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Commonwealth of Virginia
Virginia Health Reform Initiative

Preliminary Analysis of Essential Health Benefits, Benefit Mandates, and Benchmark Plans

February 2012

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Introduction

PricewaterhouseCoopers LLP (PwC) was retained by the Virginia Department of Medical Assistance Services on behalf of the Virginia Health Reform Initiative to perform an analysis of the potential benchmark health benefit plans, using the bulletin released by the US Department of Health and Human Services (HHS), to determine the extent to which they provide coverage of the essential health benefits defined under the Patient Protection and Affordable Care Act (ACA) as well as their coverage of Virginia's mandated benefits. PwC was also asked to assess, to the extent possible with available data, the potential impact on premium rates of adding currently non-covered benefits that will be required under the definition of essential health benefits in Virginia. This report describes the results of this analysis.

Essential Health Benefits

Requirements under the Patient Protection and Affordable Care Act

As part of the health insurance reforms called for under the ACA, benefit plans will be required to offer a minimum set of "essential health benefits." This minimum set of benefits must be provided to health insurance purchasers for Individuals and Small Group coverage whether purchased through a health benefits exchange or the broader health insurance market. The required Essential Health Benefits (EHBs) must include items and services within at least the following 10 broad 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

Institute of Medicine Recommendations

The ACA required HHS to define what the EHB package should include. To assist in this effort, HHS asked the Institute of Medicine (IOM) to recommend a process to help HHS define the EHBs and support EHB updates to take into account medical advances, gaps in access, and the effect of benefit changes on healthcare costs. The IOM was not asked to decide what should be covered in the EHB, but instead to recommend a set of criteria and methods to use in deciding what should be covered. The IOM recognized the need to balance broad benefit coverage to ensure access to essential services for a wide range of needs while limiting costs to ensure coverage is affordable.

In its October 7, 2011 report, the IOM EHB committee recommended that HHS establish an initial EHB package "guided by a national average premium target" and that "the starting point in establishing the initial EHB package should be the scope of benefits and design provided under a typical small employer plan in today's market." Additionally, "Once a preliminary EHB list is developed … the package should be adjusted so that the expected national average premium for a silver plan with the EHB package is actuarially equivalent to the average premium that would have been paid by small employers in 2014 for a comparable population with a typical benefit design."

The IOM committee also recommended state flexibility regarding the EHB, stating that "for states administering their own exchanges that wish to adopt a variant of the federal EHB package, the Secretary should use statutory authority to grant such requests, provided that the state-specific EHB definition is consistent with the requirements of Section 1302 of the ACA and the criteria specified in this report, that they produce a package that is actuarially equivalent to the national package established by the Secretary, and that the request is supported by a process that has included meaningful public input." The IOM also recommended that "the Secretary should explicitly incorporate costs into updates to the EHB package" and a "National Benefits Advisory Council, appointed through a nonpartisan process … be established to offer external advice on updates, data requirements, and the research plan."

Health and Human Services Proposal

On December 16, 2011, HHS issued a bulletin outlining proposed policies that give the states flexibility to implement the ACA. Under the HHS proposal, states would select a benchmark plan that reflects both the scope of services and any limits offered by a typical employer plan. For 2014 and 2015, states would choose from one of the following benchmark health insurance plans, using enrollment data from the first quarter two years prior to the coverage year:

- 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 non-Medicaid HMO plan in the state's commercial market by enrollment

The benefits and services as well as any limits included in the benchmark plan chosen by the state would comprise the EHB package for the state. Member cost-sharing is not taken into account in determining the EHB. Health plans could modify coverage within a benefit category so long as they do not reduce the value of coverage. In other words, to the extent a health plan wishes to change a benefit, the value of the substituted benefit must be at least as high as that of the item being replaced.

In its December 16, 2011 Bulletin HHS states, "To prevent federal dollars going to state benefit mandates, the 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, some of the benchmark options will include health plans in the state's small group market and state employee health benefit plans."[1]

HHS goes on to state that mandates that apply to Small Employer insurance benefits packages can be included in the definition of the EHB if one of the Small Employer options is chosen.

To the extent a benchmark plan is chosen that does not include all of the EHB categories, the state will have the option to examine other insurance plans, including the Federal Employee Health Benefits Plan, to determine the type of benefits that must be included in the EHB.

The Commonwealth will want to consider the range of flexibility permitted to health plans in defining their compliance with EHB requirements, to protect against any selection bias or selective marketing opportunities that may be created from allowing a wide range of health insurance options.

Virginia Benefit Mandates

Virginia's insurance laws require that health insurance plans provide certain benefits, known as mandated benefits, in each individual or group contract they offer in the state. Additionally, insurers are required to offer individuals or groups the option to purchase certain benefits known as mandated offers of coverage. Exhibit 1 shows the list of Virginia mandated benefits and mandated offers.

Should Virginia choose a benchmark plan other than a Small Employer plan, it will need to review the range of covered benefits and the State mandates to determine whether anything has been excluded. If there is a particular benefit that has been mandated but is not in the benchmark plan, a decision will need to be made regarding whether the mandate applies, and how it will be treated after the transition period. Because Virginia's benefit mandates are typically covered in most state and federal employee plans and in many other plans, there are likely to be only very discrete services that are at issue. We identified the mandated benefit coverage for autism spectrum disorder to have the highest potential cost impact. Our understanding is this mandate does not currently apply to the Individual or Small Group (under 50) markets, and may not apply in 2014 if it is excluded from the definition of essential health benefits. Coverage under the benchmarks is not known based on the summary plan descriptions. There is little experience to understand the potential cost impact of this mandate, although Virginia's legislation states that groups are exempted from providing behavioral health treatment if an actuary certifies that for the most recent experience period of at least one year's duration, the costs associated behavioral health treatment not covered under the plan exceeded 1% of the premiums charged over the experience period and would lead to an increase in average premiums of more than 1% if covered.

Bariatric surgery coverage is a mandated offer for individual and small group plans in Virginia. It is now a commonly covered service for the morbidly obese in most state and federal employee plans, Medicare, Medicaid, and most large group plans. Cost estimates for this benefit when all plan participants are covered range from 0.75% to 1.5%.

[1] "Essential Health Benefits: HHS Informational Bulletin", US Department of Health and Human Services, December 16, 2011

EHBs with Potential Impact to Individual or Small Groups Premiums

To understand the implications of the EHB requirements for Virginia, we obtained information on the benefits plans offered in the Individual and Small Group insurance markets in Virginia. To begin our analysis we considered whether all of the services described in the 10 broad EHB categories are covered in commonly sold Individual and Small Group benefit plans today, taking into account the mandates described above. With the assistance of the Virginia Bureau of Insurance a survey of Virginia health plans was conducted in June, 2011, where health plans were asked to report on their five most popular plan designs in the Individual and Small Group markets, and to describe the range of benefits provided. We found several areas described as EHBs that may not be commonly covered today, including the following:

- Maternity services are typically not covered in Individual and Small Group plans offered by insurers (excluding health maintenance organizations) and small groups with less than 15 employees due to the adverse selection risk associated with offering this benefit under the existing voluntary insurance market.
- Limited coverage for Mental Health and Substance Abuse treatment is provided in Individual or Small Group products, in accordance with a statutory mandate in Virginia, which includes full parity for biologically based mental illnesses, and coverage of at least 10 inpatient days and 20 outpatient visits for other mental health and substance abuse diagnoses. EHB category #5 (page 1) provides for coverage of mental health and substance use disorder services, including behavioral health treatment. The extent to which plans cover behavioral health treatment is not clear. Typically, plans do not mention behavioral health services in their benefit plan descriptions. The exception may be treatment for autism spectrum disorder.
- While general Preventive and Pediatric services have long been typical covered benefits in both Individual and group plans, EHB category #10 (page 2) includes pediatric oral and vision care. Routine vision examinations are often covered in a typical small employer medical plan, but dental services other than for accidents typically are not. Most often dental care, including routine examinations, is provided under stand-alone dental coverage if made available to employees. Vision services, including glasses and contacts, may also be covered through stand-alone plans, again if made available.
- EHB category #7 (page 1) provides for coverage of rehabilitative and habilitative services and devices. HHS found that "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. An example of habilitative services is speech therapy for a child who is not talking at the expected age." [2]
- 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. In Virginia, these services and others are required for children to age three to help them attain the capacity to function age-appropriately within the environment and will enhance functional ability without effecting a cure.

[2] "Essential Health Benefits Bulletin", Center for Consumer Information and Insurance Oversight, December 16, 2011

Benchmark Plans

Identification of Potential Benchmark Plans

As described above, states choose from 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 non-Medicaid HMO plan in the state's commercial market by enrollment

We have interpreted the word "plan" in the above definition to mean the combination of the specific configuration of covered services, benefit limits, and cost sharing in the base medical plan, plus any optional coverage selected by the individual or employer. Since plan enrollment information with this level of detail is not readily available, we relied on the information released by HHS on January 25, 2012, which provided a list of the three largest small group products in each state according to data collected by HealthCare.gov based on June 30, 2011 enrollment. Additionally, they provided a list of the top three nationally available Federal Employee Health Benefit Program (FEHBP) plans based on March 31, 2011 enrollment data.

One limitation of the HealthCare.gov data is that it represents enrollment at the product level, which reflects the set of covered services and items but not the specific cost sharing levels or optional benefits that were purchased. In the future, HHS intends to provide this additional information on the actual benchmark options. Alternatively, substantial cooperation from the health plans in Virginia will be required to determine the small group plans with the largest enrollment in the state, particularly since the purchase of coverage riders for maternity and bariatric surgery, for example, are made available to small employers and will need to be considered in the determination of what is covered under the largest plans. Additional information on the benefit options selected by federal employees will also be required.

To identify the three largest state employee plans, we relied on 2011 open enrollment information found on the employee benefits page of the Virginia Department of Human Resource Management website (http://www.dhrm.state.va.us/hbenefits/employeestoc.html). The open enrollment report indicated that the three largest plans by enrollment all had the COVA Care Basic plan as the base, with various combinations of optional benefits. Specifically, the three state employee plans, as defined by the based medical plan plus any optional coverage, with the highest enrollment are as follows:

1. COVA Care Basic + Vision, Hearing, & Expanded Dental
2. COVA Care Basic (with no optional benefits)
3. COVA Care Basic + Out-Of-Network, Vision, Hearing, & Expanded Dental

For consistency with the product level benchmarks identified for small groups and federal employees, we used product level benchmarks for the state employees. Though smaller in enrollment than the COVA Care combinations identified above, this approach provides additional breadth to this benchmark analysis.

Insufficient information is currently available with which to determine the largest non-Medicaid commercial HMO plan. To obtain this information will most likely require a data call to the HMOs operating in Virginia.

Based on the above, Table 1 presents the potential Virginia benchmark plans/ products. Note that the specific small group and federal employee plans still need to be identified as does the largest non-Medicaid HMO plan. However, we believe the plans used for the remainder of the analysis provide a reasonable description of the range of health care benefits commonly purchased in Virginia today, and are appropriate for discussion of the effect of choosing a particular direction for defining the benchmark plan to be used.

Table 1: Preliminary Potential Virginia Benchmark Plans/Products

Small Group	State Employees	Federal Employees	Non-Medicaid HMO Plan
Anthem Health Plans of VA PPO	COVA Care	FEHBP BCBS Standard Option	To be determined
Anthem HealthKeepers HMO	COVA Connect	FEHBP BCBS Basic Option	
Optima Vantage HMO	Kaiser	Government Employees Health Association (GEHA)	

Benchmark Coverage of EHBs and Mandated Benefits

Based on the potential Virginia benchmark plans identified as described above, we compared the coverage of EHBs and Virginia's benefit mandates among the plans (see Exhibit 2). To perform the analysis, we relied on summary plan descriptions publically available on the internet. In some cases, the plan summaries reflected detailed descriptions of benefit coverage and exclusions. In others, only high-level coverage descriptions (i.e., "benefits at a glance") were obtained, and coverage of certain benefits could not be determined. In some cases, we supplemented the available information with our knowledge of industry practices to more fully complete the comparison. The health plans have not validated these comparisons, and follow up with the health plans to obtain detailed summary plan descriptions is required to more fully understand coverage differences.

The top section of the exhibit shows the 10 EHB categories specified under the ACA. Under some of these categories, we created additional breakdowns to highlight certain popular, expensive, or otherwise noteworthy benefits for which coverage varies among the potential benchmark plans or for which coverage may be of specific interest to policymakers. The next section of Exhibit 2 summarizes the coverage of Virginia's benefit mandates by the potential benchmark plans, and the bottom section summarizes the treatment of Virginia's mandated benefit offers.

Since under the HHS proposal states select a benchmark plan that reflects both the scope of services and any limits on covered benefits, we summarized information found on limits applied to the selected benefits. It is possible and likely that other benefit limitations may apply to these and other services. Limitations such as restrictive prescription drug formularies, preauthorization requirements, or limited provider networks were not considered, and based on our understanding are not a consideration in the selection of a benchmark plan to represent Virginia's EHB package. Member cost sharing is not a consideration in defining the EHB.

In general, we find that the potential benchmark plans cover substantially the same set of services. All of the identified potential benchmark plans provide broad coverage among the 10 EHB categories, with the exception of maternity and pediatric oral and vision care. Maternity is covered by all of the benchmark plans except the Anthem Health Plans Small Group PPO plans, under which it is either not covered or is available as an optional coverage for purchase.

Coverage of pediatric oral and vision care varies. In some plans, routine vision is covered and in others it is not. In some plans, routine vision is only covered if optional coverage is purchased. Dental care, other than for accidents, is typically not covered under health plans, and is only covered if separate dental coverage is purchased. In its bulletin, Center for Consumer Information and Insurance Oversight (CCIIO) stated its intent to

propose supplementing benchmark plans that do not include adequate pediatric oral or vision care with the following:

For pediatric oral services, 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.

The EHB definition would not include non-medically necessary orthodontic benefits.

For pediatric vision services the plan would be supplemented with the benefits covered by the FEDVIP vision plan with the largest enrollment.

Coverage of certain benefits specified in the 10 EHB categories, specifically habilitative services and behavioral health treatment, is less clear as summary plan descriptions rarely specify coverage within these categories.

Similarly, all of the potential benchmark plans appear to cover the vast majority of Virginia's mandated benefits. In several instances the plan descriptions were not sufficiently detailed to determine coverage of mandates. Some of these mandates related to minimum hospital stays, which is not typically included in a plan description. As described above, the autism spectrum disorder mandate is likely to have the largest cost impact.

Virginia requires that health plans offer individuals and employers coverage for certain benefits, as listed in Exhibit 2. At this time, we do not know the extent to which employers in the small group market are purchasing these optional benefits. However, based on our analysis we believe that the state and federal employee benchmark plans provide coverage for all of the mandated benefit offers.

Benchmark Coverage of Specific Benefits

Within each of the 10 EHB categories, there are a wide range of possible services and items that may be covered or may have varying limits. Potential benchmark plans will all provide at least minimal coverage within each EHB category (with the exceptions as noted above), but may differ in their coverage of certain services. For example, the potential benchmark plans all provide coverage for the EHB "Ambulatory patient services" category, but vary in their coverage of alternative medicine services that would fall under this EHB category, such as chiropractic care or acupuncture. Many of these services may not be considered "essential" but may be important to certain plan participants. Similarly, hearing aids may be covered by some plans, but not by others, or may be offered as an optional coverage with an additional premium requirement. Infertility treatment, while of high value to a small number of plan participants, is expensive and does not appear to be covered to any significant degree under any of the potential benchmark plans.

In addition to variations in covered services, there are also variations in the benefit limits applied under each of the plans. The limitations in the benchmark plans should be considered as it is both the services and the limits that comprise the EHB package for the state. Exhibit 2 provides a summary of the benefit-specific limits applied under each of the potential benchmark plans. The most common limitations were visit limits placed on ambulatory services such as home health care, physical/occupational/speech therapies, and chiropractic care. Most plans also limit the number of covered days in a skilled nursing facility. In general, plans limit preventive services to once per year, and similar limits are typically applied to vision (once per year or once every 24 months) and hearing exams. If covered, hearing aid benefits are often limited to a certain dollar amount and frequency. Additionally, though most plans do not cover the full cost of infertility diagnosis and treatment, some plans offered limited coverage. Some plans also place limits (dollar or age) on early intervention services, which is a mandated benefit in Virginia.

Under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which applies to groups over 50 employees, plans are not required to offer mental health and substance use disorder benefits, but if they are then the financial requirements and treatment limitations imposed on mental health and substance use disorder benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits. In Virginia, however, plans covering groups over 50 must include coverage for mental health and substance abuse disorders on parity with substantially all medical and surgical benefits, in accordance with §38.2-3412.1 F. Small groups are required to cover biologically based mental illnesses at parity, and to cover at least 10 inpatient days and 20 outpatient visits for other mental health and substance abuse diagnoses.

Impact of Benchmark Selection on Premium Rates

As described above, all of the potential benchmark plans cover predominantly the same set of services, with the most significant exception being maternity, which is either not covered or covered only by rider under the Anthem PPO small group benchmark product and is not typically available under individual benefit plans. Because Maternity and Newborn care is an explicit required category, the coverage will need to be added, and the cost of the coverage will increase the premium. We have estimated that adding Maternity coverage to all Individual policies will increase premium rates approximately 1%-4%. We note that Maternity coverage is not typically covered under Individual plans today due to the significant adverse selection effect that is likely to exist when the coverage is optional or when coverage can be purchased as needs arise. Besides maternity, there are differences in specific service coverage among the potential benchmarks. These include:

- Acupuncture
- Chiropractic care
- Hearing aids
- Routine vision exam

Though costs for chiropractic care and hearing aids can be relatively high, under a mandatory insurance system in which adverse selection is less of an issue, these benefits would be expected to have only a marginal impact on premium rates, below 1% of average premiums.

Summary

In summary, there are only nominal differences in the range of covered benefits in the various benchmark plan options. At a minimum, Individual and Small Group premiums will need to be augmented to reflect coverage of essential benefits Maternity and Newborn Care with an expected cost increase of 1% to 4%. Additionally, the relative importance of certain benefits such as hearing aids, chiropractic care, and telemedicine as well as appropriate benefit limits will need to be considered in the evaluation of the benchmark plan options. Optional coverage offered to Individuals and Small Groups, such as non-formulary drugs and Virginia's mandatory benefit offers, will also need to be evaluated to the extent they are included in the possible benchmark plans.

Taken together, these other service areas may increase average premium rates 2% to 4%. These estimates are preliminary and are based on currently available public information, or information provided by health plans through a data call in June 2011. Additional analysis will be needed to establish the final Benchmark plan for the Commonwealth.

Exhibits

Virginia Benefit Mandates

Exhibit 1

Overview

Virginia's insurance laws require that most health insurance plans:
1) provide certain benefits, known as mandated benefits, in each individual or group contract they offer in Virginia; and
2) offer individual policyholders and employer groups the option to purchase certain benefits known as mandated offers of coverage.

Mandated Benefits

§38.2-3408 Reimbursement for services provided by certain practitioners other than physicians
§38.2-3409 Coverage for dependent children
§38.2-3410 Terms "physician" and "doctor" to include dentist
§38.2-3411 Coverage of newborn children
§38.2-3411.2 Coverage of adopted children required
§38.2-3411.3 Coverage for Childhood Immunizations
§38.2-3411.4 Coverage for infant hearing screening and related diagnostics
§38.2-3412.1 Coverage for mental health and substance abuse services
§38.2-3412.1:01 Coverage for biologically based mental illness
§38.2-3414.1 Coverage for postpartum services
§38.2-3415 Exclusion or reduction of benefits for certain causes prohibited
§38.2-3416 Insurer required to offer conversion policy or group coverage
§38.2-3418 Coverage for victims of rape and incest
§38.2-3418.1 Coverage for mammograms
§38.2-3418.1:2 Coverage for pap smears
§38.2-3418.2 Coverage of procedures involving bones and joints
§38.2-3418.3 Coverage for hemophilia and congenital bleeding disorders
§38.2-3418.4 Coverage for reconstructive breast surgery
§38.2-3418.5 Coverage for early intervention services
§38.2-3418.6 Minimal hospital stays mastectomy, certain lymph node dissection patients
§38.2-3418.7 Coverage for PSA (prostate-specific antigen) testing
§38.2-3418.7:1 Coverage for Colorectal Cancer Screenings
§38.2-3418.8 Coverage for clinical trials for treatment studies on cancer
§38.2-3418.9 Minimum hospital stays for hysterectomy
§38.2-3418.10 Coverage for diabetes
§38.2-3418.11 Coverage for hospice care
§38.2-3418.12 Coverage for Hospitalization and Anethesia for dental procedures
§38.2-3418.14 Coverage for Lymphedema
§38.2-3418.17 Coverage for autism spectrum disorder
§38.2-3418.16 Coverage for telemedicine services

Mandated Offers of Coverage

§38.2-3407.5:1 Coverage for Prescription Contraceptives
§38.2-3411.1 Coverage for child health supervision services
§38.2-3414 Optional coverage for obstetrical services
§38.2-3417 Deductible and coinsurance options required
§38.2-3418.13 Coverage for Morbid Obesity
§38.2-3418.15 Coverage for prosthetic devices and components (applicable to policies issued or renewed on and after January 1, 2010)

Virginia Benefit Mandates

Exhibit 1

Special Information Regarding Coverage Issued by Small Employers

Under exisitng (regulations) **statutes**, small employers may purchase "(basic) health insurance coverage" for their employees, subject to the provisions in Virginia Code §38.2-3406.1 (under which coverage) may be excluded for one or more of the mandated benefits and mandated offers described above, except such coverage must include the mandates prescribed by §38.2-3418.1 (Coverage for mammograms), §38.2-3418.1:2 (Coverage for pap smears), §38.2-3418.7 (Coverage for PSA testing), and §38.2-3418.7:1 (Coverage for colorectal cancer screening). In addition, to the extent that health care services covered by these policies or subscription contracts may be legally rendered by a health care provider listed in §38.2-3408, the "(basic) health insurance coverage" product must allow for the reimbursement of such covered services when rendered by such a provider. Policies providing "(basic) health insurance coverage" may be

Source: http://www.scc.virginia.gov/boi/omb/mandated.aspx supplemented with information about the most recent Virginia mandated benefits

Coverage of Essential Benefits and Virginia Benefit Mandates by Potential Benchmark Plans

Exhibit 2

		Potential Benchmark Plans									
		Virginia Small Group			Virginia State Employees			Federal Employees			
	Benefit Category	Anthem Health Plans of VA PPO	Anthem Health Keepers HMO	Optima Vantage HMO	COVA Care	COVA Connect	Kaiser	FEHBP BCBS Standard Option	FEHBP BCBS Basic Option	Government Employees Health Association (GEHA)	Largest Virginia non-Medicaid HMO Plan
Essential Health Benefits											
1	**Ambulatory patient services**	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
	General ambulatory services	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
	Home health care services	Covered (90 visit limit per year)	Covered	Covered (limits not available)	Covered (90 visit limit per year)	Covered (90 visit limit per year)	Covered (limits not available)	Covered (limited to 2 hours per day, 25 visits per year)		Covered (50 visit limit per year)	
	Physical/Occupational Therapy	Covered (combined 20 visit limit per year)	Covered (combined 30 visit limit per year)	Covered (limits not available)	Covered	Covered	Covered	Covered (combined 75 visit limit per year)	Covered (combined 50 visit limit per year)	Covered (combined 60 visit limit per year)	
	Speech therapy	Covered (20 visit limit per year)	Covered (30 visit limit per year)	Covered (limits not available)	Covered	Covered	Covered			Covered (30 visit limit per year)	
	Chiropractic care	Covered (15 visit limit per year)	Covered (30 visit limit per year)	Not covered unless plan includes rider	Covered (30 visit limit per year)	Covered ($500 limit per year)	Covered (30 visit limit per year)	Covered (12 visit limit per year)	Covered (20 visit limit per year)	Covered (12 visit limit per year)	
	Acupuncture	Not specified	Not covered	Not covered	Not covered	Not covered	Not specified	Covered (24 visit limit per year)	Covered	Covered	
	Weight loss programs	Not covered	Not covered	Not covered	Not covered	Not covered	Not specified	Not covered	Not covered	Not covered	
	Infertility treatment	Not covered	Not covered	Not covered unless plan includes rider	Not covered	Not covered	Not specified	Limited coverage	Limited coverage	Limited coverage	
2	**Emergency services**	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
3	**Hospitalization**	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
	General hospital services	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
	Hospice	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
	Skilled nursing facility	Covered (100 day limit per year)	Covered (100 day limit per year)	Covered (limits not available)	Covered (180 day limit per stay)	Covered (180 day limit per stay)	Covered (limits not available)	Covered (limited to members with Medicare Part A coverage)	Not covered	Covered (14 day limit per stay)	
	Bariatric surgery	Offered per mandate	Offered per mandate	Offered per mandate	Covered	Covered	Not specified	Covered	Covered	Covered	

Coverage of Essential Benefits and Virginia Benefit Mandates by Potential Benchmark Plans

Exhibit 2

		Potential Benchmark Plans									
		Virginia Small Group			Virginia State Employees			Federal Employees			
	Benefit Category	Anthem Health Plans of VA PPO	Anthem Health Keepers HMO	Optima Vantage HMO	COVA Care	COVA Connect	Kaiser	FEHBP BCBS Standard Option	FEHBP BCBS Basic Option	Government Employees Health Association (GEHA)	Largest Virginia non-Medicaid HMO Plan
4	**Maternity and newborn care**	Maternity coverage available as an option on certain plans and not covered on other plans	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
5	**Mental health and substance use disorder services, including behavioral health treatment**	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
	General mental health and substance abuse treatment	Covered (20 OP visit, 25 IP day limit per year)	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
	Behavioral health treatment	Not specified	Not specified	Covered	Covered	Covered	Covered	Not specified	Not specified	Not specified	
6	**Prescription drugs**	Covered (some plans only cover drugs on Anthem's formulary unless upgraded coverage is purchased)	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
7	**Rehabilitative and habilitative services and devices**	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
	General rehabiliation services and devices	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
	Durable medical equipment	Covered	Covered ($2000 limit per year)	Covered (limits not available)	Covered	Covered	Covered	Covered	Covered	Covered	
	Hearing aids	Not covered	Not covered	Not covered	Optional coverage (hearing benefits limited to once every 4 years, $1200 hearing aid limit)			Covered (limited to $1250 per ear every year for children and every 36 months for adults)		Covered	
	Habilitative services and devices	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	
8	**Laboratory services**	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	

Coverage of Essential Benefits and Virginia Benefit Mandates by Potential Benchmark Plans

Exhibit 2

	Benefit Category	Potential Benchmark Plans: Virginia Small Group: Anthem Health Plans of VA PPO	Virginia Small Group: Anthem Health Keepers HMO	Virginia Small Group: Optima Vantage HMO	Virginia State Employees: COVA Care	Virginia State Employees: COVA Connect	Virginia State Employees: Kaiser	Federal Employees: FEHBP BCBS Standard Option	Federal Employees: FEHBP BCBS Basic Option	Federal Employees: Government Employees Health Association (GEHA)	Largest Virginia non-Medicaid HMO Plan
9	**Preventive and wellness services and chronic disease management**	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
	General preventive and wellness services and chronic disease management	Covered (preventive services limited to 1 per year)									
	Routine vision exam	Covered on some plans (1 visit limit per year)	Covered (1 visit limit per year)	Not covered	Optional coverage (limit 1 exam per 24 months)			Not covered	Not covered	Covered (1 visit limit per year)	
10	**Pediatric services, including oral and vision care**	Routine vision exam covered, dental coverage available separately		Routine vision exam does not appear to be covered in small group product, dental not covered	Pediatric dental/vision assessments covered. Basic dental covered, expanded dental available for purchase. Routine vision covered only if option is purchased.			Pediatric vision assessments covered. Expanded coverage under separate vision/dental plans if purchased			
Virginia Benefit Mandates											
Reimbursement for services provided by certain practitioners other than physicians		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Coverage for dependent children		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Terms "physician" and "doctor" to include dentist		Covered	Covered	Covered	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	
Coverage of newborn children		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Coverage of adopted children required		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Coverage for Childhood Immunizations		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Coverage for infant hearing screening and		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Coverage for mental health and substance abuse services		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Coverage for biologically based mental illness		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Coverage for postpartum services		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Exclusion or reduction of benefits for certain causes prohibited		Covered	Covered	Covered	Not stated, but reduction/exclusion not typical						
Insurer required to offer conversion poliyear or group coverage		Covered	Covered	Covered	May be eligible for extended coverage			May be eligible for spouse equity coverage, or Temporary Continuation of Coverage (TCC), or a conversion poliyear			
Coverage for victims of rape and incest		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Coverage for mammograms		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Coverage for pap smears		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	

Coverage of Essential Benefits and Virginia Benefit Mandates by Potential Benchmark Plans

Exhibit 2

	Potential Benchmark Plans									
	Virginia Small Group			Virginia State Employees			Federal Employees			
Benefit Category	Anthem Health Plans of VA PPO	Anthem Health Keepers HMO	Optima Vantage HMO	COVA Care	COVA Connect	Kaiser	FEHBP BCBS Standard Option	FEHBP BCBS Basic Option	Government Employees Health Association (GEHA)	Largest Virginia non-Medicaid HMO Plan
Coverage of procedures involving bones and joints	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Coverage for hemophilia and congenital bleeding disorders	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Coverage for reconstructive breast surgery	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Coverage for early intervention services	Covered ($5000 limit per year)	Covered ($5000 limit per year)	Covered	Covered (PT/OT/ST to maintain current functions if no chance of improvement is only available for children under age 3 who qualify for EIS)		Covered	Not specified	Not specified	Not specified	
Minimal hospital stays mastectomy, certain lymph node dissection patients	Covered	Covered	Covered	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	
Coverage for PSA (prostate-specific antigen) testing	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Coverage for Colorectal Cancer Screenings	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Coverage for clinical trials for treatment studies on cancer	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Minimum hospital stays for hysterectomy	Covered	Covered	Covered	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	
Coverage for diabetes	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Coverage for hospice care	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Coverage for Hospitalization and Anethesia for dental procedures	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Coverage for Lymphedema	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	
Coverage for autism spectrum disorder (does not apply to individual market or small group (<50) markets)	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	
Coverage for telemedicine services	Coverage is unclear, telephone consultations explicitly not covered	Coverage is unclear, telephone consultations explicitly not covered	Telemedicine services, other than emergent services, are not covered unless authorized	Covered	Covered	Not specified	Not covered	Not covered	Coverage is unclear, telephone consultations explicitly not covered	
Virginia Benefit Offers										
Coverage for Prescription Contraceptives *	Offered	Offered	Offered	Covered	Covered	Covered	Covered	Covered	Covered	
Coverage for child health supervision	Offered	Offered	Offered	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	
Optional coverage for obstetrical services	Offered	Offered	Offered	Covered	Covered	Covered	Covered	Covered	Covered	

Coverage of Essential Benefits and Virginia Benefit Mandates by Potential Benchmark Plans

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	Potential Benchmark Plans									
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Benefit Category	Anthem Health Plans of VA PPO	Anthem Health Keepers HMO	Optima Vantage HMO	COVA Care	COVA Connect	Kaiser	FEHBP BCBS Standard Option	FEHBP BCBS Basic Option	Government Employees Health Association (GEHA)	Largest Virginia non-Medicaid HMO Plan
Deductible and coinsurance options required	Offered	Offered	Offered	N/A	N/A	N/A	N/A	N/A	N/A	
Coverage for Morbid Obesity	Offered	Offered	Offered	Covered	Covered	Not specified	Covered	Covered	Covered	
Coverage for prosthetic devices and components	Offered	Offered	Offered	Covered	Covered	Covered	Covered	Covered	Covered	

* Now a Federal Mandate