



Michigan's Essential Health Benefits Benchmark Plan:
Executive Report

September 25, 2012

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Executive Summary

The Michigan Office of Financial and Insurance Regulation (OFIR) presents this Executive Report on Michigan's Essential Health Benefits Benchmark Plan. This report contains a summary of the essential health benefits requirements as well as OFIR's recommendations to the Governor regarding the selection and supplementation of an essential health benefits benchmark plan.

In making its recommendation, OFIR engaged the services of an actuarial consulting group to perform a benefits and cost analysis of the benchmark plan choices. OFIR also performed its own internal analysis of the benchmark plan candidates. OFIR's benchmark plan recommendation reflects the need to provide Michigan consumers with a benchmark plan that offers a wide range of medical, surgical, mental health, and other benefits while maintaining affordable rates.

OFIR recommends that the Priority Health HMO plan be selected as Michigan's benchmark plan. This plan is the lowest-cost benchmark plan option, which will provide an excellent framework for all individual and small group plans offered in Michigan after January 1, 2014. In addition, OFIR recommends that the FEDVIP pediatric vision plan and the MICHild dental plan be selected to supplement the Priority Health HMO benchmark plan.

Next: Overview of Essential Health Benefits →

Overview of Essential Health Benefits

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (ACA) was enacted on March 23, 2010.¹ Among other things, the ACA requires that all non-grandfathered² health insurance plans offered in the small group and individual markets³, both on and off the Exchange, provide benefits in ten required categories by January 1, 2014.⁴ These “Essential Health Benefits” (EHBs) are to be offered without annual or lifetime limits, although issuers are permitted to impose scope and duration limits.

The ten EHB categories are:

- ambulatory patient services,
- emergency services,
- hospitalization,
- maternity and newborn care,
- mental health and substance use disorder services (including behavioral health treatment),
- prescription drugs,
- rehabilitative and habilitative services and devices,
- laboratory services,
- preventive and wellness services and chronic disease management, and
- pediatric services (including oral and vision care).⁵

Each State is required to select an EHB “benchmark plan”: a plan that will serve as a reference plan, reflecting both the scope of services and any limits offered by a “typical employer plan” in the State as required by section 1302(b)(2)(A) of the ACA. Under the approach set forth by the United States Department of Health and Human Services (HHS), beginning on January 1, 2014, any small group or individual market plan offered in the State must be “substantially equivalent” to the benchmark plan in both the scope of benefits offered and any limitations on those benefits, such as visit or duration limits.

¹ The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152).

² A grandfathered plan is one that was in existence on March 23, 2010. A plan will lose its grandfathered plan status if it directly or indirectly reduces benefits or increases costs to participants. In order to retain its grandfathered plan status, a plan must include a statement in any materials provided to participants that describes the benefits provided under the plan and states that the plan “believes” that it is a grandfathered plan under the new rules. The plan must also maintain records documenting the terms of the plan that were in effect on March 23, 2010, and any other documents necessary to verify, explain or clarify its status as a grandfathered plan. 75 Fed. Reg. 34538 (June 17, 2010).

³ Grandfathered plans, large group plans, and self-insured employer plans are not required to offer EHBs, although many large group plans already offer services in most, if not all, EHB categories. However, if any of these types of plans offer EHBs, they are prohibited from applying annual or lifetime dollar limits to those benefits.

⁴ ACA § 1302(b)(1)-(2).

⁵ ACA § 1302(b)(1)(A)-(J).

Benchmark plans will be used to establish EHBs for benefit years beginning in 2014 and 2015. HHS will reassess the benchmark plan selection process for benefit years 2016 and beyond.⁶

The ACA requires HHS to define the EHBs within each of the ten categories.⁷ As part of this effort, HHS commissioned a study by the United States Department of Labor, which was issued in April 2011 and analyzed certain benefits.⁸ In addition, the Institute of Medicine issued a report in October 2011 that suggested criteria and methods for defining EHB plan offerings.⁹ HHS is expected to issue additional guidance that will further define the EHBs, although the guidance is not expected until late 2012, after states have selected their EHB benchmark plans. Among the factors HHS must take into account when defining the EHBs are:

- an appropriate balance among benefit categories;
- a prohibition against coverage decisions, reimbursement rates, or incentive programs in ways that discriminate against individuals because of their age, disability, or expected length of life;
- the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;
- prohibitions on coverage denials based on age, expected length of life, present or predicted disability, degree of medical dependency, or quality of life.¹⁰

Formal guidance from HHS regarding specific EHB definitions will not be available in advance of the September 30, 2012 deadline for States to choose a benchmark plan.

Next: Selecting a Benchmark Plan →

⁶ [Center for Consumer Information and Insurance Oversight, "Essential Health Benefits Bulletin," \(Dec. 16, 2011\)](#) ("Bulletin"), p. 2-3; FAQs, #2 and #4.

⁷ ACA § 1302(b)(1), (2).

⁸ <http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf>.

⁹ "Essential Health Benefits: Balancing Coverage and Cost." Accessed at <http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx> (last accessed on August 19, 2012).

¹⁰ ACA § 1302(b)(4)(A)-(G).

Selecting a Benchmark Plan

On December 16, 2011, the Center for Consumer Information and Insurance Oversight, a division of HHS, issued a [Bulletin](#) that provided further detail regarding how States should define EHB and select benchmark plans.¹¹ According to the Bulletin, HHS permits each State to select its EHB benchmark plan from among the following ten options:

- the largest plan in any of the three largest small group products in the State by enrollment;
- the three largest State employee health plans by enrollment;
- the three largest federal government employee options by enrollment; and
- the largest HMO plan offered in the State's commercial market by enrollment.

This approach is similar to that used in the selection of Children's Health Insurance Program (CHIP) plans and, in some states, the Medicaid program. States are required to make their benchmark plan selection in the third quarter of 2012.¹² For States that do not make a selection, HHS will designate the small group plan with the largest enrollment as the benchmark.

A state must take its chosen benchmark plan "as is." In other words, all of the benchmark plan's covered services, quantitative¹³ limitations, and exclusions become the benchmark for all individual and small group health plans offered both inside and outside of the Exchange.¹⁴ Other than supplemental services added pursuant to HHS regulations (see below), any additions to services within EHB categories not already included in the benchmark plan will not be eligible for federally funded tax credits or cost-sharing reductions related to those benefits.

However, it should be noted that the benchmark plan is a "floor," and does not prohibit carriers from adding benefits or altering certain benefit limitations. Plans may cover additional benefits beyond the EHB package as long as two rules are followed: if a plan covers abortion services, the issuer must collect separate premium checks for that coverage and cannot use any premium tax credits or other federal funding for those services. In addition, if a plan is required under state law to cover services beyond the EHBs, the state must pay any additional tax credits or cost-sharing reductions related to those benefits. In summary, a State's benchmark plan selection does not narrow consumers' choices. Instead, the EHB benchmark ensures that all consumers receive an array of health services.

¹¹ Frequently asked questions regarding the December 16, 2011 Bulletin were issued on February 17, 2012 (FAQs). See "[Frequently Asked Questions on Essential Health Benefits Bulletin](#)," [Centers for Medicare and Medicaid Services \(Feb. 17, 2012\)](#).

¹² While HHS has not formally imposed a specific deadline, States have interpreted this guidance to mean that a selection must be made by September 30, 2012.

¹³ Non-quantitative limitations (e.g., pre-authorizations, medical case management) are not part of the benchmark plan. 77 Fed. Reg. 42658, 42660 (July 20, 2012).

¹⁴ Bulletin, p. 12.

Supplementing the Benchmark Plan

Missing or Deficient Categories and Benefits

If a selected benchmark plan does not contain all ten categories of EHBs, the State is required to supplement the benchmark by “borrowing” missing benefits from one or more of the other benchmark plan options.¹⁵ An exception to this rule is that a plan may elect not to offer pediatric oral services if a standalone dental plan that covers those services as defined by EHB is offered through the same Exchange.¹⁶

If a State selects a state plan (rather than a federal plan), that State may supplement any missing categories using benefits from any other benchmark option. If a state has a “default” federal benchmark, then supplemental benefits other than pediatric dental/vision and habilitative services will be determined by looking first to the second-largest small group market benchmark plan, and then to the third-largest such plan. If none of the small group market plans offer the missing benefits, then supplemental benefits will be drawn from the Federal Employees Health Benefit Plan (FEHBP) benchmark plan with the largest enrollment.

HHS has indicated that, once a State chooses a benchmark plan, it may permit insurers to modify or make substitutions of the benefits offered by the benchmark as long as the modification or substitution is actuarially equivalent and consistent with state and federal law. Substitutions across benefit categories are apparently contemplated by the ACA, but HHS has not yet issued guidance on how such substitutions may be achieved. Furthermore, Michigan has not yet determined whether carriers will be permitted to make actuarially equivalent substitutions.

State Mandated Coverages

HHS required States to evaluate their benchmark plan candidates based on the benefits offered by those plans at the end of the first quarter of 2012 (i.e., March 31, 2012). However, any State-mandated benefits enacted on or after January 1, 2012 (e.g., Michigan's autism mandate) are not permitted to be part of EHB for 2014 or 2015, unless those benefits are already included in the benchmark plan regardless of the mandate. HHS has indicated that it may issue guidance in the future that would allow States to choose new benchmark plans after calendar years 2014 and 2015 and that any introduction, repeal or modification of the State mandates would be reflected in future construction of the EHB.

Current federal guidance indicates that, if a State chooses a benchmark plan that does not include all State-mandated benefits, the State is required to defray the cost of any mandated benefits in excess of EHB by funding any premium tax credits or cost-sharing reductions related to those benefits. However, this was not a factor in Michigan's benchmark plan selection process because all ten benchmark plan candidates covered all Michigan-mandated benefits that were enacted prior to January 1, 2012.

¹⁵ Bulletin, p. 12.

¹⁶ Bulletin, p. 10.

Pediatric Vision and Dental Benefits

In the Bulletin and subsequent FAQ, HHS noted that most benchmark plan candidates would not cover pediatric dental and vision services. HHS guidance provides options to States regarding supplementing benchmark options for these services. Plans that do not already include coverage for pediatric vision services must be supplemented with benefits from the FEDVIP vision plan with the largest enrollment. According to federal guidance, the only option to supplement vision benefits is the FEDVIP Vision plan with the highest national enrollment, the FEDVIP Blue Vision High plan. Benefits included in this plan include eye exams, lenses, frames, and contact lenses, subject to certain frequency and maximum benefit limitations.

Similarly, the State must supplement pediatric dental benefits from either the (FEDVIP) dental plan with the largest enrollment, or Michigan's CHIP program (MICHild). In the Bulletin, HHS noted that they intended to propose that the EHB definition would not include non-medically necessary orthodontic benefits.

Habilitative Services

Like pediatric dental and vision services, habilitative services are not typically covered by benchmark plan candidates. "Habilitative services" or "habilitation" are generally defined as services that focus on learning new skills or functions, as distinguished from rehabilitative services, which focus on relearning existing skills or functions. The NAIC defines habilitation as "health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings."¹⁷ HHS recognized in the Bulletin that most benchmark plan options were not likely to cover habilitative services, but also noted that it was possible that some "habilitative" services were currently classified as "rehabilitative" services (e.g., forms of occupational, physical, and speech therapy).

HHS is considering two possible options for plans to supplement benchmark plans so that they cover habilitative services:

- A carrier would be required to offer the same services for habilitative needs as it offers for rehabilitative needs and offer them at parity.
- A carrier would decide which habilitative services to cover and report the coverage to HHS; then HHS would evaluate and further define habilitative services in the future.¹⁸

Under either approach, what constitutes "habilitative services" will be determined by the plan, not by HHS or the State. In any case, a plan would be required to offer at least some habilitative benefits. It is not anticipated that HHS will issue further guidance on habilitative services before the benchmark plan selection deadline of September 30, 2012.

¹⁷ 76 Fed. Reg. 52529 (Aug. 22, 2011).

¹⁸ Bulletin, p. 11.

Mental Health Parity

All benchmark plan candidates offer some degree of mental health, behavioral health, and substance abuse services, as mandated by Michigan law. Some of the benchmark plan candidates impose limitations on these services. However, all benchmark plans must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA). The ACA expanded the MHPAEA by extending it to: qualified health plans as established by the ACA; Medicaid non-managed care benchmark and benchmark-equivalent plans; and plans offered through the individual market. Under the MHPAEA, cost-sharing (e.g., deductibles and copayments) and treatment limitations (e.g., visit or day limits) applicable to mental health or substance use disorder benefits can be no more restrictive than the cost-sharing and treatment limitations applicable to medical and surgical benefits covered by the plan. In addition, the plan or coverage cannot impose separate cost-sharing requirements or treatment limitations that apply only with respect to mental health, behavioral health, or substance use disorder benefits.

Accordingly, if a State selects a benchmark plan that offers mental health and substance abuse benefits at parity with medical-surgical benefits, those services will apply to all small group and individual plans required to offer EHB on and off the Exchange. If a State chooses a plan that does not comply with the MHPAEA, it will be required to modify the benchmark plan so that its coverage for mental health, behavioral health, and substance abuse services complies with the MHPAEA as expanded by the ACA.

Other Required Benefits and Services

The ACA requires certain benefits to be included as part of the EHB for all plans:

- women's wellness benefits;¹⁹
- current U.S. Preventive Services Task Force Recommendations (categories A and B);²⁰
- benefits included in the Bright Futures/American Academy of Pediatrics guidelines;²¹
- habilitative services;²²
- pediatric oral and vision services;²³ and
- mental health parity requirements as set forth in the MHPAEA.²⁴

Because the ACA requires all plans to offer these benefits, States will not incur any costs as a result of supplementing the benchmark plan to include them.

Next: Michigan's Benchmark Plan Options →

¹⁹ ACA § 1302(b)(1)(I); 45 CFR 147.130(a)(1)(iv).

²⁰ ACA § 1302(b)(1)(I); 45 CFR 147.130(a)(1)(i). The recommendations currently in force are dated August 2010.

²¹ ACA § 1302(b)(1)(I); 45 CFR 147.130(a)(1)(iii).

²² ACA § 1302(b)(1)(G).

²³ ACA § 1302(b)(1)(J).

²⁴ Bulletin, p. 12.

Michigan's Benchmark Plan Options

Selection Process

In order to identify the largest small group plans by enrollment, the largest state employee plan, and the largest insured commercial non-Medicaid HMO, OFIR obtained enrollment data from carriers for the first quarter two years prior to the coverage year (i.e., the first quarter of 2012). To facilitate states' selection of a benchmark plan option, HHS provided a list of the largest three small group products in each State. The list was based on enrollment data as of March 31, 2012, and was collected via the Health Insurance Oversight System (HIOS). OFIR and HHS identified the same plans as the "largest small group plans by enrollment."²⁵

OFIR then identified which plans had the largest enrollments. OFIR's ten benchmark plan candidates are:

- The largest plan in any of the three largest small group products in the State by enrollment: *BCBSM Community Blue PPO Plan 4; Priority Health HMO; and BCN 10 HMO.*
- The three largest State employee health plans by enrollment: *BCBSM (self-insured); PHP (HMO); Priority Health (HMO).*
- The three largest FEHBP options by enrollment: *FEHBP BCBS Standard Option; FEHBP BCBS Basic Option; FEHB GEHA Standard Option.*
- The largest HMO plan offered in the State's commercial market by enrollment: *Priority Health (HMO).*

OFIR then obtained plan documents for each of the ten benchmark candidates. OFIR staff reviewed the plan documents for each of these plans and distilled the information into a chart that allowed for a comparison of benefits and any scope or duration limitations. The chart does not include information on provider networks, formulary restrictions, or cost-sharing, because those aspects are not part of the EHB definition.²⁶

OFIR provided advance copies of the charts to the carriers whose plans were listed in the chart. These carriers provided comments and additional information, which were incorporated into the final version of the chart.

²⁵ See CCIIO, "[Essential Health Benefits: List of the Largest Three Small Group Products By State,](#)" (July 3, 2012).

²⁶ Cost-sharing differences are not part of the initial EHB benchmark plan selection. For plan years beginning in 2014, cost-sharing for self-only and family coverage may not exceed the amount established under section 223(c)(2)(A)(ii) of the Internal Revenue Code, which is the cost-sharing limit for high-deductible health plans. For 2014, that amount is limited to \$5,950 for an individual and \$11,900 for a family. Cost-sharing is defined to include deductibles, coinsurance, copayments or similar charges and any other expenditure required of an insured individual (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986) with respect to covered essential health benefits. In the case of deductibles, the law provides that plans sold after January 1, 2014 in the small group market and subject to essential benefit requirements may not impose deductibles that exceed \$2,000 for a single individuals or \$4,000 for families.

The final version of the chart was posted on OFIR's website for public comment on May 24, 2012. From May 24, 2012 through June 29, 2012, OFIR accepted public comments on the EHB chart through a dedicated email address posted on OFIR's website. In addition to the chart, OFIR also provided a slide presentation that explained EHBs and the benchmark plan selection process.

Finally, OFIR engaged the services of Wakely Consulting Group to assist in the analysis of Michigan's benchmark plan options. Wakely reviewed all plan documents and provided an analysis and report (Wakely Report), which is attached as Appendix C. The contents of the Wakely Report are discussed at length below.

Responses to Public Comment

OFIR received approximately 70 comments from Michigan citizens and organizations. OFIR staff reviewed each comment. A summary of the comments is provided below. In response to comments seeking heightened transparency of the selection process, OFIR will also accept public comments on this Executive Report from September 5, 2012 through September 19, 2012. These comments were analyzed and considered in the same manner as the first round of comments, and responses to second-round comments have been included in the final version of this report as Appendix A.

In response to several comments, it is important to emphasize that the ACA confines states' benchmark choices to the ten plans described above. States are not permitted to align or otherwise conform the selected benchmark plan to other plans or structures (e.g., the Adult Benefits Waiver program, Prepaid Inpatient Health Plans, Medicare, Medicaid). Accordingly, to the extent any commenters sought ***expansion or alignment of the benchmark plan choices***, Michigan is not permitted to vary the array of benchmark choices.

Some commenters expressed concern regarding ***medical management or utilization practices*** (e.g., prior authorization, provider limitations, formulary requirements). As noted above, non-quantitative benefit limitations are not considered to be part of the EHB; in other words, States are not authorized to consider any factor other than scope of benefits when choosing a benchmark plan. As a result, OFIR did not collect data on, and thus did not consider, cost-sharing, provider network, or utilization management components of the benchmark plan candidates. EHB determinations relate to a standard set of services that must be covered without regard to cost-sharing. OFIR notes, however, that the ACA regulates cost-sharing requirements separately, including limits on deductibles and coverage mandates.²⁷ The ACA prohibits HHS from limiting carriers' ability to impose "utilization management techniques" that were in effect as of the date of enactment of the ACA.²⁸ However, it should be noted that existing utilization management techniques will be subject to benefit design discrimination review by OFIR through the existing form review process.

²⁷ ACA § 1302(a).

²⁸ ACA § 1565(d).

The ACA does permit benchmark plans to include **scope and duration limits** (i.e., quantitative limits) on EHBs. Accordingly, OFIR considered the existence of these types of limits in its selection of a benchmark plan. However, the existence (or absence) of a scope or duration limit for a certain benefit does not necessarily mean that the benefit will be covered without limitations. Certain benefits may be subject to, for instance, medical-necessity determinations.

Many commenters expressed concern regarding coverage for **autism spectrum disorder** treatments. All ten benchmark plan candidates provide coverage for mental and behavioral health services, and coverage for habilitative services is required under EHB. Current federal guidance indicates that habilitative services may be required to be offered at parity with rehabilitative services. Therefore, it is possible that mental and behavioral health services would be available as treatment for autism spectrum disorders, to the extent that such services qualify as "habilitative" in nature. However, none of the benchmark plan candidates provide coverage for applied behavioral analysis (ABA) for autism. It is possible that, in future guidance, HHS will specifically require treatment for autism spectrum disorders, including ABA, be covered under the "habilitative services" or "mental and behavioral health services" EHB categories.

Michigan's autism mandate, which requires coverage for several forms of autism treatment including ABA, takes effect on October 15, 2012. Per HHS guidance, the mandate could not be considered in evaluating benchmark plan candidates because they were evaluated based on the benefits offered at the end of the first quarter of 2012 (i.e., March 31, 2012). Therefore, Michigan was not permitted to apply the mandate to the benchmark plans and was not permitted to consider it in the benchmark plan selection process. However, HHS has indicated that it will revisit the benchmark plan selection process for benefit years 2016 and beyond, so it is possible that any mandates that have taken effect since January 1, 2012, including the autism mandate, will be included in future EHB benchmark determinations. In addition, if HHS issues subsequent guidance that categorizes ABA as an "essential health benefit," then all plans in Michigan, regardless of whether they are offered on the Exchange or off-Exchange, will be required to cover ABA for autism.

Many commenters expressed a desire to include coverage for **specific services** in the benchmark plan (e.g., respite care, access to community-based services, wraparound care). While OFIR recognizes the importance of such services to Michigan residents, it is important to note that HHS does not permit states to add benefits to a selected benchmark plan, beyond what must be added to supplement a benchmark plan to ensure all ten EHB categories are represented. As noted above, benchmark plans are considered a "floor," and while carriers are permitted to add specific benefits to their version of the benchmark plan (via riders or otherwise), states are not permitted to do so.²⁹ Accordingly, unless the benchmark plan already includes a certain benefit, the benefit cannot be supplemented by the state.

²⁹ Bulletin, p. 2.

Some commenters asked that services currently categorized as “Ambulatory Services” be re-categorized as “Post-Acute Care Services.” States are not permitted to re-name or otherwise alter the *EHB categories* established by HHS.

Several commenters inquired about *prescription drug coverage*. The Bulletin indicated that HHS intends to duplicate the flexibility of Medicare Part D with respect to the EHB standard for prescription drug coverage, in which plans must cover the categories and classes of drugs set forth in the benchmark but may choose specific drugs within those classes and categories.³⁰ The Bulletin also noted that HHS does not intend to require the protected classes the Secretary has identified under Medicare Part D.³¹ However, HHS has not yet established final guidance on this issue.

Many commenters expressed concern about the potential for *benefit discrimination*. OFIR notes that, under the ACA, any scope and duration limitations contained in a plan would be subject to review pursuant to statutory prohibitions on discrimination in benefit design. As noted above, OFIR's existing form review process will serve as an additional check against discrimination in benefit design. Similarly, a number of commenters inquired as to whether prescription drug coverage in the benchmark plan would be subject to formulary restrictions. Guidance is forthcoming from HHS on a drug class list for prescription drug coverage, so Michigan is unable to comment on the approach to this issue.

Some commenters urged against including any of the benefits categorized as “*Miscellaneous Benefits*” on the EHB chart because including these benefits would increase the cost of coverage for Michigan residents. As is the case with supplementation of benefits, states are not permitted to “subtract” benefits from the selected benchmark plan. As a result, any benefits that are currently part of the selected benchmark plan will automatically become part of the benchmark.

One commenter requested that the selected benchmark plan include affordable access to *contraception*. Under the ACA, prescription contraceptives³² are part of the suite of women's preventive health care services that must be provided without deductibles or co-pays in all new policies beginning August 1, 2012. Certain nonprofit religious employers are exempt from this requirement.³³

³⁰ Bulletin, p. 12-13.

³¹ Bulletin, p. 13, n. 34.

³² “Prescription contraceptives” includes all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, by prescription. See Health Resources and Services Administration Guidelines at <http://www.hrsa.gov/womensguidelines/> (accessed Aug. 28, 2012).

³³ Group health plans sponsored by certain religious employers, and group health insurance coverage in connection with such plans, are exempt from the requirement to cover contraceptive services. A religious employer is one that: (1) has the inculcation of religious values as its purpose; (2) primarily employs persons who share its religious tenets; (3) primarily serves persons who share its religious tenets; and (4) is a non-profit organization under Internal Revenue Code section

One commenter indicated concern that all patients should have the right to an **independent third-party review** of claim denials. Under the ACA and Michigan law³⁴, patients have the right to appeal coverage decisions. These laws set forth requirements for how insurance companies handle initial appeals and how consumers can request a reconsideration of a decision to deny payment for services. If an insurer upholds its decision to deny payment, the ACA provides consumers with the right to appeal the decisions to an outside, independent decision-maker, regardless of the type of insurance or State of residence of the insured. OFIR will continue to administer Michigan's independent third-party review program in a manner that is consistent with Michigan law and these ACA requirements.

One commenter inquired whether a selected benchmark plan would include any **riders**. According to recent guidance issued by HHS, riders can be considered part of the benchmark plan if they are part of the most popular benefit combination in the product.³⁵ In other words, the benchmark plan consists of the plan plus the combination of riders that is most commonly purchased. As described below, OFIR's recommended plan included only one such rider: a prescription drug rider. In response to public comment, OFIR has attached the prescription drug rider to the certificate of coverage for the recommended plan.

Several commenters urged that Michigan choose its own benchmark plan rather than "**default**" to the largest small employer plan, as outlined above. As described below, Michigan's benchmark plan selection took into account numerous factors, including the impact of premium increases on Michigan consumers. There was minimal difference in benefits and costs between the "default" plan and the recommended benchmark plan.

Finally, numerous commenters requested heightened **transparency** and opportunities for additional public input. Accordingly, this report is being released for public comment on September 5, 2012. Public comments were accepted through September 19, 2012. Comments were summarized in this final version of this Executive Report (see Appendix A).

Next: Comparing Michigan's Benchmark Plans →

6033(a)(1) and section 6033(a)(3)(A)(i) or (iii). 45 C.F.R. §147.130(a)(1)(iv)(B). See [Federal Register Notice: Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 46621 \(Aug. 3, 2011\)](#).

³⁴ See Michigan's [Patient's Right to Independent Review Act, MCL 550.1901 et seq.](#)

³⁵ See [Final Rule, Patient Protection and Affordable Care Act; Data Collection To Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans, 77 Fed. Reg. 42658 \(July 20, 2012\)](#).

Comparing Michigan's Benchmark Plans

As described above, OFIR compared the benefits covered by each of the ten benchmark plan options. Subsequently, Wakely gathered more data in order to provide cost comparisons across the plans, including cost data on dental and vision benefits.

Cost Comparison

Each State's selection of an EHB plan will inevitably result in some increase in premium rates because individual and small group plans will be required to meet EHB requirements, thereby ensuring a richer array of benefits. The Wakely Report contains a detailed analysis of the premium impact of each benchmark plan option.

In assessing the impact on premiums, Wakely estimated a per member per month (PMPM) premium impact, projected for 2014, for each benefit coverage that was not the same for all ten benchmark options.³⁶ Benefit differences related to habilitative services, pediatric oral, and pediatric vision were not included because those benefits will need to be supplemented regardless of which plan is chosen.³⁷ Accordingly, Wakely provided a separate section detailing the premium impact of these supplemental services.³⁸ Benefit costs were analyzed using industry data and principles of actuarial judgment, and were adjusted to be specific to Michigan.³⁹

The PMPM premium impacts do not represent the total cost to all health care consumers. Instead, they denote the costs relative to all other benchmark plans. While differences in specific benefits are obviously an important component of the cost analysis, the focus of the Wakely Report was on the relative richness of the entire benchmark plan option.⁴⁰

Importantly, Wakely's analysis of premium impacts assumed no cost-sharing.⁴¹ As a result, the premium impact for a silver plan on the Exchange would be approximately 70% of the premium impact given, because silver plans must meet an approximately 70% actuarial value standard. Likewise, a gold plan would result in approximately 80% of the premium impact given.

In assessing the cost impact of benefit limits, monetary benefit limitations (e.g., annual limits for specific benefits) were converted to visit/day/unit limitations based on estimated costs per visit/day/unit.⁴²

³⁶ Wakely Report, p. 9.

³⁷ *Id.*, p. 8.

³⁸ See *id.*, pp. 14-18.

³⁹ *Id.*, p. 8.

⁴⁰ See *id.*, p. 10.

⁴¹ Wakely Report, p. 9.

⁴² *Id.*

Finally, the Wakely Report does not address the premium impact of habilitative services, because this will be a plan-determined benefit that could result in a wide range of benefits in premium impacts.⁴³

The Wakely Report indicates that the lowest-cost benchmark plan option is the Priority Health HMO plan.⁴⁴ The next-lowest cost plan was BCBSM's Community Blue PPO Plan 4, to which Wakely assigned a \$2.00-\$2.50 PMPM premium impact over the Priority Health HMO. The highest-cost plan was the FEHBP BCBS Basic Option, which would result in a \$14.50-\$18.25 PMPM premium impact (due in part to its inclusion of an adult dental benefit, which was not included in the Michigan benchmark plan candidates).⁴⁵

Next: OFIR Recommendations →

⁴³ *Id.*, p. 19.

⁴⁴ The Priority Health HMO plan is listed twice because it fell into two of the benchmark plan candidate categories: largest commercial HMO and largest small group plan.

⁴⁵ Wakely Report, p. 11.

OFIR Recommendations***Note on the Default Option***

In reviewing the benefits and cost analysis, there are a few clear indications for choosing the lowest-cost plan (Priority Health HMO) over the default plan (BCBSM Community Blue PPO). Both plans cover many of the same basic services, although there are some variations in covered services, including visit limitations for hospice and skilled nursing facility care; coverage for infertility treatments, coverage for genetic testing, and coverage for weight management programs for morbid obesity. According to the Wakely Report, choosing the default plan would result in slightly higher costs over the lowest-cost plan: approximately \$2.00-\$2.50 per member per month in increased premium costs.

A potential advantage to choosing a plan rather than deferring to the default option is that Michigan would retain the ability to supplement the selected plan, including the ability to choose the MICHild dental program instead of the FEDVIP program for pediatric dental benefits. This result could be avoided by actively choosing the default plan rather than permitting the federal government to choose it.

On the other hand, because this benchmark plan will only be in effect for two years, Michigan will have the option to choose and supplement a benchmark plan in 2016 and beyond. In addition, because the default plan—by definition—already covers the largest portion of the small group market, choosing it over the lower-cost plan could result in the least disruption to the small group market.

Pediatric Vision Benefits Recommendation

As noted above, benchmark plans that do not already include coverage for pediatric vision services must be supplemented with benefits from the FEDVIP vision plan with the largest enrollment. According to federal guidance, the only option to supplement vision benefits is the FEDVIP Vision plan with the highest national enrollment, the FEDVIP Blue Vision High plan. Accordingly, OFIR recommends the selection of this plan to supplement the benchmark plan.

Pediatric Dental Benefits Recommendation

OFIR recommends that the pediatric dental benefits category be supplemented using benefits from the MICHild dental program. This program is comprehensive and has a proven record of meeting the pediatric dental needs of Michigan children. It is also the lowest-cost pediatric dental plan supplement option, at a \$4.00-5.25 PMPM premium impact.

Benchmark Plan Recommendation

OFIR recommends that the Priority Health HMO plan be selected as Michigan's benchmark plan for coverage years 2014 and 2015. It is OFIR's opinion that this plan helps mitigate the rate increases that will result from the implementation of the EHB requirement; minimizes the impact of the EHB on consumers; and provides a wide array of benefits in the EHB categories.

OFIR adhered to certain guidelines in developing a benchmark plan recommendation; namely, that the recommended plan should:

- After supplementation, include all ten categories of EHBs;
- Include coverage for all Michigan-mandated services;
- Minimize the impact of increased rates on consumers;
- Provide comprehensive coverage while maintaining affordability.

In addition, OFIR took into consideration the following:

- Consumer and other stakeholder input;
- Potential costs associated with defraying the cost of State-mandated coverage not included in the selected benchmark plan;
- Scope and duration limitations for covered benefits;
- Consumer demand for particular plans;
- Ease of administration of the selected benchmark plan.

Several important findings resulted from OFIR's and Wakely's analysis of the ten benchmark plan candidates:

- Covered benefits are largely consistent across the benchmark plan options.
- None of the benchmark plan candidates provide services in all ten EHB categories. As described above, most plans require supplementation in pediatric dental and vision care and habilitative services.
- Variations in particular covered services included, but were not limited to, number of rehabilitation visits, covered days of skilled nursing facilities, and fertility drugs.
- Some benchmark plan candidates did not include mental health benefits at parity with medical/surgical benefits. However, because the ACA requires all plans to comply with federal mental health parity laws, lack of parity was not considered.
- All plans (including the FEHBP plans) included all Michigan-mandated services.

It should be noted that the implementation of the ACA's EHB requirements will result in some rate increases for all consumers nationwide. In developing the benchmark recommendation, OFIR focused on achieving a balance between ensuring that all EHB requirements were met and mitigating rate increases for Michigan consumers. OFIR believes that the selection of Priority Health's HMO plan achieves the best balance between comprehensiveness and cost-effectiveness for Michigan consumers.

* * *

This Executive Report is based on informal guidance issued by HHS, including the Bulletin, FAQs, federal data collection requirements for EHB, and teleconferences with the Center for Consumer Information and Insurance Oversight. HHS has not yet issued formal regulations on Essential Health Benefits. Key items yet to be determined include prescription drug formulary requirements and definitions of EHB categories, notably habilitative services. OFIR does not expect the issuance of formal EHB regulations to alter its benchmark recommendation. However, any future regulations may result in higher or lower estimates than those referenced in this Executive Report and the Wakely Report.

Appendix A
State of Michigan
Essential Health Benefits
Response to Second Round of Public Comments

Responses to Second Round of Public Comment

In response to comments seeking heightened transparency of the selection process, OFIR established a second period for accepting public comments on this Executive Report, from September 5, 2012 through September 19, 2012. OFIR received approximately 28 comments from Michigan citizens and organizations, and OFIR staff reviewed each comment.

Many commenters expressed concern about the recommended plan's compliance with the federal **Mental Health Parity and Addiction Equity Act (MHPAEA)**. As described on page 7 of the report (above), if a State chooses a plan that does not comply with the MHPAEA, the plan must be modified so that its coverage for mental health, behavioral health, and substance abuse services complies with the MHPAEA as expanded by the ACA. As several commenters noted, many of the benchmark plan candidates would not meet federal parity requirements. This is likely so because they are small group plans and small group plans are not required to comply with federal parity laws until January 1, 2014.

Unfortunately, as is the case with many aspects of the essential health benefits benchmark selection process, HHS has not provided any guidance as to how mental health parity compliance will be accomplished. States have been informed only that all benchmark plans must comply with federal parity law. Accordingly, until federal guidance is issued, OFIR will continue to review each plan submitted for purchase on the Exchange for compliance with all applicable state and federal laws, including the MHPAEA. OFIR will utilize the most current guidance for ensuring compliance with the MHPAEA: the Interim Final Rules implementing the MHPAEA, issued on February 2, 2010.⁴⁶

Several commenters noted the ambiguity surrounding **prescription drug benefits** under the recommended benchmark plan. Unfortunately, as with mental health parity, this is an area where States must await further guidance from HHS before offering definitive advice. The EHB Bulletin notes that:

[I]n a State where the default benchmark is in place but that default plan did not offer prescription drug benefits, the benchmark would be supplemented using the prescription drug benefits offered in the largest small group benchmark plan option with coverage for prescription drugs. If none of the three small group market benchmark options offer prescription drug benefits, that category would be based on the largest plan offering prescription drug benefits in FEHBP.⁴⁷

As several commenters pointed out, prescription drug benefits for the Priority HMO plan are available only via a rider. This rider has been obtained from Priority Health, and is appended to the plan's certificate of coverage, which can be linked to via the chart posted as Exhibit 1

⁴⁶ 75 Fed. Reg. 5410 (Feb. 2, 2010).

⁴⁷ EHB Bulletin, p. 10.

("Michigan Essential Health Benefits Comparison"). Where other plans provided prescription drug coverage via a rider, those riders have also been appended to their plan documents.

Additionally, please note that OFIR will continue to enforce the statutory requirement that insurers must provide for exceptions from the formulary limitation when a nonformulary alternative is a medically necessary and appropriate alternative.⁴⁸

One commenter requested that OFIR recognize certain health providers and health centers as **qualified providers and qualified provider sites**. Provider networks and sites are not part of the EHB plan selection process, and OFIR has no authority to recognize any specific providers or sites.

Some commenters raised the question of **non-quantitative benefit limitations**, such as medical necessity determinations and pre-authorization requirements. As described above, States are not authorized to consider any factor other than scope of benefits when choosing a benchmark plan. In addition, States await further guidance from HHS on medical necessity and other non-quantitative standards and their application in EHB benchmark plans. Accordingly, this information was not taken into account during the recommendation process.

One commenter asked whether the **day limit on hospice care** in the recommended benchmark plan violated anti-discrimination requirements in the ACA based on health status. OFIR notes that the ACA's anti-discrimination provision applies only to Secretary of HHS, and prohibits the Secretary, in defining the EHB, from "mak[ing] coverage decisions, determin[ing] reimbursement rates, establish[ing] incentive programs, or design[ing] benefits in ways that discriminate against individuals because of their age, disability, or expected length of life."⁴⁹ Because HHS has not yet issued specific guidance on what specific benefits are "essential health benefits," OFIR cannot offer any guidance as to whether day limits on hospice care would violate this provision.

Several commenters requested that Michigan's benchmark plan include **adult dental benefits**. The only benchmark candidates that include adult dental coverage are the three FEHBP plans. As the Wakely Report makes clear, adult dental coverage is the reason why the FEHBP plans are much more expensive than other benchmark plan candidates.⁵⁰ While the comprehensiveness of benefits was obviously an important consideration in the recommendation process, it was necessary to balance this consideration against a concern for affordability. OFIR notes that standalone adult dental plans will be available to those Michigan residents who wish to purchase them.

Some commenters expressed concern regarding **visit limitations on outpatient rehabilitative services**, including speech, occupational, and physical therapy. OFIR notes that all benchmark

⁴⁸ MCL 500.3406(o).

⁴⁹ ACA § 1302(4)(B).

⁵⁰ Wakely Report, p. 11.

plan candidates include visit limitations on these services, and that the limitations are largely similar across all benchmark plan candidates. In addition, the ACA expressly permits scope, duration, and visit limits to be imposed, even on essential health benefits, so OFIR is not authorized to strip any such limits from the recommended essential health benefits benchmark plan.

One commenter asked whether insurers would be permitted to vary the **deductibles** from those currently imposed by the recommended plan. While HHS is expected to issue further guidance on cost-sharing variations, OFIR notes that variations in deductibles, co-payments, co-insurance, and out-of-pocket limits are critical to determining a plan's actuarial value, and thus its "metal level" on the Exchange. That said, OFIR believes that insurers will be permitted to vary cost-sharing provisions.

One commenter asked whether non-HMO insured plans would be permitted to refuse to offer coverage for services classified as "**miscellaneous**." No plan may refuse to cover any benefits covered by the selected benchmark plan. All services covered by the selected benchmark plan are required to be offered as part of Michigan's EHB package, regardless of the type of insurer offering the plan.

One commenter asked whether all insurers would be required to include only the **in-network EHBs** listed in the recommended plan. As with the "miscellaneous" benefits addressed in the previous paragraph, all plans offering coverage on the Exchange must cover the same benefits offered by the benchmark plan, regardless of whether those benefits are classified as in-network or out-of-network.

Finally, many commenters reiterated a desire for more **opportunity for public comment**. In addition to the two public comment periods offered by OFIR, HHS has indicated that it will solicit and accept public comments when it publishes all 50 States' EHB benchmark selections in the Federal Register. This will provide a formal opportunity for consumers and organizations to offer comments to HHS on the EHB selection.

Appendix B
State of Michigan
Essential Health Benefits Selection
Notification Letter to Secretary Sibelius



STATE OF MICHIGAN
EXECUTIVE OFFICE
LANSING

RICK SNYDER
GOVERNOR

BRIAN CALLEY
LT. GOVERNOR

September 28, 2012

The Honorable Kathleen Sebelius, Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Sebelius:

Pursuant to section 1302(b)(2)(A) of the federal Patient Protection and Affordable Care Act (ACA), I am writing to inform you that Priority Health's HMO plan has been selected as Michigan's benchmark essential health benefits plan for coverage years 2014 and 2015. Priority Health's HMO plan – as supplemented by the MICHild dental program (for pediatric dental coverage) and the FEDVIP Blue Vision High plan (for pediatric vision coverage) – will form the minimum coverage requirements under the ACA for Michiganders in the non-grandfathered small group and individual insurance markets.

It is important to note that Michigan selects its essential health benefits benchmark based on the limited guidance presently available from the federal government on essential health benefits and the benchmarking process. Based on this guidance, the selection of Priority Health's HMO plan as Michigan's essential health benefits benchmark plan is expressly limited to plan years 2014 and 2015 and may be reevaluated at a later date.

Staff from the Michigan Office of Financial and Insurance Regulation will enter the coverage details for Michigan's benchmark selection into the U.S. Department of Health & Human Service's Health Insurance Oversight System (HIOS). I anticipate the HIOS data submission to be completed within the coming week.

Sincerely,

A handwritten signature in blue ink that reads "Rick Snyder".

Rick Snyder
Governor

Enclosure

Appendix C
State of Michigan
Essential Health Benefits Analysis and Results
Wakely Consulting Group



State of Michigan
Essential Health Benefits
Analysis and Results - Updated
August 16, 2012

Julie Peper, FSA, MAAA
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- Essential Health Benefits – Overview
- Goals of Analysis
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 - State Mandated Benefits
 - Supplemental Benefit Gaps and Options
 - Pediatric Vision
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 - Habilitative Services
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Essential Health Benefits - Overview

- Beginning in 2014, individual and small group health plans will be required under the Affordable Care Act to offer an Essential Health Benefits (EHBs) package.
- Ten potential benchmark options:
 - the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;
 - any of the largest three State employee health benefit plans by enrollment;
 - any of the largest three national FEHBP plan options by enrollment; or
 - the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.
- Benefits are placed into the 10 service categories defined by HHS (some subjectivity exists with these placements).
- Default benchmark is largest plan by enrollment in the largest product in the State's small group market.

Goals of Analysis

- Ultimate goal is to assist in the selection of the Essential Health Benefit (EHB) benchmark by quantifying the premium impact of the different benchmark options.
- Other key considerations in selecting a benchmark
 - Coverage of state mandates
 - Benefit gaps that must be supplemented from other plans (pediatric oral, pediatric vision and habilitative services)
 - Since benefits may be substituted within categories (and potentially across categories) as long as they are substantially similar and actuarially equivalent, the relative richness of each plan should be the focus compared to the specific benefits covered
- Reference documents (embedded in appendix)
 - File prepared by the State of Michigan labeled “EHB comparison final3”
 - File prepared by the State of Michigan labeled “EHB comparison dental and vision 8-6-12”

Current Guidance (Subject to Change)

- No annual or lifetime dollar limits (quantity limits allowed)
- Benefit substitutions are expected to be allowed within categories and possibly across categories as long as actuarially equivalent and substantially similar.
 - Actuarially equivalent defined according to CHIP regulations
 - Substantially similar not clearly defined
 - Thus, if the selected benchmark covers a benefit, it does not guarantee it will be a covered benefit in 2014
- Recent guidance changes:
 - Riders can be considered as part of the benchmark option if they are part of the most popular benefit combination in the product
 - Guidance forthcoming on drug class list for prescription drug coverage but have indicated a change from recent guidance
 - Non-quantitative limits (e.g. pre-authorizations) are not part of the EHB

Comparison of Benchmark Options

- Analysis compares the benefit differences of the ten benchmark plans:
 - Small Group 1 – BCBSM Community Blue PPO Plan 4
 - Small Group 2 – Priority Health HMO
 - Small Group 3 – BCN10 HMO
 - State Plan 1 – BCBSM Self-Insured
 - State Plan 2 – PHP HMO
 - State Plan 3 – Priority Health HMO
 - HMO – Priority Health HMO
 - FEHBP – BCBS Standard Option
 - FEHBP – BCBS Basic Option
 - FEHBP – GEHA Standard Option

Comparison of Benchmark Options

- The State of Michigan compared the benefits covered by each of the 10 benchmark options.
- Benefits were grouped into the 10 required categories.
- Wakely made edits if more detail was needed to accurately price the benefit differences.
- Any quantity limits are captured (e.g. limit of 10 chiropractic visits per year).
- Non-quantitative limits are excluded from the comparison.
- Supplemental (dental and vision) benefit and premium comparison is included in the benchmark analysis.

Premium Impact of Benefit Differences

- For each benefit coverage that is not the same for all 10 benchmark options, a premium impact for the benefit differences was estimated.
- For consistency, benefits that need to be supplemented for at least one plan were not included in the premium impact analysis. Thus, benefit differences related to habilitative services, pediatric oral and pediatric vision are not included in the medical premium impact, although pediatric oral and pediatric vision are included in their own premium impact section.
- Benefit costs were analyzed with the following information:
 - Industry data
 - Actuarial judgment if limited data available

Premium Impact of Benefit Differences

- Impacts were estimated by considering the benefit independent of downstream effects. For example, if infertility treatment is covered it might also increase maternity costs, including a higher incidence of high cost multiple births. However, only the estimated cost of the infertility benefit is included in the estimates.
- Premium impacts are 2014 Per Member Per Month (PMPM) projections.
- The analysis spreads the PMPM premium impact over all members. For example, the cost of pediatric dental will be spread over the entire population, not just the pediatric population.
- Premium impacts assume no member cost sharing. Thus, the impact for a silver plan would be approximately 70% of the impact shown.
- Where necessary, dollar limits (e.g. \$2000/year alternative medicine limit) were converted to visit/day/unit limits based on an estimated allowed cost per visit/day/unit.

Premium Impact of Benefit Differences

- Estimated premium impacts were developed for each benefit difference (any benefit that was not the same for all 10 benchmark options). The premium impacts were summed for all benefit differences by benchmark option. The plan with the lowest premium impact is the leanest plan and is used as the baseline plan. All other plans are shown relative to the baseline. For example, if a plan's Premium Impact is \$2.50-\$3.50, it is that much richer than the baseline plan and the baseline plan's premium would need to increase by this amount if this plan was chosen as the benchmark.
- While specific benefit differences can be important, the focus is on the relative richness of the benchmark options.
- PMPM impacts do not represent the premium change to each individual or group but rather the relative impact to all other benchmark plans. For example, if an individual plan is significantly leaner than the baseline plan the premium will need to increase to at least the baseline benchmark. If the selected benchmark is richer than the baseline the premiums will increase further.

Premium Impact of Benefit Differences

- The Priority Health Small Group and the HMO plans are the leanest plans (i.e. baseline plans) as these two plans are the same.
- The FEHBPs are the richest plans with their limited adult dental benefit driving the premium differences.

Benchmark Option	Premium PMPM Impact of Benefit Differences
Small Group 2 - Priority Health (HMO)	\$0.00 - \$0.00
HMO - Priority Health (HMO)	\$0.00 - \$0.00
Small Group 1 - BCBSM Community Blue PPO Plan 4	\$2.00 - \$2.50
State Plan 3 - Priority Health (HMO)	\$2.00 - \$2.50
Small Group 3 - BCN10 (HMO)	\$2.75 - \$3.50
State Plan 1 - BCBSM (Self-insured)	\$3.50 - \$4.50
State Plan 2 - PHP (HMO)	\$4.00 - \$5.00
FEHBP - BCBS Standard Option	\$5.50 - \$7.00
FEHB - GEHA Standard Option	\$13.00 - \$16.25
FEHBP - BCBS Basic Option	\$14.50 - \$18.25

Premium Impact of Benefit Differences

- For each benefit listed in the comparison, the premium impact is noted (none, not significant, low, medium and high).
- The benefit differences with the highest impact (greater than or equal to \$1.00 PMPM):
 - Dental – Adult Preventive and Basic (Miscellaneous)
 - Infertility (Miscellaneous)
 - Fertility Drugs (Prescription Drugs)
 - PT/OT/ST (Rehabilitative and habilitative services)
- The benefit differences with a moderate impact (greater than or equal to \$0.50 but less than \$1.00 PMPM):
 - SNF (Hospitalization)
- The benefit differences with a low impact (greater than or equal to \$0.15 but less than \$0.50 PMPM):
 - Chiropractic (Miscellaneous)
 - Home Health Care Services (Ambulatory)
 - Hearing Aids – Adults (Rehabilitative and habilitative services)
 - Mental Health / Substance Abuse (Mental health and substance use disorder)

State Mandated Benefits

- State must defray the costs of any state benefit mandates not covered by the chosen benchmark.
- According to the analysis provided by the state, all of the benchmark options cover each mandate.
- Reference document is embedded in the appendix with the label “EHB Comparison Benefit Impact Grid 08.16.2012 Final”.

Supplemental Benefit Gaps and Options

- The benefit gaps that will need to be supplemented vary by benchmark option.
- HHS guidance on supplemental options varies by benefit (discussed later).

Benchmark Option	Habilitative Services	Pediatric Oral	Pediatric Vision
Small Group 1 - BCBSM Community Blue PPO	NC	NC	NC
Small Group 2 - Priority Health (HMO)	NC	NC	NC
Small Group 3 - BCN10 (HMO)	NC	NC	NC
State Plan 1 - BCBSM (Self-insured)	NC	NC	NC
State Plan 2 - PHP (HMO)	NC	NC	NC
State Plan 3 - Priority Health (HMO)	NC	NC	NC
HMO - Priority Health (HMO)	NC	NC	NC
FEHBP - BCBS Standard Option	√ limited	√ limited	NC
FEHBP - BCBS Basic Option	√ limited	√ limited	NC
FEHB - GEHA Standard Option	√ limited	√ limited	NC

√ Covered benefit. Limited benefits are noted.

NC Not a covered benefit

Pediatric Vision

- None of the benchmark options currently cover pediatric vision. Thus, this benefit will need to be supplemented.
- Per federal guidance, the only supplemental vision option is the FEDVIP Vision plan with the highest national enrollment (BlueVision High plan)
 - Benefits cover eye exams, lenses, frames and contact lenses (limits apply both in frequency and maximum benefit).
- Premium impacts assume current dollar limits are converted to quantity limits.
- Some high level pricing assumptions still exist such as the percent of the population that will be eligible for pediatric vision services. The pediatric age limit is still undefined by the Center for Consumer Information and Insurance Oversight (CCIIO). For this analysis, the pediatric benefits are assumed to be covered through age 18.

Pediatric Vision

Benefit - Applies to Children Only	FEDVIP - BlueVision High Plan
<i>Estimated Premium Impacts</i>	
PMPM - 100% AV	\$1.00 - \$1.50
PMPM - 70% AV	\$0.75 - \$1.00
Annual Family of 4 - 70% AV	\$25 - \$39

<i>Diagnostic</i>	
Eye Exam	√ limit 1 / yr
<i>Eyewear</i>	
Lenses	√ limit 1 pair / yr
Frame	√ limit 1 / yr \$150 allowance
Contact Lenses	√ limit 1 / yr \$150 allowance in lieu of eyeglasses (\$600 for medically necessary)

Pediatric Dental

- Only the federal plans have pediatric dental coverage so this benefit will need to be supplemented for all of the other benchmarks
- Supplemental Options
 - FEDVIP Dental plan with highest national enrollment (MetLife Dental PPO – High Option)
 - State of Michigan CHIP dental plan - MICHild
- The benefits for the two supplemental options are both comprehensive with only minimal differences in limits and exclusions
 - Orthodontics does not need to be included unless medically necessary even if included in the benefits of the supplemental option
- Premium impacts for the two options are similar with any benefit differences offsetting each other.
- Some high level pricing assumptions still exist such as the percent of the population that will be eligible for pediatric dental services. The pediatric age limit is still undefined by CCIIO. For this analysis, the pediatric benefits are assumed to be covered through age 18.

Pediatric Dental

Benefit - Applies to Children Only	State of MI MIChild	FEDVIP - MetLife Dental PPO
<i>Estimated Premium Impacts ¹</i>		
PMPM - 100% AV	\$5.75 - \$7.25	\$6.00 - \$7.50
PMPM - 70% AV	\$4.00 - \$5.25	\$4.25 - \$5.25
Annual Family of 4 - 70% AV	\$151 - \$191	\$155 - \$196

- See embedded file prepared by the State of Michigan in the appendix and labeled “EHB comparison dental and vision 8-6-12” for detailed benefit comparison.

Habilitative Services

- As a transitional approach for habilitative services, the HHS EHB Bulletin discusses two alternative options that HHS is considering¹:
 - A plan would be required to offer the same services for habilitative needs as it offers for rehabilitative needs and offer them at parity.
 - A plan would decide which habilitative services to cover and report the coverage to HHS. HHS would evaluate and further define habilitative services in the future.
- Under either approach, a plan would be required to offer at least some habilitative benefit.
- Since HHS has indicated that this will be a plan determined benefit, there is a large range of possible benefits and premium impacts. Thus, no premium impact is estimated at this time.

¹ Frequently Asked Questions on Essential Health Benefits Bulletin at <http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf>

Overall Impact to Premiums

- Overall premium impacts driven by the pediatric benefits.
- Medical and Prescription drug benchmark options may also impact the overall impact significantly depending on the benchmark chosen.

Benefit Category	Range of Premium PMPM Impacts
Medical and Prescription Drug	\$0.00 - \$18.25
Pediatric - Vision	\$1.00 - \$1.50
Pediatric - Dental	\$5.75 - \$7.50
Total EHB (100% AV)	\$6.75 - \$27.25

Caveats

- This document is for discussion purposes.
- Benefit information included in the comparisons is based on information provided by the state or is publicly available. This information should be reviewed for accuracy.
- Actual premium impacts will vary from the estimates provided. These impacts will also vary by factors such as health insurer, benefit design (metal level) and the demographics of the enrollees.
- Does not include the impact of habilitative services since this benefit still needs to be defined.
- This report is to aid the State of Michigan in its Exchange planning process. All results presented in this report are specific to the State of Michigan. Other uses and application to other states may be inappropriate.

Appendix - Reference Documents

- Medical Benefits Summary - PDF prepared by the State of Michigan labeled “EHB comparison final3”



EHB comparison
final3

- Dental and Vision Summary - PDF prepared by the State of Michigan labeled “EHB comparison dental and vision 8-6-12”



EHB comparison
dental and vision 8-6-12

- Mandates and Benefit Impact - PDF prepared by the State of Michigan (with some additional comments provided by Wakely for clarity) labeled “EHB Comparison Benefit Impact Grid 08.16.2012 Final”



EHB Comparison
Benefit Impact Grid 08.16

**EXHIBIT 1
MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON***



Benefits provided by potential benchmark major medical plans - data as of 3/31/12

Grouped in the 10 categories of Essential Health Benefits required by the ACA.

See <http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>

Terms:

MB - Michigan mandated benefit

Benefits [3]	Small Group			HMO	State Employee Plans			Federal Employee Plans			Michigan Mandate
	BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCN10 (HMO)	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBSM Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	
1. Ambulatory patient services - Federal Mandate											
Primary Care Visit to Treat an Injury or Illness	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3519(3)
Specialist Visit	Yes	Yes must be participating provider A non-participating provider requires prior approval	Yes referral required except OB/GYN	Yes must be participating provider A non-participating provider requires prior approval	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3519(3)
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Outpatient Surgery Physician/Surgical Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Home Health Care Services	Yes	Yes	Yes	Yes	Yes	Yes limited to 60 visits per calendar year	Yes	Yes	Yes	Yes	MB 500.3519(3)
Hospice Care	Yes	Yes maximum of 45 days per contract year	Yes	Yes maximum of 45 days per contract year	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3406c 550.1417
Breast Cancer Outpatient Treatment Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Doesn't specifically include or exclude this benefit	Doesn't specifically include or exclude this benefit	Doesn't specifically include or exclude this benefit	MB 500.3406d 550.1416
2. Emergency Services - Federal Mandate											
Emergency Room Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3406k 500.3519(3) 550.1418

**EXHIBIT 1
MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON***

Benefits [3]	Small Group			HMO	State Employee Plans			Federal Employee Plans			Michigan Mandate
	BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCN10 (HMO)	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBSM Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	
Emergency Transportation/Ambulance	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3406f 500.3519(3)
Urgent Care Centers or Facilities	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
3. Hospitalization - Federal Mandate											
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3519(3)
Inpatient Physician and Surgical Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3519(3)
Transplants	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3519(3)
Antineoplastic Surgery Drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3406e 550.1416a
Inpatient Hospital Services Other Than Those for the Treatment of Mental Illness	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3519(3)
Skilled Nursing Facility	Yes up to a maximum of 120 days	Yes maximum of 45 days per contract year	Yes maximum of 45 days per contract year	Yes maximum of 45 days per contract year	Yes 120 days per admission for in-network	Yes non-network benefits are limited to 100 days per year	Yes 730 days per confinement	Yes[1]	Yes[1]	Yes	
4. Maternity and newborn care - Federal Mandate											
Prenatal and Postnatal Care	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3519(3)
Delivery and All Inpatient Services for Maternity Care	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3519(3)
5. Mental health and substance use disorder services, including behavioral health treatment - Federal Mandate											
Mental/Behavioral Health Inpatient Services	Yes	Yes up to 20 days per contract year	Yes up to 30 days per calendar year	Yes up to 20 days per contract year	Yes[2]	Yes	Yes	Yes	Yes	Yes	MB 500.3406b 550.1401b
Mental/Behavioral Health Outpatient Services	Yes	Yes up to 20 days per contract year	Yes up to 20 visits per member per calendar year	Yes up to 20 days per contract year	Yes[2]	Yes	Yes	Yes	Yes	Yes	MB 500.3519(3)

**EXHIBIT 1
MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON***

Benefits [3]	Small Group			HMO	State Employee Plans			Federal Employee Plans			Michigan Mandate
	BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCN10 (HMO)	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBSM Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	
Substance Abuse Disorder Inpatient Services	Yes	Yes	Yes limited to one program of treatment per 12 month period. Combined with outpatient services	Yes	Yes[2]	Yes	Yes	Yes	Yes	Yes	MB 550.1414a(1)
Substance Abuse Disorder Outpatient Services	Yes	Yes	Yes limited to one program of treatment per 12 month period. Combined with inpatient services	Yes	Yes[2]	Yes	Yes	Yes	Yes	Yes	MB 500.3425 500.3519(3) 550.1414a(4)
Autism Therapy	No	No	No	No	No	No	No	Covers PT/ST/OT	Covers PT/ST/OT	Covers PT/ST/OT	[4]
6. Prescription drugs - Federal Mandate											
Generic Drugs	Yes with pharmacy rider	Yes	Yes with pharmacy rider	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Preferred Brand Drugs	Yes with pharmacy rider	Yes	Yes with pharmacy rider	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Non-Preferred Brand Drugs	Yes with pharmacy rider	Yes	Yes with pharmacy rider	Yes	Yes	Yes[2]	Yes[2]	Yes[2]	Yes[2]	Yes[2]	
Specialty Drugs	Yes with pharmacy rider	Yes	Yes with pharmacy rider	Yes	Yes	Yes[2]	Yes[2]	Yes[2]	Yes[2]	Yes[2]	
Preferred Tobacco Cessation Products must be prescribed by a Physician and obtained from a Network Retail Pharmacy	Yes with pharmacy rider	Yes	Yes with pharmacy rider	Yes	Yes	Yes	Yes	Yes	Yes	Yes	

**EXHIBIT 1
MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON***

Benefits [3]	Small Group			HMO	State Employee Plans			Federal Employee Plans			Michigan Mandate
	BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCN10 (HMO)	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBSM Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	
Growth Hormone Therapy	Yes	Not excluded	Yes if medically necessary	Not excluded	Yes	Yes 0% Coinsurance	Not excluded				
Infertility Treatment Prescription Drugs	Yes	No	Yes 50% copayment	No	Yes	Yes 40% coinsurance	No	No	No	No	
7. Rehabilitative and habilitative services and devices - Federal Mandate											
Outpatient Rehabilitation Services	Yes limited to a combined maximum of 60 visits for PT/ST/OT	Yes maximum of 30 visits per contract year each for: (1) PT/OT/Chiropractic office visits; (2) ST; and (3) cardiac and pulmonary rehab	Yes limited to one period of treatment for any combination of therapies within 60 consecutive days per episode	Yes maximum of 30 visits per contract year each for: (1) PT/OT/Chiropractic office visits; (2) ST; and (3) cardiac and pulmonary rehab	Yes limited to a combined maximum of 90 days per calendar year for PT/ST/OT	Yes limited to 60 visits per year for a combo of PT/ST/OT and pulmonary rehab. Any combo of cardiac rehab limited to 36 visits per year.	Yes maximum of 30 visits per contract year each for: (1) PT/OT/Chiropractic office visits; (2) ST; and (3) cardiac and pulmonary rehab	Benefits are limited to 75 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three	Benefits are limited to 75 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three	Benefits are limited to 75 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three	
Habilitation Services	No	No	No	No	No	No	No	Covers PT/ST/OT for conditions such as autism	Covers PT/ST/OT for conditions such as autism	Covers PT/ST/OT for conditions such as autism	[4]
Durable Medical Equipment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	

**EXHIBIT 1
MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON***

Benefits [3]	Small Group			HMO	State Employee Plans			Federal Employee Plans			Michigan Mandate
	BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCN10 (HMO)	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBSM Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	
Hearing Aids	No	No	No	No	Yes benefits limited to once every 36 months unless significant hearing loss occurs earlier and is certified by your physician	Yes limited to \$880 for monaural or \$1600 binaural once every 36 months	Yes Hearing aid is limited to \$500 per aid.				
Breast Cancer Rehabilitation Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3406d 550.1416
Mastectomy Prosthetics	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3406a 550.1415
8. Laboratory services - Federal Mandate											
Diagnostic Test (X-Ray and Laboratory Tests)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3519(3)
Imaging (CT and PET Scans, MRIs)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3519(3)
Breast Cancer Diagnostic Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3406d 550.1416
9. Preventive and wellness services and chronic disease management - Federal Mandate											
Preventive Care/Screening/Immunization	Yes panel physician only	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3519(3)
10. Pediatric services, including oral and vision care - Federal Mandate											
Dental Check-Up for Children	No	No	No	No	No	No	No	Yes	Yes	Yes	
Vision Exam for Children	No	No	No	No	No	No	No	No	No	No	
Eye Glasses for Children	No	No	No	No	No	No	No	No	No	No	
General Pediatric Care	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3406n 500.3519(3) 550.1401g
Miscellaneous											

**EXHIBIT 1
MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON***

Benefits [3]	Small Group			HMO	State Employee Plans			Federal Employee Plans			Michigan Mandate
	BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCN10 (HMO)	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBSM Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	
Chiropractic Office Visits	24 visits per calendar year	Yes visits are included in the maximum of 30 visits per contract year for PT/OT	Yes	Yes visits are included in the maximum of 30 visits per contract year for PT/OT	24 visits per calendar year for chiropractic manipulation	20 visits per calendar year	Yes visits are included in the maximum of 30 visits per contract year for PT/OT	Yes Osteo and chiro manipulative treatment limited to combined total of 12 visits per person, per calendar year	Yes Osteo and chiro manipulative treatment limited to combined total of 12 visits per person, per calendar year	Yes 12 visits per person per calendar year for manipulation of the spine	
Diagnosis and treatment of infertility, e.g. endometriosis, blockage of fallopian tubes, varicocele	No	Diagnosis only	Diagnosis and treatment, excludes artificial insemination and IVF	Diagnosis only	No, only if with another medical condition	Yes \$10,000 per calendar year; Diagnosis, Artificial Insemination covered	Diagnosis only	Yes Infertility drugs used in conjunction with ART procedures excluded	Yes Infertility drugs used in conjunction with ART procedures excluded	Yes Limited to a max of \$3000 per person per calendar year	
Morbid Obesity weight management program	No	Yes	No weight management programs offered at a discount rate	Yes	Yes lifetime max of \$300	Yes 1 weight management program per lifetime	Yes	Yes	Yes	Yes	

**EXHIBIT 1
MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON***

Benefits [3]	Small Group			HMO	State Employee Plans			Federal Employee Plans			Michigan Mandate
	BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCN10 (HMO)	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBSM Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	
Morbid Obesity surgical treatment	Yes	Yes 1 per lifetime	Yes subject to medical criteria	Yes 1 per lifetime	Yes If this is for weight loss surgery, this is payable if the medical criteria is met	Yes Must be ordered by primary care physician, provided by a network physician in a designated facility, and covered person must qualify under current morbid obesity policy which included medically necessary services	Yes 1 per lifetime	Yes	Yes	Yes	
Acupuncture only for certain conditions specified in contract	No	No	No	No	Yes 20 treatments per calendar year	No	No	Yes 24 visits per calendar year	Yes 24 visits per calendar year	Yes 20 visits per calendar year	
Wigs and supplies (cancer or alopecia only)	No	No	No	No	Yes \$300 per lifetime except for children	No	No	Yes Any amount over \$350 for one wig per lifetime (no deductible)	Yes Any amount over \$350 for one wig per lifetime (no deductible)	No	
Genetic Testing	No	Yes coverage for women only including pregnant women	Yes when authorized by BCN	Yes coverage for women only including pregnant women	No	Yes coverage for certain Medically Necessary Genetic Tests with prior author-ization	Yes coverage for women only including pregnant women	Yes Diagnostic only	Yes Diagnostic only	Yes Requires referral, precertifi- cation, prior authorization	

**EXHIBIT 1
MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON***

Benefits [3]	Small Group			HMO	State Employee Plans			Federal Employee Plans			Michigan Mandate
	BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCN10 (HMO)	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBSM Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	
Evaluation and treatment of chronic pain	Yes	Yes	Yes	Yes	Doesn't specifically include or exclude this benefit	Yes	Yes	Doesn't specifically include or exclude this benefit	Doesn't specifically include or exclude this benefit	Doesn't specifically include or exclude this benefit	
Reconstructive Procedures - covers medically necessary services for reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function	Yes	Yes	Yes	Yes	Reconstructive surgery is covered only for the correction of 1) birth defects 2) conditions resulting from accidental injuries 3) deformities resulting from certain surgeries, such as breast reconstruction following mastectomies	Yes	Yes	Yes	Yes	Yes	
Blepharoplasty of upper lids, breast reduction, panniculectomy*, rhinoplasty*, septorhinoplasty*, and surgical treatment of male gynecomastia *sleep apnea treatment procedures	Yes provided BCBSM's specific medical criteria is met	Yes	Yes subject to medical criteria	Yes	Blepharoplasty is only procedure specifically mentioned - based on medical policy. If the reason for the service is cosmetic, the service is not payable	Yes	Yes	No	No	Yes Requires referral, precertification, prior authorization	

**EXHIBIT 1
MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON***

Benefits [3]	Small Group			HMO	State Employee Plans			Federal Employee Plans			Michigan Mandate
	BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCN10 (HMO)	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBSM Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	
Services related to Temporomandibular Joint Syndrome or Dysfunction	Yes dental surgery directly to the temporomandibular joint and related anesthesia services	Yes	Yes	Yes	Benefits for TMJ or jaw-joint disorder are limited to: 1) surgery directly to the jaw joint, 2) x-rays (including MRIs), 3) trigger point injections, 4) arthrocentesis (injection procedures)	Yes if medically necessary and not part of dental treatment	Yes	No Surgery only	No Surgery only	No Surgery only	
Orthognathic Surgery	Yes surgical corrections of skeletal abnormalities	Yes	Yes	Yes	Yes	Yes covered if medically necessary	Yes 50% coverage	No	No	Yes Severe sleep apnea only, cleft palate, and Pierre Robin Syndrome	

Abbreviations: BCBSM = Blue Cross Blue Shield of Michigan; BCN = Blue Care Network; CT = computed tomography; GEHA = Government Employees Health Association; MRI = magnetic resonance imaging; PET = positron emission tomography; PT = physical therapy; OT = occupational therapy; ST = speech therapy; ART = Assisted Reproductive Technology

Footnotes for table

- [1] The FEHBP BCBS Standard and Basic options cover skilled nursing facilities only when approved by a case manager.
- [2] Coverage for Non-Preferred Brand Drugs and Specialty Drugs requires special permission.
- [3] The chart greatly simplifies the benefits offered. For more specificity, please refer to the Certificates of Coverage for each plan that are linked in the column headings.
- [4] Implementation of Autism Bill (Senate Bill 414, 415, and 918) will take place 10/2012. Not part of Essential Health Benefits as these are defined as of 3/31/12.

***The data provided in this chart is not legal advice and is intended for informational purposes only. This chart has been compiled by the Michigan Office of Financial and Insurance Regulation based on presently available enrollment data and benefit design, utilizing the essential health benefit (EHB) definitions and categories as delineated in the most recent guidance provided by the federal government. The U.S. Department of Health and Human Services (HHS) has directed states to choose the EHB benchmark from certain enumerated plans, including the largest HMO and small group plans in the state, identified by enrollment data as reported to HHS for the first quarter of 2012. The data provided in this chart is subject to change as additional federal guidance is provided with regard to EHB.**

**MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON
DENTAL AND VISION**

DENTAL

	<i>State of MI</i>	<i>Federal Employee Plans</i>
Benefits	MICHild BCBSM	FEDVIP Dental MetLife
Diagnostic		
Initial exam	Yes	Yes
Routine checkup	Yes	Yes
Bitewing X-rays	Yes	Yes
Diagnostic tests	Yes	Yes
Preventive		
Cleanings	Yes	Yes
Flouride treatments	Yes under age 19	Yes up to age 22
Space maintainers	Yes under age 14	Yes
Dental sealants on first and second permanent molars	Yes	Yes
Restorative		
Fillings of amalgam, plastic composite or similar materials and stainless steel crowns	Yes	Yes
Metallic onlays	Yes	Yes
Porcelain or ceramic crown substrate	Yes	Yes
Endodontics		
Pulpotomy for primary teeth	Yes	Yes
Anterior, bicuspid and molar root canal	Yes	Yes
Anterior, bicuspid and molar root canal therapy	Yes	Yes
Periodontics		
Periodontal scaling and root planing	Yes	Yes
Gingivectomy or gingivoplasty	Yes	Yes
Prosthodontics (removable)		
Maxillary dentures	Yes	Yes

**MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON
DENTAL AND VISION**

DENTAL

	<i>State of MI</i>	<i>Federal Employee Plans</i>
Benefits	MICHild BCBSM	FEDVIP Dental MetLife
Prosthodontics (fixed)		
Porcelain, ceramic and cast metal retainers for resin bonded fixed prosthesis	Cast metal is covered. Porcelain and ceramic are not covered.	Yes
Implant services	No	Yes
Oral & Maxillofacial Surgery		
Simple extractions	Yes	Yes
Adjunctive General Services		
Consultation by a second dentist not providing treatment	Yes	Yes
Exams and treatment for an emergency condition	Yes	Yes
Emergency treatment for temporary relief of pain	Yes	Yes

VISION

	<i>Federal Employee Plans</i>
Benefits	FEDVIP Vision FEP BlueVision
Vision exam and glaucoma test	Yes Glaucoma test is not specifically included or excluded
Eyeglass frames (wire, plastic or metal)	Yes
Eyeglass lenses	Yes
Medically necessary contact lenses	Yes

**EXHIBIT 1
MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON***



Benefits provided by potential benchmark major medical plans - data as of 3/31/12
Grouped in the 10 categories of Essential Health Benefits required by the ACA.

Terms:

MB - Michigan mandated benefit

Benefits [3]	Pricing Impact	Small Group			HMO	State Employee Plans			Federal Employee Plans			Michigan Mandate
		BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCN10 (HMO)	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBSM Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	
1. Ambulatory patient services - Federal Mandate												
Primary Care Visit to Treat an Injury or Illness	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3519(3)
Specialist Visit	None	Yes	Yes must be participating provider A non-participating provider requires prior approval	Yes referral required except OB/GYN	Yes must be participating provider A non-participating provider requires prior approval	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3519(3)
Other Practitioner Office Visit (Nurse, Physician Assistant)	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Outpatient Surgery Physician/Surgical Services	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Home Health Care Services	Low	Yes	Yes	Yes	Yes	Yes	Yes limited to 60 visits per calendar year	Yes	Yes	Yes	Yes	MB 500.3519(3)
Hospice Care	Not Significant	Yes	Yes maximum of 45 days per contract year	Yes	Yes maximum of 45 days per contract year	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3406c 550.1417
Breast Cancer Outpatient Treatment Services	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Doesn't specifically include or exclude this benefit	Doesn't specifically include or exclude this benefit	Doesn't specifically include or exclude this benefit	MB 500.3406d 550.1416
2. Emergency Services - Federal Mandate												
Emergency Room Services	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3406k 500.3519(3) 550.1418
Emergency Transportation/Ambulance	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3406l 500.3519(3)
Urgent Care Centers or Facilities	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	

**EXHIBIT 1
MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON***

Benefits [3]	Pricing Impact	Small Group			HMO	State Employee Plans			Federal Employee Plans			Michigan Mandate
		BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCN10 (HMO)	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBSM Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	
3. Hospitalization - Federal Mandate												
Inpatient Hospital Services (e.g., Hospital Stay)	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3519(3)
Inpatient Physician and Surgical Services	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3519(3)
Transplants	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3519(3)
Antineoplastic Surgery Drugs	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3406e 550.1416a
Inpatient Hospital Services Other Than Those for the Treatment of Mental Illness	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3519(3)
Skilled Nursing Facility	Medium	Yes up to a maximum of 120 days	Yes maximum of 45 days per contract year	Yes maximum of 45 days per contract year	Yes maximum of 45 days per contract year	Yes 120 days per admission for in-network	Yes non-network benefits are limited to 100 days per year	Yes 730 days per confinement	Yes[1]	Yes[1]	Yes	
4. Maternity and newborn care - Federal Mandate												
Prenatal and Postnatal Care	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3519(3)
Delivery and All Inpatient Services for Maternity Care	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3519(3)
5. Mental health and substance use disorder services, including behavioral health treatment - Federal Mandate												
Mental/Behavioral Health Inpatient Services	Low	Yes	Yes up to 20 days per contract year	Yes up to 30 days per calendar year	Yes up to 20 days per contract year	Yes[2]	Yes	Yes	Yes	Yes	Yes	MB 500.3406b 550.1401b
Mental/Behavioral Health Outpatient Services	Low	Yes	Yes up to 20 days per contract year	Yes up to 20 visits per member per calendar year	Yes up to 20 days per contract year	Yes[2]	Yes	Yes	Yes	Yes	Yes	MB 500.3519(3)
Substance Abuse Disorder Inpatient Services	Not Significant	Yes	Yes	Yes limited to one program of treatment per 12 month period. Combined with outpatient services	Yes	Yes[2]	Yes	Yes	Yes	Yes	Yes	MB 550.1414a(1)

**EXHIBIT 1
MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON***

Benefits [3]	Pricing Impact	Small Group			HMO	State Employee Plans			Federal Employee Plans			Michigan Mandate
		<u>BCBSM Community Blue PPO Plan 4</u>	<u>Priority Health (HMO)</u>	<u>BCN10 (HMO)</u>	<u>Priority Health (HMO)</u>	<u>BCBSM (Self-insured)</u>	<u>PHP (HMO)</u>	<u>Priority Health (HMO)</u>	<u>FEHBP BCBSM Standard Option</u>	<u>FEHBP BCBS Basic Option</u>	<u>FEHB GEHA Standard Option</u>	
Substance Abuse Disorder Outpatient Services	Not Significant	Yes	Yes	Yes limited to one program of treatment per 12 month period. Combined with inpatient services	Yes	Yes[2]	Yes	Yes	Yes	Yes	Yes	MB 500.3425 500.3519(3) 550.1414a(4)
Autism Therapy	Not Significant	No	No	No	No	No	No	No	Covers PT/ST/OT	Covers PT/ST/OT	Covers PT/ST/OT	[4]
6. Prescription drugs - Federal Mandate												
Generic Drugs	Not Significant	Yes with pharmacy rider	Yes	Yes with pharmacy rider	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Preferred Brand Drugs	Not Significant	Yes with pharmacy rider	Yes	Yes with pharmacy rider	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Non-Preferred Brand Drugs	Not Significant	Yes with pharmacy rider	Yes	Yes with pharmacy rider	Yes	Yes	Yes[2]	Yes[2]	Yes[2]	Yes[2]	Yes[2]	
Specialty Drugs	Not Significant	Yes with pharmacy rider	Yes	Yes with pharmacy rider	Yes	Yes	Yes[2]	Yes[2]	Yes[2]	Yes[2]	Yes[2]	
Preferred Tobacco Cessation Products must be prescribed by a Physician and obtained from a Network Retail Pharmacy	None	Yes with pharmacy rider	Yes	Yes with pharmacy rider	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Growth Hormone Therapy	None	Yes	Not excluded	Yes if medically necessary	Not excluded	Yes	Yes 0% Coinsurance	Not excluded				
** Infertility Treatment Prescription Drugs	High	Yes	No	Yes 50% copayment	No	Yes	Yes 40% coinsurance	No	No	No	No	

**EXHIBIT 1
MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON***

Benefits [3]	Pricing Impact	Small Group			HMO	State Employee Plans			Federal Employee Plans			Michigan Mandate
		BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCN10 (HMO)	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBSM Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	
7. Rehabilitative and habilitative services and devices - Federal Mandate												
** Outpatient Rehabilitation Services	High	Yes limited to a combined maximum of 60 visits for PT/ST/OT	Yes maximum of 30 visits per contract year each for: (1) PT/OT/Chiro-practic office visits; (2) ST; and (3) cardiac and pulmonary rehab	Yes limited to one period of treatment for any combination of therapies within 60 consecutive days per episode	Yes maximum of 30 visits per contract year each for: (1) PT/OT/Chiro-practic office visits; (2) ST; and (3) cardiac and pulmonary rehab	Yes limited to a combined maximum of 90 days per calendar year for PT/ST/OT	Yes limited to 60 visits per year for a combo of PT/ST/OT and pulmonary rehab. Any combo of cardiac rehab limited to 36 visits per year.	Yes maximum of 30 visits per contract year each for: (1) PT/OT/Chiro-practic office visits; (2) ST; and (3) cardiac and pulmonary rehab	Benefits are limited to 75 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three.	Benefits are limited to 75 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three.	Yes. Speech Therapy is limited to 30 visits per calendar year. 60 visits per person per calendar year for the combined services: physical or occupational therapy.	
Habilitation Services	Not Significant	No	No	No	No	No	No	No	Covers PT/ST/OT for conditions such as autism	Covers PT/ST/OT for conditions such as autism	Covers PT/ST/OT for conditions such as autism	[4]
** Durable Medical Equipment	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	

**EXHIBIT 1
MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON***

Benefits [3]	Pricing Impact	Small Group			HMO	State Employee Plans			Federal Employee Plans			Michigan Mandate
		BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCN10 (HMO)	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBSM Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	
** Hearing Aids	Low	No	No	No	No	Yes benefits limited to once every 36 months unless significant hearing loss occurs earlier and is certified by your physician	Yes limited to \$880 for monaural or \$1600 binaural once every 36 months	Yes Hearing aid is limited to \$500 per aid.	Yes Hearing aids for children up to age 22, limited to \$1,250 per ear per calendar year. Hearing aids for adults age 22 and over, limited to \$1,250 per ear per 36-month period.	Yes Hearing aids for children up to age 22, limited to \$1,250 per ear per calendar year. Hearing aids for adults age 22 and over, limited to \$1,250 per ear per 36-month period.	Yes Hearing aids for children up to age 22, limited to \$1,250 per ear per calendar year. Hearing aids for adults age 22 and over, limited to \$1,250 per ear per 36-month period.	
Breast Cancer Rehabilitation Services	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3406d 550.1416
Mastectomy Prosthetics	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3406a 550.1415
8. Laboratory services - Federal Mandate												
Diagnostic Test (X-Ray and Laboratory Tests)	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3519(3)
Imaging (CT and PET Scans, MRIs)	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	500.3519(3)
Breast Cancer Diagnostic Services	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3406d 550.1416
9. Preventive and wellness services and chronic disease management - Federal Mandate												
Preventive Care/Screening/Immunization	None	Yes panel physician only	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3519(3)
10. Pediatric services, including oral and vision care - Federal Mandate												
** Dental Check-Up for Children	None	No	No	No	No	No	No	No	Yes	Yes	Yes	
Vision Exam for Children	None	No	No	No	No	No	No	No	No	No	No	
Eye Glasses for Children	None	No	No	No	No	No	No	No	No	No	No	
General Pediatric Care	None	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	MB 500.3406n 500.3519(3) 550.1401g
Miscellaneous												

**EXHIBIT 1
MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON***

Benefits [3]	Pricing Impact	Small Group			HMO	State Employee Plans			Federal Employee Plans			Michigan Mandate
		<u>BCBSM Community Blue PPO Plan 4</u>	<u>Priority Health (HMO)</u>	<u>BCN10 (HMO)</u>	<u>Priority Health (HMO)</u>	<u>BCBSM (Self-insured)</u>	<u>PHP (HMO)</u>	<u>Priority Health (HMO)</u>	<u>FEHBP BCBSM Standard Option</u>	<u>FEHBP BCBS Basic Option</u>	<u>FEHB GEHA Standard Option</u>	
Chiropractic Office Visits	Low	24 visits per calendar year	Yes visits are included in the maximum of 30 visits per contract year for PT/OT	Yes	Yes visits are included in the maximum of 30 visits per contract year for PT/OT	24 visits per calendar year for chiropractic manipulation	20 visits per calendar year	Yes visits are included in the maximum of 30 visits per contract year for PT/OT	Yes Osteo and chiro manipulative treatment limited to combined total of 12 visits per person, per calendar year	Yes Osteo and chiro manipulative treatment limited to combined total of 12 visits per person, per calendar year	Yes 12 visits per person per calendar year for manipulation of the spine	
** Diagnosis and treatment of infertility, e.g. endometriosis, blockage of fallopian tubes, varicocele	High	No	Diagnosis only	Diagnosis and treatment, excludes artificial insemination and IVF	Diagnosis only	No, only if with another medical condition	Yes \$10,000 per calendar year; Diagnosis, Treatment and Artificial Insemination covered	Diagnosis only	Yes Infertility drugs used in conjunction with ART procedures excluded	Yes Infertility drugs used in conjunction with ART procedures excluded	Yes Infertility drugs used in conjunction with ART procedures excluded	
Morbid Obesity weight management program	Not Significant	No	Yes	No weight management programs offered at a discount rate	Yes	Yes lifetime max of \$300	Yes 1 weight management program per lifetime	Yes	Yes	Yes	Yes	

**EXHIBIT 1
MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON***

Benefits [3]	Pricing Impact	Small Group			HMO	State Employee Plans			Federal Employee Plans			Michigan Mandate
		<u>BCBSM Community Blue PPO Plan 4</u>	<u>Priority Health (HMO)</u>	<u>BCN10 (HMO)</u>	<u>Priority Health (HMO)</u>	<u>BCBSM (Self-insured)</u>	<u>PHP (HMO)</u>	<u>Priority Health (HMO)</u>	<u>FEHBP BCBSM Standard Option</u>	<u>FEHBP BCBS Basic Option</u>	<u>FEHB GEHA Standard Option</u>	
Morbid Obesity surgical treatment	Not Significant	Yes	Yes 1 per lifetime	Yes subject to medical criteria	Yes 1 per lifetime	Yes If this is for weight loss surgery, this is payable if the medical criteria is met	Yes Must be ordered by primary care physician, provided by a network physician in a designated facility, and covered person must qualify under current morbid obesity policy which included medically necessary services	Yes 1 per lifetime	Yes	Yes	Yes	
Acupuncture only for certain conditions specified in contract	Low	No	No	No	No	Yes 20 treatments per calendar year	No	No	Yes 24 visits per calendar year	Yes 24 visits per calendar year	Yes 20 visits per calendar year	
Wigs and supplies (cancer or alopecia only)	Not Significant	No	No	No	No	Yes \$300 per lifetime except for children	No	No	Yes Any amount over \$350 for one wig per lifetime (no deductible)	Yes Any amount over \$350 for one wig per lifetime (no deductible)	No	
Genetic Testing	Not Significant	No	Yes coverage for women only including pregnant women	Yes when authorized by BCN	Yes coverage for women only including pregnant women	No	Yes coverage for certain Medically Necessary Genetic Tests with prior author-ization	Yes coverage for women only including pregnant women	Yes Diagnostic only	Yes Diagnostic only	Yes Requires referral, precertification, prior authorization	
Evaluation and treatment of chronic pain	Not Significant	Yes	Yes	Yes	Yes	Doesn't specifically include or exclude this benefit	Yes	Yes	Doesn't specifically include or exclude this benefit	Doesn't specifically include or exclude this benefit	Doesn't specifically include or exclude this benefit	

**EXHIBIT 1
MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON***

Benefits [3]	Pricing Impact	Small Group			HMO	State Employee Plans			Federal Employee Plans			Michigan Mandate
		<u>BCBSM Community Blue PPO Plan 4</u>	<u>Priority Health (HMO)</u>	<u>BCN10 (HMO)</u>	<u>Priority Health (HMO)</u>	<u>BCBSM (Self-insured)</u>	<u>PHP (HMO)</u>	<u>Priority Health (HMO)</u>	<u>FEHBP BCBSM Standard Option</u>	<u>FEHBP BCBS Basic Option</u>	<u>FEHB GEHA Standard Option</u>	
Reconstructive Procedures - covers medically necessary services for reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function	Not Significant	Yes	Yes	Yes	Yes	Reconstructive surgery is covered only for the correction of 1) birth defects 2) conditions resulting from accidental injuries 3) deformities resulting from certain surgeries, such as breast reconstruction following mastectomies	Yes	Yes	Yes	Yes	Yes	
Blepharoplasty of upper lids, breast reduction, panniculectomy*, rhinoplasty*, septorhinoplasty*, and surgical treatment of male gynecomastia *sleep apnea treatment procedures	Not Significant	Yes provided BCBSM's specific medical criteria is met	Yes	Yes subject to medical criteria	Yes	Blepharoplasty is only procedure specifically mentioned - based on medical policy. If the reason for the service is cosmetic, the service is not payable	Yes	Yes	No	No	Yes Requires referral, precertification, prior authorization	
Services related to Temporomandibular Joint Syndrome or Dysfunction	None	Yes dental surgery directly to the temporo-mandibular joint and related anesthesia services	Yes	Yes	Yes	Benefits for TMJ or jaw-joint disorder are limited to: 1) surgery directly to the jaw joint, 2) x-rays (including MRIs), 3) trigger point injections, 4) arthrocentesis (injection procedures)	Yes if medically necessary and not part of dental treatment	Yes	No Surgery only	No Surgery only	No Surgery only	

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MICHIGAN ESSENTIAL HEALTH BENEFITS COMPARISON***

Benefits [3]	Pricing Impact	Small Group			HMO	State Employee Plans			Federal Employee Plans			Michigan Mandate
		BCBSM Community Blue PPO Plan 4	Priority Health (HMO)	BCN10 (HMO)	Priority Health (HMO)	BCBSM (Self-insured)	PHP (HMO)	Priority Health (HMO)	FEHBP BCBSM Standard Option	FEHBP BCBS Basic Option	FEHB GEHA Standard Option	
Orthognathic Surgery	Not Significant	Yes surgical corrections of skeletal abnormalities	Yes	Yes	Yes	Yes	Yes covered if medically necessary	Yes 50% coverage	No	No	Yes Severe sleep apnea only, cleft palate, and Pierre Robin Syndrome	
** Adult Dental - diagnostic & preventive	High	No	No	No	No	No	No	No	√ limit 2 visits / yr limited benefit	√ limit 2 visits / yr	√ limit 2 visits / yr	
** Adult Dental - basic	High	No	No	No	No	No	No	No	√ limited benefit	NC	√ limited benefit	

Abbreviations: BCBSM = Blue Cross Blue Shield of Michigan; BCN = Blue Care Network; CT = computed tomography; GEHA = Government Employees Health Association; MRI = magnetic resonance imaging; PET = positron emission tomography; PT = physical therapy; OT = occupational therapy; ST = speech therapy; ART = Assisted Reproductive Technology

Footnotes for table

- [1] The FEHBP BCBS Standard and Basic options cover skilled nursing facilities only when approved by a case manager.
 - [2] Coverage for Non-Preferred Brand Drugs and Specialty Drugs requires special permission.
 - [3] The chart greatly simplifies the benefits offered. For more specificity, please refer to the Certificates of Coverage for each plan that are linked in the column headings.
 - [4] Implementation of Autism Bill (Senate Bill 414, 415, and 918) will take place 10/2012. Not part of Essential Health Benefits as these are defined as of 3/31/12.
- ** Modified for clarity by Wakely Consulting

***The data provided in this chart is not legal advice and is intended for informational purposes only. This chart has been compiled by the Michigan Office of Financial and Insurance Regulation based on presently available enrollment data and benefit design, utilizing the essential health benefit (EHB) definitions and categories as delineated in the most recent guidance provided by the federal government. The U.S. Department of Health and Human Services (HHS) has directed states to choose the EHB benchmark from certain enumerated plans, including the largest HMO and small group plans in the state, identified by enrollment data as reported to HHS for the first quarter of 2012. The data provided in this chart is subject to change as additional federal guidance is provided with regard to EHB.**