

HEALTH BENEFITS EXCHANGE AND INSURANCE OVERSIGHT WORK GROUP

Group Report

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Kathleen Moran
Amy Poe
Jonas Swartz
John Yeatts

I. CONSUMER CHOICE AND HEALTH INSURANCE

Introduction

The dominant model of choice in health care is one of a rational consumer who carefully considers his choices and weighs alternatives using the information available to him (Mechanic 139). However, reality is significantly different from this ideal. This is especially true when we consider how consumers choose a health care plan. Increasingly, consumers are overwhelmed by the bewildering array of choices available to them and are unable to find the information they need to choose between plans or interpret plan information.

Importantly, this problem is not confined to a particular demographic. For example, in a recent exercise conducted in this course, health professions students were asked to evaluate the personal circumstances of a fictitious Medicare beneficiary and to recommend a prescription drug plan. Even among this group, presumably better informed about health issues than the average consumer, choosing between the numerous plans was difficult. In light of these findings, we attempt to answer three questions: One, what are consumer priorities in choosing a health plan? Two, what drives decision-making when choosing a health plan? Finally, how much choice is too much choice?

Consumer Priorities in Choosing a Health Plan

Health care consumers have experienced a proliferation not only in the number of health plans available to them, but also in the amount of information they have available when choosing among plans. While we know that consumers differentiate between the options available to them, little is known about the criteria they use in making their decisions. What are consumer priorities in choosing a health plan? Much of the evidence on consumer choice in health care is based on the results of focus groups and surveys and, as such, is largely descriptive. While acknowledging that “there are sufficient differences among consumers...to make it impossible to establish a rigid hierarchy of priorities” it is nevertheless possible to outline many of these priorities (Mechanic 139).

One source of information on consumer choice is the Consumer Information Project (CIP) of 1994, a partnership between the National Committee for Quality Assurance (NCQA), the Picker/Commonwealth Program for Patient-Centered Care, and the Agency for Health Care Policy and Research (AHCPR). The findings of the CIP were as follows: Consumers of health plans want information on how a plan works, how much a plan costs, the extent of coverage, an indicator of overall quality, and some measure of consumer satisfaction (Edgman-Levitan and Cleary 44). Additionally, consumers want a rating of these factors from “people like themselves” even though they acknowledge the difficulty in standardizing definitions of “satisfaction” (44).

The Research Triangle Institute (RTI) study of Medicare and Medicaid beneficiaries’ preferences presents findings that were in some ways similar to those of the CIP. In the focus groups associated with the RTI study, consumers were most interested in the scope of benefits, cost, details about how the plan works, access, physician communication/interpersonal skills,

users' past experiences with the physician/system, and some measure of how the data are collected. Moreover, focus group members in the RTI study wanted aggregate measures to use in comparing plans. Again, members were interested in how people like themselves ranked the plans (Edgman-Levitan and Cleary 49).

In Massachusetts, Tumlinson et al. report the findings from the 1994 Health Care Information Needs Survey given to Massachusetts state employees in conjunction with the Massachusetts Health Data Consortium. Of thirteen possible information items offered to employees to use in evaluating health plans, only five were considered "essential": specific plan benefits, average out-of-pocket costs, quality of primary care physicians available, premium price, and a list of participating physicians and hospitals. The results of this survey also suggest what consumers value the least: ratings by independent experts, percentage of persons satisfied overall with their plan, quality of mental health and substance abuse care available, and comparisons of convenience (eg use of ID card, waiting times).

Another source of information on consumer choice comes from Health Management Organizations (HMOs). Medicare beneficiaries newly enrolled or dis-enrolled from an HMO were surveyed from 1994 onwards by the Office of Inspector General of the U.S. Department of Health and Human Services. While these surveys were specific to HMOs, their relevance to consumer choice is apparent. Survey respondents indicated that they valued short wait times to see physicians, physicians that take complaints seriously and provide patients with the appropriate care, and a system that doesn't sacrifice quality for holding down costs. Generally, respondents endorsed a plan that was perceived by them to improve their health (Office of Inspector General A-3).

Another HMO-focused study was a 1995 Kaiser Foundation study of senior citizens enrolled in HMOs. The study found that senior citizens wanted "comparative data on benefits and quality of care" and "descriptive information about how managed care plans function" (Edgman-Levitan and Cleary 47). They also wanted specific information about a physician: where he/she trained, gender, location, and "patient satisfaction information"(47). Interestingly, the focus group members wanted information about how consumer satisfaction information was collected and what it meant. Summary satisfaction ratings were unsatisfactory (48). "Word of mouth" information from friends, family, and coworkers was most important to them.

In evaluating these results of these studies, several trends become apparent. First, there are several factors are consumers consider extremely important in choosing a health plan. These factors include cost (premiums and out-of-pocket expenses), benefits (how a plan works and the services covered), access (physicians in the network and flexibility in choice), quality (provider training, quality of patient/physician relationship) and satisfaction (standardized peer reviews). Information that is less important to consumers is satisfaction ratings by independent "experts," non-standardized peer reviews, summary satisfaction ratings, comparisons of convenience (e.g. average waiting times), and quality of mental health and substance abuse treatment available.

There are several considerations that should be taken into account when interpreting this data. First, consumer priorities are shaped by individual needs. For lower income individuals,

questions of quality and access are most important. For chronically ill patients, questions of comprehensiveness, referral structure, and cost are most important. Second, there is a difference between an issue being important and actually being salient to the decision making process. Third, differences in how individuals choose coverage for themselves may differ from how they select coverage as a proxy for family members. No data currently exists to analyze these potential differences.

Consumer Decision Making

While identifying the types of information consumers want in choosing a health care plan is important, research on decision making indicates that an all-you-can-eat buffet of information may do little to facilitate good decision making. Summing years of evidence from behavioral economics and behavioral psychology, Richard Thaler and Cass Sunstein wrote a book on improving decision making through “choice architecture.” In their book, *Nudge*, the authors propose differentiating “Humans”--real, irrational, illogical, flawed decision makers--from “Econs”--logical, rational, perfect decision makers able to mathematically process all available information to make decisions. Research indicates that bridging the gulf between “Human” and “Econ” decision making requires understanding common “Human” shortcomings and creating tools to account for them.

Many health care choices are complex, requiring a person to understand and integrate multiple variables and expert-level knowledge. Research shows that decision makers have difficulty in weighing variables. Even though an individual may care about the cost of a plan, the quality of its prescription drug coverage, and its access to particular physicians, he may have difficulty in evaluating the relative values of these variables and employing them simultaneously to arrive at a decision. In their study of how buyers of insurance for large employers use data, Hibbard et al. suggest that people make better decisions when they have manageable amounts of information. “People can efficiently process and use only five or six variables or pieces of data in each decision” (Hibbard and Jewett 176). Even with the optimal number of variables, however, individuals may struggle to compare data that are not presented on the same scale. Using cost (measured in dollars) and quality (measured using a variety of scales) as an example, individuals may discount the less familiar data on quality and place more value on cost since cost is presented in a familiar format. “When faced with trade-offs, people tend to take shortcuts that may undermine their own interests” (Hibbard and Jewett 177).

There is evidence, however, that individuals are able to successfully juggle disparately scaled variables like quality and cost data. In one study, the Consumer Assessment of Health Plan Study (CAHPS), investigators presented quality data alongside information on cost and benefits to the experimental group while presenting only information on cost and benefits to the control group. The investigators found that the subjects made significantly different choices when they were provided quality data. Thus, in this controlled environment, individuals were able to integrate quality information with their preferences on scope of benefits and cost. (Spranca et al. 2010). While notable, the results of this study should be interpreted with caution. Presumably not all consumers have health literacy comparable to study participants. Moreover, the information burden in the “real” world is higher and consumers may not be presented the

same quality of information as presented in this study. Too, consumers may not devote as much protected time to the decision making process as subjects in this study.

Thaler and Sunstein, the authors of *Nudge*, directly address consumer decision making about Medicare Part D prescription drug plans (PDPs). When they first became available in 2006, PDPs offered Medicare beneficiaries the option of supplemental prescription drug coverage. Beneficiaries could choose among PDPs or Medicare Advantage Plans, the latter covering outpatient costs in addition to prescription drugs. As a market-based solution to subsidized prescription drug coverage, plans gave Medicare beneficiaries access to between 50 and 60 stand-alone PDPs and 15 to 142 joint plans in their area (Thaler and Sunstein 163).

Unfortunately, as Thaler and Sunstein point out, the enrollment process was and is exceedingly cumbersome for seniors and their loved ones trying to choose the right plan. The *Medicare Plan Finder* tool through the Medicare website provides an abundance of data consumers might use in choosing a PDP, but it does not organize the information in a way that facilitates good choices. Navigating the online system requires comfort with using the Internet and exploring websites, an especially challenging task considering that most Medicare beneficiaries are seniors or permanently disabled.

In a study of consumer choices of Medicare drug plans, the authors summarize past research on the choice behavior of elderly beneficiaries which finds that they “seldom engage in the choice process,” that they may be unable to use and understand comparative information on different plans, especially if it includes charts and tables, that they do not get help on these difficult decisions, and that they may show reluctance in making these decisions (Kling 2). The authors argue that this indicates that these characteristics make it difficult for beneficiaries to behave as informed consumers, making good choices. In an intervention that restructured cost information to specifically highlight the cost of an individual’s current PDP and showed potential savings by switching plans, a higher proportion of the intervention group switched plans than a control group that did not get the same data. While this study supports the notion that consumers can use the right information when it is structured to help them make choices, the authors acknowledge that their sample was more educated than the average consumer and therefore more likely to benefit from the intervention.

Too Much Choice?

In making rational decisions, humans theoretically try to maximize benefits and minimize losses. But research has shown that humans often do not act as rational decision makers meeting the requirements of “consistency and coherence” adopted by Amos Tversky and Daniel Kahneman (Tversky 453). Having too many choices impedes decisions by making an already difficult process more complicated. One problem with health care choices specifically is that people may be unfamiliar with the scope of options. Of adults in the working age population who get insurance coverage through employer-based plans, 37% have only one choice of plan. Only 20% have more than five choices (Hanoch 2009). Those purchasing coverage through the Health Benefits Exchange who had employer-based plans in the past, or who are choosing a plan for the

first time, might have difficulty with identifying key variables, weighing trade-offs, and choosing the right coverage for their future health needs.

Research on the Medicare Part D enrollment process reinforces concerns about too much choice. In a study of Medicare beneficiaries with medium to high health literacy, Czaja et al. found that 72.3% could not select a PDP using the online tool. Moreover, a majority had problems navigating the web page and finding necessary information (2009). Survey data are consistent with these experimental studies and show that Medicare beneficiaries thought they had too many choices of PDPs (Hanoch 2009, Hoadley 2008). In selecting plans, fewer than 10% managed to minimize costs and only 6-7% of enrollees changed plans during open enrollment (Hanoch 2009). Attention to how many consumers change plans is important because consumers may be able to achieve significant savings by switching plans during open enrollment. Both patient drug lists and company formularies change significantly during the year, which means that the best plan for an individual consumer is also likely to be different from year to year. Domino et al. reported that the 43% of consumers with significant changes to their drug list could achieve potential annual savings averaging \$500 (Hanoch 2009). Reluctance to review coverage during open enrollment may be evidence that consumers are satisfied with their current plans, but it also may be a sign that they do not wish to revisit the choosing process.

Experts in decision-making theory offer several suggestions to help simplify and support the choice process. Hibbard et al. recommend the overall goals of “reduc[ing] the information-processing burden,” and “support[ing] and rationaliz[ing] the choice process.”(Hibbard, Slovic, and Jewett 403) Computer-based decision aids can help facilitate rational decision-making by presenting information sequentially and in small bundles that keep consumers from considering more than three to five variables at once. These decision tools could elicit information about consumer preferences on cost, quality and access, and then provide personalized sorting or ranking of plans. Decision aids are advantageous in that they allow the computer to do some of the work in evaluating trade offs and formalize the system for weighing variables. Hibbard and colleagues also advocate global rating by experts to identify the best plans (Hibbard 1997). Such ratings could also be customized for common consumer needs like identifying the best plan for diabetes management. As noted previously, however, consumers may have limited interest in these expert ratings (Tumlinson 1997).

Standardized plan design could also help to simplify choices. Medigap plans were standardized to 10 plan designs after the Omnibus Budget Reconciliation Act of 1990. When benefits are standardized, companies may choose whether to offer a particular plan tier, but not what benefits to include in the tier or how to describe the benefits. This helps consumers make “apples-to-apples” comparisons between plans and choose based on price and quality (Hanoch et al. 1166). Subsequent studies after the Medigap reform showed a reduction in consumer complaints and confusion, and a smaller range of premiums, indicating that plans had become more competitive on cost. In a study for the Commonwealth fund, Jost recommends standardized benefits within the health exchanges because they encourage comparisons of value and performance and discourage companies from designing plans to appeal only to healthy consumers (30).

Conclusions

To facilitate rational choice in the Health Benefits Exchange, consumers need both information and structure. Research in behavioral economics and behavioral psychology demonstrates that individuals develop preferences in the process of making decisions. This runs counter to conventional notions of “Econ” decision makers, carrying a fixed set of beliefs or preferences which they use in the choice process. For the Health Benefits Exchange, this means that consumers purchasing insurance products may not know what they are looking for or how to decide on a particular plan. As noted above, individuals are interested in information on cost, benefits, access, quality and satisfaction. A system that identifies these essential variables and organizes pertinent data will empower users to perform better in the choice process. This is especially important because the choice environment is unfamiliar and complex.

The Health Benefits Exchange and Insurance Oversight Work Group could also serve consumer interests by standardizing benefits packages and descriptions of benefits. When insurance companies describe their own products without standardization, two companies may use different terminology for the same benefit: no shared cost and no co-payment (Jost 2010). Consumers, in turn, have to interpret whether these two descriptions mean the same thing. Sets of benefits packages with slight variations in coverage can be similarly vexing for consumers already considering multiple variables. The Exchange will include plan designs with at least four levels of cost-sharing from Bronze, a 60/40 split, to Platinum, a 90/10 split. If companies are allowed to design plans with actuarial equivalency, rather than straightforward standardized benefits, subtle differences may obscure the simplicity of the tiered structure. In contrast, standardized benefit packages would encourage consumers to compare offerings based on performance and value, and force companies to compete on those metrics. The Health Exchange will best serve new beneficiaries with a well-designed decision tool and standardized choice landscape.

II. METHODOLOGY FOR ANALYSIS OF COMPARISON FOR NORTH CAROLINA AND FEDERAL HEALTH CARE MANDATES AFTER THE ENACTMENT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

We were tasked with comparing the health care mandates as determined by the State of North Carolina with the federal health care mandates included in the Patient Protection and Affordable Care Act (PPACA). We began with a list of twenty-eight mandates for the state of North Carolina.

We compared the descriptions given by the state for the mandated provisions for health care coverage to the various provisions included in the PPACA. We used the actual Patient Protection and Affordable Care Act Bill along with the new guidelines that Secretary of Health and Human Services has issued on preventive services and information on the services that will be covered as part of the preventive benefits (Healthcare.gov). Sections 1302 (essential health benefits requirements) and 1001 (which amends Section 2713 of the Public Health Service Act and deals with coverage of preventive benefits) proved most beneficial in evaluating which NC

mandates align with the federal mandates. While we were able to locate specific language pertaining to most of the NC mandates in the PPACA, there were some NC mandates for which we could not determine coverage. This is partially due to the fact some the NC mandates are very state and population specific, in addition to the fact that others have not been completely defined by the PPACA. Some of these provisions will be defined with more certainty in the future by the Secretary of Health and Human Services, as the provisions of the PPACA are appropriated and implemented.

Once we compared the language and coverage of the NC mandates with the PPACA, we created tables (abbreviated tables below, full tables attached) that are divided by three distinct categories. The first category includes the provisions that will be covered by federal funds because they are either: (1) included in a federal mandate that aligns with a NC mandate; (2) a covered preventive services because of its rating as a Grade A or B recommendation of the United States Preventive Services Task Force; or (3) is covered under the Bright Futures Recommendations of Preventive Pediatric Health Care (Table 1). The second category includes the provisions for which we think there will be coverage, but the coverage may not be equivalent to coverage currently in the NC mandate (Table 2). The third, and final, category of provisions includes those mandates we do not think will be covered by the PPACA (Table 3). Thus, the second and third categories are services for which NC will have to foot all or some of the bill should the state decide to maintain the coverage mandate.

In order to provide a comprehensive review and allow for accurate calculations based on all possible cost scenarios, we decided to include the cost estimates for each of the twenty-eight mandates that we could find, which included 25 of the 28 mandates. We used the Health Insurance Mandates for the States 2009 manual produced by the Council for Affordable Health Insurance as the basis for our information. This manual provided us with estimates of what percentage of a given premium the cost of coverage would be for each provision/mandate.

Based on the comparison of NC mandates to the coverage provisions and mandates included in PPACA, and the relevant cost estimates for the provisions mandated by the state, our goal was to provide useful information that would help the state of North Carolina determine the costs of coverage that fall outside of the federal government's purview under the PPACA.

However, it will be impossible to fully understand the cost implications of maintaining the state's current mandates until we understand what services will be covered as part of the essential benefits package, and the scope of coverage of these services.

Table 1: Mandates Likely to be Covered to the Same Extent as Currently Covered in North Carolina

| NC Statute / Reg Number | Short Description | Costs as a percentage of premium |
|------------------------------------|---|---|
| 58-51-25(b) + federal mandate | Extension of eligibility for a dependent child who takes a leave of absence from a postsecondary institution of learning due to a medical leave of absence from the institution | <1% |
| 58-51-50(f) + federal mandate | Equity in benefits for Chemical Dependency/Addiction in employer group health benefit plans covering 51 or more employees. | 5% to 10% |
| 58-51-62 + | Coverage for reconstructive breast surgery following a mastectomy | <1% |
| 58-3-220(i) + federal mandate | Equity in benefits for Mental Health in employer group health benefit plans covering 51 or more employees. | 5% to 10% |
| 58-3-169 + | Minimum inpatient stays following delivery of a baby | <1% |
| 58-3-170 | Treat maternity as any other illness | 1% to 3% |
| 58-3-174 | Coverage for bone mass measurement | <1% |
| 58-3-190 | Coverage for emergency care | <1% |
| 58-3-260 | Coverage for newborn hearing screening | <1% |
| 58-51-57 | Coverage for mammograms and cervical cancer screening | <1% for each |
| 58-51-58 | Coverage for prostate cancer screening | <1% |
| T11 12.0324 | Coverage to treat HIV/AIDS | unknown |
| 58-51-50 | Minimum benefit offering for Alcoholism/Drug Abuse Treatment (Applicable only to group and blanket policies) | 5% to 10% |
| 58-3-270 | Coverage for ovarian cancer surveillance tests | <1% |
| 58-3-179 | Coverage for colorectal cancer screening | <1% |
| 58-3-220 | Mental Illness Minimum Coverage Requirements (Applicable only to group policies) | 3% to 5% |

Table 2: Mandates Likely to be Covered but Not to the Same Extent as Currently Covered in North Carolina

| NC Statute / Reg Number | Short Description | Costs as a percentage of premium |
|------------------------------------|--|---|
| 58-3-285 | Coverage for hearing aids | <1% for minors |
| 58-3-178 | Coverage for prescription drug contraceptives or devices | 1% to 3% |
| 58-3-122 | Anesthesia and hospital charges for dental procedures for certain individuals | <1% |
| 58-51-30 | Coverage for newborn and foster children and coverage for congenital defects and anomalies | Foster children <1, congenital defects 1-3% , new born 1-3% |
| 58-51-61 | Coverage for certain treatment of diabetes | <1% for diabetic supplies and <1% for self management |
| 58-3-280 | Coverage for the diagnosis and treatment of lymphadema | <1% |
| T11 12.0323 | Coverage for complications of pregnancy | unknown |
| 58-3-255 | Coverage for certain clinical trials | <1% |

Table 3: Mandates Unlikely to be Covered

| NC Statute / Reg Number | Short Description | Costs as a percentage of premium |
|------------------------------------|---|---|
| 58-3-168 | Coverage for postmastectomy inpatient care. | <1% |
| 8-51-16 | Coverage for Intoxicants and narcotics | unknown |
| 58-51-59 | Coverage for certain off-label drug use for the treatment of cancer | <1% |
| 58-3-121 | TMJ Joint Dysfunction Coverage | <1% |

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Appendix A
NC Insurance Mandates That Are Likely To Be Covered Under ACA

| NC Statute/Reg Number | Short Description | Longer Description | Federal Statute (ACA)/Reg Number | Description of what provision provides coverage | Will coverage be equal to or less than that required by NC law? | Costs as a percentage of premium |
|-------------------------------|---|---|--|---|---|----------------------------------|
| 58-51-25(b) + federal mandate | Extension of eligibility for a dependent child who takes a leave of absence from a postsecondary institution of learning due to a medical leave of absence from the institution | Requires insurers to extend the eligibility of a dependent child in accordance with the requirements of the Federal "Michelle's Law" when a dependent child takes a leave of absence from a postsecondary institution of learning due to medical leave of absence. | Michelle's Law | Michelle's Law (Public Law 110-381) prohibits a group health from terminating coverage of a dependent child under the plan due to a medically necessary leave of absence from a postsecondary educational institution before the date that is the earlier of (A) the date that is 1 year after the first day of the medically necessary leave of absence; or (B) the date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage. | This is will be fully covered most likely, due to the federal mandate | <1% |
| 58-51-50(f) + federal mandate | Equity in benefits for Chemical Dependency/Addiction in employer group health benefit plans covering 51 or more employees. | Requires when a plan that provides both surgical and medical benefits AND chemical dependency/addiction benefits that the plan must comply with the applicable standards of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; only applicable to employer groups with 51 or more employees. | Federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 | Requires insurance companies to treat mental health on an equal basis with physical illnesses, when policies cover both. | This is will be fully covered most likely, due to the federal mandate | 5% to 10% |
| 58-51-62 + federal mandate | Coverage for reconstructive breast surgery following a mastectomy | Requires coverage for reconstructive breast surgery following a mastectomy if the plan provides coverage for the mastectomy. | The Women's Health and Cancer Rights Act of 1998 | Under the WHCRA, mastectomy benefits must cover: Reconstruction of the breast that was removed by mastectomy Surgery and reconstruction of the other breast to make the breasts look symmetrical or balanced after mastectomy Any external breast prostheses (breast forms that fit into your bra) that are needed before or during the reconstruction Any physical complications at all stages of mastectomy, including lymphedema | This is will be fully covered most likely, due to the federal mandate | <1% |
| 58-3-220(i) + federal mandate | Equity in benefits for Mental Health in employer group health benefit plans covering 51 or more employees. | Requires when a plan that provides both surgical and medical benefits AND mental health benefits that the plan must comply with the applicable standards of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; only applicable to employer groups with 51 or more employees. | Federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 | Requires insurance companies to treat mental health on an equal basis with physical illnesses, when policies cover both. | This is will be fully covered most likely, due to the federal mandate | 5% to 10% |
| 58-3-169 + federal mandate | Minimum inpatient stays following delivery of a baby | Requires that when a plan provides maternity coverage coverage is provided with respect to a mother and her newborn child for a minimum of 48 hours of inpatient length of stay following a normal vaginal delivery, and a minimum of 96 hours of inpatient length of stay following a cesarean section, without requiring the attending provider to obtain authorization from the insurer or its representative. | The Newborns' and Mothers' Health Protection Act | (a) Requirements for minimum hospital stay following birth (1) In general A group health plan, and a health insurance issuer offering group health insurance coverage, may not— (A) except as provided in paragraph (2)— (i) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or (ii) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a cesarean section, to less than 96 hours; or (B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)). | This is will be fully covered most likely, due to the federal mandate | <1% |
| 58-3-170 | Treat maternity as any other illness | Requires that when a plan provides maternity coverage that the benefits for the necessary care and treatment of maternity are no less favorable than physical illness in general. | 1302 | (b) ESSENTIAL HEALTH BENEFITS.— (1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories: (A) Ambulatory patient services. (B) Emergency services. (C) Hospitalization. (D) Maternity and newborn care. (E) Mental health and substance use disorder services, including behavioral health treatment. | This will most likely be covered by the ACA and requirements will be similar to those of NC | 1% to 3% |

Appendix A
NC Insurance Mandates That Are Likely To Be Covered Under ACA

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|----------|--|--|--|---|---|-----|
| 58-3-174 | Coverage for bone mass measurement | Requires coverage for qualified for scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass. | 1302 and 2713 | <p align="center">(b) ESSENTIAL HEALTH BENEFITS.—</p> <p>(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:</p> <p>(A) Ambulatory patient services. (B) Emergency services. (C) Hospitalization. (D) Maternity and newborn care. (E) Mental health and substance use disorder services, including behavioral health treatment. (F) Prescription drugs. (G) Rehabilitative and habilitative services and devices. (H) Laboratory services.</p> <p>(I) Preventive and wellness services and chronic disease management. (J) Pediatric services, including oral and vision care.</p> <p>IN SEC. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES. “(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for— “(1) evidence-based items or services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force</p> | This will most likely be covered by the ACA and requirements will be similar to those of NC | <1% |
| 58-3-190 | Coverage for emergency care | Requires coverage for emergency services to the extent necessary to screen and to stabilize the person covered under the plan and shall not require prior authorization of the services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person. This includes requiring treating emergency care provided at an out-of-network provider as an in-network benefit. | 1302 | as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that - (i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and (ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network; | This will most likely be covered by the ACA and requirements will be similar to those of NC | <1% |
| 58-3-260 | Coverage for newborn hearing screening | Requires coverage for newborn hearing screening ordered by the attending physician pursuant to G.S. 130A-125 | 1302 and 2713 this provision is covered under HRSA requirements via Bright Futures | <p align="center">(b) ESSENTIAL HEALTH BENEFITS.—</p> <p>(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:</p> <p>(A) Ambulatory patient services. (B) Emergency services. (C) Hospitalization. (D) Maternity and newborn care. (E) Mental health and substance use disorder services, including behavioral health treatment.</p> <p>IN SEC. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES. (a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for— (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.</p> | This will most likely be covered by the ACA and requirements will be similar to those of NC | <1% |

Appendix A
NC Insurance Mandates That Are Likely To Be Covered Under ACA

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|-------------|---|--|---|---|---|--------------|
| 58-51-57 | Coverage for mammograms and cervical cancer screening | Requires coverage for examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography. | 1302 and 2713, recommendation from the US Preventive Task Force | <p>(b) ESSENTIAL HEALTH BENEFITS.—</p> <p>(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:</p> <p>(A) Ambulatory patient services.</p> <p>(B) Emergency services.</p> <p>(C) Hospitalization.</p> <p>(D) Maternity and newborn care.</p> <p>(E) Mental health and substance use disorder services, including behavioral health treatment.</p> <p>(F) Prescription drugs.</p> <p>(G) Rehabilitative and habilitative services and devices.</p> <p>(H) Laboratory services.</p> <p>(I) Preventive and wellness services and chronic disease management.</p> <p>(J) Pediatric services, including oral and vision care.</p> <p>IN SEC. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES.</p> <p>“(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—</p> <p>“(1) evidence-based items or services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force</p> | This will most likely be covered by the ACA and requirements will be similar to those of NC | <1% for each |
| 58-51-58 | Coverage for prostate cancer screening | Requires coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer | 1302 and 2713, recommendation from the US Preventive Task Force | <p>(b) ESSENTIAL HEALTH BENEFITS.—</p> <p>(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:</p> <p>(A) Ambulatory patient services.</p> <p>(B) Emergency services.</p> <p>(C) Hospitalization.</p> <p>(D) Maternity and newborn care.</p> <p>(E) Mental health and substance use disorder services, including behavioral health treatment.</p> <p>(F) Prescription drugs.</p> <p>(G) Rehabilitative and habilitative services and devices.</p> <p>(H) Laboratory services.</p> <p>(I) Preventive and wellness services and chronic disease management.</p> <p>(J) Pediatric services, including oral and vision care.</p> <p>IN SEC. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES.</p> <p>“(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—</p> <p>“(1) evidence-based items or services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force</p> | This will most likely be covered by the ACA and requirements will be similar to those of NC | <1% |
| T11 12.0324 | Coverage to treat HIV/AIDS | HIV infection and AIDS must be treated as any other illness or sickness under the contract. | 2715 | <p>SEC. 2704. PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS OR OTHER DISCRIMINATION BASED ON HEALTH STATUS.</p> <p>“(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.”(b) ESSENTIAL HEALTH BENEFITS.—</p> <p>(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:</p> <p>(A) Ambulatory patient services.</p> <p>(B) Emergency services.</p> <p>(C) Hospitalization.</p> <p>(D) Maternity and newborn care.</p> <p>(E) Mental health and substance use disorder services, including behavioral health treatment.</p> <p>(F) Prescription drugs.</p> <p>(G) Rehabilitative and habilitative services and devices.</p> <p>(H) Laboratory services.</p> <p>(I) Preventive and wellness services and chronic disease management.</p> <p>(J) Pediatric services, including oral and vision care. ”</p> | This will most likely be covered by the ACA and requirements will be similar to those of NC | unknown |

Appendix A
NC Insurance Mandates That Are Likely To Be Covered Under ACA

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|----------|--|---|---|---|---|-----------|
| 58-51-50 | Minimum benefit offering for Alcoholism/Drug Abuse Treatment (Applicable only to group and blanket policies) | Provides for a minimum benefit offering for chemical dependency treatment for a group or blanket accident and health insurance policy. | 1302 | <p align="center">(b) ESSENTIAL HEALTH BENEFITS.—</p> <p>(1) INGENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:</p> <p>(A) Ambulatory patient services. (B) Emergency services. (C) Hospitalization. (D) Maternity and newborn care. (E) Mental health and substance use disorder services, including behavioral health treatment. (F) Prescription drugs. (G) Rehabilitative and habilitative services and devices. (H) Laboratory services. (I) Preventive and wellness services and chronic disease management. (J) Pediatric services, including oral and vision care.</p> | This will most likely be covered by the ACA and requirements will be similar to those of NC | 5% to 10% |
| 58-3-270 | Coverage for ovarian cancer surveillance tests | Requires coverage for surveillance tests for women age 25 and older at risk for ovarian cancer. | 1302 and 2713, recommendation from the US Preventive Task Force | <p align="center">(b) ESSENTIAL HEALTH BENEFITS.—</p> <p>(1) INGENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:</p> <p>(A) Ambulatory patient services. (B) Emergency services. (C) Hospitalization. (D) Maternity and newborn care. (E) Mental health and substance use disorder services, including behavioral health treatment. (F) Prescription drugs. (G) Rehabilitative and habilitative services and devices. (H) Laboratory services. (I) Preventive and wellness services and chronic disease management. (J) Pediatric services, including oral and vision care.</p> <p>IN 'SEC. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES. “(a) INGENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for— “(1) evidence-based items or services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force</p> | This will most likely be covered by the ACA and requirements will be similar to those of NC | <1% |
| 58-3-179 | Coverage for colorectal cancer screening | Requires coverage for colorectal cancer examinations and laboratory tests for cancer in accordance with the most recently published American Cancer Society guidelines. | 1302 and 2713, recommendation from the US Preventive Task Force | <p align="center">(b) ESSENTIAL HEALTH BENEFITS.—</p> <p>(1) INGENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:</p> <p>(A) Ambulatory patient services. (B) Emergency services. (C) Hospitalization. (D) Maternity and newborn care. (E) Mental health and substance use disorder services, including behavioral health treatment. (F) Prescription drugs. (G) Rehabilitative and habilitative services and devices. (H) Laboratory services. (I) Preventive and wellness services and chronic disease management. (J) Pediatric services, including oral and vision care.</p> <p>IN 'SEC. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES. “(a) INGENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for— “(1) evidence-based items or services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force</p> | This will most likely be covered by the ACA and requirements will be similar to those of NC | <1% |

Appendix A
NC Insurance Mandates That Are Likely To Be Covered Under ACA

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|----------|--|--|------|---|---|----------|
| 58-3-220 | Mental Illness Minimum Coverage Requirements (Applicable only to group policies) | Mandates equitable coverage for mental illness benefits in group health benefit plans providing that the plan shall provide benefits for the necessary care and treatment of mental illness that are no less favorable than benefits for physical illness generally, including the application of the same limits which include the deductible, co-payments, lifetime and annual dollar limits, maximum out-of-pocket limits, and any other dollar limits or fees for covered services. Permits for most mental illness conditions a 30-day inpatient/outpatient limit of visits per year and a 30 office visits per year. For certain specified conditions, the durational limits must be the same as for general physical illness. | 1302 | <p align="center">(b) ESSENTIAL HEALTH BENEFITS.—</p> <p>(1) INGENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:</p> <p>(A) Ambulatory patient services.</p> <p>(B) Emergency services.</p> <p>(C) Hospitalization.</p> <p>(D) Maternity and newborn care.</p> <p>(E) Mental health and substance use disorder services, including behavioral health treatment.</p> | This will most likely be covered by the ACA and requirements will be similar to those of NC | 3% to 5% |
|----------|--|--|------|---|---|----------|

Appendix B
NC Mandated Benefits Likely To Be Partially Covered Under ACA

| NC Statute/Reg Number | Short Description | Longer Description | Federal Statute (ACA)/Reg Number | Description of what provision provides coverage | Will coverage be equal to or less than that required by NC law? | Costs as a percentage of premium |
|-----------------------|--|---|---|--|--|----------------------------------|
| 58-3-285 | Coverage for hearing aids | Requires coverage for one hearing aid per hearing-impaired ear up to \$2500 dollars per hearing aid every 36 months for covered individuals under the age of 22 years of age. | House Bill 589 and the new statute was further amended in SB 1242 | <p align="center">(b) ESSENTIAL HEALTH BENEFITS.—</p> <p>(1) INGENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:</p> <p>(A) Ambulatory patient services.</p> <p>(B) Emergency services.</p> <p>(C) Hospitalization.</p> <p>(D) Maternity and newborn care.</p> <p>(E) Mental health and substance use disorder services, including behavioral health treatment.</p> <p>(F) Prescription drugs.</p> <p>(G) Rehabilitative and habilitative services and devices.</p> <p>(H) Laboratory services.</p> <p>(I) Preventive and wellness services and chronic disease management.</p> <p>(J) Pediatric services, including oral and vision care.</p> <p>IN 'SEC. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES.</p> <p>“(a) INGENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—</p> <p>(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.</p> | Rehabilitative and habilitative devices will be covered but because the amount of coverage has not been decided yet it is unclear as to whether or not hearing aids will be included | <1% for minors |
| 58-3-178 | Coverage for prescription drug contraceptives or devices | Requires coverage for prescription contraceptive drugs or devices when a plan provides prescription drug coverage. | 1302 and 2713 | <p align="center">(b) ESSENTIAL HEALTH BENEFITS.—</p> <p>(1) INGENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:</p> <p>(A) Ambulatory patient services.</p> <p>(B) Emergency services.</p> <p>(C) Hospitalization.</p> <p>(D) Maternity and newborn care.</p> <p>(E) Mental health and substance use disorder services, including behavioral health treatment.</p> <p>(F) Prescription drugs.</p> <p>(G) Rehabilitative and habilitative services and devices.</p> <p>(H) Laboratory services.</p> <p>(I) Preventive and wellness services and chronic disease management.</p> <p>(J) Pediatric services, including oral and vision care.</p> <p>IN 'SEC. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES.</p> <p>“(a) INGENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—</p> <p>(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.</p> | Prescription drugs will be covered but because the amount of coverage has not been decided yet it is unclear as to whether or not it will be as inclusive as NC's mandate | 1% to 3% |

Appendix B
NC Mandated Benefits Likely To Be Partially Covered Under ACA

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|----------|--|--|---------------|--|---|--|
| 58-3-122 | Anesthesia and hospital charges for dental procedures for certain individuals | Requires payment for anesthesia and hospital or facility charges for services performed in a hospital or ambulatory surgical facility in connection with dental procedures for qualified individuals. | 1302 and 1311 | <p align="center">(b) ESSENTIAL HEALTH BENEFITS.—</p> <p>(1) INGENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:</p> <p align="center">(A) Ambulatory patient services. (B) Emergency services. (C) Hospitalization. (D) Maternity and newborn care. (E) Mental health and substance use disorder services, including behavioral health treatment. (F) Prescription drugs. (G) Rehabilitative and habilitative services and devices. (H) Laboratory services. (I) Preventive and wellness services and chronic disease management. (J) Pediatric services, including oral and vision care. ""</p> <p align="center">(ii) OFFERING OF STAND-ALONE DENTAL BENEFITS.—</p> <p>Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J)).</p> | Both the term qualified individual in the NC mandate and the exact coverage of the essential health benefits package make it unclear whether this will be covered. It could be covered under hospitalization if performed in a hospital or under emergency or even ambulatory patient services depending on how they are defined. | <1% |
| 58-51-30 | Coverage for newborn and foster children and coverage for congenital defects and anomalies | Requires coverage for benefits for any sickness, illness, or disability shall be provided with the moment of the child's birth or placement in the home as a foster child. Benefits in such plans shall be the same for congenital defects or anomalies as are provided for most sicknesses or illnesses suffered by minor children that are covered by the plans. Benefits for congenital defects or anomalies shall specifically include, but not be limited to, all necessary treatment and care needed by individuals born with cleft lip or cleft palate. | 1302 | <p align="center">(b) ESSENTIAL HEALTH BENEFITS.—</p> <p>(1) INGENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:</p> <p align="center">(A) Ambulatory patient services. (B) Emergency services. (C) Hospitalization. (D) Maternity and newborn care. (E) Mental health and substance use disorder services, including behavioral health treatment. (F) Prescription drugs. (G) Rehabilitative and habilitative services and devices. (H) Laboratory services. (I) Preventive and wellness services and chronic disease management. (J) Pediatric services, including oral and vision care. "</p> | Newborns and habilitative services will be covered but it is unclear whether foster children or congenital defects will be | Foster children <1, congenital defects 1-3%, new born 1-3% |
| 58-51-61 | Coverage for certain treatment of diabetes | Requires coverage for medically appropriate and necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures used to treat diabetes. | 1302 | <p align="center">(b) ESSENTIAL HEALTH BENEFITS.—</p> <p>(1) INGENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:</p> <p align="center">(A) Ambulatory patient services. (B) Emergency services. (C) Hospitalization. (D) Maternity and newborn care. (E) Mental health and substance use disorder services, including behavioral health treatment. (F) Prescription drugs. (G) Rehabilitative and habilitative services and devices. (H) Laboratory services. (I) Preventive and wellness services and chronic disease management. (J) Pediatric services, including oral and vision care.</p> | Chronic disease management will be covered but because the amount of coverage has not been decided yet it is unclear as to whether or not it will be as inclusive as NC's mandate | <1% for diabetic supplies and <1% for self management |
| 58-3-280 | Coverage for the diagnosis and treatment of lymphadema | Requires coverage for the diagnosis, evaluation, and treatment of lymphadema, including benefits for equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education if the treatment is determined to be medically necessary. | Sect 1302 | <p align="center">(b) ESSENTIAL HEALTH BENEFITS.—</p> <p>(1) INGENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:</p> <p align="center">(A) Ambulatory patient services. (B) Emergency services. (C) Hospitalization. (D) Maternity and newborn care. (E) Mental health and substance use disorder services, including behavioral health treatment. (F) Prescription drugs. (G) Rehabilitative and habilitative services and devices. (H) Laboratory services. (I) Preventive and wellness services and chronic disease management. (J) Pediatric services, including oral and vision care.</p> | Chronic disease management will be covered but because the amount of coverage has not been decided yet it is unclear as to whether or not it will be as inclusive as NC's mandate | <1% |

**Appendix B
NC Mandated Benefits Likely To Be Partially Covered Under ACA**

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|-------------|---|--|------|---|---|---------|
| T11 12.0323 | Coverage for complications of pregnancy | Requires that a complication of pregnancy may not be treated any differently from any other illness or sickness under the contract. Specifically includes a non-electing cesarean section as a complication. | 1302 | <p align="center">(b) ESSENTIAL HEALTH BENEFITS.—</p> <p>(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:</p> <p>(A) Ambulatory patient services.</p> <p>(B) Emergency services.</p> <p>(C) Hospitalization.</p> <p>(D) Maternity and newborn care.</p> <p>(E) Mental health and substance use disorder services, including behavioral health treatment.</p> <p>(F) Prescription drugs.</p> <p>(G) Rehabilitative and habilitative services and devices.</p> <p>(H) Laboratory services.</p> <p>(I) Preventive and wellness services and chronic disease management.</p> <p>(J) Pediatric services, including oral and vision care.</p> | Maternity care will be covered but because the amount of coverage has not been decided yet it is unclear as to whether or not it will be as inclusive as NC's mandate | unknown |
| 58-3-255 | Coverage for certain clinical trials | Requires coverage for participation in phase II, phase III, and phase IV covered clinical trials for qualified individuals. | 1181 | "PART D—COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH "SEC. 1181 "(j) RULES OF CONSTRUCTION. "(1) COVERAGE.—Nothing in this section shall be construed "(A) to permit the Institute to mandate coverage, reimbursement, or other policies for any public or private payer; or "(B) as preventing the Secretary from covering the routine costs of clinical care received by an individual entitled to, or enrolled for, benefits under title XVIII, XIX, or XXI in the case where such individual is participating in a clinical trial and such costs would otherwise be covered under such title with respect to the beneficiary." | Govt may leave this to the discretion of the states, in which case NC would still be responsible for footing the bill | <1% |

Appendix C
NC Mandates Unlikely to Be Covered Under ACA

| NC Statute/Reg Number | Short Description | Longer Description | Federal Statute (ACA)/Reg Number | Description of what provision provides coverage | Will coverage be equal to or less than that required by NC law? | Costs as a percentage of premium |
|-----------------------|---|---|----------------------------------|--|--|----------------------------------|
| 58-3-168 | Coverage for postmastectomy inpatient care. | The decision whether to discharge a patient following mastectomy shall be made by the physician and the patient and based upon the individual situation presented. | 1302 | 1302 includes hospitalization as does Sec. 3106. that allows for extension of certain payment rules for long-term care hospital services | Hard to tell if it will be covered under ACA, but NC mandates minimum mastectomy stay | <1% |
| 8-51-16 | Coverage for Intoxicants and narcotics | Prohibits an exclusion in medical expense policies for claims related to or resulting from being intoxicated or under the influence of any narcotic. | | | Not likely to be covered, could not find anything in the PPACA that would likely cover it. | unknown |
| 58-51-59 | Coverage for certain off-label drug use for the treatment of cancer | Prohibits the exclusion of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA. The drug does have to be approved by the FDA and the efficacy must have been proven and accepted for treatment in an established compendium. | | | Not likely to be covered, could not find anything in the PPACA that would likely cover it. | <1% |
| 58-3-121 | TMJ Joint Dysfunction Coverage | Requires coverage for diagnostic, therapeutic, or surgical procedures involving any bone or joint of the jaw, face, or head, so long as the plan provides such services for any other bone or joint, the procedure is medically necessary to treat a condition which prevents normal functioning of the particular bone or joint involved, and the condition is caused by congenital deformity, disease, or traumatic injury. | | | Not likely to be covered, could not find anything in the PPACA that would likely cover it. | <1% |