State of Vermont
Agency of Administration

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Health Care Reform

Vermont Health Benefit Exchange: Update on Health Benefit Plans

Report of the Agency of Administration
Pursuant to Act 48 of 2011 Section 2

Submitted to the

House Committee on Health Care
Senate Committee on Health and Welfare
Senate Committee on Finance

February 2012

I. Introduction

Act 48 of 2011 requires the director of health care reform to provide the house committee on health care and the senate committees on finance and on health and welfare the following information related to the Vermont health benefit exchange, to the extent available:

> (i) a list of the federal health benefits required under the Affordable Care Act as defined in 33 V.S.A. chapter 18, subchapter 1, including covered services and cost-sharing;
> (ii) a comparison of the federal health benefits with the Vermont health insurance benefit requirements provided for in 8 V.S.A. chapter 107;
> (iii) information relating to the silver, gold, and platinum benefit levels of qualified health benefit plans that may be available in the Vermont health benefit exchange;
> (iv) a draft of qualified health benefit plan choices that may be available in the Vermont health benefit exchange;
> (v) in collaboration with the three insurers with the largest number of lives, premium estimates for draft plan choices described in subdivision (iv) of this subdivision (B); and
> (vi) the status of related tax credits, including small employer tax credits, and of cost-sharing subsidies.

HHS issued a bulletin in December 2011 describing its proposed definition of Essential Health Benefits. This bulletin was followed up in February 2012 with a list of questions and answers from HHS, which further clarified the approach HHS was taking. See Appendices A and B for these documents.

Under HHS' approach, states would be required to select a benchmark plan that all plans offered in the individual and small group markets would need to be substantially equal to. The Administration contracted with Bailit Health Purchasing to conduct an analysis of potential plans that may be selected, including the two largest plans offered in the small group market, the largest HMO offered in the state, and the state employees' health plan. The fourth option allowed by HHS -- the federal employees' health plan -- does not include state mandated benefits, and thus was excluded from the analysis. Under the proposed guidance, HHS signals that the federal government will include the cost of state mandates in its development of subsidies in 2014 and 2015. It is uncertain as to whether they will cover such costs beginning in 2016.

This report summarized the federal law and guidance available to date and provides the results of the analysis on the federal guidance performed to date. It is important to note that given that the federal guidance was not issued until December 2011, with further clarifications added this month, the Administration has not had sufficient time to complete the design of health benefit plan choices that will be available in 2014 and thus has not yet concluded the work with the insurers to cost out the plans. The Administration continues to work on the design and hopes to have proposals on the plan designs in the individual and small group market by late spring or early summer.

II. Federal Affordable Care Act Requirements and Guidance on Essential Health Benefits

The Affordable Care Act requires health plans offered in the individual and small group markets to offer a comprehensive package of items and services, known as "essential health benefits." Essential health benefits must include items and services within at least the following ten 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

On December 16, 2011, the federal Department of Health and Human Services (HHS) released guidance on EHB that signals their intent to offer states some limited flexibility in defining EHB. The purpose of this flexibility is to allow states to select a benchmark plan that reflects the scope of services offered by a "typical employer plan" in that state. If States choose not to select a benchmark, HHS intends to propose that the default benchmark will be the small group plan with the largest enrollment in the State.

The following is an excerpt from that guidance:

HHS intends to propose that essential health benefits are defined using a benchmark approach. Under the Department's intended approach announced today, States would have the flexibility to select a benchmark plan that reflects the scope of services offered by a "typical employer plan." This approach would give States the flexibility to select a plan that would best meet the needs of their citizens.

States would choose one of the following benchmark health insurance plans:

- *One of the three largest small group plans in the State by enrollment;*
- *One of the three largest State employee health plans by enrollment;*
- *One of the three largest federal employee health plan options by enrollment;*
- *The largest HMO plan offered in the State's commercial market by enrollment.*

To meet the EHB coverage standard, HHS requires that a health plan offer benefits that are "substantially equal" to the benchmark plan selected by the state and modified as necessary to reflect the 10 coverage categories. Health plans also would have flexibility to adjust benefits, including both the specific services covered and any quantitative limits, provided they continue to offer coverage for all 10 statutory EHB categories and the coverage has the same value.

To prevent Federal dollars going to state benefit mandates, the federal health reform law requires states to defray the cost of benefits required by state law in excess of essential health benefits for individuals enrolled in any plan offered through an Exchange. However, as a transition in 2014 and 2015, the benchmark options include health plans in the state's small group market and state employee health benefit plans, which include the state benefit mandates. The benchmarks will be updated in the future, however, and state mandates outside the definition of essential health benefits may not be included in future years.

Using this approach, Vermont would likely not have to use state funds to defray the costs of certain state mandates until 2016. Prior to the issuance of the federal guidance, the Administration completed a preliminary analysis of how current Vermont coverage mandates compare to the EHB package as described in federal statute. The preliminary conclusion is that many of Vermont's mandates are likely to be included in the EHB based on the statutory language in the ACA, and some will probably not be included. The preliminary analysis of how Vermont's mandates compare to the federal EHB is contained in Appendix C for reference.

After receiving the federal guidance in December 2011, the Administration, through a contractor, began analyzing three of the above benchmark plans: the two largest plans offered in the small group market, the largest HMO offered in the state, and the state employees' health plan.[1] The federal employees' health plan does not include state mandated benefits, and thus was excluded from the analysis.

The analysis to date showed overwhelming similarity across the benefits offered in each of the plans. The plans offered coverage in most of the ten benefit categories required to be provided as essential health benefits under the ACA. However, depending on which plan is selected, the state may be required to supplement coverage in the categories of prescription drug coverage, habilitative care, and pediatric oral and vision care. Our interpretation of the HHS bulletin based on the questions and answers issued this month is that the state can fill in these gaps by taking the coverage offered in those categories by one of the other benchmark plan options.[2] The plans did have a few differences in benefits (i.e., fertility treatment, private duty nursing, marital counseling, etc.). Additionally there are some differences in how the plans restrict the coverage offered, for example by limiting the population that may access the service, the number of allowable visits provided and when prior authorization is required. However, at least between the two small group plans, most of these coverage differences are unlikely to rise to a level that would make the plans so different that they could not be considered "substantially equal"—the standard that is outlined in the HHS bulletin. The Administration's initial presentation to the Green Mountain Care Board is attached as Appendix D.

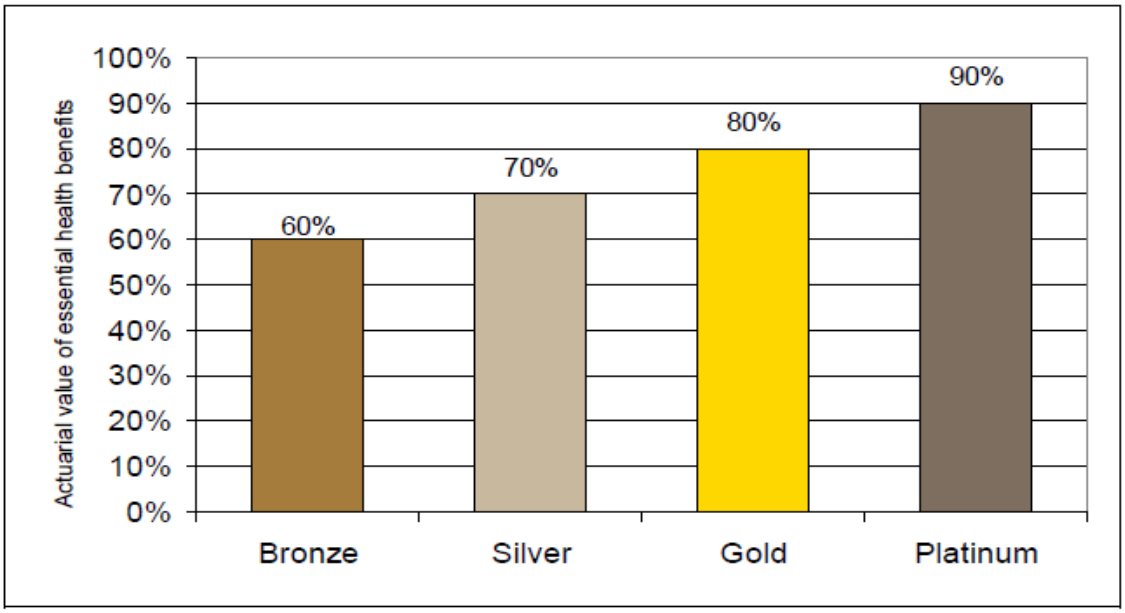
III. Federal Affordable Care Act Requirements on Cost-Sharing "Metal Levels"

The federal Affordable Care Act defines four levels of cost-sharing that must apply to all plans in the individual and small group market. The four comprehensive plans each provide the same federal Essential Health Benefits discussed above and maintain Health Savings Account out-of-pocket limits. Out-of-pocket limits are reduced for consumers with incomes below 400% FPL. The plans must have the following actuarial values as illustrated in Figure 1:

[1] As both MVP and Blue Cross Blue Shield of Vermont offer core medical benefits in all of their plans in the small group market, and BCBSVT utilizes its core medical benefits, plus riders for additional benefits to serve the large group benefit, our analysis focused on a plan from each of these insurers, plus the state employee's health plan.

[2] Riders typically were utilized in the small group plans for prescription drugs, dental and vision services.

Figure 1. Actuarial Values for Levels of Coverage Provided by Qualified Health Plans



Source: CRS analysis of the Patient Protection and Affordable Care Act.

"Actuarial value" is the percent of total claims costs that a plan will pay on average. So a gold plan, which as an actuarial value of 80%, would on average pay 80% of an individual's health care costs. The individual would therefore pay 20% of costs out of pocket (up to the out-of-pocket limit). Exchanges may offer catastrophic plans to individuals up to age 30 or to those who are exempt from the mandate to purchase coverage.

Act 48 of 2011 provides for platinum, gold, and silver plans and the House Health Care Committee had decided to add bronze plans in H.559 (2012) at the time of writing. Issuers wishing to offer plans through the Exchange must offer at least one silver and one gold plan.

IV. Federal Premium Tax Credits and Cost-Sharing Subsidies

The federal Affordable Care Act creates tax credits and cost-sharing subsidies for people with income below 400% ($5044 per month for a family of two and $7684 for a family of four) who buy private insurance through the Exchange, who do not have employer-sponsored insurance, or whose employer-sponsored insurance premium is more than 9.5% of the household income. The amount of the tax credits and cost-sharing subsidies is based on household income reported on tax returns, not based on the cost of the underlying insurance product.

The premium tax credits are applied for through the Exchange and are adjudicated electronically. The tax credits are advanced, refundable tax credits and are paid directly from the federal government to the insurance company. The individual then may elect to pay either the insurer or the Exchange. At the end of the calendar year, the refundable tax credit is trued up on the individual's tax return to ensure that the individual got an accurate amount based on their annual income. The premium tax credits are available for any plan offered through the Exchange.

In Appendix E there are a number of tables showing the premium contributions for various family sizes toward health insurance policies available through the Vermont Health Benefit Exchange, based on current FPL levels. Appendix F includes some illustrative examples of how this would impact individual situations.

In addition to premium tax credits, individuals and families with income below 250% FPL ($3153 per month for a two-person family and $4803 for a four-person family) are entitled to cost-sharing subsidies. The cost-sharing subsidies are intended to reduce out-of-pocket spending by bringing the actuarial value (the percent of an average individual's medical expenses that a plan pays) of a silver plan up to the actuarial value listed in Figure 2 below.

Figure 2. Cost-Sharing Subsidies

2011 FPL range	Actuarial value
0- 50%	97%
50 - 75%	97%
75 - 100%	97%
100 - 138%	97%
138 - 150%	94%
150 - 185%	87%
185 - 200%	87%
200 - 225%	73%
225 - 250%	73%

So an individual who purchases a silver plan (70% actuarial value), and whose income is 140% FPL, would receive a cost-sharing subsidy equal to 94% minus 70%. The cost-sharing subsidy would be paid by the federal government to the issuer of the plan the individual chooses.

The ACA requires the out-of-pocket maximum (which is the highest amount that a plan enrollee must pay in cost-sharing, including deductible, co-pays, and co-insurance) to be no more than $5950 per year; however, for people under 400% FPL, the out-of-pocket maximum is reduced according to income levels. Figure 3 shows the sliding-scale, out-of-pocket maximums under the ACA for individuals at various income levels.

Figure 3. Out of Pocket Maximums

Income level	Out-of-pocket reduction	Out-of-pocket max in $
100-200%	2/3 of maximum	$1983
200-300%	1/2 of maximum	$2975
300-400%	1/3 of maximum	$3967
400%+	Maximum	$5950

Appendices

- **A. EHB HHS bulletin 12/16/12**
- **B. EHB FAQs from HHS**
- **C. Comparison of Vermont Benefit Requirements with the Federal EHB**
- **D. Exchange Benefits presentation to GMCB**
- **E. Premium Contributions in the Vermont Health Benefit Exchange**
- **F. Examples of Family Situations in the Exchange**

ESSENTIAL HEALTH BENEFITS BULLETIN

Center for Consumer Information and Insurance Oversight

December 16, 2011

Contents

ESSENTIAL HEALTH BENEFITS BULLETIN

Purpose

The purpose of this bulletin is to provide information and solicit comments on the regulatory approach that the Department of Health and Human Services (HHS) plans to propose to define essential health benefits (EHB) under section 1302 of the Affordable Care Act. This bulletin begins with an overview of the relevant statutory provisions and other background information, reviews research on health care services covered by employers today, and then describes the approach HHS plans to propose. This bulletin only relates to covered services. Plan cost sharing and the calculation of actuarial value are not addressed in this bulletin. We plan to release guidance on calculating actuarial value and the provision of minimum value by employer-sponsored coverage in the near future. In addition, we plan to issue future guidance on essential health benefit implementation in the Medicaid program.

The intended regulatory approach utilizes a reference plan based on employer-sponsored coverage in the marketplace today, supplemented as necessary to ensure that plans cover each of the 10 statutory categories of EHB. In developing this intended approach, HHS sought to balance comprehensiveness, affordability, and State flexibility and to reflect public input received to date.

Public input is welcome on this intended approach. Please send comments on the bulletin by January 31, 2012 to: EssentialHealthBenefits@cms.hhs.gov.

Defining Essential Health Benefits

A. Introduction and Background

Statutory Provisions

Section 1302(b) of the Affordable Care Act directs the Secretary of Health and Human Services (the Secretary) to define essential health benefits (EHB). Non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent, and Basic Health Programs must cover the EHB beginning in 2014.[1] Section 1302(b)(1) provides that EHB include items and services within the following 10 benefit 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.

[1] Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to cover the essential health benefits.

Section 1302(b)(2) of the Affordable Care Act instructs the Secretary that the scope of EHB shall equal the scope of benefits provided under a typical employer plan. In defining EHB, section 1302(b)(4) directs the Secretary to establish an appropriate balance among the benefit categories. Further, under this provision, the Secretary must not make coverage decisions, determine reimbursement rates, or establish incentive programs. Benefits must not be designed in ways that discriminate based on age, disability, or expected length of life, but must consider the health care needs of diverse segments of the population. The Secretary must submit a report to the appropriate committees of Congress along with a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the scope of the EHB is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary.

In addition, section 1311(d)(3) of the Affordable Care Act requires States to defray the cost of any benefits required by State law to be covered by qualified health plans beyond the EHB.

The statute distinguishes between a plan's covered services and the plan's cost-sharing features, such as deductibles, copayments, and coinsurance. The cost-sharing features will determine the level of actuarial value of the plan, expressed as a "metal level" as specified in statute: bronze at 60 percent actuarial value, silver at 70 percent actuarial value, gold at 80 percent actuarial value, and platinum at 90 percent actuarial value.[2]

Public and Other Input

To inform the Department's understanding of the benefits provided by employer plans, HHS has considered a report on employer plans submitted by the Department of Labor (DOL), recommendations on the process for defining and updating EHB from the Institute of Medicine (IOM), and input from the public and other interested stakeholders during a series of public listening sessions detailed below.

Section 1302(b)(2)(A) requires the Secretary of Labor to inform the determination of EHB with a survey of employer-sponsored plans. On April 15, 2011, the DOL issued its report, in satisfaction of section 1302(b)(2)(A) of the Affordable Care Act, providing results on the scope of benefits offered under employer-sponsored insurance to HHS.[3] The DOL survey provided a broad overview of benefits available to employees enrolled in employer sponsored plans. The report drew on data from the 2008 and 2009 National Compensation Survey (which includes large and small employers), as well as DOL's supplemental review of health plan Summary Plan Documents, and provided information on the extent to which employees have coverage for approximately 25 services within the 10 categories of EHB outlined in the Affordable Care Act (e.g., a certain percentage of plan participants have coverage for a certain benefit).

In order to receive independent guidance, HHS also commissioned the IOM to recommend a process that would help HHS define the benefits that should be included in the EHB and update the benefits to take into account advances in science, gaps in access,

[2] As noted, these will be the subject of forthcoming guidance.

[3] Available at http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf

and the effect of any benefit changes on cost. The IOM submitted its consensus recommendations in a report entitled "Essential Health Benefits: Balancing Coverage and Cost" on October 7, 2011.[4] In order to balance the cost and comprehensiveness of EHB, the IOM recommended that EHB reflect plans in the small employer market and that the establishment of an EHB package should be guided by a national premium target. The IOM also recommended the development of a framework for updating EHB that would take into account new evidence about effective interventions and changes in provider and consumer preferences while ensuring that the cost of the revised package of benefits remains within predetermined limits as the benefit standards become more specific. The IOM recommended flexibility across States and suggested that States operating their own Exchanges be allowed to substitute a plan that is actuarially equivalent to the national EHB package. The IOM also recommended continued public input throughout the process.

Following the release of the IOM's recommendations, HHS held a series of sessions with stakeholders, including consumers, providers, employers, plans, and State representatives, in both Washington, D.C. and around the nation to gather public input. Several key themes emerged. Consumer groups and some provider groups expressed concern at the IOM's emphasis on cost over the comprehensiveness of benefits. Some consumer groups expressed a belief that small group plans may not represent the typical employer plan envisioned by the statute, while employers and health insurance issuers generally supported the IOM conclusion that EHB should be based on small employer plans. Consumer and provider groups commented that specific benefits should be spelled out by the Secretary, while health insurance issuers and employers commented that they prefer more general guidance, allowing for greater flexibility. Both provider and consumer groups expressed concern about discrimination against individuals with particular conditions. Employers and health insurance issuers stressed concern about resources and urged the Secretary to adopt a more moderate benefit package. Consumers generally favored a uniform benefits package, and many consumers requested that State mandates be included in the benefits package. Some requested a uniform benefit package so that consumer choice of plan could focus on other plan features such as premium, provider network, and quality improvement. Some employer, health insurance issuer, and State representatives focused on the need for flexibility across the country to reflect local preferences and practices. States, health insurance issuers, and employers emphasized the need for timely guidance in preparing for implementation around EHB.

B. Summary of Research on Employer Sponsored Plan Benefits and State Benefit Mandates

While the Affordable Care Act directs the Secretary to define the scope of EHB as being equal to a typical employer plan, the statute does not provide a definition of "typical." Therefore, HHS gathered benefit information on large employer plans (which account for

[4] Available at http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx

the majority of employer plan enrollees), small employer products (which account for the majority of employer plans), and plans offered to public employees.[5]

There is not yet a national standard for plan reporting of benefits.[6] While the DOL collects information on benefits offered by employer plans, no single data set includes comprehensive data on coverage of each of the 10 statutory essential health benefit categories. Consequently, to supplement information available from the DOL, Mercer,[7] and Kaiser Family Foundation/Health Research & Educational Trust (KFF/HRET)[8] surveys of employer plans, HHS gathered information on employer plan benefits from the IOM's survey of three small group issuers and supplemented this information with an internal analysis of publicly available information on State employee plans and Federal employee plans,[9] and information on benefits submitted to HealthCare.gov by small group health insurance issuers. To inform our understanding of the category of pediatric oral and vision care, HHS staff also analyzed dental and vision plans in the Federal Employees Dental/Vision Insurance Program (FEDVIP).[10] The FEDVIP program is a standalone vision and dental program where eligible Federal enrollees pay the full cost of their coverage.

Similarities and Differences in Benefit Coverage Across Markets

Generally, according to this analysis, products in the small group market, State employee plans, and the Federal Employees Health Benefits Program (FEHBP) Blue Cross Blue Shield (BCBS) Standard Option and Government Employees Health Association (GEHA) plans do not differ significantly in the range of services they cover. They differ mainly in cost-sharing provisions, but cost-sharing is not taken into account in determining EHB. Similarly, these plans and products and the small group issuers surveyed by the IOM appear to generally cover health care services in virtually all of the 10 statutory categories.

For example, across the markets and plans examined, it appears that the following benefits are consistently covered: physician and specialist office visits, inpatient and

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[5] Nomenclature used in HealthCare.gov describes "products" as the services covered as a package by an issuer, which may have several cost-sharing options and riders as options. A "plan" refers to the specific benefits and cost-sharing provisions available to an enrolled consumer. For example, multiple plans with different cost-sharing structures and rider options may derive from a single product.

[6] Section 2715 of the Public Health Service Act (PHS Act) requires group health plans and health insurance issuers in the group and individual markets to provide a Summary of Benefits and Coverage in a uniform format to consumers. HHS, DOL, and the Department of the Treasury issued proposed rules for PHS Act section 2715 at 76 FR 52442 (August 22, 2011). Further information is available at http://www.gpo.gov/fdsys/pkg/FR-2011-08-22/pdf/2011-21193.pdf and http://www.dol.gov/ebsa/faqs/faq-aca7.html.

[7] Available at http://www.mercer.com/survey-reports/2009-US-national-health-plan-survey

[8] Available at http://ehbs.kff.org

[9] HHS staff analyzed the Federal Employees Health Benefits Program (FEHBP) Blue Cross Blue Shield (BCBS) Standard Option and Government Employees Health Association Benefit plan booklets.

[10] Further information is available at https://www.benefeds.com/Portal/jsp/LoginPage.jsp

outpatient surgery, hospitalization, organ transplants, emergency services, maternity care, inpatient and outpatient mental health and substance use disorder services, generic and brand prescription drugs, physical, occupational and speech therapy, durable medical equipment, prosthetics and orthotics, laboratory and imaging services, preventive care and nutritional counseling services for patients with diabetes, and well child and pediatric services such as immunizations. As noted in a previous HHS analysis, variation appears to be much greater for cost-sharing than for covered services.[11]

While the plans and products in all the markets studied appear to cover a similar general scope of services, there was some variation in coverage of a few specific services among markets and among plans and products within markets, although there is no systematic difference noted in the breadth of services among these markets. For example, the FEHBP BCBS Standard Option plan covers preventive and basic dental care, acupuncture, bariatric surgery, hearing aids, and smoking cessation programs and medications. These benefits are not all consistently covered by small employer health plans. Coverage of these benefits in State employee plans varies between States. However, in some cases, small group products cover some benefits that are not included in the FEHBP plans examined and may not be included in State employee plans, especially in States for which benefits such as in-vitro fertilization or applied behavior analysis (ABA) for children with autism are mandated by State law.[12] Finally, there is a subset of benefits including mental health and substance use disorder services, pediatric oral and vision services, and habilitative services – where there is variation in coverage among plans, products, and markets. These service categories are examined in more detail below.

Mental Health and Substance Use Disorder Services

In general, the plans and products studied appear to cover inpatient and outpatient mental health and substance use disorder services; however, coverage in the small group market often has limits. As discussed later in this document, coverage will have to be consistent with the Mental Health Parity and Addiction Equity Act (MHPAEA).[13]

The extent to which plans and products cover behavioral health treatment, a component of the mental health and substance use disorder EHB category, is unclear. In general, plans do not mention behavioral health treatment as a category of services in summary

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[11] ASPE Research Brief, "Actuarial Value and Employer Sponsored Insurance," November 2011. Available at: http://aspe.hhs.gov/health/reports/2011/AV-ESI/rb.pdf.

[12] In addition to mandated benefits, it appears that the small group issuers the IOM surveyed also generally cover residential treatment centers, which the FEHBP BCBS Standard Option plan excludes. However, as this analysis compares three small group issuers to one FEHBP plan, it is unclear if this finding can be generalized to other plans.

[13] See Affordable Care Act § 1311(j); see also PHS Act § 2726, ERISA § 712, Internal Revenue Code § 9812. See also interim final regulations at 75 FR 5410 (February 2, 2010) and guidance published on June 30, 2010 (http://www.dol.gov/ebsa/faqs/faq-mhpaea.html), December 22, 2010 (http://www.dol.gov/ebsa/faqs/faq-aca5.html), and November 17, 2011 (http://www.dol.gov/ebsa/faqs/faq-aca7.html).

plan documents. The exception is behavioral treatment for autism, which small group issuers in the IOM survey indicated is usually covered only when mandated by States.

Pediatric Oral and Vision Care

Coverage of dental and vision care services are provided through a mix of comprehensive health coverage plans and stand-alone coverage separate from the major medical coverage, which may be excepted benefits under PHS Act section 2722.[14] The FEDVIP vision plan with the highest enrollment in 2010 covers routine eye examinations with refraction, corrective lenses and contact lenses, and the FEDVIP dental plan covers preventive and basic dental services such as cleanings and fillings, as well as advanced dental services such as root canals, crowns and medically necessary orthodontia. In some cases, dental or vision services may be covered by a medical plan. For example, the FEHBP BCBS Standard Option plan covers basic and preventive dental services.

Habilitative Services

There is no generally accepted definition of habilitative services among health plans, and in general, health insurance plans do not identify habilitative services as a distinct group of services. However, many States, consumer groups, and other organizations have suggested definitions of habilitative services which focus on: learning new skills or functions – as distinguished from rehabilitation which focuses on relearning existing skills or functions, or defining "habilitative services" as the term is used in the Medicaid program.[15,16,17] An example of habilitative services is speech therapy for a child who is not talking at the expected age .

Two of the three small group issuers surveyed by the IOM indicated that they do not cover habilitative services. However, data submitted by small group issuers for display on HealthCare.gov indicates that about 70 percent of small group products offer at least limited coverage of habilitative services.[18] Physical therapy (PT), occupational therapy (OT), and speech therapy (ST) for habilitative purposes may be covered under the rehabilitation benefit of health insurance plans, which often includes visit limits. All three issuers reporting to the IOM covered PT, OT, and ST, though one issuer did not cover these services for patients with an autism diagnosis. The FEHBP BCBS Standard Option plan also covers PT, OT, and ST. State employee plans examined appear to generally cover PT, OT, and ST.

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[14] When dental or vision coverage is provided in plan that is separate from or otherwise not an integral part of a major medical plan, that separate coverage is not subject to the insurance market reforms in title XXVII of the PHS Act. See PHS Act §§ 2722(c)(1), 2791(c)(2).

[15] For State definitions, see Md. Code Ins. § 15-835(a)(3); D.C. Code § 31-3271(3); 215 Ill. Comp. Stat. 5/356z.14(i).

[16] See 76 Fed. Reg. 52,442 and 76 Fed. Reg. 52,475.

[17] For Medicaid definition, see Social Security Act, § 1915(c)(5)(A).

[18] Data submitted in October 2011.

Comparison to Other Employer Plan Surveys

These findings are generally consistent with other surveys of employer sponsored health coverage conducted by DOL, Mercer, and KFF/HRET. The Department of Labor survey found that employees had widespread coverage for medical services such as inpatient hospital services, hospital room and board, emergency room visits, ambulance service, maternity, durable medical equipment, and physical therapy. Similarly, Mercer found employers provided widespread coverage for medical services such as durable medical equipment, outpatient facility charges, and physical, occupational, and speech therapy. The KFF/HRET survey also found widespread coverage of prescription drugs among employees with employer-sponsored coverage.

State Benefit Mandates

State laws regarding required coverage of benefits vary widely in number, scope, and topic, so that generalizing about mandates and their impact on typical employer plans is difficult. All States have adopted at least one health insurance mandate, and there are more than 1,600 specific service and provider coverage requirements across the 50 States and the District of Columbia.[19]

Almost all State mandated services are typically included in benefit packages in States without the mandate – such as immunizations and emergency services. In order to better understand the variation in State mandates, their impact on the benefits covered by plans, and their cost, HHS analyzed 150 categories of benefit and provider mandates across all 50 States and the District of Columbia. The FEHBP BCBS Standard and Basic Options are not subject to any State mandates, but our analysis indicates that they cover nearly all of the benefit and provider mandate categories required under State mandates. The FEHBP BCBS Standard Option is not subject to any State mandates, but our analysis indicates that it covers about 95 percent of the benefit and provider mandate categories required under State mandates. The primary exceptions are mandates requiring coverage of in-vitro fertilization and ABA therapy for autism, which are not covered by the FEHBP BCBS Standard Option plan but are required in 8 and 29 States, respectively.

These two mandates commonly permit annual dollar limits, annual lifetime or frequency limits, and/or age limits. Research by States with these two mandates indicates that the cost of covering in-vitro fertilization benefits raises average premiums by about one percent[20,21] and the cost of covering ABA therapy for autism raises average premiums by approximately 0.3 percent.[22] Approximately 10 percent of people covered by small

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[19] Of these 1,600 mandates, about 1,150 are benefit mandates and 450 are provider mandates.

[20] Maryland Health Care Commission. Study of Mandated Health Insurance Services: A Comparative Evaluation. January 1, 2008. Available at: http://mhcc.maryland.gov/health_insurance/mandated_1207.pdf

[21] University of Connecticut Center for Public Health and Health Policy. Connecticut Mandated Health Insurance Benefit Reviews. January, 2011. Available at: http://www.ct.gov/cid/lib/cid/2010_CT_Mandated_Health_Insurance_Benefits_Reviews_-_General_Overview.pdf

[22] California Health Benefits Review Program. Analysis of Senate Bill TBD 1: Autism. March 20, 2011. Available at: http://www.chbrp.org/docs/index.php?action=read&bill_id=113&doc_type=3.

group policies live in a State requiring coverage of in-vitro fertilization, and approximately 50 percent live in a State requiring coverage of ABA.

The small group issuers surveyed by the IOM indicated they cover ABA only when required by State benefit mandates. The FEHBP BCBS Standard Option does not cover ABA. The extent to which these services are covered by State employee plans is unclear, as there is variation between States in whether benefit mandates apply (either by statute or voluntarily) to State employee plans.

C. Intended Regulatory Approach

As noted in the introduction, the Affordable Care Act authorizes the Secretary to define EHB. In response to the research and recommendations described above, as a general matter, our goal is to pursue an approach that will:

- Encompass the 10 categories of services identified in the statute;
- Reflect typical employer health benefit plans;
- Reflect balance among the categories;
- Account for diverse health needs across many populations;
- Ensure there are no incentives for coverage decisions, cost sharing or reimbursement rates to discriminate impermissibly against individuals because of their age, disability, or expected length of life;
- Ensure compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);
- Provide States a role in defining EHB; and
- Balance comprehensiveness and affordability for those purchasing coverage.

As recommended by the IOM, HHS aims to balance comprehensiveness, affordability, and State flexibility while taking into account public input throughout the process of establishing and implementing EHB.[23] Our intended approach to EHB incorporates plans typically offered by small employers and benefits that are covered across the current employer marketplace.

We intend to propose that EHB be defined by a benchmark plan selected by each State. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that State as required by section 1302(b)(2)(A) of the Affordable Care Act. This approach is based on the approach established by Congress for the Children's Health Insurance Program (CHIP), created in 1997, and for certain Medicaid populations.[24,25] A major advantage of the benchmark approach is that it recognizes that issuers make a holistic decision in constructing a package of benefits and adopt packages they believe balance consumers' needs for comprehensiveness and affordability. As described below, health insurance

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[23] Available at http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx.

[24] Balanced Budget Act of 1997; Public Law 105-33

[25] Section 42 CFR 457.410 and 457.420

issuers could adopt the scope of services and limits of the State benchmark, or vary it within the parameters described below.

Four Benchmark Plan Types

Our analysis of offerings that exist today suggests that the following four benchmark plan types for 2014 and 2015 best reflect the statutory standards for EHB in the Affordable Care Act:

(1) the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;[26]
(2) any of the largest three State employee health benefit plans by enrollment;
(3) any of the largest three national FEHBP plan options by enrollment; or
(4) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

HHS intends to assess the benchmark process for the year 2016 and beyond based on evaluation and feedback.

To reflect the State flexibility recommended by the IOM, under our intended approach, States are permitted to select a single benchmark to serve as the standard for qualified health plans inside the Exchange operating in their State and plans offered in the individual and small group markets in their State. To determine enrollment in plans for specifying the benchmark options, we intend to propose to use enrollment data from the first quarter two years prior to the coverage year and that States select a benchmark in the third quarter two years prior to the coverage year. For example, enrollment data from HealthCare.gov for the first quarter of calendar year 2012 could be used to determine which plans would be potential benchmarks for State selection and the benchmark plan specified during the third quarter of 2012 for coverage year 2014. If a State does not exercise the option to select a benchmark health plan, we intend to propose that the default benchmark plan for that State would be the largest plan by enrollment in the largest product in the State's small group market.

Defraying the Cost of Additional Benefits

Section 1311(d)(3)(B) of the Affordable Care Act requires States to defray the costs of State-mandated benefits in excess of EHB for individuals enrolled in any qualified health plan either in the individual market or in the small group market. Similar to other Exchange decisions, the State may select the benchmark plan. The approach for 2014 and 2015 would provide a transition period for States to coordinate their benefit mandates while minimizing the likelihood the State would be required to defray the costs of these mandates in excess of EHB. In the transitional years of 2014 and 2015, if a State chooses a benchmark subject to State mandates – such as a small group market plan – that benchmark would include those mandates in the State EHB package. Alternatively,

[26] Nomenclature used in HealthCare.gov describes "products" as the services covered as a package by an issuer, which may have several cost-sharing options and riders as options. A "plan" refers to the specific benefits and cost-sharing provisions available to an enrolled consumer. For example, multiple plans with different cost-sharing structures and rider options may derive from a single product.

under our intended approach a State could also select a benchmark such as an FEHBP plan that may not include some or all of the State's benefit mandates, and therefore under Section 1311(d)(3)(B), the State would be required to cover the cost of those mandates outside the State EHB package. HHS intends to evaluate the benchmark approach for the calendar year 2016 and will develop an approach that may exclude some State benefit mandates from inclusion in the State EHB package.

Benchmark Plan Approach and the 10 Benefit Categories

One of the challenges with the described benchmark plan approach to defining EHB is meeting both the test of a "typical employer plan" and ensuring coverage of all 10 categories of services set forth in section 1302(b)(1) of the Affordable Care Act. Not every benchmark plan includes coverage of all 10 categories of benefits identified in the Affordable Care Act (e.g., some of the benchmark plans do not routinely cover habilitative services or pediatric oral or vision services). The Affordable Care Act requires all issuers subject to the EHB standard in section 1302(a) to cover each of the 10 benefit categories.[27] If a category is missing in the benchmark plan, it must nevertheless be covered by health plans required to offer EHB. In selecting a benchmark plan, a State may need to supplement the benchmark plan to cover each of the 10 categories. We are considering policy options for how a State supplements its benchmark benefits if the selected benchmark is missing a category of benefits. The most commonly non-covered categories of benefits among typical employer plans are habilitative services, pediatric oral services, and pediatric vision services.

Below, we discuss several specific options for habilitative services, pediatric oral care and pediatric vision care. Generally, we intend to propose that if a benchmark is missing other categories of benefits, the State must supplement the missing categories using the benefits from any other benchmark option. In a State with a default benchmark with missing categories, the benchmark plan would be supplemented using the largest plan in the benchmark type (e.g. small group plans or State employee plans or FEHBP) by enrollment offering the benefit. If none of the benchmark options in that benchmark type offer the benefit, the benefit will be supplemented using the FEHBP plan with the largest enrollment. For example, in 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. We are continuing to consider options for supplementing missing categories such as habilitative care, pediatric oral care and pediatric vision care if States do not select one of the options discussed below.

[27] A qualified health plan may choose to not offer coverage for pediatric oral services provided that a standalone dental benefit plan which covers pediatric oral services as defined by EHB is offered through the same Exchange.

Habilitation

Because habilitative services are a less well defined area of care, there is uncertainty on what is included in it. The NAIC has proposed a definition of habilitation in materials transmitted to the Department as required under Section 2715 of the PHSA, and Medicaid has also adopted a definition of habilitative services.[28,29] These definitions include the concept of "keeping" or "maintaining" function, but this concept is virtually unknown in commercial insurance, which focuses on creating skills and functions (in habilitation) or restoring skills and function (for rehabilitation). Private insurance and Medicare may use different definitions when relating to coverage of these services.[30] We seek comment on the advantages and disadvantages of including maintenance of function as part of the definition of habilitative services. We are considering two options if a benchmark plan does not include coverage for habilitative services:

1) Habilitative services would be offered at parity with rehabilitative services -- a plan covering services such as PT, OT, and ST for rehabilitation must also cover those services in similar scope, amount, and duration for habilitation; or
2) As a transitional approach, plans would decide which habilitative services to cover, and would report on that coverage to HHS. HHS would evaluate those decisions, and further define habilitative services in the future.

Pediatric Oral and Vision

For pediatric oral services, we are considering two options for supplementing benchmarks that do not include these categories. The State may select supplemental benefits from either:

1) The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment; or
2) The State's separate CHIP program.[31]

We intend to propose the EHB definition would not include non-medically necessary orthodontic benefits.

For pediatric vision services we intend to propose the plan must supplement with the benefits covered by the FEDVIP vision plan with the largest enrollment. The rationale for a different treatment of this category is that CHIP does not require vision services. As with habilitative services, we also seek comment on an approach that lets plans define the pediatric oral and vision services with required reporting as a transition policy.

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[28] See 76Fed. Reg. 52,442 and 76 Fed. Reg. 52,475.

[29] For Medicaid definition, see Social Security Act, Section 1915(c)(5)(A).

[30] See section 220.2(c) and (d) in the Medicare Benefits Policy Manual available here: http://www.cms.gov/manuals/Downloads/bp102c15.pdf

[31] If a State does not have a separate CHIP program, it may establish a benchmark that is consistent with the applicable CHIP standards. http://www.cms.gov/SMDL/downloads/CHIPRA%20Dental%20SHO%20Final%20100709revised.pdf

Mental Health and Substance Use Disorder Services and Parity

The MHPAEA expanded on previous Federal parity legislation addressing the potential for discrimination in mental health and substance use disorder benefits to occur by generally requiring that the financial requirements or treatment limitations for mental health and substance use disorder benefits be no more restrictive than those for medical and surgical benefits. However, although parity was applied for covered mental health and substance use disorder benefits, there was no requirement to offer such a benefit in the first instance. Also, prior to the Affordable Care Act, MHPAEA parity requirements did not apply to the individual market or group health coverage sponsored by employers with 50 or fewer employees.

The Affordable Care Act identifies coverage of mental health and substance use disorder benefits as one of the 10 categories and therefore as an EHB in both the individual and small group markets. The Affordable Care Act also specifically extends MHPAEA to the individual market. Because the Affordable Care Act requires any issuer that must meet the coverage standard set in section 1302(a) to cover each of the 10 categories, all such plans must include coverage for mental health and substance use disorder services, including behavioral health treatment. Consistent with Congressional intent, we intend to propose that parity applies in the context of EHB.

Benefit Design Flexibility

To meet the EHB coverage standard, HHS intends to require that a health plan offer benefits that are "substantially equal" to the benefits of the benchmark plan selected by the State and modified as necessary to reflect the 10 coverage categories. This is the same equivalency standard that applies to plans under CHIP.[32] Similar to CHIP, we intend to propose that a health insurance issuer have some flexibility to adjust benefits, including both the specific services covered and any quantitative limits provided they continue to offer coverage for all 10 statutory EHB categories. Any flexibility provided would be subject to a baseline set of relevant benefits, reflected in the benchmark plan as modified. Permitting flexibility would provide greater choice to consumers, promoting plan innovation through coverage and design options, while ensuring that plans providing EHB offer a certain level of benefits. We are considering permitting substitutions that may occur only within each of the 10 categories specified by the Affordable Care Act. However, we are also considering whether to allow substitution across the benefit categories. If such flexibility is permitted, we seek input on whether substitution across categories should be subject to a higher level of scrutiny in order to mitigate the potential for eliminating important services or benefits in particular categories. In addition, we intend to require that the substitution be actuarially equivalent, using the same measures defined in CHIP.[33]

To ensure competition within pharmacy benefits, we intend to propose a standard that reflects the flexibility permitted in Medicare Part D in which plans must cover the

[32] 42 CFR 457.420.

[33] 42 CFR 457.431

categories and classes set forth in the benchmark, but may choose the specific drugs that are covered within categories and classes.[34] If a benchmark plan offers a drug in a certain category or class, all plans must offer at least one drug in that same category or class, even though the specific drugs on the formulary may vary.

The Affordable Care Act also directs the Secretary to consider balance in defining benefits and to ensure that health insurance issuers do not discriminate against enrollees or applicants with health conditions. Providing guidelines for substitution will ensure that health insurance issuers meet these standards.

Updating Essential Health Benefits

Section 1302(b)(4)(G) and (H) direct the Secretary to periodically review and update EHB. As required by the Affordable Care Act, we will assess whether enrollees have difficulties with access for reasons of coverage or cost, changes in medical evidence or scientific advancement, market changes not reflected in the benchmarks and the affordability of coverage as it relates to EHB. We invite comment on approaches to gathering information and making this assessment. Under the benchmark framework, we note that the provision of a "substantially equal" standard would allow health insurance issuers to update their benefits on an annual basis and they would be expected on an ongoing basis to reflect improvements in the quality and practice of medicine. We also intend to propose a process to evaluate the benchmark approach.

[34] Drug category and class lists would be provided by the U.S. Pharmacopoeia, AHMS, or through a similar standard. Note: we do not intend to adopt the protected class of drug policy in Part D.

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Frequently Asked Questions on Essential Health Benefits Bulletin

On December 16, 2011, the Department of Health and Human Services (HHS) released a Bulletin[i] describing the approach it intends to take in future rulemaking to define the essential health benefits (EHB) under the Affordable Care Act. This document is intended to provide additional guidance on HHS's intended approach to defining EHB.

1. Under the approach described in the Bulletin, would the Secretary permit the State to adopt different benchmark plans for its individual and small group markets?

   A: No. A State would select only one of the benchmark options as the applicable EHB benchmark plan across its individual and small group markets both inside and outside of the Exchange. HHS believes that selecting one benchmark for these markets in a State would result in a more consistent and consumer-oriented set of options that would also serve to minimize administrative complexity. HHS seeks to provide flexibility to issuers by permitting actuarially equivalent substitution of benefits within the ten categories of benefits required by the Affordable Care Act.

2. When a State chooses an EHB benchmark plan, would the benefits be frozen in time, or as the benchmark plan updates benefits each year, would the benchmark plan reflect these updates?

   A: As indicated in the Bulletin, we intend to propose a process for updating EHB in future rulemaking. Under the intended approach, the specific set of benchmark benefits selected in 2012 would apply for plan years 2014 and 2015. For 2014 and 2015, the EHB benchmark plan selection would take place in the third quarter of 2012. A consistent set of benefits across these two years would limit market disruption during this transition period. As indicated in the Bulletin, HHS intends to revisit this approach for plan years starting in 2016.

3. Would States be required to defray the cost of any State-mandated benefit?

   A: The Affordable Care Act requires States to defray the costs of State-mandated benefits in qualified health plans (QHPs) that are in excess of the EHB. If a State were to choose a benchmark plan that does not include all State-mandated benefits, the Affordable Care Act would require the State to defray the cost of those mandated benefits in excess of EHB as defined by the selected benchmark.

   States have several benchmark options from which to choose, including the largest small group market plan in the State, which is the default benchmark plan for each State. Generally, insured plans sold in the small group market must comply with State mandates to cover benefits. Thus, if a small group market benchmark plan was selected, these mandated benefits would be part of the State-selected EHB. However, if there are State mandates that do not apply to the small group market,

such as mandates that apply only to the individual market or to HMOs, the State would need to defray the costs of those mandates if the mandated benefits were not covered by the selected benchmark.

As indicated in the Bulletin, the treatment of State benefit mandates is intended as a two-year transitional policy that HHS intends to revisit for plan years starting in 2016.

4. Could a State add State-mandated benefits to the State-selected EHB benchmark plan today without having to defray the costs of those mandated benefits?

   A: No. We intend to clarify that under the proposed approach any State-mandated benefits enacted after December 31, 2011 could not be part of EHB for 2014 or 2015, unless already included within the benchmark plan regardless of the mandate. Note that any State-mandated benefits enacted by December 31, 2011 would be part of EHB if applicable to the State-selected EHB benchmark plan. As mentioned above, HHS intends to revisit this approach for plan years starting in 2016.

5. How must a State supplement a benchmark plan if it is missing coverage in one or more of the ten statutory categories?

   A: We intend to propose that if a benchmark plan is missing coverage in one or more of the ten statutory categories, the State must supplement the benchmark by reference to another benchmark plan that includes coverage of services in the missing category, as described in the Bulletin. For example, if a benchmark plan covers newborn care but not maternity services, the State must supplement the benchmark to ensure coverage for maternity services. The default benchmark plan would be supplemented by looking first to the second largest small group market benchmark plan, then to the third, and then, if neither of those alternative small group market benchmark plans offers benefits in a missing category, to the FEHBP benchmark plan with the highest enrollment.

   Our research found that three categories of benefits - pediatric oral services, pediatric vision services, and habilitative services - are not included in many health insurance plans. Thus, the Bulletin describes special rules to ensure meaningful benefits in those categories:

   - **As a transitional approach for habilitative services, the Bulletin discusses two alternative options that we are considering proposing:**
     - **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.**
   - **For pediatric oral care, we are considering proposing that the State would supplement the benchmark plan with benefits from either:**

- **The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment; or**
- **The State's separate Children's Health Insurance Program (CHIP).**

- **For pediatric vision care, we are considering proposing that the State would supplement the benchmark plan with the benefits covered in the FEDVIP vision plan with the highest enrollment.**

6. One of the currently intended benchmark plans is *the largest plan by enrollment in any of the three largest products in the small group market.* What is the difference between a plan and a product?

   A: For the purpose of administering the health plan finder on HealthCare.gov, HHS has defined "health insurance product" (product) as a package of benefits an issuer offers that is reported to State regulators in an insurance filing. Generally, this filing describes a set of benefits and often a provider network, but does not describe the manner in which benefits may be tailored, such as through the addition of riders. For purposes of identifying the benchmark plan, we identify the plan as the benefits covered by the product excluding all riders. HHS intends to propose that if benefits in a statutory category are offered only through the purchase of riders in a benchmark plan, that required EHB category would need to be supplemented by reference to another benchmark as described in question 5.

7. What is the minimum set of benefits a plan must offer in a statutory category to be considered to offer coverage within the category consistent with the benchmark plan?

   A: Under the approach described in the Bulletin, a plan could substitute coverage of services within each of the ten statutory categories, so long as substitutions were actuarially equivalent, based on standards set forth in CHIP regulations at 42 CFR 457.431, and provided that substitutions would not violate other statutory provisions. For example, a plan could offer coverage consistent with a benchmark plan offering up to 20 covered physical therapy visits and 10 covered occupational therapy visits by replacing them with up to 10 covered physical therapy visits and up to 20 covered occupational therapy visits, assuming actuarial equivalence and the other criteria are met. The benchmark plan would provide States and issuers with a frame of reference for the EHB categories.

8. Can scope and duration limitations be included in the EHB?

   A: Yes. Under the intended approach, a plan must be substantially equal to the benchmark plan, in both the scope of benefits offered and any limitations on those benefits such as visit limits. However, any scope and duration limitations in a plan would be subject to review pursuant to statutory prohibitions on discrimination in benefit design. In addition, the Public Health Service Act (PHS Act) section 2711, as added by the Affordable Care Act, prohibits imposing annual and lifetime dollar limits on EHB. Note that for annual dollar limits, the prohibition generally applies in full starting in 2014, with certain restricted annual limits permitted until that time. The prohibition on annual dollar limits does not apply to grandfathered individual market policies.

9. State-mandated benefits sometimes have dollar limits. How does the intended EHB policy interact with the annual and lifetime dollar limit provisions of the Affordable Care Act?

   A: PHS Act section 2711, as added by the Affordable Care Act, does not permit annual or lifetime dollar limits on EHB. Therefore, if a benefit, including a State-mandated benefit, included within a State-selected EHB benchmark plan was to have a dollar limit, that benefit would be incorporated into the EHB definition without the dollar limit.

   However, based on the Bulletin describing our intended approach, plans would be permitted to make actuarially equivalent substitutions within statutory categories. Therefore, plans would be permitted to impose non-dollar limits, consistent with other guidance, that are at least actuarially equivalent to the annual dollar limits.

10. How would the intended EHB policy affect self-insured group health plans, grandfathered group health plans, and the large group market health plans? How would employers sponsoring such plans determine which benefits are EHB when they offer coverage to employees residing in more than one State?

    A: Under the Affordable Care Act, self-insured group health plans, large group market health plans, and grandfathered health plans are not required to offer EHB. However, the prohibition in PHS Act section 2711 on imposing annual and lifetime dollar limits on EHB does apply to self-insured group health plans, large group market health plans, and grandfathered group market health plans. These plans are permitted to impose non-dollar limits, consistent with other guidance, on EHB as long as they comply with other applicable statutory provisions. In addition, these plans can continue to impose annual and lifetime dollar limits on benefits that do not fall within the definition of EHB.

    To determine which benefits are EHB for purposes of complying with PHS Act section 2711, the Departments of Labor, Treasury, and HHS will consider a self-insured group health plan, a large group market health plan, or a grandfathered group health plan to have used a permissible definition of EHB under section 1302(b) of the Affordable Care Act if the definition is one that is authorized by the Secretary of HHS (including any available benchmark option, supplemented as needed to ensure coverage of all ten statutory categories). Furthermore, the Departments intend to use their enforcement discretion and work with those plans that make a good faith effort to apply an authorized definition of EHB to ensure there are no annual or lifetime dollar limits on EHB.

11. In the case of a non-grandfathered insured small group market plan that offers coverage to employees residing in more than one State, which State-selected EHB benchmark plan would apply?

    A: Generally, the current practice in the group health insurance market is for the health insurance policy to be issued where the employer's primary place of business is located. As such, the employer's health insurance policy must conform to the benefits required in the employer's State, given that the employer is the policyholder. Nothing in the Bulletin or our proposed approach seeks to change this

current practice. Therefore, the applicable EHB benchmark for the State in which the insurance policy is issued would determine the EHB for all participants, regardless of the employee's State of residence. Health insurance coverage not required to offer EHB, including grandfathered health plans and large group market coverage, would comply with the applicable annual and lifetime limits rule, as described in the answer to the previous question.

12. How do the requirements regarding coverage of certain preventive health services under section 2713 of the PHS Act interact with the intended EHB policy?

    A: The preventive services described in section 2713 of the PHS Act, as added by section 1001 of the Affordable Care Act, will be a part of EHB.

13. Under the intended EHB approach, would the parity requirements in MHPAEA be required in EHB?

    A: Yes. Consistent with Congressional intent, we intend to propose that the parity requirements apply in the context of EHB.

14. Could a State legislature require that issuers offer a unique set of "EHB" the way Medicaid and CHIP benchmarks have options for Secretary-approved benefits, or benchmark equivalent benefits, if the State benefits are actuarially equivalent to one of the choices that HHS defines to be EHB?

    A: No. Under the approach we intend to propose, States would be required to adhere to the guidelines for selecting a benchmark plan outlined in the Bulletin. Otherwise, EHB in that State would be defined by the default benchmark plan.

15. Would States need to identify the benchmark options themselves?

    A: HHS plans to report the top three FEHBP benchmark plans to States based on information from the Office of Personal Management. HHS also plans to provide States with a list of the top three small group market products in each State based on data from HealthCare.gov from the first quarter of the 2012 calendar year. We intend to continue working with States to reconcile discrepancies in small group market product enrollment data. If a State chooses to consider State employee plans and/or the largest commercial HMO benchmark plans, the State would be required to identify benchmark options for those benchmark plans, as is done today in Medicaid and CHIP.

16. When would States be required to select a benchmark plan?

    A: As noted in the Bulletin, we intend to propose that States must select an EHB benchmark plan in the third quarter two years prior to the coverage year, based on enrollment from the first quarter of that year. Thus, HHS anticipates that selection of the benchmark plan for 2014 and 2015 would need to take place in the third quarter of 2012 in order to provide each State's EHB package, which includes the benchmark plan, any State-supplemented benefits to ensure coverage in all statutory categories, and any adjustments to include coverage for applicable State

mandates enacted before December 31, 2011. This schedule would ensure plans have time to determine benefit offerings before QHP applications are due. Separate guidance on the selection of Medicaid benchmark plans is forthcoming.

17. How would a State officially designate and communicate its choice of benchmark plan and the corresponding benefits to HHS?

A: HHS is currently evaluating options for collecting a State's benchmark plan selection and benefit information. A State's EHB package would include the benefits offered in the benchmark plan, any supplemental benefits required to ensure coverage within all ten statutory categories of benefits, and any adjustments to include coverage for applicable State mandates enacted before December 31, 2011. HHS anticipates that submissions will be collected from States in a standardized format that includes the name of the benchmark plan along with benefit information and, if necessary, the benefits used to ensure coverage within a missing statutory category.

18. How can my State find benefit information with respect to the default benchmark plan?

A: As indicated in the Bulletin, we intend to propose that the default benchmark plan in each State would be the largest small group market product in the State's small group market. HHS anticipates that it will identify and provide benefit information with respect to State-specific default benchmark plans in the Fall of 2012.

19. By empowering the State to select an EHB benchmark plan, does HHS intend that the State executive branch (i.e., State Insurance Department) or the legislative branch must make the selection?

A: Each State would be permitted to select a benchmark plan from the options provided by HHS by whatever process and through whatever State entity is appropriate under State law. In general, we expect that the State executive branch would have the authority to select the benchmark plan. It is also possible that, in some States, legislation would be necessary for benchmark plan selection. It is important to note that, regardless of the entity making these State selections, it is the State Medicaid Agency that will be held responsible for the implementation of EHB through the Medicaid benchmark coverage option.

EHB Applicability to Medicaid:

20. How would EHB be defined for Medicaid benchmark or benchmark-equivalent plans?

A: Since 2006, State Medicaid programs have had the option to provide certain groups of Medicaid enrollees with an alternative benefit package known as "benchmark" or "benchmark-equivalent" coverage, based on one of three commercial insurance products, or a fourth, "Secretary-approved" coverage option. Beginning January 1, 2014, all Medicaid benchmark and benchmark equivalent plans must include at least the ten statutory categories of EHBs. Under the Affordable Care Act, the medical assistance provided to the expansion population of

adults who become eligible for Medicaid as of January 1, 2014, will be a benefit package consistent with section 1937[ii] benchmark authority.

For Medicaid benchmark and benchmark equivalent plans, three of the benchmark plans described in section 1937 (the State's largest non-Medicaid HMO, the State's employee health plan, and the FEHBP BCBS plan) may be designated by the Secretary as EHB benchmark plans, as described in the EHB Bulletin. A State Medicaid Agency could select any of these section 1937 benchmark plans as its EHB benchmark reference plan for Medicaid. There would be no default EHB benchmark reference plan for purposes of Medicaid; each State Medicaid Agency would be required to identify an EHB benchmark reference plan for purposes of Medicaid as part of its 2014-related Medicaid State Plan changes.

If the EHB benchmark plan selected for Medicaid were to lack coverage within one or more of the ten statutorily-required categories of benefits, the EHB benchmark plan (and therefore the section 1937 benchmark plan) would need to be supplemented to ensure that it provides coverage in each of the ten statutory benefit categories. This would be in addition to any other requirements for Section 1937 plan, including Mental Health Parity and Addition Equity Act compliance.

21. Could a State select a different EHB benchmark reference plan for its Medicaid section 1937 benchmark and benchmark equivalent plans than the EHB reference plan it selects for the individual and small group market?

    A: Yes. Under our intended proposal, a State would not be required to select the same EHB benchmark reference plan for Medicaid section 1937 plans that it selects for the individual and small group market, and it could have more than one EHB benchmark reference plan for Medicaid, for example, if the State were to develop more than one benefit plan under section 1937.

22. Could a State select its regular Medicaid benefit plan as its Section 1937 benchmark coverage package?

    A: Yes. A State could propose its traditional Medicaid benefit package as a section 1937 benchmark plan under the Secretary-approved option available under section 1937 of the Social Security Act. The State would have to ensure, either through that benefit plan or as a supplement to that plan, that the ten statutory categories of EHB are covered.

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[i] You can access the Bulletin at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

[ii] You can access section 1937 at http://www.ssa.gov/OP_Home/ssact/title19/1937.htm

Appendix C: Comparison of Vermont Benefit Requirements with the Federal EHB

#	Health Insurance Mandates Protecting Vermont Consumers – October 2011[i]	Federal Mandate (Yes or No)[ii]	Essential Health Benefit Category[iii]
1	**Alcoholism** 8 VSA 4089b - enacted in 1997 Reg. H-2000-03 Bulletin I-116 Bulletin HCA-127 Rule 10/Rule 2009-03 Alcohol or Chemical Dependence. Mandate provides for evaluation and treatment	**Yes**	**Mental Health and Substance Abuse disorder services including behavioral health**
2	**AIDS/HIV Testing/Vaccines** 8 VSA 4724(20) - subdivision added in 1988 - and Bulletin I-92 Statutory language requires insurer to retest upon written request from any individual who was denied coverage or offered reduced coverage due to previous positive test results. It does not mandate any benefit, but includes detailed confidentiality provisions and testing process.	**No**	**n/a**
3	**Alzheimer's Disease** 8 VSA 8085 enacted in 2004, effective 1/1/2005 Not applicable to health insurance only LTC insurance	**No**	**n/a**
4	**Anesthesia for certain dental procedures** 8 VSA 4100i – enacted in 2010	**No**	**n/a**
5	**Athletic Trainer** 8 VSA 4088g – enacted in 2008 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 (?)**
6	**Autism** 8 VSA 4088i – enacted in 2010, effective date delayed until 10/1/11 Autism is a brain disorder that affects three areas of development: communication, social interaction, and creative or imaginative play. Mandate provides for evaluation and treatment services. Requires coverage for treatment of children from ages 18 months to 6 years.	**No**	**Pediatric Services (?)**
7	**Chemotherapy treatment** 8 VSA 4088c – enacted in 1997 (recodified in 2003) - and Bulleting 1-116 Requires health insurers to provide coverage for medically necessary growth cell stimulating factor injections taken as part of a prescribed regimen	**No**	**Ambulatory Patient Services (?)**
8	**Chiropractic services** 8 VSA 4088a – enacted in 1999 - and Bulletin HCA-105	**No**	**Rehabilitation?**

#	Health Insurance Mandates Protecting Vermont Consumers – October 2011[i]	Federal Mandate (Yes or No)[ii]	Essential Health Benefit Category[iii]
	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.		
9	**Clinical trials for cancer patients** 8 VSA 4088b – enacted in 2001 and amended substantially in 2005 - and Regulation H-2005-03 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.**
10	**Colorectal cancer screening** 8 VSA 4100g – enacted in 2009 Colon Cancer (also commonly called colorectal cancer) refers to any cancer in the colon, rectum, appendix and anus. Mandate provides for evaluation and limits cost-sharing.	**No**	**n/a**
11	**Congenital Bleeding Disorders** Regulation 80-1 Inherited bleeding condition typically associated with low levels of absence of a blood protein essential for clotting such as hemophilia and Von Willebrands. Mandate provides for evaluation and treatment	**No**	**n/a**
12	**Contraceptive mandate:** 8 VSA 4099c – enacted in 1999 - and Bulletin HCA-105 Birth Control pharmaceuticals and devices. Mandate provides coverage for a range of FDA-approved prescription contraceptive drugs and devices.	**No**	**n/a**
13	**Craniofacial disorders** 8 VSA 4089g – enacted in 1997 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 patient Services (?)**
14	**Diabetic Self-Management and Supplies** 8 VSA 4089c – enacted in 1997, Bulletins I-116 & HCA-108 Mandate provides payment for evaluation, education & treatment for self-management and for evaluation and supplies of durable medical equipment and certain medicines for diabetics	**No**	**Preventative, wellness and Chronic disease management (?)**
15	**Drug Treatment** 8 VSA 4089b – mental health parity statute enacted in 1997 Reg H-2000-03	**Yes**	**Mental Health and Substance Abuse disorder services**

#	Health Insurance Mandates Protecting Vermont Consumers – October 2011[i]	Federal Mandate (Yes or No)[ii]	Essential Health Benefit Category[iii]
	Bulletin I-116 Bulletin H-127 Rule 10 and 2009-03 Mandate provides for evaluation, education and treatment of those dependent on both legal and illegal drugs		**including behavioral health**
16	**Emergency Treatment** Rule 10 section 10.203(E) Mandate provides for appropriate medical care in emergency situations based upon the "prudent layperson" standard.	Yes	**Emergency Services**
17	**Home Health Care** 8 VSA 4096 – enacted in 1975 An individual or group health insurance expense policy and an individual or group service contract issued by a nonprofit hospital corporation which provides hospital or medical coverage shall provide as an option coverage for home health care	No	**Rehabilitation?**
18	**Long Term Care** 8 VSA 8081 et seq and Reg. H-2009-01 Not applicable to health insurance, just to long term care insurance	No	**n/a**
19	**Mammogram** 8 VSA 4100a – enacted in 1991, amended in 2007 An x-ray of the breast to detect breast changes in women. Mandate provides for the x-ray and evaluation and limits cost-sharing.	No	**Preventative, wellness and Chronic disease management ?**
20	**Maternity** 8 V.S.A. § 4096 – Home health requires coverage for maternity and childbirth – enacted in 1975 8 V.S.A. § 4099d – plans covering maternity care must also cover midwifery and home births – enacted in 2011 Bulletin 54, 1-95, 96, and I-114 and Regulation 89-1 Mandate provides for prenatal & postpartum doctor evaluation and care during pregnancy.	Yes	**Maternity and newborn care**
21	**Maternity Stay** Bulletin 54 Bulletins 1-95 and 96 Bulletin I-114 Regulation 89-1 Those insurers that provide coverage for maternity must allow a patient to remain in the hospital for a minimum specified amount of time according to federal law (usually one to two days for vaginal delivery and three to four days for cesarean delivery) following the	Yes	**Maternity and newborn care**

#	Health Insurance Mandates Protecting Vermont Consumers – October 2011[i]	Federal Mandate (Yes or No)[ii]	Essential Health Benefit Category[iii]
	delivery of a baby		
22	**Mental Health – general** – mental health parity statute enacted in 1997 8 VSA 4089b Rule 10 Bulletin I-116 Bulletin HCA-127 Although most states define mental health as a state of emotional and psychological well-being, they often differ on what they include in evaluation and treatment. The mandate provides for the payment of mental health evaluation and treatment.	Yes	**Mental Health and Substance Abuse disorder services including behavioral health**
23	**Mental Health Parity** – mental health parity statute enacted in 1997 8 VSA 4089b Rule 10 Bulletin I-116 Bulletin HCA-127 The federal parity requirements apply only to plans that include mental health benefits in their benefit package. A health plan may not place annual or lifetime dollar limits on mental health benefits that are lower or less generous than annual or lifetime dollar limits for medical and surgical benefits offered under that plan. Due to federal law, substance abuse benefits are now included along with mental health parity benefits.	Yes	**Mental Health and Substance Abuse disorder services including behavioral health**
24	**Midwifery services and home births** 8 VSA 4099d – enacted in 2011 Requires a plan that covers maternity care also to cover services provided by licensed midwives and certified nurse midwives in a hospital or at home.	No	**Maternity and newborn care (?)**
25	**Naturopathic physicians** 8 VSA 4088d – enacted in 2007 The mandate requires health insurers to cover medically necessary health care services provided by a naturopathic physician if the services are otherwise covered under the plan.	**No**	**Prevention and Wellness (?)**
26	**Newborns** 8 VSA 4092 – enacted in 1975 A newborn is included under a parent's individual insurance policy for 31 days, as long as the policy already provides coverage for dependents.	**Yes**	**Maternity and newborn care**

#	Health Insurance Mandates Protecting Vermont Consumers – October 2011[i]	Federal Mandate (Yes or No)[ii]	Essential Health Benefit Category[iii]
27	**Off label drug use (cancer only)** 8 VSA 4100e – enacted in 2005 Coverage or offering of drugs for treating a particular disease even though they are not approved for a specific purpose by the FDA. Mandate requires health insurance plans that cover prescription drugs to cover off-label use in cancer treatment.	**No**	**Prescription drugs (?)**
28	**Oral cancer medications** 8 V.S.A. § 4100h – enacted in 2009 Requires a health insurer to provide coverage for prescribed, orally administered anticancer medications if the insurer provides coverage for cancer chemotherapy treatment	**No**	**Ambulatory patient services (?)** **Prescription drugs (?)**
29	**Pediatric Immunizations** 8 V.S.A. § 4100d – enacted in 1994 Prohibits insurers from reducing child vaccine benefits below May 1, 1993 coverage	**No**	**Pediatric services(?)** **Preventative, wellness and Chronic disease management ?**
30	**PKU/Formula/Metabolic Disease Foods** 8 VSA 4089e – enacted in 1998 - and Bulletin I-122 An insurer shall provide coverage for medical foods prescribed for medically necessary treatment for an inherited metabolic disease such as phenylketonuria (PKU)	**No**	**N/A**
31	**Prescription Drugs** 8 VSA 4089i and 8 V.S.A. 4089j – both enacted in 2004 4089j requires health insurers to provide coverage for pharmaceuticals at the same quantity and co-pay for retail and mail order pharmacies. 4089i requires coverage for prescription drugs purchased in Canada, and used in Canada or reimported legally or purchased through the I-SaveRx program on the same benefit terms and conditions as prescription drugs purchased in this country	**No**	**Prescription drugs**
32	**Prostate Cancer Screening** 8 VSA 4100f – enacted in 2007 Prostate cancer is the growth of malignant prostate glandular cells in the prostate gland. Mandate provides for the evaluation.	**No**	**Prevention and Wellness (?)**
33	**Prosthetic parity** 8 VSA 4088f – enacted in 2008	**No**	**Rehabilitation; Habilitation**

#	Health Insurance Mandates Protecting Vermont Consumers – October 2011[i]	Federal Mandate (Yes or No)[ii]	Essential Health Benefit Category[iii]
	Prosthetics deals with the production and application of artificial body parts. Mandate provides for evaluation, treatment and supplies.		**and Devices (?)**
34	**TMJ Disorders** Bulletin I-63 TMJ, temporomandibular joint disorder, is caused by the displacement of the cartilage where the lower jaw connects to the skull. Mandate provides for the evaluation and treatment.	**No**	**n/a**
35	**Tobacco Cessation programs** 8 VSA 4100j – enacted in 2010 A health insurance plan shall provide coverage of at least one three-month supply per year of tobacco cessation medication, including over-the-counter medication, if prescribed by a licensed health care practitioner for an individual insured under the plan. A health insurance plan may require the individual to pay the plan's applicable prescription drug co-payment for the tobacco cessation medication.	**No**	**Prevention and Wellness (?)**

[i] Information from the VT Department of Banking, Insurance, Securities and Health Care Administration

[ii] Information from the Council for Affordable Health Insurance *Health Insurance Mandates in the States 2009* including the following federal legal references- Mental Health Parity Act of 1996, Pub. L. No. 104-204, Title VII, 110 Stat. 2874, 2944; the Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, Title VI, 110 Stat. 2874, 2935; and the Women's Health and Cancer Rights Act of 1998, Pub. L. No. 105-277, Title IX, 112 Stat. 2681, 2681-436.

[iii] Information from the National Health Council *Essential Health Benefits White Paper* September 2010; because final definition of Essential Health Benefit has not been released, this categorization only provides a potential match. Final regulations defining Essential Health Benefits are not expected to be released from the federal government until 2012.

Appendix D.
The Green Mountain Care Board

BENEFITS: Part 1

Robin Lunge,

Director of Health Care Reform

Agency of Administration

February 16, 2012

Agenda – Today

- Introductions

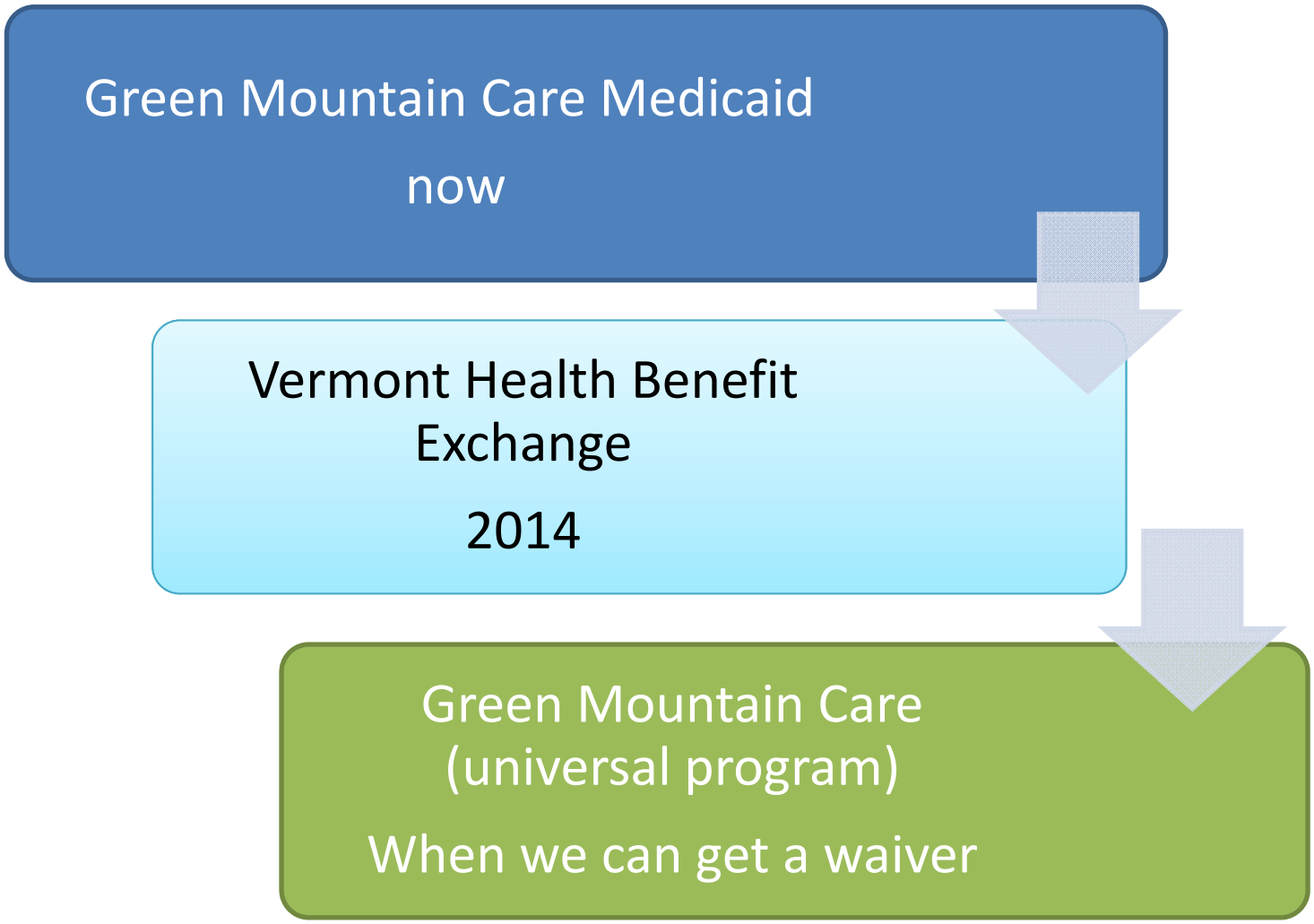
- Timelines & Key Dates
  - Health Care Reform Timeline
  - Benefit development key dates

- Vermont Health Benefit Exchange
  - Essential Health Benefits Analysis

Agenda – March 1

- Vermont Health Benefit Exchange
  - Briefly review benchmark plan differences
  - Additional information requested
  - Discussion & Possible Vote?
- Green Mountain Care
  - Vermonters' benefits today
  - Exploration of future with Green Mountain Care
  - Goal of health

Benefit Development Stages



Benefit Development - Overview

Vermont Health Benefit Exchange

- Federal Essential Benefits
  - Federal requirements & restrictions
  - Limit state flexibility
  - State additions mean state dollars
- Private Insurance Products
- State standardization possible
  - 2 national plans, possible exception
- 2014

Green Mountain Care (single payer)

- Act 48 sets minimum standards
  - Broad definitions
  - Catamount Health services as minimum
  - Minimum actuarial value requirement
  - Protections for Medicaid beneficiaries
- Flexibility in design
- After Exchange waiver is available

Benefit Development – Key Dates

Vermont Health Benefit Exchange

- Benchmark plan - now
  - First quarter 2012
- Research & develop plans
  - Spring 2012
- Consumer focus groups
  - Spring 2012
- Draft plan options available
  - May 2012

Green Mountain Care (single payer)

- Need draft package for financing plan
  - Due January 2013
- Research & develop
  - Summer/Fall 2012
- Draft plan options available
  - Late Fall/Winter 2012

Future Questions for GMC Board Discussion

Decision: Which benchmark plan should be used to establish the essential benefits in the Exchange?

Discussion: How much specificity would you like in the Exchange plan designs?

Vermont Health Insurance Benefits: Essential Health Benefits Analysis

Presented by Kate Reinhalter Bazinsky, MPH
to the Green Mountain Care Board
February 16, 2012

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What are Essential Health Benefits?

- The “Essential Health Benefits” (EHB) plan is a “reference plan” that the state will use to determine the required benefits and limitations on any small group or individual plan sold in the state starting in 2014.

- We are not talking about the Green Mountain Care Plan today.

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EHB Applies to All Small Group and Individual Plans Sold in Vermont

- The Essential Health Benefits package will apply to all small group and individual plans offered in the state
- Does not matter whether the plans are sold in the Exchange or outside of the Exchange

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Agenda

- Review of ACA Requirements
- HHS Process/ Proposed Approach
- Analysis of Potential Benchmark Plans
- Framework for Selecting a Benchmark Plan
- Discussion/ Feedback

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Review of ACA Requirements (Section 1302)

- Affordable Care Act (ACA) requires the Secretary of HHS to define “Essential Health Benefits” (EHB)

- The EHB Definition must:
  - Equal the scope of benefits in a typical employer plan
  - Not be designed in ways to discriminate based on age, disability or expected length of life
  - Must consider health care needs of diverse population

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Review of ACA Requirements

EHB Must Include Services Within 10 Categories:

- 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 chronic disease management
- Laboratory services
- Preventive and wellness services
- Pediatric services, including oral and vision care

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Review of ACA Requirements

- EHB considers the benefits covered and excluded as well as restrictions to coverage such as preferred networks and prior authorization

- EHB does not take cost-sharing into consideration

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Agenda

- Review of ACA Requirements
- HHS Process/ Proposed Approach
- Analysis of Potential Benchmark Plans
- Framework for Selecting a Benchmark Plan
- Discussion/ Feedback

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HHS Solicited Public Advice

- Department of Labor reviewed benefits in variety of employer plans
- Institute of Medicine developed consensus recommendations
- Received comments from a range of national stakeholders

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HHS Provides Guidance on EHB

- HSS released a Bulletin in December 2011
  - Provides intended regulatory approach
  - Not binding
  - Public comment was accepted through January 31, 2012.

- The HHS Bulletin:
  - Provides states a role in defining EHB
  - Requires mental health parity
  - Signals that HHS will revisit EHB for 2016 and beyond

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Proposed Approach: Use of a Benchmark Plan

- EHB will be defined by a benchmark plan selected by each state
- The benchmark plan will serve as a reference plan reflecting the scope of services and any limits offered by a "typical employer plan"
- The plans offered in the state must be "substantially equal" to this benchmark plan
  - Process used nationally in CHIP and Medicaid expansions
  - Insurers may adjust the specific services covered and any quantitative limits provided
  - Still considering whether to allow actuarially equivalent substitution

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Proposed Approach: Use of a Benchmark Plan

- If benchmark plan does not include coverage for all 10 categories, state must supplement the missing categories with the benefits from another benchmark option
  - pediatric oral & vision
  - prescription drugs
  - habilitative services

- Our interpretation of the HHS bulletin is that if a plan offers coverage through a rider, then the state can consider that part of the plan.

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Proposed Approach: State Options

- Four Benchmark Plan Options:
  1. Any of three largest products from the small group market
  2. The largest HMO operating in the state
  3. The state employee health benefits plan
  4. The Federal employee health benefits plan

- Default plan (if state doesn't select) is the largest plan by enrollment in the small group market

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Proposed Approach: State Mandates

- Per the HHS Bulletin, state mandates are included in EHB for 2014-15 if state selects a benchmark plan that includes the mandates.
- Provides flexibility to states to keep mandated benefits without concern for added state costs (at least for first two years)
- If state mandates are not included in the EHB, then states are required to defray the costs.

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Agenda

- Review of ACA Requirements
- HHS Process/ Proposed Approach
- **Analysis of Potential Benchmark Plans**
- Framework for Selecting a Benchmark Plan
- Discussion/ Feedback

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Process for Determining Vermont's Benchmark Plan

- Compare similarities and differences of potential benchmark plans
- Consider impact of different selections based on criteria
- Obtain feedback from Exchange Advisory Committee
- Make recommendation to the Green Mountain Care Board

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Potential Vermont Benchmark Plans

- Largest small group plans
  - MVP – Preferred exclusive provider plan (CY11 Q4: 7,414)
  - BCBSVT – BlueCare (estimate for CY12 Q1: 7,201)
- Largest HMO
  - BCBSVT (~31,000 enrolled; benefits are generally the same as in small group)
- State employee plan (administered by Cigna)
- Did not consider the federal employee health benefits plan

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Comparison of Potential Vermont Benchmark Plans

- Plans offer similar benefits under the 10 categories
- The differences are primarily in the details and any limitations on coverage (prior authorization, preferred provider requirements)
  - No specific definition yet for what “substantially equal to” means
  - Many differences between the small group plans are likely not to rise to level of a plan difference beyond “substantially equal”
- Vermont plans already comply with state’s mental health parity law
- State employee plan provides most comprehensive pediatric vision and oral care

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Plans Offer Benefits Across Most of the 10 Categories

Required Category	MVP EPO	BlueCare HMO*	State Plan
Ambulatory patient services	✔	✔	✔
Emergency services	✔	✔	✔
Hospitalization	✔	✔	✔
Laboratory services	✔	✔	✔
Maternity and newborn care	✔	✔	✔
Mental health and substance use disorder services, including behavioral health treatment	✔	✔	✔
Preventive and wellness services	✔	✔	✔

✔ Covers Benefits in Core Plan

(✔) Covers Benefits Through a Rider

✖ Does Not Cover Benefits

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* The BCBSVT small group plan benefits are the same as the large group BCBSVT HMO without riders.

Some Differences Across the ACA Categories

Required Category	MVP EPO	BlueCare HMO*	State Plan
Rehabilitative Services	✔	✔	✔
Habilitative services	?	?	?
Prescription drugs	(✔)	(✔)	✔
Most Pediatric services	✔	✔	✔
Pediatric Oral	(✔)	✖	(✔)
Pediatric Vision	(✔)	✔	✔

✔ Covers Benefits in Core Plan

(✔) Covers Benefits Through a Rider

✖ Does Not Cover Benefits

* The BCBSVT small group plan benefits are the same as the large group BCBSVT HMO without riders.

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Examples of Similarities Across the Plans

(In-Network Services)

Benefit	MVP EPO	BlueCare HMO*	State Plan
Emergency Services	●	●	●
Mental Health/ Substance Use Disorder Services (outpatient)	●	●	●
Office Visits for diagnosis & treatment of disease	●	●	●
Preventive Care (immunizations, annual routine physical exams, routine mammograms)	●	●	●
Outpatient Surgeries (most elective)	●	●	●
Physical, Occupational, Speech Therapy	○	○	○
Skilled Nursing Facility	○	○	○
Hearing Aids	✖	✖	✖

●	●	○	○	✖
Without Restrictions No Prior Approval	Without Restrictions Prior Approval	With Restrictions No Prior Approval	With Restrictions Prior Approval	Excluded

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* The BCBSVT small group plan benefits are the same as the large group BCBSVT HMO without riders.

Benefit Differences
(In-Network Services)

Benefit	MVP EPO	BlueCare HMO*	State Plan
Alternative or Complementary (most standard)	✖	✖	○
Dental Work (with an accident or deformity)	✖	○	●
Fertility Treatments (i.e., medications to promote fertility, artificial insemination, IVP, GIFT, ZIFT)	✖	✖	○
Orthotics	✖	○	●
Private Duty Nursing	✖	○	✖
Treatment for patients with autism (18 months to 6 years of age)	●	●	●
Vision Care: Lenses	✖	✖	○
Vision Care (routine eye exams separate from primary care vision screening)	✖	●	○

● Without Restrictions No Prior Approval
● Without Restrictions Prior Approval
○ With Restrictions No Prior Approval
○ With Restrictions Prior Approval
✖ Excluded

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* The BCBSVT small group plan benefits are the same as the large group BCBSVT HMO without riders.

Benefit Differences
(In-Network Services)

Benefit	MVP EPO	BlueCare HMO*	State Plan
Family and Marital Counseling	✖	○	●
Medical food supplements	●	○	○
Organ Transplants: Associated travel	✖	✖	○
Wig, toupee or hairpiece (for hair loss due to Chemotherapy or alopecia	✖	○	○

● Without Restrictions No Prior Approval
● Without Restrictions Prior Approval
○ With Restrictions No Prior Approval
○ With Restrictions Prior Approval
✖ Excluded

* The BCBSVT small group plan benefits are the same as the large group BCBSVT HMO without riders.

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Differences In Limitations for Covered Services (In-Network Services)

Benefit	MVP EPO	BlueCare HMO*	State Plan
Contraceptive Services (including counseling)	●	◐	◐
Durable Medical Equipment (Most DME)	○	○	○
Home Health Services (skilled nursing)	○	◐	◐
Home Infusion Therapy	●	○	●
Hospice	○	○	◐
Inpatient Care (most non-emergency services)	●	●	●
Intensive Outpatient Mental Health Programs	●	○	●
Prosthetic Devices	●	○	○
CT scans	●	●	●
Transportation (non-emergency ambulance)	○	○	●

● Without Restrictions No Prior Approval
● Without Restrictions Prior Approval
◐ With Restrictions No Prior Approval
○ With Restrictions Prior Approval
✖ Excluded

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* The BCBSVT small group plan benefits are the same as the large group BCBSVT HMO without riders.

Plans Likely to be "Substantially Equal" Despite Differences in Restrictions

- It is unlikely that any specific difference in a plan's benefit restrictions will be so important that the plan can no longer be considered "substantially equal" to the benchmark plan

- Types of potential benefit restrictions:
  - Limitations in scope of services covered
  - Limitations on the population that can access the benefit (according to medical criteria, etc.)
  - Limitations on the number of visits that a patient can use
  - Medical review requirements
  - Requirements around Physician certification or treatment plan submission
  - Limitations on the setting in which the patient may access services

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Out-of-Network Benefit Differences

Benefit	MVP EPO	BlueCare HMO	State Plan
Out-of-Network Non-Emergency Services	○	○	●
Cardiac Rehabilitation	✖	✖	◉
Home Infusion Therapy	✖	✖	◉
Mental Health/ Substance Use Disorder Services	✖	✖	●
Rehabilitation Facilities	✖	✖	◉
Skilled Nursing Facilities	✖	✖	○

● Without Restrictions No Prior Approval
◉ Without Restrictions Prior Approval
◎ With Restrictions No Prior Approval
○ With Restrictions Prior Approval
✖ Excluded

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* The BCBSVT small group plan benefits are the same as the large group BCBSVT HMO without riders.

Agenda

Review of ACA Requirements

HHS Process/ Proposed Approach

Analysis of Potential Benchmark Plans

Framework for Selecting a Benchmark Plan

Discussion/ Feedback

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Framework for Selecting a Benchmark Plan

- Plan comparison:
  - What benefits are included/excluded from particular plans?
    - Do plans include all categories within the ACA?
    - What are the major differences in prior authorization and other restrictions and requirements?
  - What are the implications of out-of-network limitations now, or in the future?
    - If anticipate differences in provider networks, how does that impact the benefit comparison with regard to out-of-network limitations?

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Framework for Selecting a Benchmark Plan

- Impact on overall insurance market
  - What does VT want its health insurance market to look like?
    - Large group market?
    - Small group market?
    - State employee's plan?
    - Hybrid of these models?

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Framework for Selection of a Benchmark Plan

- Impact on cost:
  - To individuals*
    - that purchase with a subsidy?
    - that purchase without a subsidy?
  - To small employers
    - that purchase with a tax credit?
    - that purchase without a tax credit?
  - To large employers?

*if plans are allowed to be sold outside of the exchange, benefits would be the same but consider the loss of tax credits and increases in broker's fees

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Feedback – Exchange Advisory Board

- Questions asked
  - Are these the right criteria?
  - How would you prioritize among the criteria?
  - Is there a specific plan that you would advocate for?
- Response
  - Balance between considering cost and comprehensiveness of benefits critical
  - Interest in better understanding differences between plans
  - Difficult to give guidance without understand cost data
  - Importance of considering provider network adequacy

Administration's Recommendation

- Exchange contractor is currently conducting actuarial analyses
  - High level analysis for February 27 Exchange Advisory Board meeting
  - Detailed analysis in 4-6 weeks
- Recommendation to conduct analyses on the plans most like a "typical employer plan" – MVP and BCBSVT

Agenda

- Review of ACA Requirements
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Questions for GMC Board – March 1 meeting?

Decision: Which benchmark plan should be used to establish the essential benefits in the Exchange?

Discussion: How much specificity would you like in the Exchange plan designs?

Questions & Discussion

- Is there additional information you would like for the March 1st meeting?
- Questions?

Appendix. E. Premium Contributions in the Vermont Health Benefit Exchange by family size

ACA PREMIUM LEVELS

2011 FPL range	Income (1 person)	Premium for 1-person household	
	Monthly income	% of income	Monthly amount
0-100%	$0-$931	0.0%	$0
100 - 133%	$932-$1238	2.0%	$19-$25
133 - 150%	$1239-$1397	3-4%	$37-$56
150 -200%	$1398-$1862	4-6.3%	$56-$117
200 - 250%	$1863-$2328	6.3-8.1%	$117-$189
250 - 300%	$2329-$2793	8.1-9.5%	$189-$265
300 - 350%	$2794-$3259	9.5%	$265-$310
350 - 400%	$3260-$2793	9.5%	$310-$265

2011 FPL range	Income (2 people)	Premium for 2-person household	
	Monthly income	% of income	Monthly amount
0-100%	$0-$1261	0.0%	$0
100 - 133%	$1262-$1677	2.0%	$25-$34
133 - 150%	$1678-$1892	3-4%	$50-$76
150 -200%	$1893-$2522	4-6.3%	$76-$159
200 - 250%	$2523-$3153	6.3-8.1%	$159-$255
250 - 300%	$3154-$3783	8.1-9.5%	$255-$359
300 - 350%	$3784-$4414	9.5%	$359-$419
350 - 400%	$4415-$5044	9.5%	$419-$479

2011 FPL range	Income (3 people)	Premium for 3-person household	
	Monthly income	% of income	Monthly amount
0-100%	$0-$1591	0.0%	$0
100 - 133%	$1592-$2116	2.0%	$32-$42
133 - 150%	$2117-$2386	3-4%	$64-$95
150 -200%	$2387-$3182	4-6.3%	$95-$200
200 - 250%	$3183-$3978	6.3-8.1%	$200-$322
250 - 300%	$3979-$4773	8.1-9.5%	$322-$453
300 - 350%	$4774-$5569	9.5%	$453-$529
350 - 400%	$5570-$6364	9.5%	$529-$605

2011 FPL range	Income (4 people)	Premium for 4-person household	
	Monthly income	% of income	Monthly amount
0-100%	$0-$1921	0.0%	$0
100 - 133%	$1922-$2555	2.0%	$38-$51
133 - 150%	$2556-$2882	3-4%	$77-$115
150 -200%	$2883-$3842	4-6.3%	$115-$242
200 - 250%	$3843-$4803	6.3-8.1%	$242-$389
250 - 300%	$4804-$5763	8.1-9.5%	$389-$547
300 - 350%	$5764-$6724	9.5%	$548-$639
350 - 400%	$6725-$7684	9.5%	$639-$730

Appendix F.

Examples: Different Scenarios for Vermonters Moving from Traditional Health Insurance to the Exchange

Here are some examples of what it would mean to different Vermonters to purchase health insurance in the Vermont Exchange instead of today's commercial market.

Example #1 A couple with traditional individual coverage shops in the Exchange

Before 2014 Ellen and her husband buy a two person non-group health insurance policy for which they pay $1100 each month. They have no children. Their family income is $52,000 a year. In 2014, when they buy a policy in the Vermont Health Benefit Exchange, their federal income tax credit will reduce their cost of coverage to $412 per month. They will be saving $688 every month and reduce their spending on health insurance by 63%.

Example #2 -- An single person buying coverage in the Exchange

Bill is a single self-employed electrician in St. Johnsbury. He earns $40,000 and buys one person non-group coverage with the same benefits used in Example #1. Bill's premium is $600 per month. When Bill purchases coverage in the Exchange, his federal tax credit will reduce his cost of coverage to $317 per month. His savings will be $283 per month and he will have reduced what he spends on health insurance by 47%.

Example #3 – A Family looks at buying in the exchange

John and Mary are a couple with two children. Together, their annual income is $32,000. Before 2014 they buy family non-group coverage with a $10,000

deductible that costs $700 monthly. When they shop in the exchange they find that a family plan costs $1600 a month but their tax credit would reduce their cost to $80 per month. Their insurance premium would be reduced by 89% but if they generate $10,000 in claims in a year they will also save another $7,500 because they have a lower deductible.

Example #4 –Every individual and small group can buy in the Exchange but some get no tax credit

Mr. and Mrs. Smith are married and have two children. Their combined income is $450,000 and they currently buy family non-group health insurance. The Smiths can buy one of the plans offered in the Exchange but they will not be eligible for a federal tax credit because their income exceeds the maximum income ($92,208) for which a credit is available.

Example #5 – A small company purchases exchange coverage

XYZ Company is owned by Mr. Jones who has seven employees. The XYZ payroll looks like this:

Mr. Jones	$100,000
Employee #1	$40,000
Employee #2	$36,000
Employee #3	$36,000
Employee #4	$36,000
Employee #5	$36,000
Employee #6	$36,000
Employee #7	$36,000

Mr. Jones and five of the employees have family coverage and by coincidence they each have three children; employees #6 and #7 are unmarried and have no children. Prior to 2014, XYZ buys small group coverage with a $2,500 personal deductible for everyone. This coverage costs $12,800 per month or $153,600 annually and he and his employees contribute 20% of their premium ($30,720).

Comparable health insurance in the Exchange will cost XYZ the same amount they are paying today. The company will, however, be eligible for a small-employer tax credit equal to 16% of its contribution to the cost of health insurance benefits.

Example #6 -- XYZ Can Have its Employees Purchase Non-Group Coverage in the Exchange

Mr. Jones (from Example #6) thinks: I don't save much from going into the Exchange but maybe I can still find a way to get everyone in XYZ the same coverage at less cost.

Jones estimates that if his employees purchase their current level of coverage as individuals in the Exchange in 2014 they will pay the following (the rest of the cost will be paid with federal tax credits):

Mr. Jones	$14,475 (he makes too much to get a tax credit)
Employee #1	$1600
Employee #2	$1080
Employee #3	$1080
Employee #4	$1080
Employee #5	$1080
Employee #6	$3420
Employee #7	$3420
TOTAL	$27,235

Mr. Jones sees that XYZ could save $122,880 in pretax expense because the company is no longer paying 80% of XYZ's insurance premium. The federal government would kick in $126,365 in tax credits. Likewise employees would no longer be paying 20% of the premium. Jones and his employees would have a new personal (after-tax) expense of $27,235. Mr. Jones believes he could—if he wanted—give everyone (himself included) a raise to offset at least some of his employees' cost of buying individual coverage in the Exchange and still save quite a bit. Cautiously optimistic, he calls his accountant….