Report to the Legislature: State Mandated Health Plan Benefits

Dec. 15, 2012

Washington State
Office of the
Insurance Commissioner

Executive summary

The Affordable Care Act of 2010 (ACA) expands the scope coverage for individual and small group plans beginning January 1, 2014 through a provision requiring coverage of "essential health benefits" (EHBs). Qualified health plans (QHPs), which are sold through state Health Benefit Exchanges, are included in these requirements. Beginning in 2016, the U.S. Department of Health and Human Services (HHS) may begin enforcing the provision in the ACA requiring states to defray the costs of QHP coverage for mandates that exceed those contained in the essential health benefits[1].

Washington state law directs the Insurance Commissioner to report annually to the Legislature about Washington's state-specific health benefit mandates that may result in federally-imposed costs to the state.

There are no statutory changes recommended at this time.

For 2014, Washington state will not have an obligation to defray costs for benefits required in addition to the essential health benefits package.

[1] ACA Section 1311 (d)(3)(B).

Background and legislative direction

Effective January 1, 2014, the Affordable Care Act of 2010 (ACA) requires coverage of a package of "essential health benefits" for most insurance products sold in the individual and small group markets. Qualified health plans, which are sold through the state Health Benefit Exchange, are included in these requirements.

Beginning in 2016, the U.S. Department of Health and Human Services may begin enforcing a provision in the ACA requiring states to defray the costs of QHP coverage for mandates that exceed those contained in the essential health benefits[2].

RCW 48.43.715 (4) directs the Insurance Commissioner to report annually to the Legislature about Washington's state-specific health benefit mandates that will result in federally-imposed costs to the state. This is the first report.

The specific state legislative requirement states:

"(4) Beginning December 15, 2012, and every year thereafter, the commissioner shall submit to the legislature a list of state-mandated health benefits, the enforcement of which will result in federally imposed costs to the state related to the plans sold through the exchange because the benefits are not included in the essential health benefits designated under federal law. The list must include the anticipated costs to the state of each state-mandated health benefit on the list and any statutory changes needed if funds are not appropriated to defray the state costs for the listed mandate. The commissioner may enforce a mandate on the list for the entire market only if funds are appropriated in an omnibus appropriations act specifically to pay the state portion of the identified costs."

Potential cost to the state: 2014

Because HHS permits states to define the essential health benefits package for 2014 and 2015, the state mandates in the selected benchmark base plan will not incur costs for the state. Therefore, there are no mandates with which to populate the list requested by the Legislature.

[2] ACA Section 1311 (d)(3)(B).

Scope of report

On November 26, 2012, HHS proposed rules regarding the essential health benefits, including proposing that when defrayment of the cost of additional requirement benefits is necessary, the Exchange be the entity that identifies the benefit for which payment is required for subsidized enrollees, and that issuers establish the amount due to them for the benefit, based on the prospectively-calculated amount of premium attributable to the benefit[3]. The requirement to defray costs for these benefits would be limited to the market in which the benefit is required by the state. If a benefit is required only in the individual market, the responsibility to defray cost is limited to that market[4]. HHS also proposes that state rules related to provider types, cost-sharing, or reimbursement methods not fall under the interpretation of state-required benefits, for which defrayment is required.

These rules are proposed, not final, but if HHS does not alter this standard, then the state report will only provide a reference point, as it will be difficult to forecast the cost for each individual issuer.

Nothing precludes a state from delegating this responsibility away from the Exchange to the Insurance Commissioner, as the federal rule is currently written contemplating a

[3] Proposed rule, 45 CFR 155.170, provides in pertinent part:
(a) Additional required benefits. (1) A state may require a QHP to offer benefits in addition to the essential health benefits.
(2) A state-required benefit enacted on or before December 31, 2011 is not considered in addition to the essential health benefits.
(3) The Exchange shall identify which state-required benefits are in excess of EHB.
(b) Payments. The state must make payments to defray the cost of additional required benefits specified in paragraph (a) of this section to one of the following:
(1) To an individual enrollee, as defined in §155.20 of this subchapter; or
(2) Directly to the QHP issuer on behalf of the individual described in paragraph (b)(1) of this section.
(c) Cost of additional required benefits. (1) Each QHP issuer in the state shall quantify cost attributable to each additional required benefit specified in paragraph (a) of this section.
(2) A QHP issuer's calculation shall be:
(i) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;
(ii) Conducted by a member of the American Academy of Actuaries; and
(iii) Reported to the Exchange.

[4] CMS – 9980-P at 15 (November 20, 2012 version; published in Federal Register, November 26, 2012).

federally-facilitated Exchange, or a state Exchange operated by the same agency that regulates insurance.

Additional required benefits for QHPs

The ACA does not define "mandated" benefits for purposes of its cost-offset provisions, and HHS has not finalized further regulatory guidance. The most recent proposed rule does not refer to mandates, but instead to "state-required benefit." Therefore, the benefit for which a state must make payments to defray the cost is an "additional required benefit" that a state requires of a Qualified Health Plan. A state may institute benefit requirements and not incur the responsibility to defray costs if QHPs are not required to include the benefit in addition to the essential health benefits.

In addition, if HHS continues to permit states to define the essential health benefits package, the cost defrayment requirement may remain moot after 2015. Enforcement would occur in 2016 at the earliest[5]. This initial report provides some insight into the issue for purposes of future planning, but does not establish actuarial values for state-mandated benefits that might incur costs to the state.

Washington state's statutory framework has a limited set of "required" benefits. Many benefit types included are based not on a mandatory offering, but on circumstances – when an issuer elects to provide certain types of benefit, those benefits must be covered in a specific way or to a specific extent. It is unlikely that that type of conditional requirement will be considered an additional required benefit for purposes of the federal defrayment requirement.

Washington state's insurance law has several types of health benefit requirements:

1. Mandated service offerings that must be included in a policy.
2. Mandated service offerings that need only be covered if a consumer requests them.
3. Mandated levels of service offerings that, while the benefit itself is not required, must be met *if* the plan covers the benefit.

[5] HHS "Essential Health Benefits Bulletin," December 16, 2011.

4. Benefits that must be included based on the type of policy or the market in which it is offered.
5. Mandated inclusion of providers or facilities in carrier networks.
6. Mandated eligibility requirements for coverage.

Because the ACA establishes the mandate reimbursement requirement in the context of the essential health benefits, this report's analysis focuses on mandated service offerings, and not provider, facility type, or eligibility mandates. The state code's reference, both in RCW 48.43.715 and RCW 48.47.010 (7), to "mandates" may not translate to mean that every benefit type that requires an RCW 48.47.010 assessment would trigger a defrayment responsibility. RCW 48.47.010 provides the definition:

> "Mandated health benefit," "mandated benefit," or "benefit" means coverage or offering required by law to be provided by a health carrier to:
>
> (a) Cover a specific health care service or services;
>
> (b) cover treatment of a specific condition or conditions; or (c) contract, pay, or reimburse specific categories of health care providers for specific services; however, it does not mean benefits established pursuant to chapter 74.09, 41.05, or 70.47 RCW, or scope of practice modifications pursuant to chapter 18.120 RCW

Anticipated cost to the state of certain required benefits

Actuarial value Actuarial value of a benefit is the average percent of cost for a health plan attributable to the covered service, net of cost sharing[6]. It is generally expressed as a per member per month cost, averaged over the entire insured risk pool. This is different than the unit cost for a service, which remains unchanged.

The analysis below addresses the four mandates that may result in costs to the state. Actuarial value is not estimated in this year's report because the state is not under an obligation to defray the cost for these mandates for the 2013 benefit year.

Chiropractic care Under Washington's every category of provider law (RCW 48.43.045, and WAC 284-43-205), any providers offering "chiropractic care," if it is within the scope of their license under title 18 RCW, are entitled to reimbursement for

[6] American Society of Actuaries, "Issue Brief: Actuarial Value under the Affordable Care Act" (July 2011) http://www.actuary.org/pdf/health/Actuarial_Value_Issue_Brief_072211.pdf accessed November 16, 2012,

the service. Chiropractic practitioners use their hands or an adjusting tool to perform specific manipulations of the vertebrae to ensure that the skeletal system is aligned and the nervous system is functioning properly. The American Chiropractic Association identifies chiropractic as a health care profession that focuses on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health.[7]

Current state law requires issuers to include chiropractors in their network, and to cover their services. The base-benchmark policy complies with current state law by including coverage for spinal manipulation, regardless of which type of provider provides the service.

Chiropractic care may not be considered a mandate for which the state is required to defray costs beginning in 2016, because it is arguably a mandate related to ensuring that care offered by a specific provider type (chiropractor) is covered, and the services are subsumed into the ambulatory patient services essential health benefits category. This state-mandate may be removed from consideration upon receiving further federal regulatory guidance, since the recent proposed rules specifically remove provider type requirements from the scope of the defrayment of cost requirements.

Newborn care Federal law requires coverage for hospitalization of newborns for 48 to 96 hours, depending on the type of delivery (Newborns' and Mothers' Health Protection Act of 1996). The state benefit requires a newborn to be covered under the mother's policy for the same length of time that the mother is hospitalized after delivery, up to a maximum of three weeks. For a healthy baby delivered at term, the average newborn care unit cost is $1,500 - $4,000[8].

If a family adds the baby to their policy as a dependent immediately after the 48 to 96 hour window expires, then arguably there would be no cost for the state to defray since the dependent coverage is not under a state-based mandate, but under the essential health benefits package. Additionally, because the essential health benefits include

[7] http://www.acatoday.org/level2_css.cfm?T1ID=13&T2ID=61 accessed November 16, 2012.
[8] March of Dimes Foundation

pediatric services for children (birth to age 20), the anticipated federal regulations may address coverage for newborns and the transfer or addition of children to their own dependent coverage.

Mammograms for all women regardless of age Mammograms are included in women's preventive health care services defined in detail in federal regulation, and required as part of the essential health benefits package. However, the mandate has reference limitations based on age. As of August 1, 2012, issuers were required to cover mammograms without cost sharing for women age 40 and over[9]. Washington state's mandate is not age-based, and includes women below age 40, making it broader than the federal mandate.

Actuarial studies have identified the cost of this service as "relatively low."[10] The average unit cost for a screening mammogram is $106, and for a diagnostic mammogram is $160.

The American College of Obstetricians and Gynecologists (ACOG) recommends annual screening for women age 40 and over, and screening every one to three years for women aged 20 to 39, based on risk. It is possible that the United States Preventive Services Task Force (USPSTF) recommendation will change to mirror the ACOG recommendation, eliminating the cost issue for this benefit mandate. If the essential health benefits are defined after 2016 as subject only to federal regulation, and the USPSTF recommendation remains unchanged, requiring screening mammography coverage only for women aged 40 years or older, the following would be true for Washington state:

[9] The preventive services are based on Health Resources and Services Administration (HRSA) supported health plan coverage guidelines developed by the Institute of Medicine. http://www.hrsa.gov/womensguidelines

[10] *See,e.g.,* Milliman, "Cancer Screening: Payer Cost/Benefit thru Employee Benefits Programs," (commissioned by C-Change and the American Cancer Society), http://health.utah.gov/ucan/Publications%20and%20Materials/Materials%20to%20download/Worksite/MillimanReport.pdf accessed November 16, 2012. The California Health Benefits Review Program determined that for California, the cost related to the extent to which California's mammogram mandate (identical to Washington's) would exceed the EHB mandate was .00054%. California Health Benefits Review Program, "Issue Brief: Mammography Mandates, Benchmark Plan Choices, and Essential Health Benefits" at 27 (June 7, 2012).

- Individual and small group market plans would be required to exceed the essential health benefits by covering screening mammograms for women younger than 40 years.
- Of the estimated number of women eligible to receive subsidized coverage through the Exchange, 69,000 of them are 20 to 39 years of age, out of a total of 83, 861 women ages 18 - 64[11]. Between 10.8% - 12.5% of them are estimated to remain uninsured after health care reform is implemented[12].
- A Milliman study completed in 2006 notes that current compliance with ACOG-recommended screening of women ages 20 to 39 is 88.7%, higher than compliance for those over age 40[13]. Of note is the reduced frequency of screening for this age group (once every three years).
- A recent study by the Centers for Disease Control and Prevention concluded that after health care reform and the increased access to coverage for mammograms nationwide, 18.7% more women will access the benefit than had sought a mammogram when uninsured[14]. Currently, women who lack health insurance reported the lowest use of mammography (31.5%).[15] This is supported by the conclusion of a 2004 study: "The most significant disparities in screening mammography are based on insurance status, usual source of care, and socioeconomic status."[16] Health care reform seeks to address this screening gap, as well as other health care access issues.

For the age group to whom the federal mandate applies, the Kaiser Family Foundation reports that 75.6% of women age 40 and older in Washington state were screened for mammograms in 2010[17]. The data does not distinguish whether the women were insured. CDC's 2010 report on data from 2008 showed that 70 to 84 percent of Washington women aged 50 to 74 used mammogram screening[18]. The same report noted that those insured were 25 percent more likely to be screened than those without coverage. Studies also demonstrate that where coverage is available, women in urban

[11] Source: Office of the Insurance Commissioner analysis of the Washington State Population Survey.
[12] Levy, A., Bruen, B., Ku, L., "Health Care Reform and Women's Insurance Coverage for Breast and Cervical Cancer Screening," Prev Chronic Dis 2012; 9: 120069. DOI: http://dx.doi.org/10.5888/pdc9.120069
[13] http://health.utah.gov/ucan/Publications%20and%20Materials/Materials%20to%20download/Worksite/MillimanReport.pdf at page 19, citing American Cancer Society, "Cancer Prevention and Early Detection Facts & Figures 2005," Atlanta: American Cancer Society, 2005, accessed November 16, 2012.
[14] Levy, A., Bruen, B., Ku, L., "Health Care Reform and Women's Insurance Coverage for Breast and Cervical Cancer Screening," Prev Chronic Dis 2012; 9: 120069. DOI: http://dx.doi.org/10.5888/pdc9.120069
[15] American Cancer Society, "Cancer Prevention and Early Detection Facts & Figures 2012," Atlanta: American Cancer Society, at 1 (2012).
[16] Peek, M., Jan, J. , "Disparities in Screening Mammography," J Gen Intern Med 2004 February; 19(2): 184-194.
[17] http://www.statehealthfacts.org/profileind.jsp?cat=10&sub=113&rgn=49
[18] http://www.cdc.gov/VitalSigns/pdf/2010-07-vitalsigns.pdf

areas, closest to retirement age, and with higher socio-economic status are more likely to use the benefit[19].

Washington state has one of the highest breast cancer rates in the country by state, 127.1 to 139.5 per 100,000 people, and one of the lowest rates of death from breast cancer in the nation, 16.7 to 21.1 per 100,000 people[20].

Medical food formulas Washington is one of at least 37 states requiring coverage of medically-necessary foods and formula to treat disorders identified through newborn screening. Washington's state-mandated benefit is expressed in terms of medical foods necessary due to an inborn error of metabolism.

Over 700 inborn errors of metabolism are known. They are hereditary defects that interfere with one or more biochemical functions essential for life. The annual unit cost averages between $2,275 and $12,483, depending on age. Many of the conditions are extremely rare (for example, 1 in 100,000 people); most occur with a frequency of 1 out of 30,000 to 50,000 people[21].

Statutory changes needed if funds are not appropriated

There are no recommended changes at this time.

Conclusion

For 2014, Washington state will not have an obligation to defray costs for benefits required in addition to the essential health benefits package.

[19] Davis, W., Parsons, V., Xie, D., Schenker, N., Town, M., Raghunatha, T., and Feuer, E., "State-Based Estimates of mammography Screening Rates Based on Information from Two Health Surveys," Public Health Rep., 2010 Jul-Aug; 125 (4): 567-578.
[20] http://www.cdc.gov/cancer/breast/statistics/state.htm
[21] http://www.aafp.org/afp/2006/0601/p1981.html accessed November 1, 2012.

Data Analysis

Appendix A, below, identifies relevant "mandates" contained in state law, and identifies whether or not there is a risk of Washington state needing to defray the cost for each of those benefits. Shaded rows indicate a possible category for defrayment in the future.

Appendix A: Washington's state-required benefits

RCW §	Mandate	Current markets	Subsidy Risk	Description
48.42.100	Women's health care services	All	No. EHB Categories: Ambulatory patient services, preventive and wellness services, and maternity & newborn services	Plan must provide direct access to covered women's health care services for (but not limited to: maternity care; reproductive health services; gynecological care; general examination; preventive care – medically appropriate and follow-up visits for listed services through listed provider types.
48.44.310; 48.20.412; 48.21.142	Chiropractic Care	All markets, but not all carrier types	Possibly	Chiropractic care must be covered.
48.21.320; 48.44.460 48.46.530	TMJ disorder treatment	Group market	No (most probably not a "true" mandate because it is conditional).	Must offer to cover, but enrollee need not accept.
48.43.093	Emergency services	All	No. EHB Category	Services necessary to screen & stabilize a covered person for an emergency medical condition
48.43.041	Maternity services & hospitalization	Individual	No. EHB Category and separate federal mandate	Maternity services that include, with no enrollee cost-sharing requirements beyond those generally applicable: diagnosis of pregnancy; prenatal care; delivery; care for complications of pregnancy; physician services; hospital services; operating or other special procedure rooms; radiology & laboratory services; appropriate medications; anesthesia; and services required under 48.43.115.
48.43.041	Anesthesia for maternity services	Individual	No. EHB category & separate federal mandate	Anesthesia for maternity services must be covered
48.43.185	Dental	All	Possible.	If offer hospital, medical or

RCW §	Mandate	Current markets	Subsidy Risk	Description
	anesthesia		Technically not a mandatory service offering, only conditional. Also, for children, a pediatric EHB.	ambulatory surgery center services, must cover for those who would be at risk if performed elsewhere, or those 7 and under.
48.43.115	Maternity length of stay	All	No. Mirrors federal mandate in the ACA. Also, conditional not mandatory service offering. Optional component preempted as of 2014.	If offered, a carrier must permit attending provider to decide length of stay; not deny covered eligible services for inpatient, post delivery care to mother and newborn after vaginal or caesarean delivery; coverage for post-discharge care as determined.
48.43.115	Newborn coverage	All	Uncertain to the extent that WA's requirement may exceed time frame found in federal statutory mandate. Conditional nature of the requirement preempted by federal EHB categorization of newborn services, after 2014.	Newborns must be covered for no less than three weeks, or as long as the mother is covered, if the carrier offers the mother maternity services coverage.
48.20.430 48.21.244; 48.44.344 48.46. 375	Prenatal diagnosis of congenital disorders	All	No. EHB requirement and ACA market reform for preventive care. Conditional nature of requirement preempted based on ACA market reforms.	Prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures during pregnancy to such enrollees when those services are determined to be medically necessary by the carrier in accord with standards set in rule by the board of health.
48.21.180; 48.44.420 48.46.350	Chemical Dependency treatment	Group	No. EHB category Mental health & Substance Use Disorder Treatment	Coverage for chemical dependency treatment in a licensed chemical dependency treatment center facility
48.20.580 48.21.241; 48.44.341; 48.46.291	Mental health benefits	All	No. EHB Category: mental health benefits, and prescription drug coverages	If a plan offers medical surgical benefits, must cover mental health benefits, on parity with medical surgical benefits; prescription drugs for treating mental health disorders

RCW §	Mandate	Current markets	Subsidy Risk	Description
				must be covered on parity w/ medical surgical Rx coverage
48.20.391; 48.21.143; 48.44.315; 48.46.272	Diabetes equipment and supplies, outpatient self-management, training, education and medical nutrition	All	No. EHB category: Prescription drug coverage and Ambulatory Patient Services	Must cover equipment and supplies ordered by a physician to treat diabetes
48.21.220; 48.44.320	Home health and hospice services	Group	No. EHB Category: ambulatory patient services Note: conditional mandate	Group disability and health care service contractors must offer optional coverage for home health and hospice care, if the policy provides payment for hospitalization
48.20.395 48.21.23048. 44.33048.46. 280	Reconstructive breast surgery	All	No. Federally mandated coverage; EHB category: hospitalization	Reconstructive breast surgery necessitated by a mastectomy that resulted from disease, illness or injury
48.43.043	Colorectal cancer screening	All	No. USPSTF mandated coverage, per ACA.	Colorectal cancer screening – coverage for exam and lab tests consistent with the USPSTF recommendations
48.21.225; 48.44.325 48.46.275	Mammogram diagnostic and screening services	Group	Possibly. EHB category – HRSA and USPSTF preventive coverage. However, the state benefit is not age limited – but the USPSTF coverage is, to those 40 and over. Could be additionally required for non-referenced ages.	If offer hospital or medical care benefits, must cover
48.20.392 48.21.227 48.44.327 48.46.277	Prostate Cancer Screening	All	No. EHB Preventive Health Services category (USPSTF recommendation)	If cover hospital or medical care benefits, must cover. If USPSTF recommendation on prostate screening changes, may become a mandate.

RCW §	Mandate	Current markets	Subsidy Risk	Description
48.20.520 48.21.300 48.44.440 48.46.510	Medical Food Formulas	All	Unclear.	Must cover medical food for inborn metabolic disorders, such as PKU.
48.21.310 48.44.450 48.46.520	Neurodevelop-mental mental therapy for those 6 and under	Group	No. EHB categories: mental health, pediatric and rehabilitative services (depending on diagnosis)	If cover hospital and medical benefits, must cover physical therapy, occupational therapy and speech therapy offered as neurodevelopmental therapy for those 6 and under.