North Dakota's Essential Health Benefits

Jon Godfread, Commissioner

NORTH DAKOTA
Insurance Department

What is an EHB Benchmark Plan?

- A set of benefits required to be offered by all individual and small group Affordable Care Act (ACA) plans in the state of North Dakota.
- Changing the EHB Benchmark plan would change the required ACA benefits to be offered in the individual and small group ACA plans in North Dakota.
- Approximately 11% of the ND population would be impacted by EHB Benchmark plan changes.

Selecting a New EHB Benchmark Plan

Current HHS rules concerning state selection of a new EHB Benchmark plan contain 2 essential requirements. The requirements for the new EHB Benchmark plan are that the new EHB Benchmark plan must:

- Provide a scope of benefits that is **equal to, or greater than**, the coverage within each EHB category, of the benefits provided under a typical employer plan, and
- **Does not exceed the generosity** of the most generous among the plans considered when selecting the current EHB Benchmark plan.
  - The maximum value of added benefits is the difference in value between the current EHB Benchmark Plan and the richest of the 10 EHB Options, which was $2.42.
  - North Dakota would have to pay for benefits in addition to any benefit exceeding the $2.42 under a mandated benefit
- If some of the current EHB benefits are eliminated, it could increase the amount that could be added in benefits
- When surveyed, carriers and legislators did not believe that any benefits should be eliminated

Cost Difference: New Benefit Estimates

Alternative EHBs for Consideration in the Benchmark Plan				
	NovaRest Estimate		Issuer PMPM Range	
	PMPM Estimate	% of Premium	Minimum	Maximum
Restricted Cost Sharing for Diabetes	$0.43	0.09%	$0.00	$1.49
Infertility	$2.38	0.48%	$1.98	$24.85
Hearing Loss/Aids –All Ages	$0.55	0.11%	$0.00	$0.50
Nutritional Counseling & Therapy	$0.03	0.01%	$0.00	$0.50
Periodontal Disease in Med Plan	$0.10	0.02%	$0.00	$31.35
Private Duty Home Nursing	$1.15	0.23%	$0.00	$9.00
PET Scans for Prostate Cancer	$0.13	0.03%	$0.00	$0.50
Combating Opioid Epidemic	$0.05	0.01%	$0.00	$0.50
Medication Optimization	$0.00	0.00%	$0.00	$0.50
Total Estimated Impact on Premium	**$4.82**	**0.97%**		

The New Benchmark Plan

- **Insulin/insulin supplies –** Limited out-of-pocket costs for diabetes, providing a limited cost-sharing for a 30-day supply of covered insulin drugs, not to exceed $25, regardless of the quantity or type of insulin, and of covered medical supplies for insulin dosing and administration, not to exceed $25, regardless of the quantity or manufacturer of supplies.
- **Hearing aids** - Coverage for one hearing aid per hearing-impaired ear every 36 months or more often if there is a significant change in the insured's hearing status as determined by the licensed physician or audiologist.
- **Nutritional counseling** - Coverage for dietary or nutritional screening, counseling, and therapy for obesity, diabetes-related diagnosis, or a chronic illness or condition that could be managed through nutritional or weight loss programs, up to 12 sessions every policy year, if prescribed by the insured's physician. This would also include coverage for the use of GLP1 and GIP drugs as therapy for prevention of diabetes and treatment of insulin resistance, metabolic syndrome or morbid obesity.

The New Benchmark Plan

- **Periodontal disease** - Coverage for diagnosis and treatment of periodontal disease in acute or chronic disease state if recommended by a board-certified medical practitioner based on health-related impacts or on further deterioration in disease state due to gum disease.
- **PET scans** - Coverage for position emission tomography scans for an insured who has a prostate cancer diagnosis, including an insured who is in remission or who is cured, which would include at least two different types of position emission tomography scans upon initial diagnosis if requested by a physician, and one position emission tomography scan every 6 months for the life of the insured.
- **Opioid benefits** - Plan steps to address the opioid epidemic, including limiting opioid prescriptions to 7 days, removing barriers such as prior authorization for drugs used in the treatment of opioid use disorder or opioid replacement drugs; and requiring a prescription for an easy-to-use overdose antidote when prescribing high-dose opioids.

Revision Process

- The legislature directed that a Healthcare Cost Study be completed in 2019.
- A Healthcare Cost Study was conducted and released in 2020 to the legislature and Interim Healthcare Committee, identifying areas to improve the cost of healthcare.
- Data was collected during the Healthcare Cost Study and thereafter from hospitals and insurers.
- A second round of inquiries were made to the insurance companies
  - Cost information was gathered on different potential ideas
- A resolution was passed in the legislature (HCR3011). - March 2023
- NDID and the procured consultants sought input from providers regarding potential cost savings inclusions to the EHB Benchmark Plan
  - Throughout the gathering of information (from providers and stakeholders) the EHB Benchmark Plan Revisions continued to evolve, while considering the best and newest cost savings opportunities in the industry. The goal is to address the high cost of healthcare in the state of North Dakota
- NDID procured an actuarial firm to provide an actuarial analysis of the potential cost savings ideas
  - The actuaries researched whether the cost savings benefit additions met the typicality standard and PMPM restrictions – all with the goal to reduce the cost of healthcare in North Dakota.

Revision Process

- NDID and the consultants met with federal CMS/CCIIO to identify cost-saving options
  - Discussions with CCIIO and CMS continued in person and virtually to identify the best cost savings available for inclusion in the Revised EHB Benchmark Plan
- NDID revised the Revised EHB Benchmark Plan consistent with the high-level overview laid out in the Resolution
- NDID published the Plan for comment. Not only did NDID publish the ACA Revised Benchmark Plan, we also published a summary and the actuarial report for review by stakeholders
  - Once the EHB Plan Revisions were drafted, NDID decided to provide an extended comment period for stakeholders beyond the standard requirements with CCIIO of CMS.
- NDID emailed stakeholders requesting comment
  - NDID also notified stakeholders via email. While proactive stakeholder notification is not a requirement of CCIIO or CMS, this was done in an attempt to get the important feedback necessary before proceeding to the final stages of review.
  - The Public Comment Period was open for an extended period of time of 15 days.
  - Items available (with stakeholder email notification to inspect and comment) included the ND Benchmark Plan document, Appendix C EHB Summary of Benefits Chart, and the 24-page actuarial report which outlined all of the cost assumptions and research conducted to price out the benefits to the satisfaction of CCIIO/CMS. The actuarial report clearly illustrates the generosity difference for each change to the EHB. This is how a reader is able to understand the per member per month impact in the first year. As indicated previously, the goal of the revisions is to dramatically drive down the cost of healthcare in the state of North Dakota over a period of years.

Revision Process

- NDID received one comment from BCBS of ND regarding the GLP-1 and GIP medication regarding cost sharing.
  - NDID confirmed with CCIIO/CMS that cost sharing is allowed. Insurers generally are free to set cost sharing for specific EHB, provided that the insurer limits overall cost sharing for the EHB to the annual limitation on cost sharing, meets actuarial value requirements, and the benefit design is not discriminatory.
- NDID submitted the Revised Benchmark Plan for review to CMS/CCIIO
  - NDID submitted all studies and plan documents as part of this final submission. The actuarial study which was created and signed off on by an accredited actuarial firm (NovaRest) was also evaluated by CMS/CCIIO under this submission. The process was to ensure the calculations met federal requirements and pricing.
- NDID made verbiage revisions within the plan documents of the Revised Benchmark based on CMS feedback
- CCIIO/CMS approved the 2025 ACA Benchmark Plan
- NDID Issued a Press Release announcing the Federal approval

Frequently Asked Questions

Why were diabetes prevention and morbid obesity drugs included in the essential health benchmark plan coverage for dietary or nutritional screening, counseling, and therapy for obesity, diabetes related diagnosis, or a chronic illness or condition?

Consistent with the Resolution, the chronic condition of morbid obesity has been shown to be best managed (in the most cost-effective way) through weight loss programs that include GLP1 or GIP drugs, if prescribed by the insured's physician;

NDID is prioritizing driving down healthcare costs by addressing the known cost drivers in the population.

Frequently Asked Questions

Can Insurers utilize Prior Authorization and Copays with the EHB Benchmark Plan?

EHB regulations do not prohibit insurers from applying reasonable medical management techniques. An insurer could use prior authorization but could not implement prior authorization in a manner that discriminates on the basis of membership in a particular group based on factors such as age, disability, or expected length of life that are not based on nationally recognized, clinically appropriate standards of medical practice evidence or not medically indicated and evidence-based.

Frequently Asked Questions

Can insurers use cost sharing with the EHB Benchmark Plan?

Under Federal law, insurers generally are free to set cost sharing for specific EHB, provided that the insurer limits overall cost sharing for the EHB to the annual limitation on cost sharing, meets actuarial value requirements, and the benefit design is not discriminatory.

Frequently Asked Questions

What are the specific coverage requirements for weight loss drugs as opposed to GLP-1s used for diabetes management?

The EHB change added GLP-1s and GIP drugs as therapy for prevention of diabetes and treatment of insulin resistance, metabolic syndrome and/or morbid obesity. Other requirements for diabetes management have not changed.

Benefit Considerations

Grand Forks Herald

In an op-ed, a BCBSND executive cited that health insurers and employers are promoting preventative care and wellness programs.

Read Online

SHRM

HR managers are seeing weight loss drugs as tools to health insurance packages to boost mental & physical health.

Read Online

Accolade

81% of HR decision-makers believe weight loss drugs are desired by their employees.

Read Online

Final Thoughts

- Coverage of obesity drugs will cost money
- NovaRest study estimated cost of nutrition counseling at approx. $0.52 per member per month
  - Includes GLP-1 and GIP drugs
- Insurers feel it will cost more, but we need to see the trend before we assume the worst
- ROI: Getting consumers healthy & decreased cost for more life-threatening diseases

Preventing Diabetes

- According to the American Diabetes Association, the total estimated cost of diagnosed diabetes in the United States was $327 billion in 2017, including $237 billion in direct medical costs and $90 billion in reduced productivity. People with diagnosed diabetes, on average, have medical expenditures approximately 2.3 times higher than what expenditures would be in the absence of diabetes.

Preventing Diabetes – Cost Savings

Preventing diabetes can lead to substantial cost savings such as:

- **Medical Costs:** Individuals with diabetes incur significant expenses for medications, glucose monitoring supplies, visits to healthcare providers, and other diabetes management necessities.
- **Complication Avoidance:** Diabetes is associated with serious complications such as cardiovascular disease, kidney damage, eye damage (retinopathy), and neuropathy. Preventing diabetes reduces the risk of these complications, thus avoiding the high costs associated with their treatment, including surgeries, long-term medications, and specialized care.

Preventing Diabetes – Cost Savings

- **Hospitalizations:** Preventing diabetes can lead to fewer hospitalizations, thereby saving substantial costs.
- **Productivity Loss:** Indirect costs due to lost productivity, disability, and premature mortality are also reduced when diabetes is prevented. Individuals without diabetes are more likely to maintain regular employment and have fewer disability claims.
- **Insurance Premiums and Out-of-Pocket Costs:** Prevention can lead to lower insurance costs and fewer out-of-pocket payments for medical care.

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North Dakota EHB Benchmark Plan

Changes Coming in 2025

"We have heard from consumers in every corner across the state about what is important for them when they go to a healthcare facility or pharmacy and utilize their health insurance policy," said Insurance Commissioner Jon Godfread. "The healthcare needs of North Dakotans evolve, and we have done extensive research to determine how insurance policies can best support as many consumers as possible. This approval comes after studying our options, taking public comment, and with legislative approval. It was a long process, but in the end, will benefit North Dakota consumers who purchase their health care through the ACA marketplace."

At the time of implementation, it will have been ten years since the last update to the ACA Benchmark Plan. NDID did extensive research and has attempted to be responsive to new medical breakthroughs that stand to get North Dakotans well while also creating long term savings. Please find information about the process and implementation of the 2025 ACA Benchmark Plan Revisions:

hat is the EHB Benchmark Plan?

Answer: The Affordable Care Act requires non-grandfathered health plans in the individual and small group markets to cover essential health benefits (EHB), which include items and services in the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

What population does the EHB Benchmark Plan affect?

Answer: The Affordable Care Act non-grandfathered health plans in the individual and small group. This does not affect PERS.

When will the new benefits take effect?

Answer: January 1, 2025

When was the last change to the ACA Benchmark Plan?

Answer: 2015

What was the process for the EHB Benchmark Plan revisions for Plan Year 2025?

Answer:

- The legislature directed that a Health Care Cost Study was completed in 2019.
- A Healthcare Cost Study was conducted and released in 2020 to the legislature and Interim Healthcare Committee, identifying areas to improve the cost of health care.
- Data was collected during the Healthcare Cost Study and thereafter from hospitals and insurers.
  A second round of inquiries were made to the insurance companies. Cost information was gathered on different potential ideas

What benefits has CCIIO/CMS approved to be updated in the 2025 ACA Benchmark Plan?

Answer:

- Insulin/Insulin supplies: Limits out-of-pocket costs for diabetes, providing limited cost sharing for a 30-day supply of covered insulin drugs and of covered medical supplies for insulin dosing and administration.
  Hearing aids: Coverage for one hearing aid per hearing-impaired ear every 36 months or more when deemed medically necessary by a licensed physician or audiologist.
- Nutritional benefits: Coverage for dietary or nutritional screening, counseling, and therapy for obesity, diabetes-related diagnosis or chronic illness or condition that could be managed through nutritional or weight loss programs (up to 12 sessions every policy year if deemed medically necessary by the insured's physician).
- Weight loss drugs: Coverage for the use of glucagon-like peptide-1 (GLP1) and gastric inhibitory polypeptide (GIP) drugs as therapy for the prevention of diabetes and treatment of insulin resistance, metabolic syndrome, or morbid obesity.
- Periodontal disease: Coverage for diagnosis and treatment of periodontal disease in acute or chronic disease state if deemed medically necessary by a board-certified medical practitioner.
- PET scans: Coverage for positron emission tomography (PET) scans of an insured who has a prostate cancer diagnosis, including at least two different types of PET scans upon 2 initial diagnoses and one PET scan every 6 months for the life of the insured. Also provided without a cancer diagnosis.
- Opioids: Limit opioid prescriptions to 7 days, removing barriers such as prior authorization for drugs used in the treatment of opioid use disorder or opioid replacement drugs and requiring prescription drugs for an easy-to-use antidote when prescribing high-dose opioids.

Can Insurers utilize Prior Authorization and Copays with the EHB Benchmark Plan?

Answer: EHB regulations do not prohibit insurers from applying reasonable medical management techniques. An insurer could use prior authorization but could not implement prior authorization in a manner that discriminates on the basis of membership in a particular group based on factors such as age, disability, or expected length of life that are not based on nationally recognized, clinically appropriate standards of medical practice evidence or not medically indicated and evidence based.

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Why were diabetes prevention and morbid obesity drugs included in the essential health benchmark plan coverage for dietary or nutritional screening, counseling, and therapy for obesity, diabetes related diagnosis, or a chronic illness or condition?

- Consistent with the Resolution, the chronic condition of morbid obesity has been shown to be best managed (in the most cost-effective way) through weight loss programs that include GLP1 or GIP drugs, if prescribed by the insured's physician;
  NDID is prioritizing driving down health care costs with addressing the known cost drivers in the population.

- North Dakota is 11th in the Nation for the rate of new cancers:

Leading Cancer Cases and Deaths, All Races and Ethnicities, Male and Female, 2020

In 2020, the latest year for which incidence data are available, in the United States, **1,603,844 new cases of cancer** were reported, and **602,347 people died of cancer**. For every 100,000 people, **403 new cancer cases were reported** and **144 people died of cancer**.

Cancer is the second leading cause of death in the United States, exceeded only by heart disease. **One of every five deaths in the United States is due to cancer.**

Attention users: *Use caution when interpreting 2020 data. The COVID-19 pandemic disrupted health services, leading to delays and reductions in cancer screening, diagnosis, and reporting to some central cancer registries. This may have contributed to the decline in new cancer cases for many sites in 2020.*

Rate of New Cancers in the United States, 2020

All Types of Cancer, All Ages, All Races and Ethnicities, Male and Female
Rate per 100,000 people

95% Confidence Interval: Hide Show
Show 50 entries

Area	Cancer Type	Year	Sex	Race	Age-Adjusted Rate	Case Count	Population
Kentucky	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	463.4	26,240	4,477,251
Iowa	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	455.1	18,381	3,163,561
Maine	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	449.5	9,151	1,350,141
West Virginia	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	447.5	11,445	1,784,787
New Jersey	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	443.3	50,346	8,882,371
Minnesota	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	436.4	30,505	5,657,342
Georgia	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	434.0	53,485	10,710,017
Louisiana	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	433.8	24,734	4,645,318
Wisconsin	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	431.3	32,961	5,832,655
Ohio	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	428.9	65,151	11,693,217
North Dakota	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	428.2	3,843	765,309

Source: CDC

Cancer burden: North Dakota

All Types of Cancer, 2020

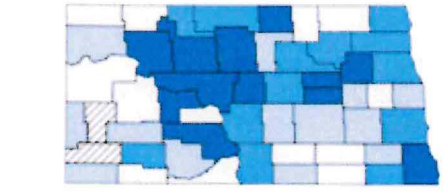
In North Dakota in 2020, there were **3,843 new cases of cancer**. For every 100,000 people, **428 cancer cases were reported**.

The same year, there were **1,308 people who died of cancer**. For every 100,000 people in North Dakota, 139 died of cancer.

Attention users: *Use caution when interpreting 2020 data. The COVID-19 pandemic disrupted health services, leading to delays and reductions in cancer screening, diagnosis, and reporting to some central cancer registries. This may have contributed to the decline in new cancer cases for many sites in 2020.*

Rate of New Cancers in North Dakota

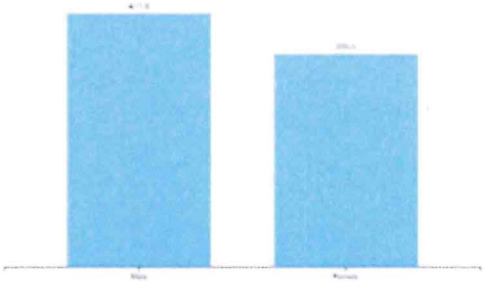
All Types of Cancer, All Ages, All Races and Ethnicities, Male and Female, 2016-2020
Rate per 100,000 people



Rate per 100,000 people

Rate of New Cancers, All Races and Ethnicities, Both Sexes

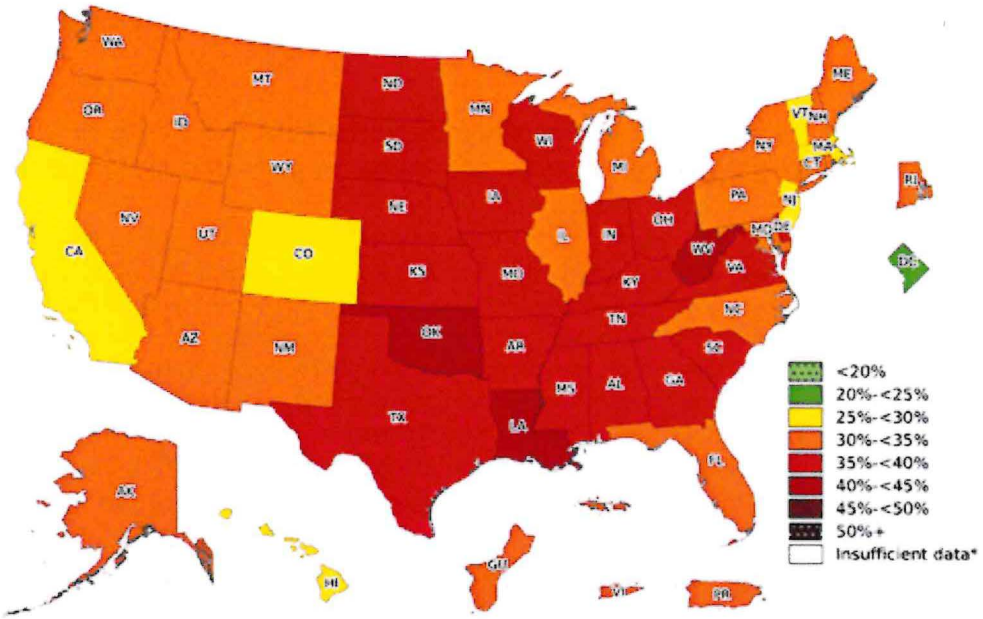
All Types of Cancer, 2020
Rate per 100,000 people



Source: CDC

Map: Overall Obesity

Prevalence[1] of Obesity Based on Self-Reported Weight and Height Among U.S. Adults by State and Territory, BRFSS, 2022



Was there actuarial analysis and estimated PMPM impact calculated for the weight loss drugs that can be shared?

Answer: Please see page 19 and 20 of the REVISED Actuarial Report and Exhibit A attached hereto.

Can you share the methodology or research for which drugs were determined to be included? (For example is it all of the GLP-1s? Just those FDA approved for weight loss? Or something else?)

Answer: Please see the Revised Actuarial Report and Exhibit A attached hereto.

Would it be beneficial to edit the language within the document to not call out specific medications?

Answer: The documents have been approved by the federal government. The timeline for requested edits to documents was during the exposure period in April and May.

Will Prior Authorization be allowed to ensure members utilizing the drugs meet FDA approved guidelines?

Answer: EHB regulations do not prohibit insurers from applying reasonable medical management techniques. An insurer could use prior authorization, but could not implement prior authorization in a manner that discriminates on the basis of membership in a particular group based on factors such as age, disability, or expected length of life that are not based on nationally recognized, clinically appropriate standards of medical practice evidence or not medically indicated and evidence-based.

What are the specific coverage requirements for weight loss drugs as opposed to GLP-1s used for diabetes management?

The EHB change added GLP-1s and GIP drugs as therapy for prevention of diabetes and treatment of insulin resistance, metabolic syndrome and/or morbid obesity. Other requirements for diabetes management have not changed.

Did NovaRest apply long-term $3-4 PMPM savings in year one of mandated coverage of GLP1 and GIP medications?

Answer: No, the savings estimate for the nutritional counseling component was done over a 25-year basis. The savings was the average annual over the 25 years. The savings in year one would be very small compared to savings in later years. Savings in out years for the GLP1 and GIP medications is unknown (and was not applied to the assumptions). Even though, it can reasonably assumed that there may be a large cost savings where there is the reduction of frequency and severity of cancer or cardiovascular events, due to patients having received treatment for obesity, a diabetes related diagnosis, or a chronic illness or condition, NovaRest assumed a worst case scenario. They conservatively did not assume savings in future years for the GLP1 and GIP drugs.

We would like the Department to comment on why the GLP1 and GIP drugs for treatment of morbid obesity were not presented in the initial information and data request so that carriers would have had adequate opportunity to provide input ahead of the final public comment period. The additional benefits proposed in the information and data request under the category of nutritional counseling made no mention of GLP1 and GIP drugs, yet they are included in the new EHB benchmark plan. The first notation that nutritional counseling included coverage for GLP1 and GIP drugs did not appear until April, when it should have been noted in the initial data request so that carriers could have provided more specific cost analysis for this coverage. In addition, the legislative resolution did not contemplate the inclusion of these drugs as an expansion of nutritional counseling as a signal that they would be included.

Answer: The EHB Benchmark Plan Revisions was an evolving process. NDID sought extra input beyond any necessary requirements. Throughout the whole process, the Resolution was not necessary and not all inclusive. It was a high-level summary of the potential benefit designs. The GLP1 and GIP medications are therapy for the previously noted conditions in the Resolution. There was extensive process, and lack of review by stakeholders does not negate that.

What percentage of the eligible population was assumed to utilize the new coverage in plan year 1?

Answer: Please see the Revised Actuarial Report and Exhibit A attached hereto.

What is the percentage of the obesity percentage that is publicly available?

Answer: Please see the Revised Actuarial Report and Exhibit A attached hereto.

3. Alternatives: The EHB Benchmark Plan already covers nutritional counseling and bariatric surgery, which we believe are more cost-effective alternatives. GLP-1 and GIP treatment is not a mandated treatment for the intended population.

Insurers have pointed out higher utilization rates than our initial assumptions, but we lacked claims data at the time of valuing the benefit. Even if claims data were available, it would have likely been 2021 claims data which reflects a partial year for Wegovy. Insurers are likely considering data from 2022 and emerging 2023, which we did not have access to.

However, we question whether insurers are accurately assessing the intended population. While there has been increased publicity and celebrity endorsements around GLP-1 and GIP drugs, we contend that this increased utilization is not specific to preventing diabetes and treatment for the intended population of morbidly obese individuals or those with insulin resistance and metabolic syndrome. The majority of GLP-1 and GIP drugs are approved for diabetes management, which does not reflect the intended benefit or the intended population. Additionally, we do not believe off-label use is required to be considered for the generosity and typicality benchmark analysis. The EHB Benchmark Plan does not disallow medical management, which we expect insurers will use to ensure usage is restricted to the intended population.

Regarding cost savings, insurers inquired whether we included a $3-4 per member per month (PMPM) savings assumption in year 1 for GLP-1 and GIP drugs for the intended population. We chose not to include such an assumption for conservatism due to the lack of utilization data and long-term impact studies. We firmly believe that this benefit has the potential to reduce healthcare costs for various conditions, including the prevention of diabetes, cardiovascular disease, and cancer, among others. Diabetes alone incurs significant costs, including insulin and related products, amputation, renal disease, and increased expenses associated with comorbidities arising from diabetes and morbid obesity.