

September 12, 2013

# **Options for Coverage of Treatment for Autism Spectrum Disorder in Minnesota**

**Report to the Minnesota Legislature**

Submitted by the Minnesota Department of Commerce

For information about this report, please contact Peter Brickwedde by phone at 651-539-1443, or by email at [peter.brickwedde@state.mn.us](mailto:peter.brickwedde@state.mn.us)

# Table of Contents

Introduction – Page 4

Executive Summary – Page 5

What is Autism Spectrum Disorder (ASD)? – Page 6

What are the Treatments for ASD? – Page 6

How is Treatment Covered in Other States? – Page 7

How is Treatment for ASD Covered in Minnesota? – Page 8

The cost of treatment for Intensive Behavioral Therapies (IBT) in Minnesota – Page 9

Options for Future Coverage of IBT in Minnesota – Page 10

Appendix A – Page 17

Bibliography – Page 19

## Introduction:

In the 2013 Legislative Session, the Legislature charged the Minnesota Department of Commerce with preparing a report on options for coverage of treatment for autism spectrum disorders in Minnesota.

Omnibus Health and Human Services Finance Bill, Session Law 2013 Chapter 108

### **STUDY AND RECOMMENDATIONS REGARDING MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION.**

By August 15, 2013, the Department of Commerce shall study and report to the legislature on reasonable and efficient options for coverage for high-quality, medically necessary, evidence-based treatment of autism spectrum disorders up to age 18, including whether the Minnesota Comprehensive Health Association could provide coverage options through January 1, 2016, under Minnesota Statutes, chapter 62E.

# Executive Summary

In the 2013 Legislative Session, the Legislature charged the Minnesota Department of Commerce with preparing a report on options for coverage of treatment for autism spectrum disorders (ASD) in Minnesota. This report fulfills that requirement.

The report provides a broad overview of ASD, the treatments available for ASD and discusses how ASD treatment is covered in Minnesota as well as other states. The report discusses the costs of IBT treatment in Minnesota and closes by laying out policy options for future coverage of IBT in the state for the Legislature to consider.

# What is Autism Spectrum Disorder?

Autism Spectrum Disorder (ASD) is a condition that usually appears in children who are around one or two years old, and results in difficulty in communicating with people. The severity of ASD can range from extremely disabling to very mild symptoms that cause only minor difficulties. Due to the wide range of effects, ASD is called a “spectrum.”

For most of the twentieth century, autism was not well understood by the public or by the medical profession. The medical profession is now widely trained in recognizing the symptoms of ASD and referring affected children to specialists. The recently released Diagnostic and Statistical Manual (DSM-5) includes a single ASD category instead of several different diagnoses. The former diagnoses included the following: autistic disorder, Asperger disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified (PDD-NOS).

The Centers for Disease Control and Prevention (CDC) estimated in its report, “*Prevalence of Autism Spectrum Disorders*,” that one in 88 children in the United States has been identified as having ASD. The study looked at data from 14 communities. Autism spectrum disorders are almost five times more common among boys than girls, with 1 in 54 boys identified. The number of children identified with ASDs ranged from one in 210 children in Alabama to one in 47 children in Utah. The largest increases from prior estimates were among Hispanic and black children.

One indication of the prevalence of ASD in Minnesota is the information in a May 5, 2012 report from the Minnesota Department of Education entitled, “Minnesota Autism Spectrum Disorder (ASD) Needs Survey 2011-2012.” This report states that 15,378 individuals under 21 years of age in Minnesota have a primary disability of ASD, and that those individuals represent 12 percent of all students that receive special education services.

# What kind of treatment is available for children with ASD?

Children with ASD benefit from a variety of therapies, including physical therapy, occupational therapy, socialization therapy, pharmacotherapy and intensive behavioral therapy. There is currently no treatment for ASD that completely resolves its symptoms. One treatment option that may reduce symptoms is intensive behavioral therapies (IBT) which is generally initiated soon

after diagnosis and is often time-consuming and expensive. These therapies include applied behavioral analysis (ABA), intensive early intervention behavior therapy (IEIBT), and Lovaas therapy.

A report to the Minnesota Department of Human Services (DHS) in February, 2013 by the Health Services Advisory Council stated in its Executive Summary on page ES-4, “HSAC supported DHS’ commitment to covering supportive and medically necessary, client- and family-centered services for children and adults with ASD. The science of treating ASD is still emerging. Indeed, the evidence for most interventions across the lifespan of a person with ASD is insufficient even to draw preliminary conclusions.”

## How is treatment for ASD covered in other states?

Many states have passed laws requiring that private health insurance cover some type of treatment for autism. These state mandates differ in the specific treatments that must be covered, and also differ in the dollar caps that may be applied to the coverage by the insurers.

According to the National Conference of State Legislatures, 31 states have laws mandating coverage for autism:

“A total of 37 states and the District of Columbia have laws related to autism and insurance coverage. At least 31 states—Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island, South Carolina, Texas, Vermont, Virginia, West Virginia and Wisconsin—specifically require insurers to provide coverage for the treatment of autism. Alabama requires insurers to offer autism coverage in certain situations. Vermont amended their law to cover treatment for early childhood developmental disorders, which includes autism spectrum disorders. Other states may require limited coverage for autism under mental health coverage or other laws.”

Not all of these states, however, provide coverage for IBT despite mandating coverage for ASD treatment broadly. According to documents submitted by states to the federal Center for Consumer Information and Insurance Oversight (CCIIO), at least 14 states affirmatively cover IBT for autism as part of their essential health benefits (EHB) set. Many other states include autism coverage but do not specify whether this includes IBT. The specific provisions and limits on coverage for autism vary widely based on that state’s mandates and the benchmark plan they are using to define their EHB plans. Many other states specifically exclude coverage for IBT. Consequently, access to IBT coverage for consumers across the country is uneven.

## How is treatment for ASD covered in Minnesota?

Insurance/HMO plans in Minnesota generally cover many therapies for ASD, including physical, occupational and speech therapy, mental health care, and pharmacological management.

Currently, in the markets the state of Minnesota has regulatory authority over, most children's health coverage does not include coverage for IBT. Generally, only those children covered by Medical Assistance or the state's high risk pool, the Minnesota Comprehensive Health Association (MCHA), have coverage for IBT. In 2010, 96 individuals received autism treatments in MCHA and in 2011, 129 individuals received autism treatments in MCHA.

Most individual and small employer plans do not currently include coverage for IBT (some Minnesota companies have chosen self-insured products, which the state does not have regulatory authority over, that do include coverage for IBT). For example, a certificate of coverage for a small group health insurance policy approved in 2012 had the following exclusion:

**"SERVICES NOT COVERED:**

Intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders, including Applied Behavioral Analysis (ABA), Intensive Early Intervention Behavior Therapy (IEIBT), and Lovaas."

Coverage for IBT for ASD is currently available through Medical Assistance programs administered by the state Department of Human Services (DHS). A study by DHS's Health Services Advisory Council issued in February, 2013 indicates that over 17,000 people with an ASD diagnosis were enrolled in public programs in 2010, and 10,020 of them received "long-term service and support (LTSS)." Children under age 18 with an ASD diagnosis made up 10,056 of that population, and 2,556 of them received LTSS. Children under 18 with an ASD diagnosis were 2.8% of the total population of children enrolled in public programs.

Coverage for IBT was available for several years through some health insurance plans provided by Blue Cross and Blue Shield, but, as of this report, no actively marketed products in the private market have been identified that provide IBT coverage.

The 2013 legislature passed legislation that requires health coverage sold to fully insured employers and self-insured political subdivisions with 51 or more employees to include coverage of IBT in 2014. The bill also requires that health coverage for state employees include



coverage of IBT (See Appendix A). The state has no authority, however, to mandate coverage of IBT by self-insured plans established by employers outside of the state's regulatory jurisdiction, and most of those plans do not cover IBT.

## The cost of treatment for IBT in Minnesota

Cost estimates for treatment of IBT vary widely depending on the nature of the treatment. In MCHA, 96 people received autism treatment in 2010 at a total cost of \$4,541,615. In 2011, 129 people received autism treatment at a total cost of \$6,420,269. The cost does not include deductibles or co-insurance paid by the patients' families to the clinics. The MCHA population contains a higher than average proportion of children with ASD.

Eric V. Larsson, Ph.D.'s paper "*What is the Cost Impact of Covering ABA*" estimates a cost of \$32 per enrolled child per year. This estimate includes only one type of IBT. This estimate applies to a general population that has insurance with a mandate for autism coverage and a population that is assumed to have an average proportion of children with ASD. In addition, many states with mandated coverage limit the amount paid by a health plan toward IBT each year, which can lower an estimated per-enrollee cost.

In a fiscal note prepared for H.F. 181 during the 2013 legislative session, DHS estimated that 414 children would receive intensive behavior therapy in fiscal 2013 at an average cost per year of \$40,548. This implies a total cost per year of \$16,786,872.

In the same fiscal note, Minnesota Management and Budget (MMB) reported that 51 members in the State Employees Group Insurance Program (SEGIP) population received IBT treatments in 2011. MMB projected in the fiscal note that an additional 23 members not previously receiving IBT treatments would begin receiving them if SEGIP resumed providing coverage for IBT. MMB projected that the total cost per year would be \$4,829,240.

## Options for future coverage of IBT in Minnesota

While the federal government has not set out the process for doing so, states are expected to be able add benefits to their Essential Health Benefit (EHB) set beginning in 2016. Once this process is identified, Minnesota may add IBT coverage to its EHB set to provide coverage for consumers in the individual and small group market beginning in 2016.

Expanding coverage for IBT in Minnesota before 2016, however, is a challenging issue. Many options for expanding coverage in 2014 and 2015 would require future legislative action and potentially could be subjected to a challenge as to whether action would constitute an additional state mandate. Due to the limited time available to implement coverage changes that would apply to products sold offering coverage in 2014, the Department recommends that future legislative action to expand coverage be effective beginning in 2015. It is important to note that the Legislature's expansion of mandated coverage to the large group market will result in more coverage for IBT in the private market than any prior time in Minnesota.

This section outlines several avenues for providing coverage in 2014 and 2015 for legislative consideration. For each option, this section evaluates:

- How efficiently a consumer could obtain coverage for IBT services ( "efficiency for consumers");
- The potential cost of obtaining that coverage for consumers ("cost for consumers");
- The potential costs to the state of Minnesota associated with providing that coverage avenue for consumers ("cost for the state"); and
- Whether that option would require legislative action.

Options for Future Coverage in Minnesota	Efficiency for Consumers	Cost for Consumers	Cost for the State	Legislative Action Required?
<b>Expanding the mandated insurance/HMO coverage that now applies to large employers</b>	<b>High</b> – this option would provide increased access to IBT coverage for consumers who purchase coverage in the individual & small group markets	<b>Low</b> – Consumers would not see an increase related to their costs as insurers' costs of providing coverage would be reimbursed by the State of Minnesota	<b>High</b> – Because federal law requires a state to reimburse the cost of coverage mandated by a state that is not in its Essential Health Benefits (EHB) package, Minnesota would be responsible for the cost of adding a mandated benefit in this manner	<b>Yes</b>
<b>Mandating that insurers offer optional coverage for IBT</b>	<b>Low</b> – this option provides an avenue for coverage, but may be cost prohibitive for consumers	<b>High</b> - Insurance companies would assume that the only buyers would be people who are planning to use the coverage creating adverse selection. Premiums would be expected to approximately equal the actual costs of providing treatment which would be cost prohibitive to most consumers	<b>None</b>	<b>Yes</b>
<b>Expanding the availability of public program coverage of IBT</b>	<b>Low</b> – Income limits for public programs eligibility would restrict access to coverage	<b>Low</b> – the cost of public programs for consumers are calculated based on family income levels	<b>Unknown</b> – The cost to the state of expanding access to public programs would depend on the number of newly eligible children and whether federal matching funds would be available for them	<b>Yes</b>
<b>Creating a special program to allow children with ASD to continue to enroll in MCHA through 2015</b>	<b>Medium</b> – coverage provided by MCHA would be a short-term solution for consumers as the MCHA program is expected to close at the end of 2014	<b>High</b> – the cost of providing this coverage would be similar to the cost of mandating the coverage in the individual and small group markets, but would initially be paid by health plans through an MCHA assessment	<b>Unknown</b> – keeping MCHA open to provide coverage would result in administrative costs for the program and could potential reduce federal reinsurance dollars received by the state in the next 3 years	<b>Yes</b>
<b>Expand mandated coverage in 2015 using revised MCHA assessment</b>	<b>High</b> – creating a rider in the existing individual and small group markets could increase avenues for coverage of IBT for consumers	<b>Medium</b> – the cost to consumers would be similar to the cost of providing the coverage directly through MCHA, but consumers would purchase health coverage in the private market. This could also provide an incentive for insurers to work with IBT providers to implement cost containment strategies to reduce the impact on premiums in the marketplace	<b>Unknown</b> –MCHA would need to retain some staff and administrative costs during 2015 in order to administer the revised assessment process and may need a federal waiver or determination that the state is not responsible for reimbursing for costs	<b>Yes</b>

- **Expanding the Mandated Insurance/HMO Coverage that Now Applies to Large Group Market**

The state has authority over insurance coverage provided by health plan companies, including insurance companies, nonprofit health service plan corporations (Blue Cross and Blue Shield of Minnesota), and HMOs. The state mandated coverage for autism services by fully insured large employers and certain self-insured political subdivisions regulated under state law beginning in 2014 (See Appendix I). The state could mandate that health plans in the small employer group market and the individual/family market include coverage for IBTs beginning in 2015.

### **Efficiency for Consumers**

**High** – Consumers would be able to efficiently access coverage under this option. Consumers would have increased avenues to purchase health insurance products that provide coverage for IBT in the individual and small group markets. This option would not apply to individuals who are currently uninsured or receiving coverage from self-funded employers.

### **Potential Cost for Consumers**

**Low** – Consumers would not see an increase related to their costs as insurers' costs of providing coverage to consumers would be reimbursed by the State of Minnesota. Because federal law requires a state to reimburse the cost of coverage mandated by a state that is not in its EHB package, Minnesota would be responsible for the cost of adding a mandated benefit in this manner.

### **Potential Costs for State**

**High** –The Commerce Department projected in a fiscal note prepared for H.F.181 during the 2013 legislative session that the cost to the state of this mandate would be \$7,665,000 in fiscal year 2015, and the consolidated fiscal note had a cost to the state of \$10,344,000 if the mandate applied to SEGIP. The consolidated cost reflects a savings of \$2,150,000 to DHS due to enrollees in public programs moving to private health plan coverage. Total cost would likely increase each year in the future, due to price increases, greater availability of providers, and the movement of families with autistic children into these insurance plans.

## **Legislative Action Required?**

Yes.

- **Mandating Optional Insurance/HMO Coverage**

The state could mandate that insurers offer optional coverage for IBTs in the individual/family and small group markets beginning in 2015. This may function as a supplement to an insurance policy or “rider” that an individual or employer could opt to purchase for an additional premium.

### **Efficiency for Consumers**

**Low** – This option provides an avenue for consumers to access coverage, but it may be cost prohibitive to purchase.

### **Potential Cost for Consumers**

**High** – Insurance companies would assume that the only buyers would be people who are planning to use the coverage which would create adverse selection. Premiums would be expected to be approximately equal to the actual costs of providing treatment which would be cost prohibitive to most consumers.

### **Potential Cost for State**

**None** – There would not be a cost to the state for this option.

## **Legislative Action Required?**

Yes.

- **Expanding Public Program Coverage of IBT**

Several hundred children with ASD are currently served by Medical Assistance in Minnesota. The state could expand Medical Assistance eligibility to cover more children with ASD who receive IBT.

### **Efficiency for Consumers**

**Low** – The efficiency of expanding eligibility to more children would not be likely to reach more than a small proportion of the children with ASD who need IBT services because of income

limits that determine public program eligibility would restrict access to coverage. Consumers with incomes that exceed eligibility thresholds would not be able to access IBT coverage under this option.

### **Potential Cost for Consumers**

**Low** – The cost for consumers would be low under this option because costs for public programs are calculated based on family income levels.

### **Potential Cost for State**

**Unknown** – The cost to the state of expanding access to public programs would depend on the number of newly eligible children and whether federal matching funds would be available for them. The state could capture administrative efficiencies by utilizing existing structures within state government to negotiate with providers, enroll applicants, and adjudicate claims for IBT services.

### **Legislative Action Required?**

Yes.

- **Creating a Special Program to Allow Children with ASD to Continue to Enroll in MCHA Through 2015**

The Legislature could mandate that MCHA remain open through 2015 and that coverage for IBT be available to consumers.

### **Efficiency for Consumers**

**Medium** – Consumers would have an avenue to coverage under this option, but it would be a short-term solution. During the 2013 legislative session, the Commissioner of the Department of Commerce was given authority to prepare for the eventual, appropriate termination of coverage provided through MCHA. The Commerce Department released a draft MCHA Transition Plan on June 30, 2013.

The [final] draft MCHA Transition Plan calls for MCHA plans to cease accepting new applicants on January 1, 2014 and calls for MCHA to close its program and transition remaining enrollees

to new coverage at the end of 2014. This option would likely complicate or delay the ultimate closing of MCHA.

### **Potential Cost for Consumers**

**Medium** – The cost of providing this coverage would be similar to the cost of mandating the coverage in the individual and small group markets, but would initially be paid by health plans through an MCHA assessment. The current MCHA assessment is based on each insurer and HMO's share of the total premiums for health insurance in Minnesota. The needed contribution is allocated among companies in proportion to their total premium income.

Accepting new applicants for autism coverage and providing this coverage through MCHA until the end of 2015 would be costly per enrollee if the only remaining MCHA enrollees were children receiving coverage for autism treatment due to the small scale of the operation. In addition, this option would complicate the effort to close the MCHA program as directed by the Legislature.

### **Potential Cost for State**

**Unknown** – Keeping MCHA open to provide coverage for ASD treatment will result in administrative costs for the state. This option may expose Minnesota to the possibility of reimbursing the plans for the coverage, as it could be considered a mandated coverage even with the use of MCHA's assessment infrastructure to spread the costs to the individual, small group, large group and self-insured markets. In addition, this would also not qualify for the transitional federal reinsurance program that otherwise could reduce the costs of providing the coverage in the traditional markets.

### **Legislative Action Required?**

Yes.

- **Expand Mandated Coverage in 2015 Using a Revised MCHA Assessment Mechanism**

The Legislature could require MCHA to remain open to new enrollees seeking IBT coverage during 2014. Beginning in 2015, a rider to the existing individual and small group market could be made available to consumers purchasing a health insurance product outside of MCHA. The

Legislature could restructure MCHA's existing assessment authority to cover the cost of the rider so that the direct writer of the individual or small group policy would administer the policy and the costs attributable to IBT and be reimbursed by MCHA. This option may complicate or delay the ultimate closing of MCHA.

### **Efficiency for Consumers**

**High** –Creating a rider in the existing individual and small group markets could increase avenues for coverage of IBT for consumers beginning in 2015.

### **Potential Cost for Consumers**

**Medium** – The cost of providing this coverage would be similar to the cost of providing coverage directly through MCHA, but consumers would purchase health coverage in the private market beginning in 2015. This could also provide an incentive for insurers to work with IBT providers to implement cost containment strategies to reduce the impact on premiums in the marketplace.

### **Potential Cost for State**

**Unknown** – MCHA would need to retain some staff and incur administrative costs in 2015 in order to administer the revised assessment process and respond to consumer inquiries. This option may also expose Minnesota to the possibility of reimbursing the plans for the coverage, as it could be considered a mandated coverage even though the rider would be added to existing policies in the standard markets.

### **Legislative Action Required?**

Yes.



# Appendix I

Sections from Laws of 2013, Chapter 108

Sec. 2. Minnesota Statutes 2012, section 43A.23, is amended by adding a subdivision to read:

Subd. 4. **Coverage for autism spectrum disorders.** For participants in the state employee group insurance program, the commissioner of management and budget must administer the identical benefit as is required under section 62A.3094.

**EFFECTIVE DATE.** This section is effective January 1, 2016, or the date a collective bargaining agreement or compensation plan that includes changes to this section is approved under Minnesota Statutes, section 3.855, whichever is earlier.

Sec. 3. **[62A.3094] COVERAGE FOR AUTISM SPECTRUM DISORDERS.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in paragraphs (b) to (d) have the meanings given.

(b) "Autism spectrum disorders" means the conditions as determined by criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(c) "Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's condition, and diagnostic testing and preventative services. Medically necessary care must be consistent with generally accepted practice parameters as determined by physicians and licensed psychologists who typically manage patients who have autism spectrum disorders.

(d) "Mental health professional" means a mental health professional as defined in section 245.4871, subdivision 27, clause (1), (2), (3), (4), or (6), who has training and expertise in autism spectrum disorder and child development.

Subd. 2. **Coverage required.** (a) A health plan issued to a large employer, as defined in section 62Q.18, subdivision 1, must provide coverage for the diagnosis, evaluation, multidisciplinary assessment, and medically necessary care of children under 18 with autism spectrum disorders, including but not limited to the following:

(1) early intensive behavioral and developmental therapy based in behavioral and developmental science, including, but not limited to, all types of applied behavior analysis, intensive early intervention behavior therapy, and intensive behavior intervention;

(2) neurodevelopmental and behavioral health treatments and management;

(3) speech therapy;

(4) occupational therapy;

(5) physical therapy; and

(6) medications.

(b) The diagnosis, evaluation, and assessment must include an assessment of the child's developmental skills, functional behavior, needs, and capacities.

(c) The coverage required under this subdivision must include treatment that is in accordance with an individualized treatment plan prescribed by the enrollee's treating physician or mental health professional.

(d) A health carrier may not refuse to renew or reissue, or otherwise terminate or restrict, coverage of an individual solely because the individual is diagnosed with an autism spectrum disorder.

(e) A health carrier may request an updated treatment plan only once every six months, unless the health carrier and the treating physician or mental health professional agree that a more frequent review is necessary due to emerging circumstances.

(g) An independent progress evaluation conducted by a mental health professional with expertise and training in autism spectrum disorder and child development must be completed to determine if progress toward function and generalizable gains, as determined in the treatment plan, is being made.

Subd. 3. **No effect on other law.** Nothing in this section limits the coverage required under section 62Q.47.

Subd. 4. **State health care programs.** This section does not affect benefits available under the medical assistance and MinnesotaCare programs and does not limit, restrict, or otherwise reduce coverage under these programs.

**EFFECTIVE DATE.** This section is effective for health plans offered, sold, issued, or renewed on or after January 1, 2014.

# Bibliography

- “Annual Report to the Missouri Legislature, Insurance Coverage for Autism Treatment & Applied Behavior Analysis”. Statistics Section. February 1, 2013.
- “Autism Spectrum Disorder Task Force: Strategic Plan Report.” December 2012.
- Autism Treatment Association of Minnesota. “Collection of Testimonies & Closing Comments.” 2013.
- “California Health Benefits Review Program, Analysis of Assembly Bill 171: Autism.” March 26, 2011.
- Garrett, Ellie, and Jeffrey S. Schiff. “Autism Spectrum Disorders, Report to the Minnesota Commissioner of Human Services”. February 2013.
- “Laws of Alaska”. HCS SB 74(RLS) am H. 2012.
- “Minnesota Autism Spectrum Disorder (ASD) Needs Survey 2011-12.” May 5, 2012.
- Norton, Kim. “Autism Spectrum Disorder Coverage”. May 10, 2013.
- Novak, Donna and Marti Hooper. “A Report to the Joint Standing Committee on Insurance and Financial Services of the 124th Maine Legislature. Review and Evaluation of LD 1198 An Act To Reform Insurance Coverage To Include Diagnosis for Autism Spectrum Disorders.” December 2009. Corrected January 14, 2010.
- Wyman, Oliver. “Actuarial Cost Estimate: Iowa House File 1 and Senate File 1, Bills for An Act Requiring Coverage for Autism Spectrum Disorders”. January 22, 2010.
- The Center for Consumer Information & Insurance Oversight. “Additional Information on Proposed State Essential Health Benefits Benchmark Plans” <http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html>