North Dakota Essential Health Benefit Benchmark Plan Actuarial Report and Certification

Review and Evaluation of Proposed Changes to the North Dakota EHB-Benchmark plan for Plan Year 2025

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Executive Summary

Project Description

North Dakota is interested in updating its Essential Health Benefits Benchmark Plan (EHB-BP). To facilitate this review, the North Dakota Insurance Division (NDID) has directed its contracted actuarial firm, NovaRest, to assist in analyzing potential changes to the current North Dakota EHB-BP.

The purpose of this report is to provide an actuarial report and an actuarial certification developed by an actuary who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies, which affirms:

- That the State's EHB-BP provides a scope of benefits that is equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at 45 CFR § 156.110(a), the scope of benefits provided under a typical employer plan, as defined at 45 CFR § 156.111 (b)(2)(i); and

- That the State's EHB-BP does not exceed the generosity of the most generous among the plans listed in paragraphs 45 CFR § 156.111 (b)(2)(ii)(A) and (B)

I, Richard Cadwell, am associated with the firm of NovaRest Actuarial Consulting, Inc. I am an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries and am qualified to provide this opinion.

NovaRest is an actuarial consulting firm that has extensive experience performing mandated benefit reviews. We have utilized generally accepted actuarial methodologies to arrive at this opinion.

We are providing this report solely for the use of supporting North Dakota's proposed changes to its EHB-BP. The intended users of this report are North Dakota and those federal agencies to which the application is submitted. The distribution of this report to any other parties does not constitute advice from or by us to those parties. The reliance of other parties on any aspect of our work is not authorized by NovaRest and is done at the other party's own risk.

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Proposed Changes

North Dakota is proposing revise its current EHB-BP (BlueCare 90 500) to add the following:[1]

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. 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.

Conclusion

The North Dakota Public Employees Retirement System (NDPERS) Grandfathered PPO plan was one of the ten base-benchmark plan options for North Dakota's 2017 plan year EHB selection and represents a Typical Employer Plan. We estimate the NDPERS Grandfathered PPO plan provides $2.00-$2.50 PMPM more expected value at 100 percent actuarial value (AV) than the current EHB-BP (BlueCare Gold 90 500). The proposed EHB-BP is the same as the current EHB-BP except that it expands the current coverage as discussed above, which we estimate would increase the expected value of benefits by $2.19 PMPM at 100 percent actuarial value.

[1] https://ndlegis.gov/assembly/68-2023/regular/documents/23-3060-01000.pdf

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Because of this, we believe the scope of benefits of the proposed EHB-BP is equal to that of a Typical Employer Plan.

The Federal Employee Health Benefits Standard Plan (FEHBP) administered by Blue Cross Blue Shield of North Dakota was one of the ten base-benchmark plan options for North Dakota's 2017 plan year EHB selection and represents the most generous among a set of comparison plans.[2] We estimate that the FEHBP offers $3.22 PMPM more expected value than the current EHB-BP at 100 percent actuarial value. We estimate the expanded coverage would increase the expected value of benefits by $2.19 PMPM at 100 percent actuarial value. Therefore, the proposed EHB-BP does not exceed the generosity of the most generous among a set of comparison plans.

Background

Ten Original Plans Considered

North Dakota originally considered ten (10) category plan combinations as potential Benchmark Plans. It considered three (3) small group plans, three (3) state plans, three (3) FEHBPs, and one (1) commercial non-Medicaid Health Maintenance Organization (HMO). The considerations included the following:

1. Small Group 1 – Medica Choice Passport PPO
2. Small Group 2 – Classic Blue PPO
3. Small Group 3 – CompChoice 80 PPO
4. State Plan 1 – North Dakota Public Employees Retirement System (NDPERS). Health Care Coverage (grandfathered). Plans are issued by Blue Cross Blue Shield of North Dakota.
5. State Plan 2 – North Dakota Public Employees Retirement System. Health Care Coverage (non-grandfathered). Plans are issued by Blue Cross Blue Shield of North Dakota.
6. State Plan 3 – North Dakota Public Employees Retirement System. High deductible health plan. This benefit plan is a high deductible health plan designed to comply with Section 223 of the U.S. Internal Revenue Code and is intended for use with a Health Savings Account (HSA). Plans are issued by Blue Cross Blue Shield of North Dakota
7. FEHBP – BCBS Standard Option PPO
8. FEHBP – BCBS Basic Option PPO
9. FEHBP – Government Employees Health Association (GEHA)
10. HMO – Sanford Health Plan

[2] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Example-Acceptable-Methodology-for-Comparing-Benefits.pdf

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North Dakota Benchmark Plan Chosen

The original EHB-BP chosen was the Largest HMO plan, a Sanford Health Plan. The plan included 2 supplemental categories: Pediatric Oral and Pediatric Vision.

North Dakota adopted the Blue Cross Blue Shield of North Dakota small group exchange plan, BlueCare Gold 90 500 as the EHB-BP beginning 2017.[3] There were no additional supplemental categories.[4] For the 2017 plan year, we are not aware of an updated analysis which identified the ten potential benchmark plans, and therefore assume the comparison plans did not change with the exception of the BlueCareGold 90 500 being included as one of the largest small group plans.

Guidance and Requirements for Changing Benchmark Plans

CMS is providing states three (3) new options for selection starting in plan year 2020, including:[5]

- Option 1: Selecting the EHB-benchmark plan (EHB-BP) that another state used for the 2017 plan year.
- Option 2: Replacing one or more categories of EHBs under its EHB-BP used for the 2017 plan year with the same category or categories of EHB from the EHB-BP that another state used for the 2017 plan year.
- Option 3: Otherwise selecting a set of benefits that would become the state's EHB-BP.

North Dakota is opting to choose Option 3: Otherwise selecting a set of benefits that would become the state's EHB-BP. The proposed EHB-BP would cover all the benefits included in the current EHB-BP, except that it would limit cost sharing for insulin/insulin supplies; add coverage for hearing aids and PET scans; and expand coverage for nutritional counseling (include coverage for the use of GLP1 and GIP drugs), periodontal disease, and opioid benefits.

If a state opts to select a new EHB-BP utilizing any of the selection options at 45 CFR § 156.111(a), the state is required under 45 CFR § 156.111(e)(2)(i) and (ii) to submit an actuarial certification and associated actuarial report from an actuary who is a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies.

[3] https://www.cms.gov/cciio/resources/data-resources/ehb
[4] https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Final-List-of-BMPs_4816.pdf
[5] https://www.govinfo.gov/content/pkg/FR-2018-04-17/pdf/2018-07355.pdf

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This actuarial certification and associated actuarial report must affirm that the State's EHB-BP:[6]

- Provide a scope of benefits equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at 45 CFR § 156.110(a), the scope of benefits provided under a typical employer plan, as defined at 45 CFR § 156.111(b)(2)(i), and
- Not exceed the generosity of the most generous among a set of comparison plans, as defined at 45 CFR § 156.111(b)(2)(ii).

Expected Value of Benefits to be Added to the new EHB Benchmark Plan

NovaRest then analyzed the impact of expanding coverage for insulin/insulin supplies; add coverage for hearing aids and PET scans; and expand coverage for nutritional counseling, periodontal disease, and opioid benefits. More information on the methodology can be found in **Appendix A**.

1. Insulin/Insulin Supplies

Insulin drugs and medical supplies for insulin dosing and administration, are covered under the current EHB-BP. The proposed EHB-BP would not add new benefits or services, but instead would limit the member's out-of-pocket cost for the insulin and supplies. Specifically, a cost sharing for 30-day supply of:

A) Covered insulin drugs which may not exceed twenty-five ($25) dollars per pharmacy or distributor, regardless of the quantity or type of insulin drug used to fill the covered individual's prescription needs, where insulin includes the following categories:

a. Rapid-acting insulin
b. Short-acting insulin
c. Intermediate-acting insulin
d. Long-acting insulin
e. Premixed insulin product
f. Premixed insulin/GLP-1 RA product
g. Concentrated human regular insulin

[6] https://www.govinfo.gov/content/pkg/FR-2018-04-17/pdf/2018-07355.pdf

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B) Covered medical supplies for insulin dosing and administration, the total of which may not exceed twenty-five ($25) dollars per pharmacy or distributor, regardless of the quantity or manufacturer of supplies used to fill the covered individual's prescription needs.

a. Blood glucose meters
b. Blood glucose test strips
c. Lancing devices and lancets
d. Ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone strips
e. Glucagon, injectable or nasal forms
f. Insulin pen needles
g. Insulin syringes

Analysis of Additional Generosity

The NovaRest analysis described in **Appendix A** resulted in approximately $0.57 PMPM for the limited out-of-pocket costs of diabetic drugs and supplies at 100% actuarial value. The issuers estimated between $0.00 to $1.49 PMPM or 0.00% to 0.30% of premium.

2. *Hearing Aids*

North Dakota's current EHB-BP excludes "communication aids or devices to create, replace or augment communication abilities, including hearing aids, …"[7]. The proposed EHP-BP would include coverage for one hearing aid per hearing-impaired ear every 36 months unless there is a significant change in the insured's hearing status as determined by a licensed physician or audiologist. Issuers may impose pre-authorization or other limits to provide a benefit commensurate with this limit.

- The hearing loss must be documented by a licensed physician or audiologist
- Devices must be purchased from licensed audiologists

Analysis of Additional Generosity

The NovaRest analysis described in **Appendix A** resulted in approximately $0.73 PMPM for the added coverage of hearing aids at 100% actuarial value. The issuers' estimates were between $0.20 and $0.50 PMPM or 0.04% to 0.10% of premium.

[7] Certificate of Insurance for BlueCare 90 500 Group Benefit Plan

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3. *Nutritional Counseling*

The current EHB-BP covered in-network nutritional counseling up to 4 visits per member per benefit period for hyperlipidemia, gestational diabetes, diabetes mellitus, obesity, and outpatient nutritional care services for Phenylketonuria (PKU).[8] In-network nutritional counseling for hypertension covered up to 2 visits per member per benefit period.

Outpatient nutritional care services is covered when provided by a Licensed Registered Dietician when ordered by a Professional Health Care Provider for assessment of food practices and dietary/nutritional status, and diet counseling for preventive and therapeutic needs for the diagnosed medical conditions.

Nutritional counseling for control of dental disease, oral hygiene instruction and personal hygiene and convenience items is specifically excluded.

In addition to the current EHB-BP, under the ACA services that have an "A" or "B" recommendation rating from the United States Preventive Service Task Force (USPSTF) must be covered at no cost sharing.[9] As of the time of this report nutritional screening is recommended with a B rating for obesity, Dyslipidemia, Diabetes, Hypertension or elevated blood pressure, or Mixed or multiple risk factors such as metabolic syndrome or an estimated 10-year CVD risk of ≥7.5%.[10,11]. As of the time of this report nutritional counseling is recommended with a B rating for obesity, Dyslipidemia, Hypertension or elevated blood pressure, or Mixed or multiple risk factors such as metabolic syndrome or an estimated 10-year CVD risk of ≥7.5% with a median of 12 contacts. [12,13]

We note the USPSTF recommendations are subject to change. For example, diabetes was removed from the nutritional counseling B recommendation to a separate C recommendation which reflects including all non-cardiovascular disease risk factors.[14]

The proposed benefit would require coverage and reimbursement 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 twelve

[8] Certificate of Insurance for BlueCare 90 500 Group Benefit Plan

[9] https://www.cdc.gov/nchhstp/highqualitycare/preventiveservices/index.html#:~:text=Medicare%20%E2%80%93%20Under%20the%20ACA%2C%20USPSTF,under%20part%20A%20or%20enrolled

[10] https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/healthy-diet-and-physical-activity-counseling-adults-with-high-risk-of-cvd

[11] https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes

[12] https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/healthy-diet-and-physical-activity-counseling-adults-with-high-risk-of-cvd

[13] https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/obesity-in-adults-interventions

[14] https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/healthy-lifestyle-and-physical-activity-for-cvd-prevention-adults-without-known-risk-factors-behavioral-counseling

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sessions every policy year, if prescribed by the patient'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.

Analysis of Additional Generosity

The NovaRest analysis described in **Appendix A** resulted in approximately $0.52 PMPM for the added coverage of nutritional counseling including 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 at 100% actuarial value. Two issuers estimated $0.00 PMPM, and one estimated $0.50 PMPM or a range of 0% to 0.10% of premium for the impact of nutritional counseling, not including the impact of GLP1 and GIP drugs.[15]

4. *Periodontal Disease*

The current EHB-BP includes dental coverage only for children under 19 years of age, or for people who have dental policies. The proposed benefits would require all health issuers to provide coverage for diagnosis and treatment of periodontal disease when recommended by a board-certified medical practitioner based on health-related impacts or further deterioration in existing acute or chronic disease state due to gum disease. This would apply to all ages.

Analysis of Additional Generosity

The NovaRest analysis described in **Appendix A** resulted in approximately $0.13 PMPM at 100% actuarial value as the cost of diagnosis and treatment of periodontal disease. The issuers estimated between $0.00 and $31.35 PMPM. Removing the outlier $31.35 PMPM estimate produces an issuer range of $0.00 to $0.50 PMPM or 0% to 0.10% of premium.

5. *PET Scans*

Coverage for prostate cancer is not directly discussed in the EHB-BP, other than prostate cancer screenings. Our understanding from discussions with medical providers is that issuers will cover CT scans and bone scans as part of prostate cancer treatment. It is unclear what scans are covered after prostate cancer treatment and it is unclear under which situation PET scans and what types of PET scan agents are currently covered. Providers report that issuers may cover one PET scan, but if a PET scan with another agent is recommended after the first scan, the second may be denied. The carriers' responses indicate PET scans would be covered with no limitations if medically necessary, although the definition of medically necessary is not clear. No carriers reported denied claims for PET scans.

[15] The proposal to require coverage for GLP1 and GIP drugs was added after we asked issuers about a potential cost impact.

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The proposed EHB-BP would cover PET scans for any member who has received a prostate cancer diagnosis including those in remission or who have been cured. The coverage would include at least two different types of PET scans (FDG, PSMA, Choline, etc.) upon initial diagnosis if requested by a physician, and one PET scan every six months for the life of the member.

Analysis of Additional Generosity

The NovaRest analysis described in **Appendix A** resulted in approximately $0.17 PMPM for PET scans for prostate cancer at 100% actuarial value. The issuers estimated $0.00 to $0.50 PMPM or 0% to 0.10% of premium.

6. Opioid Benefits

Currently the EHB-BP does not directly mention treatment for opioid use disorder. The proposed addition would require that an intranasal spray opioid reversal agent would be prescribed when prescriptions of opioids are 50 MME and higher. In addition, it would remove prior authorization requirements for Buprenorphine and similar opioid replacement drugs.

Analysis of Additional Generosity

The NovaRest analysis described in **Appendix A** resulted in approximately $0.07 PMPM for opioid benefits at 100% actuarial value. The issuers estimated $0.00 - $0.50 PMPM or 0.0% to 0.1% of premium.

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Meeting the Typical Employer Plan Requirement

45 CFR § 156.111(b)(2)(i) requires that an EHB-BP "Provide a scope of benefits equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at 45 CFR § 156.110(a), the scope of benefits provided under a typical employer plan."[16]

During North Dakota's selection for the 2017 plan year, BlueCare Gold 90 500 was selected as the EHB-BP, and NDPERS Grandfathered PPO plan was included in the 10 comparison plans, and therefore represents a typical employer plan.

NDID provided NovaRest the results of the benefit analysis performed in the process of selecting their 2017 EHB-BP. The benefit differences between the plans are identified in Table 1:

Table 1:
Differences in Covered Benefits

	BlueCare Gold 90 500	**NDPERS Grandfathered PPO**
Private Duty Nursing	Not Covered	Covered
Infertility Services (Diagnostics, Treatment, Office Visits, and other Services)	Not Covered	$20,000 Lifetime Maximum per Member
Glasses/contact following cataract surgery-Adult	Not Covered	One (1) pair of eyeglasses or contact lenses per Member when purchased within 6 months following a covered cataract surgery
Organ Transplant – Transportation costs	Not Covered	Covered
Sexual Dysfunction Drugs	Not Covered	Covered
Child Hearing Aids Covered	Not Covered	Covered
Contraceptives	Covered	Not Covered
Smoking Cessation Drugs	Benefits are subject to a Maximum Benefit Allowance of 2 quit attempt cycles per Member per Benefit Period.	Not Covered
Pediatric Preventive Dental	Covered	Not Covered
Pediatric Basic Dental	Covered	Not Covered

[16] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-156/subpart-B/section-156.111

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To estimate the difference in the expected value of the benefits at 100% actuarial value, each benefit was analyzed using either prior studies of mandated benefits or EHBs in other states, or we built cost estimates from first principles (using the basic assumption of cost per service and number of services per 1,000). The expected value, by benefit, is displayed in Table 2:

Table 2: Expected Value of Differences in Covered Benefits at 100% AV		
	BlueCare Gold 90 500	**NDPERS Grandfathered PPO**
Private Duty Nursing		$1.40-$1.70 PMPM
Infertility Services (Diagnostics, Treatment, Office Visits, and other Services)		$1.50-$1.70 PMPM
Glasses/contact following cataract surgery-Adult		$0.20-$0.30 PMPM
Organ Transplant - ONLY TRANSPORT		$0.00-$0.10 PMPM
Sexual Dysfunction Drugs		$1.00-$1.10 PMPM
Child Hearing Aids Covered		$0.10-$0.20 PMPM
Contraceptives	$0.70-$0.80 PMPM	
Smoking Cessation Drugs	$0.20-$0.30 PMPM	
Pediatric Preventive Dental	$0.50-$0.60 PMPM	
Pediatric Basic Dental	$0.80-$0.90 PMPM	
Sum of Expected Value of Benefits	**$2.20-$2.60 PMPM**	**$4.20-$5.10 PMPM**
Additional Expected Value of NDPERS Grandfathered PPO		**$2.00-$2.50 PMPM**

We estimate the NDPERS Grandfathered PPO plan provides $2.00-$2.50 PMPM more expected value than the current EHB-BP (BlueCare Gold 90 500). The proposed EHB-BP adds $2.19 PMPM in value over the current EHB-BP (BlueCare Gold 90 500) due to limiting out-of-pocket costs for diabetes drugs and supplies ($0.57 PMPM); adding coverage for hearing aids ($0.73 PMPM) and PET scans ($0.17 PMPM); and expanding coverage for nutritional counseling ($0.52 PMPM), periodontal disease ($0.13 PMPM), and opioid benefits ($0.07 PMPM).

Therefore, we believe the proposed EHB-BP meets the 45 CFR § 156.111(b)(2)(i) requirement that the EHB-BP provides a scope of benefits equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at 45 CFR § 156.110(a), the scope of benefits provided under a typical employer plan.

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Meeting the Generous Plan Requirement

45 CFR § 156.111(b)(2)(ii) requires that an EHB-BP "not exceed the generosity of the most generous among a set of comparison plans."

The FEHBP was one of the 10 base-benchmark plan options for North Dakota's 2017 plan year EHB selection and represents the most generous among a set of comparison plans.

We performed a benefit comparison between the FEHBP and the current EHB-BP, identifying and pricing benefits included in the FEHBP that are not in the current EHB-BP and vice versa. More information can be found in **Appendix B**. We determined the expected value of the FEHBP is $3.22 PMPM more generous than the current EHB-BP, at 100 percent actuarial value, as discussed by CMS as an acceptable methodology. [17]

The cost PMPM of each proposed new benefit is shown in Table 3.

Table 3:
Expected Value of Proposed Benefits to be Added to EHB-BP at 100% AV

	PMPM Impact
Diabetes Drugs and Supplies	$0.57 PMPM
Hearing Aids	$0.73 PMPM
Nutritional Counseling	$0.52 PMPM
Periodontal Disease	$0.13 PMPM
PET Scans	$0.17 PMPM
Opioid Benefits	$0.07 PMPM
Total Expected Value of Proposed Benefits to be Added	**$2.19 PMPM**

Since we estimate the FEHBP is $3.22 PMPM richer than the current EHB-BP, adding $2.19 in benefits to the current EHB-BP would result in a proposed EHB-BP plan that does not exceed the generosity of the most generous among a set of comparison plans.

[17] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Example-Acceptable-Methodology-for-Comparing-Benefits.pdf

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Certification

I, Richard Cadwell, am associated with the firm of NovaRest Actuarial Consulting, Inc. I am an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries. NovaRest was hired by the North Dakota Insurance Division to provide an actuarial certification, consistent with updated guidance provided by the Department of Health and Human Services, Centers for Medicare and Medicaid Services, in support of North Dakota's proposed changes to their Essential Health Benefit Benchmark Plan. I meet the Academy qualification standards for rendering the certification.

It is mine and NovaRest's belief that the proposed Essential Health Benefit Benchmark Plan complies with the following requirements included in the Centers for Medicare and Medicaid Services guidance regarding selecting a new Essential Health Benefit Benchmark Plan.

- That the State's EHB-BP provides a scope of benefits equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at 45 CFR § 156.110(a), the scope of benefits provided under a typical employer plan; and
- That the State's EHB-BP does not exceed the generosity of the most generous among a set of comparison plans

The actuarial methodologies utilized in order to arrive at our opinion are those considered generally accepted within the industry and are consistent with all applicable Actuarial Standards of Practice.

Sincerely,

Richard Cadwell, ASA, MAAA

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Reliance

NovaRest relied upon the following information:

- Interviews with medical providers. These providers do not opine on the results of the analysis offered in this paper.
- A carrier data survey.
- Plan year 2023 North Dakota ACA rate and form filing materials.
- A prior benefit comparison analysis provided by the NDID.
- 2021 information provided in the NAIC Supplemental Health Care Exhibit.

Limitations

Opinions in this report should not be construed as providing legal advice.

Estimates in this report are precise enough to be used to confirm that CMS requirements are met but should not be used for any other purposes.

This report should only be used by NDID and CMS for the purposes intended and not for any other purposes.

This report should only be communicated in its entirety and not in parts or out of context.

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Appendix A – NovaRest Estimate of Proposed Coverage

Data

The report entitled "Review and Evaluation of Proposed Changes to the North Dakota EHB Benchmark Plan Proposed EHB Cost Impacts" provides the complete description of the analysis which is described below. Please note the analysis performed in the "Review and Evaluation of Proposed Changes to the North Dakota EHB Benchmark Plan Proposed EHB Cost Impacts" report was done assuming a 75% actuarial value. This was converted to 100% actuarial value for the above certification.

For all estimates, we relied on public information, interviews with medical providers, plan year 2023 ND carrier rate filing information and 2021 ND carrier financials. We did not have access to actual carrier claims data. For demographic information, we use information from the US Census Bureau, including Vintage Population Estimates and the American Community Survey. We assumed a 5.5% annual cost medical trend[18] and 75% carrier cost sharing[19]. For dental services, we assume a 2.5% trend, as dental trend estimates are lower than medical trends.[20] We note our estimates do not vary significantly between the individual and small group markets as the membership and the current premiums in the markets are within 5% of each other. Please note our estimates represent a market average, the impact on each carrier will vary based on numerous factors such as coverage level, population, and covered benefits.

Assumptions and Methodology

Insulin Drugs and Supplies

There are approximately 54,372 people in North Dakota with diagnosed diabetes, many of which use insulin.[21] While there are some cases of non-diabetic insulin use, we only considered Type 1, Type 2, and Gestational Diabetes. We used CDC data to estimate the age distribution of those with diabetes in North Dakota[22], as we assume those over 65 would be covered by Medicare. Additionally, 15% of the under 65 population would be impacted by the EHB-BP change.[23] 31% of diabetes patients are treated with insulin.[24] In addition, 2% to 10% of pregnancies result in

[18] Projected Private Health Insurance Spending Per Enrollee 2021. National Health Care Expenditures: Table 17 Health Insurance Enrollment and Enrollment Growth Rates. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected
[19] 2021 incurred to allowed from combined ND carriers plan year 2023 rate filing URRTs was 76%.
[20] https://www.segalco.com/consulting-insights/2022-health-plan-cost-trend-survey
[21] https://diabetes.org/sites/default/files/2021-10/ADV_2021_State_Fact_sheets_North%20Dakota.pdf
[22] https://www.cdc.gov/diabetes/data/statistics-report/diagnosed-undiagnosed-diabetes.html
[23] 2021 SHCE covered lives for health, life and P&C individual and small group business compared to 2021 Vintage population estimates in North Dakota.
[24] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4714726/

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gestational diabetes[25], where 20% of those[26] or approximately 40 more people[27] would use insulin for an extended period. We estimate approximately 1,740 insulin users are covered by individual and small group ACA products.

There is not much information on the distributions of the type(s) of insulin used and the dosage(s), as it is prescribed on an individualized basis. We found the cost per unit for the various types of insulin covered by the proposed benefit[28,29] and insulin supplies for a 30-day supply[30.31.32]. For insulin, we assumed 62 units of insulin a month.[33]

We used 25% as the current member cost sharing on insulin and insulin products. We used the difference between 25% of insulin cost and $25 cap as the cost shifted to issuers with the proposed EHB-BP change. We performed the same analysis for insulin supplies.

We note some issuers have implemented cost sharing caps on insulin[34] or have moved certain insulin to preferred tiers where member cost sharing is as low as $5 for a monthly supply.

Hearing Aids

According to a CDC report from 2014 to 2016, 20.9% of North Dakotans aged 18 and over suffered some level of hearing loss.[35] Further, the CDC cites 14.9% of children aged 6-19 experienced some level of Low- or High-frequency loss of at least 16-decible hearing level in one or both ears. Men are nearly twice as likely to have hearing loss than women.[36]

NovaRest performed a hearing aid and hearing loss study in 2014 for the state of Maine. This prior work and the estimated issuer costs were considered when looking at a possible hearing EHB in North Dakota. Adjustments were made to account for hearing loss prevalence between the two states (21.9% for Maine vs 20% for ND). Additionally, the average cost of a hearing aid in the 2 states (2014 in Maine, 2022 estimate in North Dakota) along with the demographic difference under 65 were accounted for in the development of the PMPM estimate. The estimate also considers the availability of audiologists and hearing aid providers within a reasonable

[25] https://www.cdc.gov/diabetes/basics/gestational.html
[26] https://www.tommys.org/pregnancy-information/pregnancy-complications/gestational-diabetes/taking-medication-and-insulin-gestational-diabetes
[27] Pregnancies based on American Community Survey data in North Dakota.
[28] https://www.goodrx.com/healthcare-access/research/how-much-does-insulin-cost-compare-brands
[29] https://cardiab.biomedcentral.com/articles/10.1186/s12933-020-01211-4
[30] https://health.costhelper.com/glucose-meter.html#:~:text=Typical%20costs%3A,on%20the%20meter's%20extra%20features.
[31] https://www.goodrx.com/glucagon?dosage=amphastar-of-1mg&form=kit&label_override=glucagon&quantity=1&sort_type=popularity
[32] https://www.healthline.com/health/type-2-diabetes/insulin-prices-pumps-pens-syringes#insulin-vials-and-syringes
[33] https://www.americanactionforum.org/research/insulin-cost-and-pricing-trends/
[34] https://www.medica.com/newsroom/news-releases/2021/06/medica-introduces-insulin-cost-relief-program-in-north-dakota
[35] https://www.cdc.gov/nchs/data/health_policy/hearing_loss_table_SEs.pdf
[36] https://www.nidcd.nih.gov/health/statistics/quick-statistics-hearing

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proximity to the member. North Dakota is among the top 5 states in the US in per capita audiology services. As a potentially new EHB, there could be pent up demand in the first year. Cost estimate assumes a multi-year impact.

Nutritional Counseling and Therapy

The proposed language requires, providing 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."

We were unable to find a definitive list of all chronic illnesses or condition that could be managed through nutritional or weight loss programs, however, there are approximately 410,000 people in North Dakota that have at least 1 chronic disease[37], or about 53% of the population. We estimate 85% of those age 65 and older have at least 1 chronic disease,[38] leaving approximately 47% of the under-age 65 population with chronic disease, or about 41,000 members who would be eligible for benefits. While we assume 47% of the population are eligible for benefits as described above, we expect low usage of the benefit. AARP found usage rates for nutritional counseling under 1% for eligible Medicare enrollees.[39] Additionally, while individuals may use the benefit, we find it unlikely that individuals will use all 12 sessions or will continue to use the service every year.

Additionally, we consider the population who would use of GLP1 and GIP drugs as therapy for prevention of diabetes and treatment of insulin resistance, metabolic syndrome or morbid obesity. Our understanding is that these drugs have been used for a long period of time as diabetes treatment where it is currently covered, but expansion into prevention of diabetes and treatment of insulin resistance, metabolic syndrome or morbid obesity is not currently covered. The FDA has approved semaglutide and liraglutide injections for chronic weight management in patients with a body mass index (BMI) of 27 kg/m2 or greater who have at least one weight-related ailment or in patients with a BMI of 30 kg/m2 or greater.[40,41] For our cost estimate of GLP1 and GIP drugs, we assume 27.2% of the population would be eligible, which is the percentage of North Dakotans with a BMI of 30 or greater.[42] We do not have data on patients between a BMI of 27 and 30 with another weight-related element, which we assume would be a small population. We assume usage of GLP1 and GIP drugs to the formulary as therapy for prevention of diabetes and treatment of insulin resistance, metabolic syndrome or morbid obesity would be similar to usage of nutritional counseling, considering it would require a prescription

[37] https://www.fightchronicdisease.org/sites/default/files/download/PFCD_ND_FactSheet_FINAL1.pdf
[38] https://www.nia.nih.gov/health/supporting-older-patients-chronic-conditions
[39] https://www.aarp.org/health/medicare-insurance/info-2019/medicare-nutrition-counseling-benefit.html
[40] https://www.fda.gov/news-events/press-announcements/fda-approves-new-drug-treatment-chronic-weight-management-first-2014
[41] https://www.fda.gov/drugs/news-events-human-drugs/fda-approves-weight-management-drug-patients-aged-12-and-older#:~:text=Saxenda%20has%20been%20approved%20since,activity%20for%20adults%20as%20well.
[42] https://www.cdc.gov/obesity/stateprograms/fundedstates/pdf/north-dakota-state-profile.pdf

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and FDA approval is for use in "for use in addition to a reduced calorie diet and increased physical activity."[43]

We assumed an annual cost of $950 for nutritional counseling and $80 for screening.[44] We estimate a cost of $14,000 annually for GLP1 and GIP drugs based on an average cost of GLP1 and GIP drugs commonly covered by commercial marketplaces.[45]

To determine the net cost as described above, we assume nutritional screening is fully covered for obesity, Dyslipidemia, Diabetes, Hypertension or elevated blood pressure, and CVD currently. We believe nutritional counseling is fully covered for all except diabetes which is covered up to 4 visits. We assume obesity, dyslipidemia, Hypertension or elevated blood pressure, and CVD represent 30% of the population and 9% of the population reflects diabetes. [46] Additionally, we assumed an annual savings ranging from $3-$4 based on the USPSTF study,[47] which provided the expected 25-year cost savings from interventions. For GLP1 and GIP drugs we assume 12 months of usage, as drugs would be used for chronic weight management.[48]

Periodontal Disease

The proposed benefit would only provide coverage if deterioration in existing acute or chronic disease state. Periodontitis can include minor or moderate which would require cleanings or minor procedures, which we assume would not be covered under the proposed language. We assume only severe cases would be covered, as those cases are likely to worsen acute or chronic disease states. We also assume members who have dental policies would also use dental coverage to cover mild or moderate cases. Considering prevalence rates by age, [49] and members who would already have dental coverage, we estimate the proposed benefit would impact approximately 2,500 members in North Dakota.

We began by grouping CPT codes together that relate to each type of treatment in order to determine a range of costs. Costs were obtained from a 2016 dental fee survey done by the American Dental Association and the Health Policy Institute.[50] Specifically, costs from the West North Central Division were used. This area includes Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota. Where information for a certain code or procedure was not available, the general practitioner and periodontist national averages were used.

[43] https://www.fda.gov/news-events/press-announcements/fda-approves-new-drug-treatment-chronic-weight-management-first-2014
[44] https://diabetesjournals.org/care/article/40/5/640/36827/Cost-effectiveness-of-the-2014-U-S-Preventive
[45] https://www.goodrx.com average retail price
[46] http://www.ndhealth.gov/phsp/documents/health_status_assessment_report_for_north_dakota.pdf
[47] https://diabetesjournals.org/care/article/40/5/640/36827/Cost-effectiveness-of-the-2014-U-S-Preventive
[48] https://www.fda.gov/news-events/press-announcements/fda-approves-new-drug-treatment-chronic-weight-management-first-2014
[49] https://www.nidcr.nih.gov/research/data-statistics/periodontal-disease/adults
[50] https://ebusiness.ada.org/Assets/docs/32418.pdf

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We assumed that services would only be utilized by adults aged 30 to 64 for severe periodontitis and those with dental insurance would use dental benefits rather than medical.

PET Scans

The Cancer Statistics Center estimates 600 new cases of prostate cancer per year in North Dakota, which is more than any other type of cancer.[51] The Prostate Cancer Foundation indicates 60% of prostate cancers are diagnosed in men over the age of 65.[52] According to medical providers we've interviewed, Medicare does include some coverage for PET scans. However, 290 cases of prostate cancer for the under 65 population still makes it among the most common cancer types. We estimate 33 new cases per year would be impacted by the proposed benefit.

Using the information described in the demand for this benefit we are able to determine the estimated new prostate cancer cases for those who would be covered by the EHB-BP changes. We use the Prostate Cancer Foundation to allocate these expected cases into age ranges[53] although we do not include any cases for under age 40.[54] We then perform a durational analysis using a 98% 5-year survival rate for people with prostate cancer[55] to determine the ultimate number of members who would be eligible for 2 PET scans per year if prescribed by their doctor, removing members when we estimate they would turn age 65 and be eligible for Medicare coverage.

While the medical professional we interviewed recommended 1 PET scan every six months for the life of the member, we expect lower utilization for those who have been cured or are in remission. Additionally, typical prostate screenings are much less expensive than PET scans.

The cost of a PET scan is variable, and we were not able to find a definitive answer even during our interviews with medical providers. Our research produces estimates from less than $2,000 to $12,000 per scan based on the type and if it covers the whole body. We used a cost of $5,750.[56]

[51] https://cancerstatisticscenter.cancer.org/#!/state/North%20Dakota
[52] https://www.pcf.org/about-prostate-cancer/what-is-prostate-cancer/prostate-cancer-survival-rates/#:~:text=By%20the%20Numbers%3A%20Diagnosis%20and%20Survival&text=Prostate%20cancer%20incidence%20increases%20with,for%20men%2070%20and%20older.
[53] Ibid.
[54] https://www.cancer.org/cancer/prostate-cancer/about/key-statistics.html
[55] https://www.cancer.net/cancer-types/prostate-cancer/statistics#:~:text=The%205%2Dyear%20survival%20rate%20for%20people%20with%20prostate%20cancer,the%20local%20or%20regional%20stage.
[56] https://www.newchoicehealth.com/pet-scan/cost

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According to our carrier survey, all carriers will cover PET scans when medically necessary, while the definition of medically necessary is unclear. We interpret this to mean one PET scan per new case and assume 50% of follow-up scans would be considered medically necessary.

We found two sources of cost savings for implementing this benefit.

- The first is the PET scans would replace the bone scans/CT scans that are currently used. According to our discussions with medical providers, bone scans/CT scans would not be required if 2 types of PET scans were used. We estimate $685 per CT scan and $180 per bone scan.[57]
- Second is a cost avoidance that comes from the effectiveness of the PET scans compared to conventional scans which is in the form of less complications from the cancer and less surgeries. We found two studies which show cost savings[58,59], when converted to US dollars we use a cost savings estimate of $977 per new case.

Opioid Benefits

The ND Board of Pharmacy indicated 70,417 member months in 2021 or about 5,900 patients with over 50 MME in opioids.

The ND Board of Pharmacy also indicated 28,220 scripts for Buprenorphine and equivalents in 2021. We estimate approximately 92% of these scripts were for generic Buprenorphine which we expect will not have prior authorization. However, there are still over 2,000 brand scripts that may have prior authorization requirements to help members avoid or get off opioids.

About 15% of those under the age of 65 would be covered by proposed changes to the EHB-BP.[60]

[57] https://www.newchoicehealth.com/places/north-dakota/bismarck/ct-scan#:~:text=A%20CT%20Scan%20in%20Bismarck,for%20a%20CT%20Angiography%20%2D%20Pelvis.
[58] https://www.cancernetwork.com/view/pet-scanning-worth-cost-cancer-not-only-worth-cost-sometimes-cost-cutter
[59] https://www.urotoday.com/video-lectures/journal-club/video/2245-the-cost-effectiveness-of-psma-pet-ct-when-compared-with-conventional-imaging-an-analysis-informed-by-the-propsma-trial-journal-club-christopher-wallis-zachary-klaassen.html
[60] 2021 SHCE covered lives in the individual and small group market compared to 2021 vintage population estimates in North Dakota.

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Intranasal Opioid

We began with the member months of patients receiving over 50 MME from the ND Board of Pharmacy. We then used the opioid prescription counts by age[61] to distribute these member months into age groups. Older age groups tend to use more prescriptions, we assume over age 65 would be covered by Medicare.

We do not expect that every eligible prescription would be filled. We assume 9% will fill the prescription based on a study of prescriptions made to new users,[62]who we believe would likely fill the prescription and considered twice that amount in other cases. We used a cost per script of $145.[63]

Some carriers already cover intranasal when prescribed, but do not influence provider prescribing patterns.

Removal of Prior Authorization for Buprenorphine and Equivalents

We started with the count of Buprenorphine scripts in 2021 provided by the ND Pharmacy Board, by type and categorized the scripts into generic and brand, which was approximately 92% generic. We then used the opioid prescription counts by age[64] to distribute these member months into age groups.

We assumed there would be shifting from the generic to brand Buprenorphine equivalents as a result of removing the prior authorization. For the brand, which we calculate as 8% of scripts, we assume an increase in utilization of 4% (50% of the 8% current usage) to 8% (100% of the 8% current usage) as a result of removing prior authorization. The brand drugs have a higher cost than generic. We estimate $367 per brand script versus $91 per generic script, so an increase in $276 per script.[65]

[61] https://www.hhs.nd.gov/health/opioid
[62] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2781924
[63] https://www.drugs.com/price-guide/narcan
[64] https://www.health.nd.gov/opioid
[65] https://www.drugs.com/

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Appendix B – NovaRest Estimate of Generosity Difference

Based on prior work done to select the current state EHB-BP, we believe the Federal Employee Health Benefits Plan (FEHBP) administered by Blue Cross Blue Shield of North Dakota remains the highest actuarial value plan among the 10 plans considered. The report entitled "Review and Evaluation of Proposed Changes to the North Dakota EHB Benchmark Plan Proposed EHB Cost Impacts" provides the complete description of the analysis which is described below. Please note the analysis performed in the "Review and Evaluation of Proposed Changes to the North Dakota EHB Benchmark Plan Proposed EHB Cost Impacts" report was done assuming a 75% actuarial value. The numbers were adjusted to a 100% actuarial value for the purposes of the Actuarial Report and Certification.

Benefits included in the FEHBP not included in the Current EHB-BP

In order to assess the impact on premium of potential new EHBs, we identified benefits included in the FEHBP that are not in the EHB-BP that would need to be adjusted out to have comparable sets of benefits. To develop claim estimates and percent of premium, each benefit was analyzed using either prior studies of mandated benefits or EHBs in other states, or we built cost estimates from first principles (using the basic assumption of cost per service and number of services per 1,000). The estimated impact of these benefit adjustments, at 75% actuarial value, is as follows:

- 0.63% of premium
- $3.11 Premium impact

The richest plan premium impact excludes routine adult dental services, which cannot be an EHB, and gender reassignment surgery which may be a required benefit due to new CMS discrimination guidance.

Covered Benefits in EHB-BP not Included in Richest Plan

In order to assess the impact on premium of potential new EHBs, we identified benefits included in the EHB-BP that are not in the FEHBP (richest) that would need to be adjusted out to have comparable sets of benefits. To develop claim estimates and percent of premium, each benefit was analyzed using either prior studies of mandated benefits or EHBs in other states, or we built cost estimates from first principles (using the basic assumption of cost per service and number of services per 1,000). The estimated benefit adjustments, at 75% actuarial value, are as follows:

- 0.14% of premium
- $0.69 premium impact

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Generosity Difference

When we consider the total value to the benefits in the FEHBP and not in the current EHB-BP we see that there is approximately $3.11 more benefit in the FEHBP. Then we have to consider the benefits in the EHB-BP that are not in the FEHBP of $0.69. The difference shows that the value of the FEHBP is $2.42 more PMPM than the current Benchmark plan, at 75% actuarial value. [66] The difference at 100% actuarial value, discussed by CMS as an acceptable methodology, is $3.22 PMPM.

[66] This does NOT include routine adult dental services and gender reassignment surgery. While covered under the FEHBP Plan and specifically excluded by the EHB-BP, our interpretation of the federal rules indicate they cannot be considered as a difference in value.

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