes equipment, supplies and self-management – small group, 1.3% of premium, individual, 1.1% of premium;
  - Contraceptives – small group, 0.8% of premium; individual, 0.7% of premium;
  - General anesthesia for dental care under specified conditions – small group and individual, 0.1% of premium;
  - Minimum maternity stay – small group, 0.7% of premium; individual, 0.6% of premium; and

- Mental illness, drug and alcohol abuse – small group, 5.9% of premium; individual, 4.9% of premium.

Council for Affordable Health Insurance (CAHI), Health Insurance Mandates in the States, 2010

- This report includes a summary chart that provides the following aggregated cost estimates reflecting costs across all states that have a mandated benefit requirement for each category:
  - Autism – 1% to 3% of annual premium;
  - Breast Reconstruction – Less than 1% of annual premium;
  - Contraceptives – 1% to 3% of annual premium;
  - Dental Anesthesia – Less than 1% of annual premium;
  - Diabetes Self-Management – Less than 1% of annual premium;
  - Diabetic Supplies – Less than 1% of annual premium;
  - Emergency Room Services – Less than 1% of annual premium;
  - HPV Vaccine – Less than 1% of annual premium;
  - Mammography Screening – Less than 1% of annual premium;
  - Minimum Maternity Stay – Less than 1% of annual premium;
  - Mental Health Parity – 5% to 10% of annual premium;
  - Prosthetics and/or Orthotics – Less than 1% of annual premium; and
  - Well-Child Care – 1% to 3% of annual premium.

The following chart summarizes the costs described above for each Iowa mandated benefit requirement.

Iowa Mandated Benefit	Annual Estimated Cost in Other States
Autism	Cost per person: Low: $9.60; Medium: $15.10; High: $24.70 (VA) 1 to 1.5 percent annual premium increase (PA) $48 per person (SC) $41.30 to $49.20 per person (WI) $122.04 per family policy (NJ) 1.7% of premium in group plans (CT) 1% to 3% of premium (National per CAHI estimate)
Breast Reconstruction	$10.80 for individual and $28.14 for family coverage (TX) 0.2% of premium in small group and individual plans (MD) Less than 1% of annual premium (National per CAHI estimate)
Contraceptives	$4.75 for individual and $11.41 for family coverage (TX) 0.4% of premium in group and individual plans (CT) 0.8% of premium in small group plans; 0.7% in individual (MD) 1% to 3% of premium (National per CAHI estimate)
Dental Anesthesia	0.1% of premium in small group and individual plans (MD) Less than 1% of annual premium (National per CAHI estimate)
Diabetes Self-Management	$22.20 for individual and $53.53 for family coverage for both Diabetes education and supplies (TX) Group and individual plans, 0.0% of premium (CT)

	1.3% of premium in small group plans for equipment, supplies and management and 1.1% of premium in individual plans (MD) Less than 1% of annual premium (National per CAHI estimate)
Diabetic Supplies	$22.20 for individual and $53.53 for family coverage for both Diabetes education and supplies (TX) Group, 1.5% of premium for testing and treatment; 0.3% for individual plans (CT) 1.3% of premium in small group plans for equipment, supplies and management and 1.1% of premium in individual plans (MD) Less than 1% of annual premium (National per CAHI estimate)
Emergency Room Services	Less than 1% of annual premium (National per CAHI estimate)
HPV Vaccine	Less than 1% of annual premium (National per CAHI estimate)
Mammography Screening	$12.68 for individual and $30.41 for family coverage (TX) Group, 0.8% of premium; individual, 0.9% of premium (CT) Small group, 0.8% of premium; individual, 0.7% of premium (MD) Less than 1% of annual premium (National per CAHI estimate)
Minimum Maternity Stay	Small group, 0.7% of premium; individual, 0.6% of premium (MD) Less than 1% of annual premium (National per CAHI estimate)
Mental Health Parity	5% to 10% of annual premium (National per CAHI estimate)
Prosthetics	0.1% of premium for small group and individual for prosthetics (MD) Less than 1% of annual premium (National per CAHI estimate)
Well-Child Care	Small group, 2.1% of premium; individual, 1.7% (MD) 0.6% of premium in group plans (CT) 1% to 3% of annual premium (National per CAHI estimate)

The information we were provided by the state did not indicate which markets (small group, large group, individual) or types of plans (HMO, preferred provider organization or indemnity) are required to include each of these benefits. However, if the mandates are all applicable to all small group benefit plans, we would expect each of the potential small group benchmark plans to include all of the Iowa mandates. If that is the case, the state can avoid having to pay costs associated with any of these mandates by selecting as its benchmark plan one of the small group plans that includes all the mandated benefits. If the state selects as a benchmark a plan that does not include any of the mandates, however, the state will have to decide whether to eliminate the mandated benefit requirement for all QHPs or pay the costs associated with the mandates that exceed the EHB requirements for plans sold in the Exchange. Additionally, if the state selects a small group plan as its benchmark, but some of these mandates apply only to individual plans and small group plans, the state could be responsible for the costs associated with the individual mandates that are required for plans sold in the Exchange.

5. FINDINGS AND CONCLUSIONS

This section of the report presents HMA's key findings and conclusions.

- **Selection of one of the three largest small group plans as the EHB benchmark is the most logical decision to avoid market disruption and to ensure consistency with Iowa's current market approach to provide comprehensive coverage at an affordable price.**

  Selecting a small group benefit plan as the Iowa benchmark is likely the most practical decision for several reasons. First and foremost, assuming the selected small group benchmark includes all of the state's mandated benefits, Iowa will avoid the need to defray the costs of mandated benefits since they are included in the benchmark. As explained earlier in this report, the mandated benefit information we were provided did not indicate to which markets the mandated benefits are applicable. However, the state also should evaluate whether the individual plans are subject to mandated benefits that do not also apply to the small group market as the state would be responsible for defraying any mandates not included in the selected small group benchmark plan. While our analysis did not include this evaluation due to the limited information we were provided, this review should be completed prior to selection of a benchmark plan.

  Additionally, selection of a small group plan is likely to present the least disruption to the current insurance market. Insurers participating in the Exchange must meet numerous new requirements to become certified for the Exchange, including obtaining approval of the policy forms they will offer. Because small group insurers will already have policy forms that are likely to be largely compliant with these new requirements, using one of the three small group policy forms as the benchmark will simplify the policy approval policy required as a condition of QHP certification. Selection of another benchmark – such as one of the FEHBP plans – is likely to require more significant policy revisions to comply with the state's requirements and may discourage some plans from participating.

  Selection of a more comprehensive EHB benchmark, such as the benefit plans offered to state or federal employees, also will likely result in an increase in premiums for small business owners to accommodate the higher levels of coverage. While the small employer benchmark options will require some benefit enhancements to meet the federal minimum requirements, the revisions will be more limited than what would be required if the state selected a more comprehensive plan offered to state or federal employees. Some increase in premiums is likely regardless of which plan is selected, but is likely to be lower with a small group benchmark than with a more comprehensive benefit plan.

  Further, selection of a small group plan is more consistent with the benefits typically provided in individual plans. Since the individual plans are subject to compliance with the benchmark benefits and commonly provide the most restrictive coverage, selection of the small group benchmark will provide an easier transition for plans sold in the individual market and may help minimize premium cost increases that would occur if required to include the more comprehensive benefit plans offered in the state and federal employee benefit plans.

  Finally, selection of a small group plan will provide consistency for employers who are already insured, and will minimize the transition for covered enrollees. Because the required changes will be more limited than if the state chose another benchmark plan, the consumer education

requirements will be easier to address than those required if the state required more comprehensive revisions associated with one of the other benchmark options.

- **Prior to selection of a benchmark, Iowa should seek clarification from health plans to confirm benefit coverages that were not clearly indicated in the documents reviewed by HMA. Iowa also should be prepared to evaluate any new benchmark plans identified in the updated list HHS will release prior to selection of the state's benchmark.**

  Because the state did not provide its own list of mandated benefits but instead provided HMA with a list developed by the CAHI, we strongly recommend that IID determine whether the state has any additional mandated benefits that were omitted from the CAHI list. We also have noted throughout our evaluation that the small group insurance policy documents, as well as other plan documents we reviewed, were silent or provided minimal information on numerous benefits, and suggest Iowa confirm with health plans the specific benefits provided for the 10 EHB categories of coverage prior to selecting a benchmark. For example, two of the small group market benchmark options appear to offer prescription benefits only as an added benefit available as a rider. HHS stated that, if benefits in a required category are offered only through a rider, the benchmark plan is considered to be missing those benefits. Other plan documents provided no information on numerous benefits as noted throughout our summary table. Because the state will be required to supplement the benchmark with coverage from another benchmark plan that includes the missing services (including benefits available through a rider), the state should obtain any necessary clarification from health plans on all 10 categories of benefits to fully understand the additional services that will be required and which plans include services that may be used to serve as the benchmark supplement.

  We suggest that the state (or a contractor) develop a comprehensive benefit survey analysis form for completion by the three largest small employer plans and the largest commercial HMO plan. This information would provide the state with a more accurate and reliable assessment.

  Finally, the potential benchmark plans we reviewed were based on HHS' identification of the largest plans in 2011. HHS will release an updated list of the largest plans based on enrollment for the first quarter of 2012, from which the state must select a benchmark in the third quarter of 2012. It is possible the updated list will differ from the initial list, and the state must be prepared to conduct a quick assessment of any revisions.

- **Iowa should not include any new mandated benefits in the EHB benchmark plan as doing so will require the state to pay the costs associated with the additional services.**

  The CCIIO "Frequently Asked Questions on Essential Health Benefits Bulletin" states that any state-mandated benefit enacted after December 31, 2011 cannot be part of the EHB for 2014 or 2015 unless the benefit would already be included within the benchmark plan regardless of the mandate. Thus, any new mandated benefits that may be enacted during the current Iowa legislative session likely would not be included in the EHB unless the state determines that the benefit would have been included even in the absence of the mandated benefit requirement.

- **Iowa will need to ensure the selected benchmark plan also complies with additional requirements not addressed in this evaluation.**

  This evaluation does not address scope and duration limits of coverage. HHS has stated that EHB benchmark plans can include scope and duration limitations on specific benefits, but they

must meet statutory prohibitions on discrimination in the benefit design.[19] Prior to selecting a benchmark plan, the state will need to ensure the selected plan complies with these additional provisions, which are expected to be addressed in more detail in the forthcoming federal EHB regulations.

- **Iowa should establish a process for collecting annual information on mandated benefit costs to be sure it has data that likely will be needed when HHS reconsiders its treatment of state mandated benefits.**

  Because HHS has indicated that it intends to re-evaluate the treatment of state mandated benefits in benchmark plans for plan years beginning in 2016, the state may want to establish a process for tracking costs associated with those benefits in the event the information would be necessary for future evaluation. If the federal position is revised and the inclusion of state mandated benefits in benchmark plans is considered to be outside the EHB defined scope of benefits, the state will need an accurate estimate of how much those benefits would cost to identify the state's financial responsibility if it decides to continue requiring inclusion of any of those mandates. While the review of other states' costs is a reasonable substitute at this time, more exact information will be important for future evaluation, particularly for those mandates for which the requirements vary significantly from state to state. For example, the specific benefit requirements for states' autism services vary widely, which is reflected in the wide range of cost estimates. HHS states in the December EHB bulletin that it will review the treatment of mandated benefits during calendar year 2016 and will develop an approach that may exclude some mandates from inclusion in the Iowa benchmark plan. Should that occur, the state will need more exact cost estimates to understand the potential impact if Iowa is required to pay the cost of mandates in excess of the EHB for QHP enrollees.

  In considering its options for future data collection and analysis, the state may want to review the annual mandated benefit reports published by the Maryland Health Care Commission and the Texas Department of Insurance, both of which are described in Section 4 of this report.

- **Iowa should consider options for streamlining the policy form revisions that will be required of insurers and the impact those changes could have on carriers' decision to participate in the Iowa Exchange and non-Exchange insurance markets**.

  Based on the review of benchmark options, it is certain that existing health plans will require some policy revisions to comply with the minimum requirements, regardless of which benchmark plan the state selects. For example, it appears habilitative services likely are excluded from all of the small group benchmark options as well as other potential benchmark plans, making it is reasonable to assume that all small group and individual health plans likely will require the addition of these services. The process of policy form development and state approval will require, at the least, several months and potentially longer depending on how extensive the revisions are and the regulatory changes (i.e., new rules) may require prior to development of the forms. To streamline the process, Iowa could provide standard language for common benefit revisions/additions which policies could agree to include in exchange for

[19] See Department of Health and Human Services "Frequently Asked Questions on Essential Health Benefits Bulletin", available at: http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf.

an expedited approval process. Insurers who do not use the standard language would be subject to the standard review and approval process, which will require more time.

Additionally, depending on how Iowa structures the QHP certification process, the Exchange must allow an insurer sufficient time to obtain the policy form approval prior to, or during, the certification process. If health plans are not provided sufficient time to complete each of these steps, or even perceive the timeframes cannot be met, some plans, at least initially may decide not to participate. In developing the state's timeline for implementation, it will be important to allow sufficient time for completion of each of these regulatory processes to attract health plan participation.

APPENDIX A

SUMMARY OF POTENTIAL IOWA ESSENTIAL HEALTH BENEFITS BENCHMARK PLANS

	Iowa Small Group Plans with Largest Enrollment			Iowa State Employee Benefit Plans with Largest Enrollment			Federal Employee Health Benefit Plans with Largest Enrollment			Largest Non-Medicaid HMO Plan
Essential Health Benefit Category and Service Type	Medical Associates Community Plan[1]	United Healthcare Select Advantage HMO	Wellmark Alliant Select	Blue Access	Blue Advantage	Program 3 Plus	FEHBP BCBS Standard Option	FEHBP BCBS Basic Option	Government Employees Health Association	Wellmark HMO
EHB Category: Ambulatory Patient Services										
Primary Care Physician Services	X	X	X	X	X	X	X	X	X	X
Specialty Physician visits	X	X	X	X	X	X	X	X	X	X
Home Health services	X	X[2]	X[3]	X	X	X	X[4]	X[4]	X[5]	X
Chiropractic Care	X	X[6]	X[7]	X	X	X	X[8]	X[8]	X[7]	X[9]
Acupuncture	UK	UK	X[10]	No	No	No	X[11]	X[11]	X[12]	No
Infertility Treatment	X[13]	X[14]	X[15]	No	No	No	X	X	X	No
Outpatient Surgery	X	X	X	X	X	X	X	X	X	X
Second Surgical Opinion	UK	UK	UK	X	X	X	X	X	X	UK
Telehealth	UK	UK	UK	UK	UK	UK	No	No	No	UK
Allergy Testing	X	X	X	X	X	X	X	X	X	X
Chemotherapy	X	X	X	X	X	X	X	X	X	X
IV Infusion Services	X	X	X	X	X	X	X	X	X	X
Radiation Therapy	X	X	X	X	X	X	X	X	X	X
Dialysis	X	X	X	X	X	X	X	X	X	X
Voluntary Sterilization	UK	UK	X	X	X	X	X	X	X	No
Termination of Pregnancy	UK	UK	X[16]	UK	UK	UK	X[17]	X[17]	X[17]	No[18]
EHB Category: Emergency Services										
Emergency Room Services	X	X	X	X	X	X	X	X	X	X
Transportation – Ambulance	X	X	X	X	X	X	X	X	X	X
Transportation – Air Ambulance	UK	UK	X	X	X	X	X	X	X	X
Urgent Care/Emergency Clinics (non-hospital facilities)	X	X	X	X	X	X	X	X	X	X

Key: X = Benefit is Provided No = Benefit is Not Provided UK=Unknown whether benefit is provided LC=Likely Covered

	Iowa Small Group Plans with Largest Enrollment			Iowa State Employee Benefit Plans with Largest Enrollment			Federal Employee Health Benefit Plans with Largest Enrollment			Largest Non-Medicaid HMO Plan
Essential Health Benefit Category and Service Type	**Medical Associates Community Plan[1]**	**United Healthcare Select Advantage HMO**	**Wellmark Alliant Select**	**Blue Access**	**Blue Advantage**	**Program 3 Plus**	**FEHBP BCBS Standard Option**	**FEHBP BCBS Basic Option**	**Government Employees Health Association**	**Wellmark HMO**
EHB Category: Hospitalization										
General Inpatient Hospital Care	X	X	X	X	X	X	X	X	X	X
Inpatient Physician Services	X	X	X	X	X	X	X	X	X	X
Inpatient Surgical Services	X	X	X	X	X	X	X	X	X	X
Non-Cosmetic Reconstructive Surgery	X	UK	X	X	X	X	X	X	X	X
Bariatric Surgery	UK	X[19]	X	No	No	X[20]	X[21]	X[21]	X[21]	X
Transplants	X	X	X	X	X	X	X	X	X	X
Congenital Abnormalities Correction	UK	UK	X	X	X	X	LC	LC	LC	X
Anesthesia	X	X	X	X	X	X	X	X	X	X
Hospice Care	X	X	X	X	X	X	X	X	X	X
Skilled Nursing Facility	UK	X[22]	X[23]	X[24]	X[24]	X	No	No	X[25]	X[26]
Maternity and Newborn Care										
Inpatient Hospital Care – Delivery and Nursery Newborn Care	X	X	X	X	X	X	X	X	X	X[27]
OB/GYN Physician Services	X	X	X	X	X	X	X	X	X	X[27]
Nurse Midwife Services	UK	UK	UK	No	No	No	X	X	X	UK
Prenatal Care	X	X	X	X	X	X	X	X	X	X[27]
Childbirth Education Classes	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK
Lactation Consultant	UK	UK	UK	UK	UK	UK	X	X	UK	UK
Postnatal Care	X	X	X	X	X	X	X	X	X	X
Mental Health and Substance Abuse										
Mental/Behavioral Health Inpatient Treatment	X[28]	X	X[29]	X	X	X	X	X	X	X[30]
Mental/Behavioral Health Outpatient Treatment	X	X	X	X	X	X	X	X	X	X[30]
Substance Abuse Inpatient Treatment	X[31]	X	X	X	X	X	X	X	X	X[32]
Substance Abuse Outpatient Treatment	X	X	X	X	X	X	X	X	X	X[33]
Detoxification	X	UK	UK	UK	UK	UK	UK	UK	X	UK
Autism Diagnosis and Treatment	LC[34]	LC[34]	X	X	X	X	X[35]	X[35]	UK	X

Key: X = Benefit is Provided No = Benefit is Not Provided UK=Unknown whether benefit is provided LC=Likely Covered

	Iowa Small Group Plans with Largest Enrollment			Iowa State Employee Benefit Plans with Largest Enrollment			Federal Employee Health Benefit Plans with Largest Enrollment			Largest Non-Medicaid HMO Plan
Essential Health Benefit Category and Service Type	**Medical Associates Community Plan[1]**	**United Healthcare Select Advantage HMO**	**Wellmark Alliant Select**	**Blue Access**	**Blue Advantage**	**Program 3 Plus**	**FEHBP BCBS Standard Option**	**FEHBP BCBS Basic Option**	**Government Employees Health Association**	**Wellmark HMO**
Prescription Drugs										
Retail Prescription Drugs	No[36]	No[37]	X	X	X	X	X	X	X	X
Mail Order Drugs	No[36]	No[38]	X	X	X	X	X	X	X	X
Rehabilitative and Habilitative Services and Devices[39]										
Rehab: Physical Therapy	X[40]	X	X	X[41]	X[41]	X	X[42]	X[43]	X[44]	X[45]
Rehab: Occupational Therapy	X	X	X	X[41]	X[41]	X[46]	X[42]	X[43]	X[44]	X[45]
Rehab: Speech Therapy	X	X	X	X[41]	X[41]	X[46]	X[42]	X[43]	X[47]	X[45]
Rehab: Palliative Therapy	X	UK	UK	UK	UK	UK	No	No	No	UK
Habilitative: Physical Therapy	UK	N[48]	UK	UK	UK	UK	X[42]	X[43]	X[44]	UK
Habilitative: Occupational Therapy	UK	N	UK	UK	UK	UK	X[42]	X[43]	X[44]	UK
Habilitative: Speech Therapy	UK	N	No	UK	UK	UK	X[42]	X[43]	X[47]	No
Habilitative: Palliative Therapy	UK	N	UK	UK	UK	UK	No	No	No	UK
Skilled Nursing Services w Rehab	UK	UK	X	X[24]	X[24]	X	No[49]	No49	No[50]	X
Durable Medical Equipment	X	X[51]	X	X	X	X	X	X	X	X
Prosthetics	X	X	X	X	X	X	X	X	X	X
Prosthetics Repair and Maintenance	UK	UK	UK	UK	UK	UK	X	X	X	UK
Hearing Aids	UK	X[52]	X[53]	No	No	No	X[54]	X[54]	X	No
Laboratory Services										
Lab Tests	X	X	X	X	X	X	X	X	X	X
X-Rays	X	X	X	X	X	X	X	X	X	X
Imaging -MRI, CT and PET scans	X	X	X	X	X	X	X	X	X	X
Sleep Studies	UK	UK	X[55]	X[55]	X[55]	X[55]	X	X	UK	X[55]
Diagnostic Genetic Tests	UK	UK	X	X	X	X	X	X	X	X
Pathology	X	X	X	X	X	X	X	X	X	X
Preventive and Wellness Services and Chronic Disease Management										
Preventive care – Physician visits	X	X[56]	X[57]	X	X	X	X	X	X	X
Cancer Screening	X[58]	X	X[58]	X	X	X	X	X	X	X
Pediatric Immunizations	X	X	X[59]	X	X	X	X	X	X	X
Adult Immunizations	UK	X	X	X	X	X	X	X	X	X

	Iowa Small Group Plans with Largest Enrollment			Iowa State Employee Benefit Plans with Largest Enrollment			Federal Employee Health Benefit Plans with Largest Enrollment			Largest Non-Medicaid HMO Plan
Essential Health Benefit Category and Service Type	**Medical Associates Community Plan[1]**	**United Healthcare Select Advantage HMO**	**Wellmark Alliant Select**	**Blue Access**	**Blue Advantage**	**Program 3 Plus**	**FEHBP BCBS Standard Option**	**FEHBP BCBS Basic Option**	**Government Employees Health Association**	**Wellmark HMO**
Smoking Cessation	UK	UK	X[60]	No	No	No	X	X	X	X[61]
Nutritional Counseling	UK	UK	X[62]	X[62]	X[62]	X[62]	X	X	X[63]	X[64]
Osteoporosis Screening	UK	UK	UK	UK	UK	UK	X	X	X	UK
Vision Exam	X	UK	X	X	X	No	X[65]	X[65]	X[65]	X
Pediatric Services (Including Oral and Vision Care)										
Physician Services	X	X	X	X[66]	X[66]	X[66]	X	X	X	X
Vision Exam	X	UK	X	X	X	No	X	X	X	X
Hearing Exam	UK	UK	X	X	X	X	X	X	X	X
Eye Glasses/Contacts	UK	UK	X	No	No	No	X[67]	X[67]	No	No
Dental – preventive	No	No	X[68]	No	No	No	X[67]	X[67]	X	No
Dental – restorative	No	No	X[68]	No[69]	No[69]	No[69]	X[67]	X[67]	X	No
Pediatric formula for PKU and medical conditions	UK	UK	UK	UK	UK	UK	X	X	UK	UK
Inclusion of State Mandated Benefits										
Autism	LC[70]	LC[70]	X	X	X	X	X[35]	X[35]	UK	X
Breast Reconstruction	X	X	X	X	X	X	X	X	X	X
Contraceptives	LC[70]	LC[70]	X	X	X	X	X	X	X	X
Dental Anesthesia	LC[70]	LC70	LC[70]	X[67]	X[67]	X[67]	UK	UK	UK	LC[70]
Diabetes Self-Management	LC[70]	LC[70]	X	X	X	X	UK	UK	UK	X
Diabetic Supplies	LC[70]	LC[70]	X	X	X	X	X	X	X	X
Emergency Room Services	X	X	X	X	X	X	X	X	X	X
HPV Vaccine	LC[70]	LC[70]	X	X[71]	X[71]	X[71]	X[72]	X[72]	X[72]	X
Mammography Screening	X	X	X	X	X	X	X	X	X	X
Minimum Maternity Stay	X	X	X	X	X	X	X	X	X	X
Mental Health Parity	LC[73]	LC[73]	LC[73]	UK	UK	UK	X	X	X	X
Prosthetics	X	X	X	X	X	X	X	X	X	X
Well-Child Care	X	X	X	X	X	X	X	X	X	X
Continuity of Care for Pregnant Women	X	X	X	X	X	X	UK	UK	UK	X
Continuity of Care for Terminally Ill Patients	X	X	X	X	X	X	UK	UK	UK	X
Continued Coverage for Persons in Cancer Clinical Trials	X	X	X	X	X	X	X	X	X	X

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Mental Illness Treatment of Veterans	**LC[74]**	**LC[74]**	**LC[74]**	**LC[74]**	**LC[74]**	**LC[74]**	**LC[74]**	**LC[74]**	**LC[74]**	**LC[74]**
Skilled Nursing Care in a Hospital	**X**	**X**	**X**	**X**	**X**	**X**	**UK**	**UK**	**UK**	**X**

[1] As explained in the report, Medical Associates states this plan is grandfathered under the ACA and is not permitted to continue to market this plan to new enrollees without making modifications. As such, this specific benefit plan would not be eligible as a benchmark plan. See section ???? of the report for additional information.
[2] Benefits limited to a range of 60-120 days per year depending on benefits selected.
[3] Plan offers various options with bracketed ranges of coverage and limitations.
[4] Benefits limited to 25 annual visits.
[5] Benefits limited to 50 annual visits.
[6] Benefits limited to a range of 10-60 visits per year and total payments of $500 to $10,000 per year depending on benefits selected.
[7] Benefits limited to a range of visits, which varies based on employer's selection.
[8] Benefits limited to 1 office visit and 12 spinal manipulations annually.
[9] Benefits limited to a range of visits, which varies based on employer's selection.
[10] Benefits limited to a range that varies based on plan selected by employer.
[11] Benefits limited to 24 annual visits.
[12] Benefits limited to 20 annual visits.
[13] Limited coverage, but details not described in summary of benefits document; subject to 50% coinsurance
[14] Lifetime maximum benefits of $15,000 to $40,000 per individual, including prescription drugs.
[15] Covered in some plans, with varying limitations.
[16] Covered only for medical reasons; elective abortions are not covered.
[17] Benefits available in cases of rape, incest, or to protect the life of the mother.

[18] Benefit summary states voluntary abortion is not covered, but does not address whether coverage is available in non-voluntary cases, such as when the mother's life is at risk or in cases of rape or incest.
[19] Benefits limited to a lifetime maximum that could range from $50,000 to $250,000 per enrollee depending on benefits selected.
[20] Approval based on eligibility criteria, which was not available in materials provided for review.
[21] To qualify, must be morbidly obese for 2 or more years and have participated in weight loss program.
[22] Benefits limited to a range of 40 to 120 days per year depending on benefits selected.
[23] Benefits limited to 90 days annually.
[24] Benefits limited to 120 days annually.
[25] Benefits limited to 14 days annually.
[26] Skilled nursing in a hospital or facility is limited to 30 days per year. Skilled nursing home visits are available under approved circumstances, with limitations.
[27] Maternity and related child newborn care is only covered under form 9QR9QV9Z29Z4; maternity is not covered in other plans except for complications of pregnancy.
[28] Mental health non-biologically based services for physician and outpatient care are limited to 20 visits per year combined. Inpatient services limited to 20 days per year. Day care/patient care services limited to 10 days per year. Non-biologically based limits do NOT apply to biologically based limits. For biologically-based mental health services, no limits on physician visits/medicine checks; in-patient services limited to 30 days per year. Outpatient visits limited to 52 visits per year. Biologically based treatments DO apply toward non-biologically based mental health limits.
[29] Behavioral health services for mental health and chemical dependency are limited to 52 outpatient visits and 30 inpatient hospital days per year for groups of 2-50 employees. Limits do not apply to groups with 51 to 100 employees.
[30] Coverage is subject to a range of annual limitations which employer selects at time of purchase.
[31] Inpatient detox limited to once per year. Outpatient rehabilitation limited to 2 programs per lifetime. Payment contingent upon completion of entire program; requires 50% coinsurance payment.
[32] Benefits are subject to a range of limitations based on plan selected by employer; excludes coverage for residential treatment facilities.
[33] Benefits are subject to a range of limitations based on plan selected by employer.
[34] Because autism coverage is a state mandated benefit, these plans likely include at least the minimally required state coverage, but we were unable to determine whether benefits were included due to the limited information included in the summary of benefits documents provided by the State.
[35] Must meet specific criteria; coverage limited to specific procedures
[36] Summary of benefits does not include description of prescription drugs, but it appears coverage may be added.
[37] The summary of benefits document does not list prescription drugs as a covered benefit. However, in a reference to treatment of infertility services, the benefit limitations refer to prescription drug benefits, which suggests that prescription drugs may be an added benefit. We assume that because drug benefits are not listed in the summary of benefits, that they are only available through a rider. Consistent with the CMS EHB bulletin, the assessment of EHB benchmark plans should not include benefits available by rider or under a separate benefit plan.
[38] Summary of benefits does not list prescription drugs as a covered benefits, but it appears coverage may be added.
[39] Plans generally provided very limited or no information on coverage of habilitative services. The State will need to confirm what services are included prior to selecting a benchmark plan.
[40] Therapy benefits are limited to 30 combined visits per calendar year for all types of therapy (speech, physical and occupational)

[41] Benefits limited to 60 visits annually.
[42] Benefits limited to 75 combined visits per year for PT, OT and ST
[43] Benefits limited to 50 combined visits per year for PT, OT and ST
[44] Benefits limited to 60 combined visits per year for PT, OT
[45] Limited number of services available based on policy form bracketed options and purchaser's choice; Policy form 9R39QZ limits coverage to 35 annual visits
[46] Benefits covered if hospital-based billed or as an approved home health service.
[47] Benefits limited to a maximum of 30 annual visits
[48] Therapy benefits are described in the summary of benefits as "rehabilitative," which suggests habilitative services are not a covered benefit. However, the summary of benefits does not provide that level of detail; the actual policy form and benefit exclusions will need to be reviewed to determine exactly what therapy services are covered.
[49] Covers up to 75 visits PT/OT/ST for facility patients but does not cover facility charges
[50] Plan provides 15 days at SNF after discharge from hospital, but services are not defined
[51] Maximum benefits are limited to a range of $2,500 to $40,000 per year, depending on level of coverage purchased.
[52] Maximum benefits are limited to a range of $2,500 to $5,000 per year, depending on level of coverage purchased.
[53] Covered in some plan options, but not all.
[54] Limited to $1250 annually for children; one hearing aid per 36 months for adults
[55] Benefits provided only for sleep apnea.
[56] Wellness services (including exams, immunizations, lab work, and x-rays) are not covered for ages 7 years and up under the Tier 3 Point of Service plan level under this policy form option.
[57] Preventive physical exams, immunizations, lab work and x-rays are not covered for ages 7 years and up under the Tier 3 Point of Service plan level.
[58] Unable to determine which screenings are covered.
[59] Preventive physical exams, immunizations, lab work and x-rays are not covered for ages 7 years and up under the Tier 3 Point of Service plan level.
[60] Covered in some plans, but excluded in others depending on level of coverage selected.
[61] Medical evaluation related to nicotine dependence is covered; the plan of coverage does not mention whether smoking cessation classes are covered.
[62] Benefits covered only if related to diabetes education.
[63] Benefits limited to $250 annually
[64] Nutritional counseling is provided as a benefit of diabetes education.
[65] Routine screenings are not covered; benefits limited to illness or injury
[66] Pediatric well-check visits covered to age 7.
[67] Covered, with restrictions
[68] Dental may be purchased as an added benefit. If dental is not purchased, only treatment for accidental injury is covered.
[69] Benefits only available for accidental injuries.
[70] Because this is a required mandate, we assume it is likely covered; however, the schedule of benefits we were provided does not provide this level of detail so it is impossible to say with certainty this benefit is included. The state should confirm this information with the insurer.
[71] Assume vaccine is covered as it is not listed as an exclusion.

[72] Plan covers CDC recommended immunizations, so HPV is covered for those populations for which CDC recommends.
[73] Because this is a mandate requirement, it is likely the small group plans include parity coverage. However, the plan documents either did not specify parity and/or referenced coverage in grandfathered plans that do not include parity coverage.
[74] Asssume benefits would be included under mental health/substance abuse coverage provided to all enrollees.