To: Vermont Health Benefit Exchange Advisory Board
From: Bailit Health Purchasing (Beth Waldman, Amy Lischko, Joshua Slen, Brendan Hogan)
Re: Overview of Essential Health Benefits Requirements of the PPACA and Implications for Vermont
Date: March 30, 2011

This memo presents some background information on the Essential Health Benefit requirements included in the PPACA, describes the potential impact of different options on the State of Vermont, and recommends a process for analyzing those options when additional information becomes available from the federal government.

Background

Section 1302 of the PPACA requires that health plans offered through an Exchange and all Medicaid state plans must cover a minimum set of health care service categories. Specifically, the PPACA defines essential health benefits to include:

- 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;
- Prevention and wellness services;
- Chronic disease management; and,
- Pediatric services, including oral and vision care.

The Secretary of Health and Human Services is charged with providing further specificity and consulting with the Department of Labor to establish coverage parameters based on what is included in typical employer plans. The PPACA also requires that in defining the Essential Health Benefits that the Secretary shall:

- Ensure an appropriate balance among categories of services;
- Not make decisions that discriminate on the basis of age, disability, or life expectancy;
- Take into account the diversity of the population; and,
- Ensure that emergency room services cannot require prior authorization

The Secretary has charged the Institute of Medicine (IOM) with making recommendations on the criteria and methods for determining and updating the essential health benefits package. To date, IOM has held two public meetings to obtain

input on its efforts. It is currently anticipated that the IOM recommendations will be made in the fall of 2011. After receiving the IOM's recommendations HHS will need to make decisions through the federal rule making process. This process is likely to take the better part of a year to complete, placing the timing for knowing details regarding what is in and what is out of the essential health benefit out to sometime towards the end of calendar year 2012. However, not knowing the details cannot stop the State from moving forward with designing and implementing an exchange as one must be operational on January 1, 2014.

Potential Impact on the State of Vermont

Today, many states, including Vermont have state mandated benefits that may or may not fall within the Essential Health Benefits as ultimately defined by the Secretary. Section 1311 of the PPACA specifies that states may continue to require health plans to offer state mandated benefits, but if a state has such a requirement than the state will be responsible for paying the cost differential for such coverage for plans offered within the Exchange. This provision applies to everyone served through an Exchange plan, not just those who are eligible to receive a premium subsidy.

The Department of Banking, Insurance, Safety and Health Care Administration (BISCHA) considers the state to have 15 insurance mandates, including those described in detail in Table One below as well as state requirements for guaranteed issue and community ratings.[1] Mandated benefits do not apply to self-insured plans. Importantly, the cost of state mandated benefits today is borne by the insurer or the purchaser, it is not borne by the state. Table One includes a preliminary analysis of whether Vermont's mandates arguably fit within one of the categories of services mandated by the PPACA.

Vermont does not have current information on the cost of each of its state mandated benefits. The state's insurers have estimated that state mandated benefits have a small overall impact on premiums in Vermont, ranging from 1% to 5% of total premiums.[2]

[1] We are exploring whether there are additional service requirements in the state that may be considered mandates from the federal perspective as a national report shows Vermont having 42 mandates. BISCHA is reviewing this report and we will provide an update as to the appropriate list of mandates to compare against for purposes of the Essential Health Benefits as soon as possible.

[2] Source: Information provided by Cigna, MVP and BCBS of Vermont during interviews for current insurance market study.

Table One: Comparison of Vermont's State Mandated Benefits to Federally Mandated Benefits and Potential Matching Categories of Services Required by the PPACA as Essential Health Benefits

#	Health Insurance Mandates Protecting Vermont Consumers – March 2011[3]	Federal Mandate (Yes or No)	Essential Health Benefit Category
1	**Chiropractic services:** Requires provision of clinically necessary health care services provided by a chiropractic physician licensed in Vermont for treatment within the scope of practice but limiting adjunctive therapies to physiotherapy modalities and rehabilitative exercise.	**No**	**N/A**
2	**Clinical trials for cancer patients:** Provides for payment of routine costs for a patient participating in a cancer clinical trial, including when one is not available in VT or NH.	**No**	**PPACA requires in other section.**
3	**Chemotherapy treatment:** Requires health insurers to provide coverage for medically necessary growth cell stimulating factor injections taken as part of a prescribed regimen.	**No**	**Ambulatory Care (?)**
4	**Naturopathic physicians:** Requires health insurers to provide coverage for medically necessary health care services covered by the plan when provided by a naturopathic physician licensed in Vermont for treatment within their scope of practice.	**No**	**Prevention and Wellness (?)**
5	**Prosthetic parity:** Requires health insurers to provide coverage for prosthetic devices at least equivalent to the federal Medicare program. Any dispute concerning coverage and the application of this section shall be subject to the independent external review.	**No**	**Rehabilitation; Habilitation and Devices (?)**
6	**Coverage for covered services provided by athletic trainers:** Requires health insurers to reimburse a licensed athletic trainer who acts within the scope of practice if the health insurer would reimburse another health care provider for those services.	**No**	**Rehabilitation; Habilitation and Devices (?)**
7	**Contraceptive mandate:** Any individual or group health insurance plan must provide coverage for outpatient contraceptive services, including sterilizations, and must provide coverage for all FDA-approved prescription contraceptive drugs and devices if the plan provides coverage for other prescription drugs. An insurer may not establish any rate, term or condition that places a greater financial burden on an insured or beneficiary for access to contraceptive services or prescription contraceptive drugs and devices than for access to treatment, prescriptions or devices for any other health condition.	**No**	**N/A**

[3] Source: Vermont Department of Banking, Insurance, Securities and Health Care Administration.

#	Health Insurance Mandates Protecting Vermont Consumers – March 2011[3]	Federal Mandate (Yes or No)	Essential Health Benefit Category
8	**Health insurance coverage, mental health and substance abuse:** Provides that a health plan shall (1) not establish any rate, term, or condition that places a greater burden on an insured for access to treatment for a mental health condition than for access to treatment of other health conditions (2) cannot exclude any provider who is willing to meet the terms and conditions for participation established by the health insurer (3) make any deductible or out of pocket limits required under a health plan apply to both mental and physical health conditions.	**Yes**	**Mental Health and Substance Abuse**
9	**Diabetes treatment:** Requires a health insurer to provide coverage for the equipment, supplies, and self-management training for the treatment of insulin dependent diabetes prescribed by a health care professional, who may be required to be under contract with the insurer.	**No**	**Chronic disease management**
10	**Treatment of inherited metabolic diseases:** Requires health insurers to provide coverage for medical foods prescribed for medically necessary treatment of inherited metabolic disease (must be at least $2500 for 12 months)	**No**	**Prevention and Wellness (?)**
11	**Craniofacial disorders:** Requires health insurers to provide coverage for diagnosis and medically necessary treatment, including surgical and nonsurgical procedures, for a musculoskeletal disorder that affects any bone or joint in the face neck or head and is the result of accident, trauma, congenital defect, developmental delay or pathology.	**No**	**Hospitalization (?) or Ambulatory Services (?)**
12	**Retail pharmacies filling of prescriptions:** Retail pharmacies shall be permitted to fill prescriptions in the same manner and at the same level of reimbursement as they are filled by mail order pharmacies with respect to quantity of drugs or days of supply of drugs dispensed.	**No**	**Prescription Drugs**
13	**Autism mandate:** Requires coverage for treatment of children from ages 18 months to 6 years.	**No**	**Pediatric Services (?)**

Recommended Analysis

Once it is clear which state-mandated benefits fall outside of the Essential Health Benefits definition, Vermont will need to make a choice for each state-mandated benefit to either:

- Amend state law to remove the mandate, or

- Appropriate state funds to pay for the additional benefit for individuals purchasing coverage in the Exchange.

To make this decision, Bailit recommends that the State of Vermont consider several factors, including:

- Cost to the state of including each mandate
- Approximate number of Vermont residents utilizing each mandate on an annual basis
- Impact of each mandate on individual utilizers (e.g., likelihood that a mandate saves lives, increases life expectancy, improves overall functioning, reduces other potential costs, improves general quality of life)

Based on these findings, Vermont should then weigh the cost of each mandate against its benefit and prioritize mandates by which are most important to keep based on pre-determined criteria to be defined by the State with input from stakeholders. The state should also consider potential sources of funding for any mandates that Vermont would like to continue.

Conclusion

The PPACA broadly defines Essential Health Benefits and leaves significant authority to the Secretary of Health and Human Services to ultimately provide a workable definition for states and insurers. It is unclear how detailed the final definition will be and therefore, how great the impact will be on overall health insurance benefits to be offered in Vermont and impact on the state's mandated benefits. Prior to HHS releasing its final guidance, Vermont can conduct a number of activities including:

- begin to categorize its state mandate benefits,
- determine which state mandated benefits are likely to fall outside of the Essential Health Benefits definition based on required coverage categories,
- develop a criteria for determining priorities of existing state mandates, and
- develop and conduct an analysis of each state mandated benefit likely to fall outside of the Essential Health Benefit definition (including cost, number of utilizers and impact as described above)