

	A	B	C
1	 on the State EHB-benchmark Plan		OMB Control Number: 0938-1174 Expiration Date: 02/28/2024
2	Instructions: All fields on this template are required to be completed. Please make sure to answer all fields and confirm that the new EHB-benchmark Plan covers all 10 EHB categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. Under Section D, please complete the "Explanation" column with sentences describing how the State is complying with the specific requirement; single word responses such as Yes, No, or N/A are not sufficient responses.		
3	SECTION A		
4	Points of Contact for the State's EHB- benchmark Plan Selection	Primary	Secondary
5	Name	Julie Holmes	Craig VanAalst
6	Agency	Kansas Insurance Department	Kansas Insurance Department
7	Phone Number	785-296-6410	785-296-3765
8	Email	Julie.Holmes@ks.gov	Craig.VanAalst@ks.gov
9	SECTION B		
10	EHB-Benchmark Plan Selection Options	State's Selections	
11	State	Kansas	
12	Under which option of 45 CFR 156.111(a), is the State selecting its new EHB-benchmark Plan?	§ 156.111(a)(3) - Select a set of benefits that would become the State's EHB-benchmark plan	
13	For what plan year is the State selecting its new EHB-benchmark Plan to begin applying?	Plan Year 2025	
14	If using §156.111(a)(1), which other State's EHB-benchmark Plan is the State using for its EHB-benchmark plan?	Not Applicable to State's Selection Option	
15	SECTION C		
16	EHB Category Criteria for a State EHB-benchmark Plan at 45 CFR 156.111	Does the State's EHB-benchmark Plan cover the category?	If the State's is using §156.111(a)(2), select the other State's EHB-benchmark Plan being used for the particular category
17	Ambulatory patient services	Yes	Not Applicable to State's Selection Option
18	Emergency services	Yes	Not Applicable to State's Selection Option
19	Hospitalization	Yes	Not Applicable to State's Selection Option
20	Maternity and newborn care	Yes	Not Applicable to State's Selection Option
21	Mental health and substance use disorder services, including behavioral health treatment	Yes	Not Applicable to State's Selection Option
22	Prescription drugs*	Yes	Not Applicable to State's Selection Option
23	If the State is using the option under §156.111(a)(3), did the State provide a complete and accurate formulary drug list under the Appendix D entitled "Rx Template" in this workbook?	Yes	Not Applicable to State's Selection Option
24	Rehabilitative and habilitative services and devices	Yes	Not Applicable to State's Selection Option
25	Laboratory services	Yes	Not Applicable to State's Selection Option
26	Preventative, wellness, and chronic disease management	Yes	Not Applicable to State's Selection Option
27	Pediatric services, including oral and vision care	Yes	Not Applicable to State's Selection Option

APPENDIX B: ESSENTIAL HEALTH BENEFITS (EHB)-BENCHMARK PLAN ACTUARIAL CERTIFICATE TEMPLATE

Instructions for Completing Appendix B:

Under §156.111(e)(2), States must submit an actuarial certification as part of the EHB-benchmark selection process affirming that the State's EHB-benchmark plan:

- provides a scope of benefits that is equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.111(a), the scope of benefits provided under a typical employer plan as defined at §156.111(b)(2)(i); and
- does not exceed the generosity of the most generous among plans listed at §156.111(b)(2)(ii)(A) and (B).

States must complete all fields of this actuarial certification. CMS will consider any partial or blank fields as incomplete. The actuarial report associated with this certification must be submitted as an attachment. Actuarial reports should be uploaded in a format that prevents further editing after submission. For example, States can scan copies of the Actuarial Report or convert documents into a PDF format to upload

SECTION 1: BACKGROUND INFORMATION

State

1. Which EHB-benchmark plan option (at 45 CFR §156.111(a)) is the State using to make changes to its EHB-benchmark plan? (*Only provide one selection*)

(a)(1) - Selecting the EHB-benchmark plan that another State used for the 2017 plan year under §156.100 and §156.110

(a)(2) - Replacing one or more categories of EHBs under §156.110(a) under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another State used for the 2017 plan year under §156.100 and §156.110.

(a)(3) - Otherwise selecting a set of benefits that would become the State's EHB-benchmark plan.

SECTION 2: TYPICAL EMPLOYER PLANS DETERMINATION FOR §156.111(b)(2)(i)

2. Which definition of a typical employer plan at §156.111(b)(2)(i) was used for the determination under this actuarial certification and associated report? (*Only provide one selection*)

One of the selecting State's 10 benchmark plan options established at §156.100 of this subpart, and available for the selecting State's selection for the 2017 plan year.

The largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in the State, as product and plan are defined at §144.103, provided that: (1) The product has at least ten percent of the enrollment among the five largest large group health insurance products in the State; (2) The plan provides minimum value, as defined under §156.145; (3) The benefits are not excepted benefits, as established under §146.145(b), and §148.220; and the benefits in the plan are from a plan year beginning after December 31, 2013.

3. In accordance with §156.111(b)(2)(i), does the State's proposed EHB-benchmark plan provide a scope of benefits that are equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), the scope of benefits provided under a typical employer plan?

Yes

No

	A	B	C	D	E	F	G	H
1	 te's EHB-benchmark Plan's Benefits and Limits							OMB Control Number: 0938-1174 Expiration Date: 02/28/2024
2	Instructions: All fields on this template that are marked red are required to be completed. To ensure that this Benefits and Limits Summary Template corresponds with the EHB-benchmark plan document, please indicate the page number in which the benefit is covered under Column H if answering "Covered" under Column C (for example, "Covered" in Column C, "pg. 12" in Column H). If there is a quantitative limit on a benefit, then complete the Limit Quantity and Limit Unit fields. If there are no exclusions for a benefit, then leave the Exclusions field blank. Add an explanation in Column H to provide more details on a benefit.							
3	A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
4	Primary Care Visit to Treat an Injury or Illness	Yes	Covered	No				
5	Specialist Visit	Yes	Covered	No				
6	Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No				Professional Providers include Physician Assistants. Registered Nurses qualify as Eligible Providers.
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				
8	Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				
9	Hospice Services	Yes	Covered	No			Blood.	
10	Routine Dental Services (Adult)	No	Not Covered	No				
11	Infertility Treatment	Yes	Covered	No			Excludes In vitro fertilization, in vivo fertilization or any other medically-aided insemination procedure.	Plan covers Diagnosis and treatment of cause of infertility. Benefits are available for covered services such as office visits, laboratory tests, and radiological studies to diagnose the cause of infertility. Benefits are also provided for the necessary treatment of the condition unless the treatment is identified as non-covered (see exclusions). For example, corrective surgical procedures, therapeutic injections, and drug therapy regimens (Pregnyl, Clomid, Clomiphene, Ovidrel, Gonol, Follistim and Cetrotide) are all covered services when medically necessary. Benefits are also available for tests, such as ultrasound, performed to monitor the effectiveness of the fertility drug therapy. Also for any necessary pregnancy testing performed as an integral part of the overall infertility treatment program. Benefits are excluded, however, for any procedures, tests, or other services that are exclusively provided to monitor the effectiveness of non-covered fertilization procedures.
12	Long-Term/Custodial Nursing Home Care	No	Not Covered	No				
13	Private-Duty Nursing	Yes	Covered	No			Excludes services provided by a member of the Insured's immediate family; Provided by a person who normally lives in the Insured's home; or Which are Custodial/Maintenance care. The Company has the right to determine which services are Custodial/Maintenance care.	
14	Routine Eye Exam (Adult)	No	Not Covered	No				
15	Urgent Care Centers or Facilities	Yes	Covered	No				
16	Home Health Care Services	Yes	Covered	No			Excludes services provided by a member of the Insured's immediate family; Provided by a person who normally lives in the Insured's home; or Which are Custodial/Maintenance care. The Company has the right to determine which services are Custodial/Maintenance care.	Includes educational visits with a limit of three per year on educational visits.
17	Emergency Room Services	Yes	Covered	No				
18	Emergency Transportation/Ambulance	Yes	Covered	No				Emergency transportation/ambulance within 500 mile radius.
19	Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No			Blood.	
20	Inpatient Physician and Surgical Services	Yes	Covered	No				
21	Bariatric Surgery	Yes	Covered	No				Bariatric surgery is Covered for patients with a Body Mass Index (BMI) of 35 kg/m2 or greater who are at high risk for increased morbidity due to at least one specific obesity related comorbid medical condition(s).
22	Cosmetic Surgery	No	Not Covered	No				

	A	B	C	D	E	F	G	H
	A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
3								
23	Skilled Nursing Facility	No	Not Covered	No				
24	Prenatal and Postnatal Care	Yes	Covered	No				Also covers surrogate mother if there is a petition to adopt within 90 days of birth.
25	Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				Also covers surrogate mother if there is a petition to adopt within 90 days of birth.
26	Mental/Behavioral Health Outpatient Services	Yes	Covered	No				Includes Applied Behavior Analysis for insureds with Autism Spectrum Disorder.
27	Mental/Behavioral Health Inpatient Services	Yes	Covered	No				
28	Substance Abuse Disorder Outpatient Services	Yes	Covered	No				
29	Substance Abuse Disorder Inpatient Services	Yes	Covered	No				
30	Generic Drugs	Yes	Covered	No				
31	Preferred Brand Drugs	Yes	Covered	No				
32	Non-Preferred Brand Drugs	Yes	Covered	No				
33	Specialty Drugs	Yes	Covered	No			Coverage for Specialty Prescription Drugs will be limited to a supply sufficient for 34 consecutive days of therapy.	
34	Outpatient Rehabilitation Services	Yes	Covered	Yes	90	Day(s) per Benefit Period	Excludes vocational rehabilitation; Cognitive therapy; social rehabilitation.	These therapies include but are not limited to PT, OT, and ST. Further, "[Rehab] Services are covered only if they are expected to result in significant improvement in the Insured's condition. The Company, with appropriate medical consultation, will determine whether significant improvement has occurred". "Speech Therapy", limited to one service per day up to a maximum benefit of 90 daily services per Insured per Benefit Period. This limitation is not applicable to Mental Illness or Substance Use Disorders.
35	Habilitation Services	Yes	Covered	No				
36	Chiropractic Care	Yes	Covered	No				
37	Durable Medical Equipment	Yes	Covered	No		Item(s) per 3 Years	Items for comfort or convenience are not covered. Included within the definition of convenience items are: (a) Pieces of equipment used to provide exercise to functioning and non-functioning portions of the body when leased, purchased, or rented for use outside a recognized institutional facility. (b) Those pieces of equipment designed to provide the walking capability for individuals with nonfunctioning legs.	"Benefits are limited to the amount normally available for a basic (standard) item which allows necessary function. Basic (standard) medical equipment is equipment that provides the essential function required for the treatment or amelioration of the medical condition at a Medically Necessary level. Charges for deluxe or electrically operated medical equipment are not covered, beyond the extent allowed for basic (standard) items. Deluxe describes medical equipment that has enhancements that allow for additional convenience or use beyond that provided by basic (standard) equipment."
38	Hearing Aids	Yes	Covered	Yes	1			Either one (1) or two (2) devices every 3 years depending on whether hearing loss is unilateral or bilateral. Hearing test and documented severity of hearing loss required by licensed Audiologist. Prescription hearing aids for documented severe or profound hearing loss only; over-the-counter hearing aids for documented mild or moderate hearing loss only.
39	Imaging (CT/PET Scans, MRIs)	Yes	Covered	No			Diagnostic tests and evaluations are ordered, requested or performed solely for the purpose of resolving issues in the context of legal proceedings, including those concerning custody, visitation, termination of parental rights, civil damages or criminal actions.	
40	Preventive Care/Screening/Immunization	Yes	Covered	No				
41	Routine Foot Care	Yes	Covered	No				Covered when systemic conditions such as metabolic, neurologic, or peripheral vascular disease exists and results in medically significant circulatory deficits or decreased sensation to the foot.
42	Acupuncture	No	Not Covered	No				
43	Weight Loss Programs	No	Not Covered	No				
44	Routine Eye Exam for Children	Yes	Covered	No				
45	Eye Glasses for Children	Yes	Covered	No				
46	Dental Check-Up for Children	Yes	Covered	No				
47	Rehabilitative Speech Therapy	Yes	Covered	Yes	90	Day(s) per Benefit Period		Limited to one service per day up to a maximum benefit of 90 daily services per Insured per Benefit Period. This limitation is not applicable to Mental Illness or Substance Use Disorders.
48	Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	No			Materials used for occupational therapy are excluded.	
49	Well Baby Visits and Care	Yes	Covered	No				
50	Laboratory Outpatient and Professional Services	Yes	Covered	No			Diagnostic tests and evaluations are ordered, requested or performed solely for the purpose of resolving issues in the context of legal proceedings, including those concerning custody, visitation, termination of parental rights, civil damages or criminal actions.	
51	X-rays and Diagnostic Imaging	Yes	Covered	No			Diagnostic tests and evaluations are ordered, requested or performed solely for the purpose of resolving issues in the context of legal proceedings, including those concerning custody, visitation, termination of parental rights, civil damages or criminal actions.	
52	Basic Dental Care - Child	Yes	Covered	No				

	A	B	C	D	E	F	G	H
	A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
3								
53	Orthodontia - Child	Yes	Covered	No				Orthodontic services require prior authorization and are only covered for eligible children with cases of severe orthodontic abnormality caused by genetic deformity (such as cleft lip or cleft palate) or traumatic facial injury resulting in serious health impairment to the beneficiary at the present time.
54	Major Dental Care - Child	Yes	Covered	No				
55	Basic Dental Care - Adult	No	Not Covered	No				Basic dental care for adults not covered by CHIP.
56	Orthodontia - Adult	No	Not Covered	No				
57	Major Dental Care - Adult	No	Not Covered	No				Major dental care for adults not covered by CHIP.
58	Abortion for Which Public Funding is Prohibited	No	Not Covered	No			Voluntary Abortions.	Covered when life of the mother is in jeopardy.
59	Transplant	Yes	Covered	No			There is no coverage hereunder for any transplant not specifically listed as covered or for supplies or services provided directly for or relative to human organ transplants not specifically listed as covered.	Benefits are provided for the following human organ transplants: Cornea; heart; heart-lung; kidney; pancreas; liver; lung (whole or lobar, single or double); small intestine; and multivisceral transplants.
60	Accidental Dental	Yes	Covered	No				Oral Surgical Services and Services for Accidental Injuries to Sound Natural Teeth, limited to: (1) Surgical procedures of the jaw and gums. (2) Removal of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth. (3) Removal of exostoses (bony growths) of the jaw and hard palate. (4) Treatment of fractures and dislocations of the jaw and facial bones. (5) Surgical removal of impacted teeth. (6) Treatment of Sound Natural Teeth caused by an Accidental Injury. This includes replacement of Sound Natural Teeth lost due to the Accidental Injury. (7) Intra oral dental imaging services in connection with covered oral surgery if treatment begins within 30 days. (8) General anesthesia for covered oral surgery. (9) Cylindrical endosseous dental implants, mandibular staple implants, subperiosteal implants and the associated fixed and/or removable prosthetic appliance when provided because of an Accidental Injury. (10) Cylindrical endosseous dental implants, mandibular staple implants, subperiosteal implants and the associated fixed and/or removable prosthetic appliances following surgical resection of either benign or malignant lesions (NOT including inflammatory lesions).
61	Dialysis	Yes	Covered	No				Plan covers Hemodialysis.
62	Allergy Testing	Yes	Covered	No				Allergy testing and treatment.
63	Chemotherapy	Yes	Covered	No				
64	Radiation	Yes	Covered	No				
65	Diabetes Education	Yes	Covered	No				Outpatient self-management training and education, including medical nutrition therapy, for insulin dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin using diabetes when provided by a certified, registered or licensed health care professional with expertise in diabetes and the diabetic (1) is treated at a program approved by the American Diabetes Association; (2) is treated by a person certified by the national certification board of diabetes educators; or (3) is, as to nutritional education, treated by a licensed dietitian pursuant to a treatment plan authorized by such healthcare professional.

	A	B	C	D	E	F	G	H
	A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
66	Prosthetic Devices	Yes	Covered	No			(1) Benefits are not provided for eyeglasses and contact lenses. Exception: Benefits are available for the initial eyeglasses/contacts following surgery for cataracts, aphakia, or pseudophakia, or an insured under 12 years of age is eligible for subsequent eyeglasses/contacts following cataract surgery when there is a minimum change of .25 diopter. (2) Benefits are not provided for hearing aids, hair prosthesis or dental appliances including plates, bridges, prostheses or braces. (3) Benefits are not provided for items of wearing apparel except coverage is available for two postmastectomy bras per insured per Benefit Period. A post-mastectomy bra is a bra that is specifically designed and intended to support single or bilateral breast prostheses. (4) Benefits are limited to the allowable amount for a basic/standard appliance which provides the essential function(s) required for the treatment or amelioration of the medical condition. (5) Charges for deluxe or electrically operated appliances or devices are not covered beyond the allowable amount for basic/standard appliances. Deluxe describes medical devices or appliances that have enhancements that allow for additional convenience or use beyond that provided by a basic/standard device or appliance. (6) Benefits are not provided for custom or over-the-counter orthotic devices, appliances including shoe inserts.	Benefits are limited to the amount normally available for a basic (standard) appliance which allows necessary function. Basic (standard) medical devices or appliances are those that provide the essential function required for the treatment or amelioration of the medical condition at a Medically Necessary level.
67	Infusion Therapy	Yes	Covered	No				
68	Treatment for Temporomandibular Joint Disorders	Yes	Covered	No			Phase II irreversible treatment; equilibration of occlusion, coronoplasty, occlusal adjustment; slides and/or photographs; non-prescription drugs, vitamins, nutrition supplements; stretching and other exercises; coolant sprays; moist heat therapy; hot packs; massage, either manual or by machine; acupuncture; cold packs; range of motion treatments; diet survey; nutrition counseling; rental or purchase of transcutaneous electrical nerve stimulators; office visits; periapical, bitewing and full-mouth radiographs; orthodontic treatment, including both fixed and removable appliances used for the purpose of moving teeth.	
69	Nutritional Counseling	Yes	Covered	No				Covered as defined in Preventive Services requirement.
70	Reconstructive Surgery	Yes	Covered	No				Cosmetic and reconstructive are generally excluded, but excepted from this exclusion are: a. Cosmetic or reconstructive repair of an Accidental Injury. b. Reconstructive breast surgery in connection with a Medically Necessary mastectomy that resulted from a medical illness or injury. This includes reconstructive surgery on a breast on which a mastectomy was not performed in order to produce a symmetrical appearance. c. Repair of congenital abnormalities and hereditary complications or conditions, limited to: (1) Cleft lip or palate. (2) Birthmarks on head or neck. (3) Webbed fingers or toes. (4) Supernumerary fingers or toes. d. Reconstructive services performed on structures of the body to improve/restore impairments of bodily function resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes. For purposes of this provision, the term "cosmetic" means procedures and related services performed to reshape structures of the body in order to alter the individual's appearance.
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EHB-benchmark Plan Formulary Drug List

OMB Control Number: 0938-1174
Expiration Date: 02/28/2024

If the State is selecting the option at 45 CFR 156.111(a)(3) to change its EHB-benchmark Plan, the State must submit to CMS a formulary drug list using this template when the State submits its EHB-benchmark plan. Please note that, pursuant to 45 CFR 156.122, if the EHB-benchmark plan does not include any coverage in a USP category and/or class, then the count is zero. EHB plans must cover at least one drug in that USP category and/or class.

Instructions: The State must submit the template provided by HHS for the formulary drug list as a list of RxNorm Concept Unique Identifiers (RXCUIs). A complete list of RXCUIs for all prescription drugs that are covered by the new State's EHB-benchmark Plan, regardless of tier placement and medical utilization management. If the State is creating its own benchmark plan, the States should use the most recent RxNorm information.

RXCUIs group chemically identical drugs into code numbers by ingredient, strength, dose form and brand name. For example:

- RXCUI 860975 = Metformin 500 MG Oral Tablet
- RXCUI 860977 = Metformin 500 MG Oral Tablet [Glucophage]
- RXCUI 860981 = Metformin 750 MG Oral Tablet

Enter only RXCUIs numerical values below.

RxCUI	
91792	
92582	
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92752	
93181	
94345	
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Overview of State Documentation Requirements for EHB-benchmark Plans

OMB Control Number: 0938-1174
Expiration Date: 02/28/2024

The below chart provides an overview of the documents that a State needs to submit when selecting an EHB-benchmark Plan. These documents vary based on which option the State is using to select for its EHB-benchmark Plan.

State Documentation Requirements	Option 1: Select another State's EHB-benchmark Plan [in accordance with §156.111(a)(1)]	Option 2: Replace category or categories of benefits from another State's EHB-benchmark Plan [in accordance with § 156.111(a)(2)]	Option 3: Otherwise select a set of benefits for the State's EHB-benchmark Plan [in accordance with §156.111(a)(3)]	Does this document require use of a specific template?
	Required?	Required?	Required?	Required?
Confirmations: Complies with §156.111(a), (b), and (c)	Yes	Yes	Yes	Yes
Actuarial certification and report: 1) Equal to, greater than, the scope of benefits provided under a typical employer plan 2) Does not exceed the generosity of the most generous among certain plans	Yes	Yes	Yes	For the certification, yes; For the report, no
	Yes	Yes	Yes	For the certification, yes; For the report, no
State's EHB-benchmark plan document: 1) Describes benefits and limits in accordance with §156.111(e)(3) 2) Provides formulary drug list for the State's EHB-benchmark Plan	Yes	Yes	Yes	No
	No	No	Yes	Yes
EHB Summary Chart: Provides a summary of the State's EHB-benchmark Plan	Yes	Yes	Yes	Yes

PRA Disclosure Statement

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ESSENTIAL HEALTH BENEFITS (EHB) STATE SUBSTITUTION NOTIFICATION

BEGINNING A STATE OPT-IN

1. Will your State allow EHB substitution between EHB categories (optional field)?

Yes

No

2. If "Yes" to question 1, what plan year will the State begin allowing substitutions between EHB categories (optional field)?

3. If "Yes" to question 1, between which EHB category or categories will the State allow substitutions? Note that prescription drug substitutions are not allowed.

Ambulatory patient services

Rehabilitative and habilitative services
and devices

Emergency services

Laboratory services

Hospitalization

Preventive and wellness services and
chronic disease management

Maternity and newborn care

Pediatric services, including oral and
vision care

Mental health and substance
use disorder services including
behavioral health treatment

ENDING A STATE OPT-IN

4. If the State has been allowing between EHB category substitution, check this box if the State intends to terminate between EHB category substitution (optional field)?

Yes – terminate between EHB category substitution

5. If yes to question 4, what plan year will the State begin terminating between EHB category substitution (optional field)?

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4. What plan was the basis for determining that the State's proposed EHB-benchmark plan's scope of benefits are equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), the scope of benefits provided under a typical employer plan?

5. Briefly describe the methods, assumptions, and data used to determine that the State's proposed EHB-benchmark plan provides a scope of benefits that are equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), the scope of benefits provided under a typical employer plan.¹

- Compare the benefits being offered, and
- Compare the costs of the level of those benefits.

SECTION 3: LIMITATION ON EXCEEDING GENEROSITY FOR §156.111(b)(2)(i)

6. In accordance with §156.111(b)(2)(ii), does the State's proposed EHB-benchmark plan definition exceed the generosity of the most generous among a set of comparison plans, including 1) the State's EHB-benchmark plan used for the 2017 plan year, and 2) any of the State's base-benchmark plan options for the 2017 plan year described in §156.100(a)(1), supplemented as necessary under §156.110?²

Yes

No

7. Which plan or plans were used as the basis to determine the most generous plan for this comparison?

8. Briefly describe the methods, assumptions and data used to determine whether the State's EHB-benchmark plan does not exceed the generosity of the most generous among a set of comparison plans:

- Compare the benefits being offered, and
- Compare the costs of the level of those benefits.

¹ A copy of the *Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii)* is available on CCIO's Regulation and Guidance webpage at <https://www.cms.gov/ccio/resources/regulations-and-guidance/index.html>. The actuary's response to Questions 4 and 8 may be the same or different.

² The Essential Health Benefits: List of the Largest Three Small Group Products by State for 2017 is available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Top3ListFinal-5-19-2015.pdf>. States' EHB-benchmark plans used for the 2017 plan year are available at https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Final-List-of-BMPs_4816.pdf.

SECTION 4: CERTIFICATION LANGUAGE

45 CFR §156.111(e)(2) requires that a State selecting its EHB-benchmark plan must submit an actuarial certification and an associated actuarial report from an actuary, who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies that affirms:

- (i) That the State's EHB-benchmark plan provides a scope of benefits equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), the scope of benefits provided under a typical employer plan as defined at §156.111(b)(2)(i); and
- (ii) That the State's EHB-benchmark plan does not exceed the generosity of the most generous among the plans listed in §156.111(b)(2)(ii)(A) and (B).

The analysis described in this document and supported in the actuarial report attached to this document was:

- (i) conducted by a member of the American Academy of Actuaries, and
- (ii) performed in accordance with generally accepted actuarial principles and methods, including complying with all applicable Actuarial Standards of Practice (ASOP).

Name of Actuary Completing Form

Actuary Signature

Date

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1174 (Expires 02/28/2024)**. The time required to complete this information collection is estimated to average **47 hours or 2,820 minutes per response for States. For Form 1, the estimate is 4 hours. For Form 2, the estimate is 19 hours. For Form 3, the estimate is 12 hours. For Form 4, the estimate is 12 hours.** If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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	A	B	C
28	* Note: Due to the availability of drugs in the market, the exact drug count for a given State will be established in the EHB drug count tool, but for the purposes of the State's EHB- benchmark Plan, the display will be the same drug count as the 2017 EHB-benchmark plan.		
29	SECTION D		
30	Under Section D, please complete the "Explanation" column with sentences describing how the State is complying with the specific requirement; single word responses such as Yes, No, or N/A are not sufficient responses.		
31	EHB-Benchmark Plan Requirements	State's Confirmations	Explanation
32	Does the State's EHB-benchmark Plan definition meet the requirements of §156.111(b)(1) with regard to scope of benefits?	Yes	
33	Is the State's EHB-benchmark Plan equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), the scope of benefits provided under a typical employer plan as defined and established at §156.111(b)(2)(i)?	Yes	
34	Has an actuary, who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies, affirmed that the State's new EHB-benchmark plan provides a scope of benefits that is equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), to the scope of benefits provided under a typical employer plan as defined at §156.111(b)(2)(i) and in accordance with §156.111(e)(2)?	Yes	
35	Does the State's EHB-benchmark Plan not exceed the generosity of the most generous the plans listed at §156.111(b)(2)(ii) ?	Yes	
36	Has an actuary, who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies, affirmed that the new EHB-benchmark plan does not exceed the generosity of the most generous the plans listed at §156.111(b)(2)(ii) and in accordance with §156.111(e)(2)?	Yes	
37	Is the State's EHB-benchmark Plan unduly weighting benefits towards any of the categories of benefits (§156.111(b)(2)(iii))?	No	
38	Does the State's EHB-benchmark Plan provide benefits for diverse segments of the population in accordance with §156.111(b)(2)(iv)?	Yes	
39	Did the State provide reasonable public notice and an opportunity for public comment on the State's selection of its EHB-benchmark Plan that includes posting a notice on its opportunity for public comment with associated information on a relevant State Web site in accordance with §156.111(c)? Please provide the public notice dates and applicable website address in the "Explanation" column.	Yes	March 3 - April 11, 2023 https://insurance.kansas.gov/ehb/
40	Are non-EHB benefits excluded from the EHB-benchmark Plan in accordance with §156.115(d)? (Non-EHB benefits include adult vision, adult dental, long-term care, cosmetic orthodontia)	Yes	
41	Has the State converted any benefits in its EHB-benchmark Plan restricted by annual or lifetime dollar limits as defined by §147.126 to non-dollar limit benefits?	No	
42	Does the EHB-benchmark Plan include benefits mandated by State action taking place after 2011, other than for purposes of compliance with Federal requirements, for which payment is required under §155.170?	No	
43	Are the EHB-benchmark Plan's benefits designed such that they do not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions as prohibited by §156.125 and in accordance with §156.111(b)(2)(v)?	Yes	
44	Is there any additional information CMS should know?	No	

	A	B	C
	PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1174 (Expires 02/28/2024). The time required to complete this information collection is estimated to average 47 hours or 2,820 minutes per response for States. For Form 1, the estimate is 4 hours. For Form 2, the estimate is 19 hours. For Form 3, the estimate is 12 hours. For Form 4, the estimate is 12 hours. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ****CMS Disclosure**** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Ken Buerger at Ken.Buerger@cms.hhs.gov.		
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