

# **A Review of Rhode Island's Mandated Benefits and Recommendations for Future Reviews**

**A Legislative Report Required by Section 6(m) of the Rhode Island Health Care Reform Act  
of 2013**

**Submitted by the Rhode Island Office of the Health Insurance Commissioner**

**May 5, 2014**

## Executive Summary

The Rhode Island Office of the Health Insurance Commissioner (OHIC) developed this mandated benefits report at the direction of the Legislature.<sup>1</sup> According to at least one report, Rhode Island leads all states in the number of mandated benefits required, including benefit, provider and coverage mandates.<sup>2</sup> Today, Rhode Island does not have a specific process in place to review current or proposed mandated benefits on an ongoing basis.

Per the legislation the report covers the following topics:

- the impact of the current mandated benefits on cost of health insurance for fully insured employers;
- current provider and insurer mandates that are unnecessary and/or duplicative due to existing care standards;
- a state-by-state comparison of health insurance mandates and the extent to which Rhode Island mandates exceeds other states' benefits; and,
- recommendations for amendment to the existing mandated benefits based on this review.

The objective of this report is to perform a preliminary analysis of Rhode Island's current mandates and most importantly, to propose a new in-depth process for both retrospective and prospective review of mandates. Both current and new mandates should be based in sound clinical and scientific medical evidence and should balance cost and benefit.

The State contracted with Bailit Health Purchasing, LLC to conduct this examination. To conserve resources, the State did not use an actuary for the work described in this report. Instead, costs of each mandate were estimated by using data provided by carriers in Rhode Island or by looking at cost estimates completed by other states. In particular, estimates from Massachusetts and Connecticut are used since they are neighboring states with similar populations, mandates, and insurance environments. It is important to note that there are sometimes differences among states not only in the specific details of the mandate but also in the prevalence of disease and cost of provider services. Therefore, the estimates provided in this report should only be used to give policymakers a sense of the potential cost of a given mandate in Rhode Island.

Many of the States' mandated benefits are also federally-mandated benefits or fall within the Essential Health Benefit (EHB) construct. The estimated cost of these mandated benefits equal \$50.16, or approximately 11% of the monthly premium. Whether or not mandated by the State, these benefits are likely to be included in health coverage. Provider benefits are also likely to be maintained where the State's provider mandates are generally focused on providing alternative providers that are typically of lower cost.

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<sup>1</sup> Section 6m of the Rhode Island Health Reform Act of 2013.

<sup>2</sup> See Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013.

There are a smaller number of mandates that appear to be outside of an EHB category. With these mandates, the State has a greater ability to impact whether the service is included in coverage, and the State has a direct cost concern in that the State may be responsible for the cost of any mandated benefits that fall outside of one of the ten EHB categories once the EHB definition is finalized. It is estimated that these mandates cost \$8.36 pmpm, or approximately 2% of the premiums within the State, with the off-label use of prescription drugs, infertility and home health mandates making up the majority of those costs. By way of reference, 2% of written premium for the three major health insurance companies in calendar year 2012 (\$1,305,410,760) was \$26,108,215.

Based on our research of other state review processes, the report lays out a comprehensive set of criteria and a process to guide the State in its ongoing review of mandated benefits that incorporates the Affordable Care Act's (ACA's) EHB requirements,<sup>3</sup> and considers additional mandates in a manner that balances breadth of coverage with an individual's ability to afford that coverage. As recommended, the process includes a periodic retrospective review of current mandates and a prospective review of all newly proposed mandates. The process designates OHIC, an independent agency reporting directly to the governor, as the official reviewer of mandates, with input from other state agencies including but not limited to, EOHHS, Medicaid, DOH, BHDDH, the Lt. Governor's Office, and HSRI, and directs the Office to consider the medical efficacy, cost, and social impact of each mandate, and provide the Legislature with recommendations on whether to maintain or accept new mandates. The process further calls for proponents of particular mandates to provide supportive documentation and propose potential savings to fund the cost of any proposed mandate.

Like many other states, a number of Rhode Island's mandates were established 10-20 years ago and have not been revisited even though standards of care for medical treatment, and federal law have evolved. Conducting periodic, standardized reviews of all mandated benefits, in addition to the review of newly proposed mandates, is important and will provide the State with a greater understanding of whether and how these benefits contribute to the overall health policy goals of the State aimed at improving both the quality and efficiency of care.

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<sup>3</sup> For 2014 and 2015, EHBs are state defined based on the state's selection of a benchmark plan, and may also include state-mandated benefits to the extent included in the benchmark plan, whether or not they would fall into one of the essential health benefits categories. When referring to EHBs here, however, we are referring to the ten categories of benefits included within the ACA. This proposal assumes that the ten categories will be further defined over time to be consistent nationally. However, given that this approach is not yet in place and may not be implemented, it will be important for Rhode Island to consider over time what the ultimate impact of EHBs is on Rhode Island's review of state mandated benefits. Also it is important to remember that the EHB construct is applicable in the individual and small group marketplace. Until 2016, that includes employers with 50 or fewer employees. Beginning in 2016, it will include employers with 100 or fewer employees. However, there will always be some fully insured employers with more than 100 employees or self-insured employees that are not required to meet the EHB requirements (though the insurance needs to be comprehensive enough to count as creditable coverage).

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## I. Introduction

The Rhode Island Legislature directed the Office of the Health Insurance Commissioner (OHIC) to complete a study of the State's mandated benefits. Specifically, the legislation requires the State to submit a report by April 1, 2014 that includes:

- the impact of the current mandated benefits on cost of health insurance for fully insured employers;
- current provider and insurer mandates that are unnecessary and/or duplicative due to existing care standards;
- a state-by-state comparison of health insurance mandates and the extent to which Rhode Island mandates exceeds other states' benefits; and,
- recommendations for amendment to the existing mandated benefits based on this review.

All states have laws mandating that specific health care benefits be included in insurance coverage. State mandated benefits can serve to make health care coverage more comprehensive in the fully insured small group and individual insurance markets, but they also can increase the cost of coverage. This report will provide the Legislature with a clear understanding of how Rhode Island's current mandated benefits compare to those required in other states, and the estimated impact of those benefits on both access to care and the cost of care. This report provides recommendations for the Legislature's consideration on how to consider mandated benefits on an ongoing basis.

Given the implementation of the Patient Protection and Affordable Care Act (ACA) and its requirements for provision of Essential Health Benefits (EHBs), now is a particularly good time to review the State's mandated benefits and to consider how to frame current and new proposals for mandated benefits. The ACA requires that all individual and small group plans<sup>4</sup>, both in and out of the Exchange offer ten "essential health benefits"<sup>5</sup> including:

- ambulatory patient services
- emergency services
- hospitalization
- laboratory services
- maternity and newborn care
- mental health & substance use disorder services, including behavioral health services
- pediatric services, including oral and vision care
- prescription drugs
- preventive and wellness services and chronic disease management
- rehabilitative and habilitative services and devices

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<sup>4</sup> Until 2016, small group plans will only include employers with 50 or fewer employees. Beginning in 2016, small group plans will expand to include those employers with 100 or fewer employees. The EHB requirements do not extend to fully-insured large group plans, self-insured plans, or grandfathered plans. While state mandated benefits do not apply to self-insured plans, they do apply to large group plans.

<sup>5</sup> See Patient Protection and Affordable Care Act. Section 1302(b)(1)(E).

Many of Rhode Island's mandates appear to fall within one of these ten categories. The ACA directed the U.S. Department of Health and Human Services (HHS) to further define EHBs. In doing so, HHS opted to allow states flexibility during the first two years of the law's implementation, 2014 and 2015. Each state was required to select a Base-Benchmark plan by December 26, 2012 from one of four options described in the Federal Register<sup>6</sup> including (1) The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market; (2) any of the largest three state employee health benefit plans by enrollment; (3) any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment that are open to Federal employees; or (4) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state. If a state did not recommend a benchmark plan, the default benchmark was determined to be the largest small group plan in the state. Rhode Island selected Blue Cross Blue Shield of Rhode Island's (BCBSRI) - Vantage Blue Preferred Provider Organization (PPO) as its Base-Benchmark plan. In addition to any benefits specifically falling within an EHB category, all benefits in this Base-Benchmark plan are considered an EHB in Rhode Island for 2014 and 2015.

Depending on what choice a state made, the Base-Benchmark plan may include state-mandated benefits to the extent that benefit is offered through the selected plan, as is the case in Rhode Island. For years 2014 and 2015 the federal government will cover the costs of all benefits included in the state's selected Base-Benchmark plan. However, beginning in 2016, HHS may choose to define EHB differently and also may begin enforcing a provision in the ACA requiring states to defray the costs of coverage for mandates that exceed those contained in the EHB for individuals purchasing subsidized coverage in a state Exchange.<sup>7</sup>

This potential direct cost to the State serves as a clear reminder that there are costs to implementing mandated benefits and that in implementing mandates it is important for states to balance the need to ensure that a particular type of coverage is available for a consumer with the impact of that requirement on health insurance premiums while considering the medical efficacy and scientific basis of that treatment.

## **II. Methodology**

OHIC contracted with Bailit Health Purchasing, LLC (Bailit) to conduct this study on behalf of the Department. To keep the costs of this report reasonable, OHIC leveraged pre-existing work on mandated benefits from the State's insurers and studies conducted in neighboring states instead of using an actuary to conduct detailed cost estimates.

In developing the report, Bailit first reviewed each of the State's benefit and provider mandates.<sup>8</sup> As detailed below, the review categorizes and describes each State mandate. Then Bailit compared each benefit mandate to other states to determine the number of states with a

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<sup>6</sup> <http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf>, accessed 03/14/14

<sup>7</sup> ACA Section 1311 (d)(3)(B).

<sup>8</sup> In one national review of mandates, Rhode Island is shown as having the highest number of mandated benefits (70) of any state. See *Health Insurance Mandates in the States 2012*, Council for Affordable Health Insurance (CAHI) 2013. The CAHI report includes benefit (requires coverage of a particular service), provider (requires inclusion of a particular provider) and coverage (requires coverage of a particular population) mandates. In contrast, this report focuses mainly on benefit mandates and touches on provider mandates, but excludes coverage mandates.

similar benefit mandate and to compare details of the specific mandates. Bailit began by reviewing the comprehensive mandate report published annually by the Council for Affordable Health Insurance (CAHI) to identify states with potentially similar mandates.<sup>9</sup> Where available, Bailit considered reports and analyses that have been conducted in other states, particularly reports from Connecticut<sup>10</sup>, Massachusetts<sup>11</sup>, and Maryland<sup>12</sup> to leverage pre-existing work on mandated benefits. In addition, Bailit reviewed various advocacy and provider association sources that report on mandated benefits.

Bailit interviewed or received completed surveys from each of the four insurers (BCBSRI, United Health Care, Tufts Health Plan, and Neighborhood Health Plan of Rhode Island) that are offering coverage through HealthSource RI. In these interviews, Bailit solicited feedback on the approach to the report, and obtained cost and other policy information. Their input is reflected throughout this report.

To develop the estimated cost impact of mandates on a per member per month (pmpm) basis in Rhode Island, Bailit considered including not only direct cost (cost of all services required by the mandate), but also indirect costs (cost of services provided outside of the mandate that can be attributed to the mandate, or cost savings from provision of certain mandated services). In the end, because of the use of secondary data sources and analysis, the analysis presented here uses only direct costs as that was what was most commonly reported by insurance carriers and other state reports.

Bailit used two data gathering methods to conduct this analysis. First, Bailit requested pmpm cost estimates from the four Rhode Island carriers from their fully insured plans, when available. BCBSRI provided their cost estimates for the majority of mandates discussed within this report. Most of their estimates were in 2010 dollars. Bailit then used BCBSRI -specific premium increases for years 2011-2014 and inflated these estimates accordingly. It should be noted that this method does not account for any potential differences in provider contracts or utilization of these services. Where available, input from the other Rhode Island carriers is also noted. In instances where Rhode Island carriers were not able to share cost estimates for a particular mandate, Bailit reviewed at least two other state estimates to provide a range of costs. These cost estimates are from nearby states with a similar mandate, similar health care costs and who had recently conducted mandated benefit reviews including Massachusetts, Connecticut, and Maryland.<sup>13</sup> Wherever possible based on the similarity of each mandate, Massachusetts is used as the comparison state. If a cost estimate from Massachusetts was not available, a cost

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<sup>9</sup> The CAHI report only provides general categories of mandates and the name of states with a mandate falling in to the category. After identifying a state as potentially having a mandate based on the CAHI report, however, it was important to look specifically at a state's legislation or another detailed report to obtain more information on each of the mandates.

<sup>10</sup> [http://www.ct.gov/cid/lib/cid/2010\\_CT\\_Mandated\\_Health\\_Insurance\\_Benefits\\_Reviews\\_-\\_General\\_Overview.pdf](http://www.ct.gov/cid/lib/cid/2010_CT_Mandated_Health_Insurance_Benefits_Reviews_-_General_Overview.pdf).

<sup>11</sup> <http://www.mass.gov/chia/docs/r/pubs/13/comprehensive-mandate-review-report-2013-1-10.pdf>.

<sup>12</sup> [http://mhcc.dhmf.maryland.gov/healthinsurance/Documents/healthinsurance/mandated\\_2012\\_2012\\_0106.pdf](http://mhcc.dhmf.maryland.gov/healthinsurance/Documents/healthinsurance/mandated_2012_2012_0106.pdf).

<sup>13</sup> Because the mandates are all slightly different, the comparisons to other states only give a sense of impact of the cost of each mandate rather than an exact analysis.

estimate from Connecticut was preferred and lastly to Maryland.<sup>14</sup> Other states' estimated costs were sometimes adjusted based on the differences in the mandated benefit requirements and always inflated to 2014 dollars using analyses conducted by the Centers for Medicare and Medicaid Services (CMS), as noted.

Based on all of the data collected during the research phase, Bailit worked closely with OHIC to develop recommendations for ongoing review of current and new mandated benefits, particularly in light of the changes implemented due to the ACA.

### **III. Review of Current State Mandated Benefits**

State mandated health benefits are directed at ensuring that individuals who purchase coverage in the individual or small group market receive access to services that the State requires health insurance carriers to provide. In Rhode Island, those mandated benefits are typically found in state statute governing these entities and the different plans that may be offered.<sup>15</sup> State mandated benefits do not apply to self-insured plans, Medicare or Medicaid.

This section of the report reviews the current health and provider mandates in the State, and for the health benefits, compares Rhode Island's mandates to those included in other states. Each analysis includes a cost impact of the particular mandate, based on existing Rhode Island data and/or by making reasonable estimates of a general cost impact based on reports developed for Massachusetts, Connecticut and/or Maryland.

Rhode Island's mandated benefits were assessed in three different categories:

- 1) Service mandates that were either federally mandated before the ACA or which fit squarely within one of the ten EHB categories defined by the ACA;
- 2) Service mandates which are currently in Rhode Island's EHB Base-Benchmark plan but which may not be considered an EHB by HHS in the future; and
- 3) Provider mandates.

#### **A. State Mandated Health Benefits which are also federally mandated or likely to be included as Essential Health Benefits**

The first group of benefits reviewed is those that are likely to fall within one of the ten categories of services included as an EHB or are otherwise federally mandated. This is done to highlight the overlap between existing State mandated benefits and federally mandated benefits. It is likely that with these mandates there is little marginal impact caused by the State mandate. That is, even absent the State mandate, these benefits still would be required by the federal government. In addition, they are typically offered by self-insured firms due to their efficacy.

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<sup>14</sup> The proximity of the states and similarity in premium costs, make both Massachusetts and Connecticut reasonable comparison states. Only two of the benefit mandates were not also required in either Massachusetts or Connecticut (second surgical opinion and smoking cessation). For those benefits, we utilized Maryland as our comparison given its relative proximity and cost similarities.

<sup>15</sup> See Rhode Island Statutes 27-20.

Given that the definition of EHB is expected to evolve in the next few years, it is important for the State to monitor debate around the definition in order to impact it, where appropriate, and to consider whether the mandates in this group will ultimately be required based on the final EHB definition. Even if they are all included, however, self-insured firms, fully-insured firms with over 100 full-time equivalent employees and firms with grandfathered plans will not need to abide by the benefits required under EHB. Fully-insured firms and firms with grandfathered plans that are not self-insured do need to comply with State mandated benefits however. As the definition of EHB evolves, the State will want to monitor whether these excluded plans continue to offer the benefits within this group.

As detailed below, some of the State mandated benefits within this category may go further than the federal law or EHB and may include limits on cost sharing or other out-of-pocket costs for consumers which may not be addressed by federal law. Table One summarizes benefits falling within this first category. The Table includes estimated 2014 pmpm costs for each of the mandates based on the cost methodology described above to provide a sense of the impact of mandated benefits on the cost of insurance premiums. While the estimated premium impact of these mandates is high (\$50.16), given that these services are either federal mandates or squarely within an EHB category, there is limited ability for the State to impact insurance coverage by making any changes to these mandates.

**Table One: State Mandated Benefits that Overlap Significantly with Federal Mandates**

<b>Benefit</b>	<b>2014 estimated PMPM Cost</b>	<b>Comments</b>
Ambulance services	\$2.76	Benefit is required under ACA, RI law includes cost sharing limits, self-insured firms also cover
Colorectal Screening	\$4.71	Benefit is required under ACA, self-insured firms also cover
Contraceptive Coverage	\$1.38	Benefit is required under ACA – may want to wait to see what Supreme Court decides regarding religious organizations, significant differences between self-insured and fully insured firms
Diabetes Treatment	\$2.86	Benefit is required under ACA, self-insured firms also cover
Emergency Room Services	--	Benefit is required under federal law, no significant difference between self-insured and fully insured firms
Lead Screening	\$0.03	Benefit is required under ACA but no age guidelines are provided; self-insured firms also cover
Mammography	\$3.24	RI mandate aligned with recommendations from ACS, consider USPFTS, self-insured firms also cover
Pap Smears	\$1.04	Benefit is required under ACA, self-insured firms also cover
Mastectomy Treatment and Required Hospital Stays	\$0.12	Benefit is required under federal law except RI law also includes minimum hospital stays, self-insured firms also cover
Maternity Hospital Stays	\$9.93	Benefit is required under federal law, self-insured firms also cover
Mental Health and	\$12.45	Details regarding EHB beyond 2015 may be important to

<b>Benefit</b>	<b>2014 estimated PMPM Cost</b>	<b>Comments</b>
Substance Abuse		consider, self-insured firms also cover although some carve-outs are apparent
Newborn Care	\$6.03	Benefit is required under ACA, RI law also requires continuation of the infant on the parent's insurance plan and payment of premium, as appropriate, to continue newborn care after the first month of life, self-insured firms also cover
Pediatric Preventive Care	\$4.22	Benefit is required under ACA, self-insured firms also cover
Prosthetics and Orthotics	\$0.83	Details regarding EHB beyond 2015 may be important to consider, self-insured firms cover but potentially reduced dollar amounts without mandate
Smoking Cessation	\$0.56	Details regarding EHB beyond 2015 may be important to consider, some differences between self-insured and fully-insured firms
<b>Total Estimated Premium Impact</b>	<b>\$50.16</b>	

### *Ambulance Services*

Rhode Island law mandates that cost sharing for ground ambulance services may not be greater than \$50 for an individual or group health plan.<sup>16</sup> Thirteen other states<sup>17</sup> have a mandate for ambulance services. Those states generally require provision of emergency transportation as part of insurance coverage but do not typically specify limitations on cost sharing. New York's mandate also speaks to cost sharing, but requires insurers to make payment in full for ambulance services.<sup>18</sup>

Ambulance services are unlike many other health care services in that they can be provided by a patchwork of public and private providers, and the patient may not know or have control of what ambulance is providing services to them. This is particularly an issue in those areas where there are in-network and out of network ambulance services.

While ambulance services themselves in emergency circumstances will be covered as an Essential Health Benefit, having a cost-sharing limitation may continue to be important to limit an individual's financial exposure based on which ambulance service happens to provide the emergency transportation.

**Cost Impact:** Rhode Island insurers did not provide cost estimates for this mandate. The only analysis of cost impact which existed was an analysis of Connecticut's ambulance mandate. The Connecticut mandate requires coverage of ambulance services by insurance carriers but

<sup>16</sup> See § 27-20-55. Enacted in 2008.

<sup>17</sup> Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013.

<sup>18</sup>See <http://codes.lp.findlaw.com/nycode/ISC/43/4303#sthash.mWNG5vm6.dpuf>.

does not address cost-sharing responsibilities. The 2014 pmpm cost of ambulance services in Connecticut was estimated to be \$2.76.

### *Colorectal Exams*

Enacted in 2000, Rhode Island mandates coverage for colorectal examinations and laboratory tests for cancer for any non-symptomatic covered individual, in accordance with the current American Cancer Society guidelines. Thirty-seven states require coverage of colonoscopies.<sup>19</sup> Like Rhode Island, many of these states specifically tie their mandate to American Cancer Society Guidelines.

Colorectal cancer<sup>20</sup> is the third leading cause of cancer-related deaths in the United States for both men and women, accounting for approximately nine percent of all cancer deaths. The risk for developing colorectal cancer increases as people age, with the vast majority (90%) of colorectal cancers diagnosed in people aged 50 and older.

The ACA requires coverage of preventive health services with no cost sharing for all U.S. Preventive Services Task Force (USPSTF) recognized preventive services, including colorectal screening. Given that requirement, the State may want to reconsider whether it needs a state-specific mandate of colorectal screening.

Cost Impact: Rhode Island insurers did not provide estimates of the cost of the colorectal screening mandate. Both Connecticut and Maryland did provide cost estimates for colorectal screenings within their reports. Maryland's estimate was \$2.71 pmpm in 2012. For purposes of this report, Connecticut's estimate of \$4.71 pmpm for 2014 was used as the estimate of the impact of colorectal screenings in Rhode Island.

### *Contraception*

Since 2000, Rhode Island state law has mandated coverage of prescription contraceptive drugs and devices for all individual and group health insurance coverage that includes prescription drug coverage.<sup>21</sup> The mandate does not require coverage for the prescription drug RU 486.<sup>22</sup> The statute allows insurers to exclude this coverage for churches or qualified church-controlled organizations for whom such coverage is contrary to bona fide religious tenets. According to the National Conference of State Legislatures, 28 states have similar mandates in place.<sup>23</sup>

The ACA requires coverage of contraceptive methods and counseling as an EHB (women's preventive services). Because contraception is included under the category of preventive services, no cost sharing is allowed. Under the ACA, women have access to the full range of FDA-approved contraceptive methods. This includes, but is not limited to, barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling. Methods include a range of pills, the ring, the patch, the shot, implants, hormonal intrauterine

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<sup>19</sup> Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013.

<sup>20</sup> Refers to cancer of the colon or the rectum.

<sup>21</sup> See § 27-20-43.

<sup>22</sup> RU-486 (Mifepristone) is a medication that blocks the action of progesterone to cause abortion.

<sup>23</sup> See <http://www.ncsl.org/research/health/insurance-coverage-for-contraception-state-laws.aspx>

devices, non-hormonal intrauterine devices, barrier methods, and sterilization procedures. Like Rhode Island, coverage of RU 486 is not required under the ACA.

To be covered a method must be FDA approved and prescribed by a health care provider. Coverage for contraception should be without cost sharing. However, if a provider prescribes a drug and there is a generic equivalent available, a plan or issuer may cover the generic without cost-sharing and impose cost-sharing on the branded drug. If a generic version is not available, then a plan or issuer must provide coverage for the brand name drug without cost-sharing. However, the plan must have a waiver process that enables the woman to access the branded drug without cost sharing when a generic drug is available but her provider determines that the branded drug is medically appropriate for her. The final regulations regarding coverage of women's preventive health services under the ACA allows for an exception for religious employers.<sup>24</sup> However, the Supreme Court will be ruling on this issue this spring.

Given the requirement to cover contraception through the ACA, there is not a specific need for the State to mandate coverage on an ongoing basis. However, in order to continue the religious exemption in Rhode Island, depending on the Supreme Court's ruling, the State may want to maintain at least that portion of the mandate.

Cost Impact: Rhode Island insurers did not provide a cost estimate for this mandate. Estimates for the cost of contraceptive coverage ranged from \$0.94 in Connecticut to \$2.71 in Maryland. Estimates from an analysis completed on 2009 fully insured claims for Massachusetts<sup>25</sup> were inflated using national estimates for health insurance spending increases.<sup>26</sup> The 2014 pmpm cost impact of contraceptives was therefore estimated to be \$1.38.

### *Diabetes Treatment*

Rhode Island, like most states, requires coverage for diabetes treatment and supplies, including self-management education.<sup>27</sup> According to CAHI, diabetes supplies are required in 46 states, including Rhode Island and diabetes self management is required in 41 states. Diabetes treatment is required as an EHB under the ACA as part of chronic disease management.

Diabetes is one of most serious and widespread illnesses in America. With diabetes, a person cannot produce or process insulin. Diabetes is the 7<sup>th</sup> leading cause of death in the country and a number of potential complications stem from diabetes including increased risk of heart disease, stroke and hypertension, kidney disease, amputation blindness, and dental and periodontal disease.<sup>28</sup> Given these health risks and the potential health care costs, insurers undoubtedly would cover these services regardless of the State's mandate.

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<sup>24</sup>Federal Register, Published July 2, 2013, accessible at <http://www.gpo.gov/fdsys/pkg/FR-2013-07-02/pdf/2013-15866.pdf>

<sup>25</sup> <http://www.mass.gov/chia/docs/r/pubs/13/comprehensive-mandate-review-report-2013-1-10.pdf>, accessed 1/6/14

<sup>26</sup> <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/proj2012.pdf>, accessed 3/12/14

<sup>27</sup>See § 27-20.30

<sup>28</sup> National Diabetes Fact Sheet, [http://www.cdc.gov/diabetes/pubs/pdf/ndfs\\_2011.pdf](http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf)

The imperative to manage diabetes as a way to both manage health care quality and costs, combined with the requirement that diabetes treatment be included as an EHB under the ACA, makes a continuing treatment mandate in Rhode Island somewhat redundant.

Cost Impact: Rhode Island insurers did not specifically provide estimates of the cost impact of the diabetes mandate. Costs for diabetes care and treatment varied across states from \$0.45 in Maryland to \$5.59 in Connecticut possibly reflecting differences in service provision, disease prevalence, and/or difficulty in analyzing claims data. Estimates from an analysis completed on 2009 fully insured claims for Massachusetts<sup>29</sup> were inflated using national estimates for health insurance spending increases.<sup>30</sup> The 2014 pmpm cost impact of diabetes treatment was estimated to be \$2.86.

#### *Emergency Room Services*

§ 27-18-76 details how Section 1867 of the Social Security Act 42 (U.S.C. S 1395dd), as amended by Section 1001 of the ACA, should be interpreted by health plans in Rhode Island. That is, the insurer must provide access to emergency room services without the need for any prior authorization determination, even if the emergency services are provided out-of-network. Further, health plans may not impose any administrative requirements or limitations on coverage for emergency services on out of network providers that do not apply to in-network providers. According to the CAHI report, there are 42 states with an Emergency Room mandate although these vary somewhat from prudent layperson<sup>31</sup> to more broadly defined emergency room coverage.<sup>32</sup> Most states initially implemented these laws when managed care became the predominant form of coverage in the mid 1990's, notably RI's law was passed in 2012 (following passage of language within the ACA).

This mandated benefit appears redundant with federal law, particularly since emergency services are included as one of the ten categories of EHB. However, if the State is concerned about out-of-network cost sharing it may want to maintain this part of the mandate.

Cost Impact: Bailit was not able to identify any cost estimate for emergency room services. CAHI estimates the cost of this mandate to be less than 1 percent of the premium, but this estimate is not precise enough to be included in the analysis.

#### *Lead Screenings*

Since 1991, Rhode Island has mandated coverage of screenings for lead poisoning and related services for children under age six, including for group plans and for Medicaid.<sup>33</sup> Seven states, in addition to Rhode Island, have enacted similar mandates, including California, Connecticut,

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<sup>29</sup> <http://www.mass.gov/chia/docs/r/pubs/13/comprehensive-mandate-review-report-2013-1-10.pdf>, accessed 1/6/14

<sup>30</sup> <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/proj2012.pdf>, accessed 3/12/14

<sup>31</sup> Requiring insurers to provide coverage for provision of emergency services in situations where a "prudent layperson" (a person who possesses an average knowledge of health and medicine) would reasonably believe that particular symptoms required emergency treatment, regardless of the final diagnosis.

<sup>32</sup> Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013.

<sup>33</sup> § 23-24.6-9

Delaware, Massachusetts, Missouri, New Jersey and Wisconsin.<sup>34</sup> Under the ACA, health plans must provide lead screening for children at risk of exposure as part of preventive services as an EHB.

While the ACA does not provide specific guidelines regarding the age of children for which lead screening is relevant, insurers would likely continue to provide for lead screening for children under age six regardless of the mandate.

Cost Impact: Cost estimates for state mandated lead screening services in Connecticut and Massachusetts were \$0.01 to \$0.07 pmpm, respectively. BCBSRI reported 2010 costs of \$0.02 pmpm, inflated for 2014, the estimated cost of the lead screening mandate is \$0.03 pmpm.

*Mammograms/Pap Smears*

Health plans in Rhode Island must cover mammograms and pap smears, in accordance with guidelines established by the American Cancer Society, under the State’s mandate, enacted in 2005.<sup>35</sup>

In addition, plans must cover two paid screening mammograms per year if recommended by a physician, for women who have been treated for breast cancer within the last five years or who are at high risk of developing breast cancer due to genetic predisposition (BRCA gene mutation or multiple first degree relatives), a high risk lesion on prior biopsy (lobular carcinoma in situ) or atypical ductal hyperplasia.<sup>36</sup>

Every state except Utah has a mammogram mandate. Including Rhode Island, 26 states mandate pap smears.<sup>37</sup> There is an on-going debate on whether and how often either of these screenings should take place. Since Pap tests have been provided on a regular basis, cervical cancer incidence and mortality rates have decreased by almost 70%.<sup>38</sup> The survival rate for women diagnosed with precancerous lesions through the Pap test is nearly 100%, as cancer is prevented altogether. National organizations provide different guidelines in terms of when screening mammograms and Pap tests should begin and their periodicity as shown in Table Two below. In implementing the ACA, HHS follows the recommendations of the USPSTF,<sup>39</sup> which recommends mammograms to begin at age 50 (rather than age 40 as recommended by the American Cancer Society (ACS)) and that the tests be conducted every two years (rather than annually as recommended by the ACS). Likewise, for Pap tests, the USPSTF provides for screenings to start later (at age 30 rather than at age 21) and to occur every three years (instead of annually to age 30 as recommended by ACS).

**Table Two: Differences in Mammogram and Pap Test Recommendations**

Organization	Mammogram Recommendations	Pap Test Recommendations
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<sup>34</sup> Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013.

<sup>35</sup> § 27-20-17

<sup>36</sup> Ibid.

<sup>37</sup> Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013.

<sup>38</sup> <http://www.cancer.org/cancer/cervicalcancer/detailedguide/cervical-cancer-key-statistics>

<sup>39</sup> See <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html#CoveredPreventiveServicesforWomenIncludingPregnantWomen>

Organization	Mammogram Recommendations	Pap Test Recommendations
National Cancer Institute <sup>40</sup>	Every two years from aged 40-49; every 1-2 years for women 50 and older	Begin testing at age 21, and following a triennial schedule until age 29. Women age 30 and over, with three consecutive negative screenings and no risk factors, can have combined test with HPV every five years. <sup>41</sup>
American College of Obstetrics and Gynecology <sup>42</sup>	Every two years from aged 40-49; every year for women 50 and older	Begin testing at age 21 regardless of sexual history, and following a biennial schedule until age 29. Women age 30 and over, with three consecutive negative screenings and no risk factors, can move to a triennial schedule. ACOG further recommends against screening before age 21, as "it may lead to unnecessary and harmful evaluation and treatment in women at very low risk of cancer."
American Cancer Society <sup>43</sup>	Annual mammogram all women 40 and older	Begin testing three years after a woman begins vaginal intercourse, but no later than 21 years of age, with annual screenings. From age 30-70, every 2-3 if have had three successive normal screens. Women who are 70 and older with three or more successive normal tests and no abnormal tests in the past 10 years, and women with total hysterectomies, do not require screening.
U.S Preventive Services Task Force (USPSTF) <sup>44</sup>	Every two years from the age of 50 through 74.	Every three years for women age 30 and older.
American College of Preventive Medicine <sup>45</sup>	Every 1-2 years from the age of 50 to 70. Those older than 70 should continue to	Begin testing as soon as sexually active, or by age 18. Perform

<sup>40</sup> <http://www.cancer.gov/>

<sup>41</sup> National Cancer Institute, Pap and HPV Testing Fact Sheet; accessible at <http://www.cancer.gov/cancertopics/factsheet/detection/Pap-HPV-testing>

<sup>42</sup> [https://www.acog.org/About\\_ACOG/News\\_Room/News\\_Releases/2011/Annual\\_Mammograms\\_Now\\_Recommended\\_for\\_Women\\_Beginning\\_at\\_Age\\_40](https://www.acog.org/About_ACOG/News_Room/News_Releases/2011/Annual_Mammograms_Now_Recommended_for_Women_Beginning_at_Age_40); see also [https://www.acog.org/About\\_ACOG/Announcements/New\\_Cervical\\_Cancer\\_Screening\\_Recommendations](https://www.acog.org/About_ACOG/Announcements/New_Cervical_Cancer_Screening_Recommendations),

<sup>43</sup> <http://www.cancer.org/healthy/findcancerearly/cancerscreeningguidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer>,

<sup>44</sup> <http://www.uspreventiveservicestaskforce.org/uspstf/uspbrca.htm>, see also <http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm>

<sup>45</sup> <http://www.acpm.org>.

Organization	Mammogram Recommendations	Pap Test Recommendations
	receive mammograms as long as can receive treatment. Makes no specific recommendations for those under 50, instead suggests further study of potential benefit for those women at higher risk. <sup>46</sup>	annually after two consecutive tests show normal results. Testing should occur until age 65.

Where Rhode Island’s mandate specifically ties coverage to the American Cancer Society’s guidelines, the State may want to revisit its mandate, and consider whether given the ACA requirement, a mandate is even necessary.

Cost Impact: Rhode Island insurers did not estimate a cost for the mammogram or pap smear mandates. The 2014 cost estimate from Connecticut was used to estimate the cost of the mammography mandate in Rhode Island, which is \$3.24 pmpm. The estimate for pap smears was provided by Massachusetts for 2009 and inflated to 2014 dollars. Based on that, it is estimated that the impact of the mandate is \$1.04 pmpm in 2014 in Rhode Island.

*Mastectomy Treatment and Required Hospital Stays*

Well before the passage of the ACA, Congress enacted a federally mandated benefit for breast reconstruction after mastectomy as part of the Women’s Health and Cancer Rights Act (WHCRA) of 1998. Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage are required to provide coverage for certain services relating to the mastectomy in a manner determined in consultation with an individual and his or her physician. This required coverage includes all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications of the mastectomy, including lymphedema. These benefits may have a yearly deductible and can be subject to co-pays or co-insurance.

Rhode Island first enacted a similar mandate in 1997.<sup>47</sup> In addition to the requirements of the federal mandate, Rhode Island also mandates a minimum hospital stay of 48 hours for a mastectomy and 24 hours after an axillary node dissection. The stay may be shortened upon consultation with patient and physician. In those cases, the patient’s discharge plan shall include one home visit by a physician or registered nurse.<sup>48</sup>

There are 21 additional states with reconstruction mandates, and many include minimum stays similar to Rhode Island’s law.<sup>49</sup> While Massachusetts does not currently have a minimum stay mandate, the state has reviewed proposed bills to implement a minimum stay.<sup>50</sup>

<sup>46</sup>See [http://c.ymcdn.com/sites/www.acpm.org/resource/resmgr/policy-files/polstmt\\_breast.pdf](http://c.ymcdn.com/sites/www.acpm.org/resource/resmgr/policy-files/polstmt_breast.pdf)

<sup>47</sup>§ 27-20-29

<sup>48</sup>§ 27-20-29.1

<sup>49</sup>Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013. A summary of state laws can be found at:

[http://www.breastreconstruction.org/breast\\_reconstruction\\_insurance\\_coverage.html](http://www.breastreconstruction.org/breast_reconstruction_insurance_coverage.html).

<sup>50</sup> See <http://www.mass.gov/chia/docs/r/pubs/13/hb931-mastecomies.pdf>

Although the State mandate requires certain lengths of stay, it is unlikely that insurers would try to limit lengths of stay as there may be unintended consequences. Rhode Island's law was implemented before the federal law and may be considered somewhat redundant at this time.

Cost Impact: Rhode Island insurers did not provide specific cost estimates of this mandate. We reviewed Connecticut and Maryland cost estimates. Maryland found a negligible cost of \$0.00 pmpm while 2014 cost estimates from Connecticut was \$0.12 pmpm. Connecticut's estimate is used as a proxy for costs in Rhode Island since no Massachusetts estimate was available.

#### *Maternity Hospital Stays*

Since 1996, Rhode Island has required insurers to provide a minimum hospital stay of 48 hours for a vaginal delivery and 96 hours for a caesarean section.<sup>51</sup> The time may be shortened by the treating physician in consultation with the mother. In those cases, the discharge plan must include home visits, parent education, assistance with breast or bottle feeding and performance of any necessary clinical test. The State law is similar to the federal Newborns' and Mothers' Health Protection Act of 1996 which requires a minimum hospital stay: 1-2 days for vaginal delivery; 3-4 days for caesarean section. All states have a similar mandate, however, given the current practice and inclusion of this benefit as a federally mandated benefit, Rhode Island may want to consider eliminating this benefit in State law.

Cost Impact: Rhode Island insurers did not provide any specific cost estimates for this mandate. Cost estimates of maternity stays in other states varied, with Massachusetts being an outlier on the upper end. Both Maryland and Connecticut provided estimates of \$2.25 pmpm although using different years as their base. To estimate the impact of Rhode Island's mandate, the estimate provided by Massachusetts for 2009 was used and inflated to 2014 dollars, despite the fact that it was an outlier. However, it is important to recognize that this estimate may be significantly higher than what the true experience is. The estimate for Rhode Island, based on Massachusetts' estimate, is \$9.93 pmpm.

#### *Mental Health and Substance Abuse*

Rhode Island mandates coverage of mental health and substance use treatment services.<sup>52</sup> Specifically, the mandate requires parity for mental health and substance use treatment services as compared to coverage for other illnesses and diseases. The statute places specific time limits on services as follows:

- outpatient substance abuse treatment limited to 30 hours per year,
- community residential services for substance abuse limited to 30 days per year, and,
- detoxification services limited to up to 5 occurrences or 30 days per year, whichever occurs first.

Typically, substance use treatment services include chemical dependency treatment and detoxification services. In addition to being included as an EHB, federal law also requires mental health parity, including for substance use treatment services.<sup>53</sup> HHS issued final

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<sup>51</sup> § 27-20.17.1

<sup>52</sup> § 27-38.2

<sup>53</sup> See the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act [need cite].

regulations implementing the Act in November 2013. The regulations require that health plans provide similar coverage for mental health and substance use services, including charging similar co-pays and deductible, and placing similar limits on services as compared to physical health services.<sup>54</sup> Specifically the final rules require that any financial or service limitations be no more restrictive than the predominate limitations applied to “substantially all” of six categories of medical/surgical benefits.

To know whether Rhode Island’s current mandate meets the federal parity requirements, it is important to understand whether similar time limits are placed on physical health services. If there are not similar limits, then there cannot be limits on these substance use treatment services going forward. Rhode Island may want to maintain its law on mental health and substance abuse until a final ruling by HHS on EHB is made

Cost Impact: According to the CAHI report, almost all states (45) have some type of alcohol/substance abuse mandate in place, and the cost of the mandate is between 1 and 3% of the premium price. It is one of the most expensive mandates.<sup>55</sup> Rhode Island insurers have not separately estimated the cost of the state’s mental health parity mandate, including substance abuse provisions. Other states’ estimates vary widely given the large differences in the states’ laws. For example, Maryland’s estimate includes a combined pmpm for mental health and substance abuse treatment as being \$21.22 pmpm while Connecticut finds a \$0.45 pmpm cost from its mandate for treatment of “medical complications of alcoholism.” Coverage for mental illness, including substance abuse services, is much higher in Connecticut– at \$10.20 pmpm. The estimate for mental health services used here was provided by Massachusetts for 2009 and inflated to 2014 dollars. This estimate is not limited to substance abuse services. Based on Massachusetts’ review, the estimated cost impact of mental health parity in Rhode Island in 2014 is \$12.45 pmpm.

#### *Newborn care*

Rhode Island law requires that newborns be covered by their parents’ health insurance plan beginning at birth.<sup>56</sup> Under this requirement, coverage must include injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If the newborn is the first child on the policy and the addition of the child would change the family’s premium, the plan may require notification of birth and payment of the required premium within 31 days after the date of birth in order to have the coverage continue.

CAHI reports that all 50 states have a newborn coverage mandate.<sup>57</sup> 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). Moreover, newborn coverage is squarely considered an EHB, as one of the ten categories includes “maternity and newborn care.” Despite that, it may make sense for Rhode Island to keep this mandate as it requires continuation of the infant on the parent’s insurance plan and payment of premium, as appropriate, to continue newborn care after the first month of life.

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<sup>54</sup> See 78 FR 68239.

<sup>55</sup> Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013.

<sup>56</sup> DBR Reg 23. V; enacted in 2001.

<sup>57</sup> Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013.

Cost Impact: Rhode Island insurers did not estimate the cost impact of the newborn care mandate. Connecticut, which has an identical mandate to Rhode Island, did estimate cost to be \$6.03 pmpm in 2014.

#### *Pediatric Preventive Care*

Since 1998, Rhode Island has mandated coverage of pediatric preventive care.<sup>58</sup> The benefits do not need to include anything provided for by the State to all children, or for cost of the biological preparation used for vaccines. In addition to Rhode Island, 31 states require coverage of well-child care.<sup>59</sup> Rhode Island and California have the broadest mandates regarding well child care. Many states only require coverage to age six. Pediatric preventive care is required under the ACA and no cost sharing is allowed. Given that requirement and the efficacy of the benefit, the State may want to reconsider whether it needs a state-specific mandate of pediatric preventive care. Whether or not there is a mandate in place, the coverage will be required and/or provided by insurers.

Cost Impact: Rhode Island insurers did not estimate a specific cost for the pediatric preventive care mandate. Both the scope and cost of the mandates differed in Connecticut, Massachusetts and Maryland. Connecticut estimated a cost of \$2.40 pmpm while Maryland estimated a cost of \$7.67 pmpm. Massachusetts' 2009 estimate fell in the middle at \$3.42. For purposes of providing the estimated impact of the mandate for this report, Massachusetts' estimate is used and inflated to 2014 dollars, to arrive at \$4.22 pmpm.

#### *Prosthetics and Orthotics*

Rhode Island law mandates that small group and individual insurance policies provide coverage for prosthetics and orthotics at the same level as what is covered by Medicare including appropriate co-payments.<sup>60</sup> Under the mandate, benefits may be limited to devices that are the most appropriate for meeting the medical need and managed care plans may require beneficiaries to purchase these devices through a vendor located in Rhode Island.

CAHI reports that in addition to Rhode Island, 23 other states have a mandate involving prosthetics and orthotics.<sup>62</sup> Under the ACA, these services appear to be part of the ten EHBs, within the category of rehabilitative and habilitative services. Rhode Island may want to maintain its specific benefit until a final ruling regarding the details of what is and what is not included in the HHS definition of rehabilitative and habilitative services.

Cost Impact: Estimates for prosthetics and orthotics from Connecticut and Massachusetts ranged from \$0.12 in Massachusetts to \$2.94 in Connecticut. The estimate from BCBSRI fell in

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<sup>58</sup> § 27-38.1-2

<sup>59</sup> Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013.

<sup>60</sup> § 27-20-52; enacted 2006.

<sup>61</sup> Medicare covers the following services with a 20% co-payment after the Part B deductible is met: arm, leg, back, and neck braces, artificial limbs and eyes, breast prostheses (including a surgical brassiere) after a mastectomy, ostomy supplies for individuals who have had a colostomy, ileostomy, or urinary ostomy, prosthetic devices needed to replace an internal body part or function, and therapeutic shoes or inserts for people with diabetes who have severe diabetic foot disease, when prescribed and fitted by a podiatrist or other qualified individual.

<sup>62</sup> Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013.

the middle of these two estimates at \$0.64 in 2010. BCBSRI's estimate was inflated to 2014 dollars to arrive at an estimate of \$0.83 pmpm.

### *Smoking Cessation Programs*

Enacted in 2006, Rhode Island law mandates tobacco cessation programs for all individual or group plans offered in Rhode Island. The plans must include coverage for smoking cessation treatment, including FDA approved smoking cessation medication if the plan otherwise provides for coverage of prescription drugs.<sup>63</sup> Plans can limit coverage to two courses of the medication and require that it be in combination with outpatient counseling sessions. According to CAHI, six states in addition to Rhode Island include smoking cessation as a mandated benefit.<sup>64</sup> While the Rhode Island mandate allows for cost sharing, smoking cessation is considered a USPSTF service and therefore cost sharing is prohibited. Despite being a USPSTF recommended service, smoking cessation services are not currently uniformly covered by insurers.<sup>65</sup> Given the disparity in coverage in states without their own mandate, Rhode Island may want to consider keeping this mandate in place even though it is otherwise required by the federal government through the ACA.

Cost Impact: Rhode Island insurers did not provide cost estimates for the impact of the smoking cessation mandate. The only state that estimated the costs of a smoking cessation mandate was Maryland. They estimated a cost of \$0.45 in 2012. Inflated to 2014 dollars, the estimate, based on Maryland's findings, for the cost of the smoking cessation mandate is \$0.56 pmpm in Rhode Island.

## **B. State Mandated Health Benefits That Do Not Squarely Fall Within an Essential Health Benefit Category**

This second group of mandates includes those Rhode Island mandates that do not fall squarely within an Essential Health Benefits Category and therefore may not be considered an EHB by HHS in the future. Without an ongoing State mandate, it is possible that these benefits may not continue to be covered by Rhode Island insurers.<sup>66</sup> Further, if a State mandated benefit is not included as an EHB going forward, the State may be required, as provided for within the ACA, to cover the full cost of that benefit with state-only dollars for individuals who receive advanced

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<sup>63</sup>§ 27-20-53

<sup>64</sup>Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013. While CAHI identified that Connecticut was one of the six states in addition to Rhode Island with a smoking cessation mandate, our research did not identify such a mandate within Connecticut's commercial market.

<sup>65</sup> See Victoria Stagg Elliot, Despite ACA Mandate, tobacco cessation not always covered. American Medical News, posted December 17, 2012; accessible at <http://www.amednews.com/article/20121217/business/121219969/4/>; see also,

<sup>66</sup> It is important to note, however, that once a mandate is in place, it would be hard for an insurer to take away a particular benefit even if it was no longer required, because of consumer pushback or to remain competitive with other insurers in the state.

premium tax credits through HealthSource RI.<sup>67</sup> Given that, we provide a more in depth look at each of these mandates then we did to those in Section A, including providing a more detailed comparison of Rhode Island’s mandate to that of other states.

Given that the group of benefits shown in Table Three are ones in which the State may impact whether these benefits are provided by insurers, and going forward, the State may be responsible for the cost of coverage as it relates to individuals who received subsidized coverage through HealthSource RI, the State may want to monitor these benefits more closely than the benefits in Table Two above. Together, the benefits within this second category have a moderate impact on overall premium costs based on estimated 2014 pmpm costs. Although most of these mandates do not apply to Medicaid, many of these benefits are covered by Medicaid. The State should continue to closely monitor these benefits to understand the impact of the mandate on both quality and cost. In particular, infertility services, home health services and off prescription drug use are among the highest estimated cost services and should be comprehensively reviewed in the next couple of years to determine whether they should be continued once definition of EHB is finalized. In addition, given the controversy surrounding prostate screening, this benefit should also be comprehensively reviewed again in the near future.

**Table Three: State Mandated Benefits that do not Overlap Significantly with Federal Mandates**

Benefit	2014 estimated PMPM Cost	Comments
Autism	\$1.12	The State will need to better understand costs and benefits of funding this benefit should HHS not include it in EHB post 2016. Self-insured firms often do not elect coverage.
Early Intervention	\$0.29	Some of the services included under this mandate may be included under the EHB category of habilitative services, the State will need to better understand costs of funding this benefit should HHS not include it in EHB post 2016. Covered by self-insured firms.
Enteral formula	\$0.02	The State will need to better understand costs of funding this benefit post 2016, covered by self-funded firms.
Hearing Aids	\$0.14	The State will need to better understand costs of funding this benefit should HHS not include it in EHB post 2016, significant differences in benefit between fully-insured and self-insured firms.
Home Health	\$1.79	Some habilitative services can be provided as home health services, the State will need to better understand costs of funding this benefit post 2016, covered by self-insured firms.
HLA Testing	\$0.04	This testing is considered primary care, it is unclear whether mandate is necessary given ACA, covered by

<sup>67</sup> In that case, the State will need to consider both the overall impact to insurance premiums of a particular mandate, as well as the specific State cost of continuing a mandate that does not fall within an EHB category.

		self-insured firms
Infertility	\$1.29	The State will need to better understand costs of funding this benefit post 2016, significant differences in coverage between self-insured and fully-insured firms.
Lyme Disease Treatment	\$0.03	Some Lyme disease care is considered primary care, however some experimental care would not be covered without mandate
Off-Label Rx	\$3.48	Would be covered on case by case basis without mandate, covered by self-insured firms.
Prostate Screening	\$0.14	Not considered an EHB, the State will need to better understand costs of funding this benefit post 2016, covered by self-insured firms.
Second Surgical Opinion	\$00	Medicare covers for non-emergency surgeries, cost-effective, covered by self-insured firms.
Wigs	\$0.05	The State will need to better understand costs of funding this benefit post 2016, some coverage differences between self-insured and fully-insured firms.
<b>Total Estimated Premium Impact</b>	<b>\$8.36</b>	

### *Autism*

Rhode Island is one of 32 states to require coverage of certain benefits for individuals with autism spectrum disorder.<sup>68</sup> Enacted in 2012, the mandate applies to large group insurers only and requires coverage of Physical Therapy, Occupational Therapy, Speech Therapy, psychology, psychiatry and Applied Behavior Analysis (ABA) for patients with Autism who are under age 15.<sup>69</sup> As legislated, the mandate limits coverage of ABA to \$32,000 per year. Because the ACA no longer allows annual limits on benefits, insurers may need to alter their benefit to develop an actuarial equivalent benefit absent those limits.<sup>70</sup> Many autism services are considered habilitative services and as such, have the potential to be considered an EHB.<sup>71</sup> It is not yet clear, however, that there is agreement that these services are included and, if so, to what extent.

Generally, the state laws are similar in the benefits required under the Rhode Island mandate. Most, but not all, of the states passed the mandate with an annual maximum expenditure and some also included a lifetime maximum. Rhode Island's \$32,000 annual maximum for coverage is consistent with many states, though a number of states vary the maximum to allow for higher levels of coverage for those at younger ages (\$40,000-\$50,000) and lower limits (\$25,000) as

<sup>68</sup>Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013. The American Speech Language Hearing Association has a slightly different list of states <http://www.asha.org/Advocacy/state/States-Specific-Autism-Mandates> as does the National Conference of State Legislatures <http://www.ncsl.org/research/health/autism-and-insurance-coverage-state-laws.aspx>.

<sup>69</sup>§ 27-20.11

<sup>70</sup>Note that BCBSRI did not make any changes relative to the Base Benchmark Plan as this mandate is only applicable to the large group market and therefore not included within the Base Benchmark Plan.

<sup>71</sup>See <https://www.staterforum.org/weekly-insight/defining-habilitative-benefits>

children move towards their 18<sup>th</sup> birthday. Table Four below provides a summary of autism mandates across the states.

**Table Four: Sample Autism Mandates from Select States**

State	Services Included	Dollar Limit	Notes
AR	Behavioral therapy	\$50,000 annual limit up to age 9; \$25,000 annual limit between ages of 9 and 16.	Ariz. Rev. Stat. Ann. §20-826.04; §20-1057.11; §20-1402.03; §20-1404.03
CO	Evaluation and Assessment Services, Behavior training and behavior management and applied behavior analysis; occupational therapy, physical therapy, or speech therapy,	20 visits per year each for PT, OT and ST.	Colo. Rev. Stat. §10-16-104
CT	PT,OT, ST, psychiatric, psychologist, behavioral therapy	\$50,000 annual limit up to age 9; \$35,000 annual limit between age 9 and 13; \$25,000 annual limit for 13 and 14 year olds.	Conn. Gen. Stat. §38a-514b (as amended by S.B. 301 (2009))
DE	behavioral health treatment; pharmacy care; psychiatric care; psychological care; therapeutic care; and items and equipment necessary to provide, receive, or advance in the above listed services	ABA limited to \$36,000/year (updated annually for inflation)	Del. Code Ann. tit. 18, §3361 (as added by S.B. 22 [2012])
FL	Well-baby and well-child screening for diagnosing the presence of autism spectrum disorder.  Treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy, and applied behavior analysis.	Maximum annual limit of \$36,000 for individuals under age 18; with lifetime maximum of \$200,000. Individuals 18 and older may continue to receive coverage if in high school and was diagnosed with a developmental disability at 8 or younger.	Fla. Stat. Ann. §627.6686
IL	psychiatric care; psychological care; habilitative or rehabilitative care, (including ABA); therapeutic care, including behavioral, speech, occupational, and physical therapies.  Care must be prescribed by physician or licensed health care professional with expertise in treating effects of autism spectrum disorders.	Annual maximum of \$36,000; no limit on the number of visits to a service provider.	Ill. Comp. Stat. ch. 215, § 5/356z.14

State	Services Included	Dollar Limit	Notes
IN	Requires group and individual policies to provide coverage for the treatment of a pervasive developmental disorder of an insured. A pervasive developmental disorder is defined as a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.	Dollar limit and cost-sharing must be same as any that apply to physical illness generally	Ind. Code Ann. §27-8-14.2; §27-13-7-14.7
KY	Requires coverage for the diagnosis and treatment of autism spectrum disorders in the individual, small and large group markets. Treatment includes: medical care; habilitative or rehabilitative care; pharmacy care, psychiatric care; psychological care; therapeutic care (OT, PT, ST) ABA	<b>Large Group:</b> \$50,000 maximum annual benefit children age 1 through 7; \$1000 monthly limit for children age 8 through 21, <b>Small Group and Individual Market Coverage</b> \$1,000 maximum benefit per month, per covered individual.	Ky. Rev. Stat. §304.17A-142, 304.17A-143
LA	Requires any health coverage plan to provide coverage for the diagnosis and treatment of autism spectrum disorders in individuals under 21. Treatment must be prescribed by physician or psychologist and includes: habilitative or rehabilitative care; pharmacy care; psychiatric care; psychological care; therapeutic care (ST, OT, PT)	Maximum annual benefit of \$36,000 per year and a lifetime maximum benefit of \$144,000. There shall not be any limits on the number of visits an individual may make to an autism services provider.	La. Rev. Stat. Ann. §22-1050
MA	Effective January 1, 2011, requires insurance coverage for autism. Treatment includes: habilitative or rehabilitative care; pharmacy care; psychiatric care; psychological care; and therapeutic care (including ST)  Care must be prescribed by a physician or psychologist.	Dollar limits cannot be less than the annual or lifetime dollar or unit of service limitation imposed on coverage for the diagnosis and treatment of physical conditions.  No limits on number of visits to an autism services provider.  No limits on services to an individual with autism that also is provided to individuals without autism.	Mass. Gen. Laws. ch. 32A §25; ch. 175 §47AA; ch. 176A §8DD ch. 176B §4DD; ch. 176G §4V
MI	Effective January 1, 2014, requires coverage of diagnosis and treatment of autism spectrum	Coverage available through 18 years of age	Mich. Comp. Laws §550.1461(e) as added by

State	Services Included	Dollar Limit	Notes
	disorders by group and non-group plans. Treatment must be prescribed by a licensed physician or a licensed psychologist. Services include: Behavioral health treatment; Pharmacy care; Psychiatric care; Psychological care; Therapeutic care (OT, PT, ST, or SW)	and may be subject to a maximum annual benefit as follows: \$50,000 - through age 6 \$40,000.00 from 7 through 12; \$30,000 from 13 through 18.	S.B. 414; S.B. 415; S.B. 981
VT	Requires a health insurance plan to provide coverage for the diagnosis and treatment of autism spectrum disorders prescribed by a physician or psychologist, including ABA supervised by a nationally board-certified behavior analyst, for children, beginning at 18 months of age and continuing until the child reaches age six or enters the first grade, whichever occurs first. Treatment includes: habilitative or rehabilitative care; pharmacy care; psychiatric care; psychological care; and therapeutic care (includes services provided by licensed or certified speech language pathologists, occupational therapists, physical therapists, or social workers)		Required to be implemented no later than July 1, 2012  Vt. Code Ann. tit. 8 § 4088i
WI	Requires coverage of treatment of autism spectrum disorder if the treatment when prescribed by a physician, and provided by providers who are qualified to provide intensive-level services or non-intensive-level services: a psychiatrist; a psychologist; a social worker; a paraprofessional working under the supervision of a psychiatrist, psychologist or social worker; a professional working under the supervision of an outpatient mental health clinic; a speech-language pathologist; or an occupational therapist.	Must provide coverage of at least \$50,000 for intensive-level services per insured per year, with a minimum of 30 to 35 hours of care per week for a minimum duration of 4 years, and at least \$25,000 for non-intensive-level services per insured per year	Wis. Stat. §632.895(12m)

Rhode Island may want to monitor whether autism services are required as part of the habilitative EHB category. If it is not included, the State should continue to monitor the offering of this benefit and periodically review the clinical relevance of the specific services over time. The State also must consider the cost impact not only to insurance premiums as a whole, but the direct state cost of having to pay for this benefit for individuals purchasing subsidized coverage through HealthSource RI. Additionally, the State should also consider the social and medical benefits from including autism services as a mandated benefit.

Cost Impact: Both BCBSRI and Tufts shared estimated costs of the autism mandate. On average, inflated to 2014 dollars, the estimated impact on the premium is \$1.12 pmpm. This cost estimate falls within the middle of the range of estimates available in Connecticut, Massachusetts, Maryland and Rhode Island. The state laws have significant benefit differences including what services are covered and limits on service provision as displayed in Table Two above. The cost estimates range from a low of \$0.00 in Connecticut to a high of \$2.18 pmpm in Massachusetts.

## Early Intervention Services

Since 2005, Rhode Island insurers have been mandated to provide coverage for early intervention services to children under the age of three.<sup>72</sup> As written, the law places a \$5,000 limit on the benefit, per child per year. Because of the prohibition in the ACA regarding annual limits, BCBSRI reviewed this benefit and decided that putting in place a visit limit was not feasible due to the variety of services included in the scope and the way in which they are billed by EIS providers. Therefore, the annual limit was removed but no additional restriction was put in place. For the purpose of the mandate, early intervention services include, but are not limited to, speech and language therapy, occupational therapy, physical therapy, evaluation, case management, nutrition, service plan development and review, nursing services, and assistive technology services and devices for dependents from birth to age three who are certified by the Rhode Island Department of Human Services as eligible for early intervention services as included under part C of the Individuals with Disabilities Education Act (IDEA)(20 U.S.C. § 1471 et seq.) which requires states to provide a statewide, comprehensive system of early intervention services to infants and toddlers with special needs.

There are a handful of states in addition to Rhode Island with an early intervention mandate.<sup>73</sup> Like Rhode Island, many of these states tie both eligibility and services to the IDEA, as shown in Table Five below. Through part C of IDEA, infants and toddlers are eligible for a variety of early intervention services coordinated across families, community organizations and providers. Services may include audiology, assistive technology; counseling; family training; medical evaluations for diagnostic purposes; nursing, nutrition, occupational therapy, physical therapy, service coordination, speech therapy, transportation and vision services.<sup>74</sup>

**Table Five: Early Intervention Mandates**

State	Services Included	Dollar Limit	Notes
CO	Part C services	Coverage available to \$6,067, including case management costs, per calendar or policy year.	CRS 27-10.5-101(1)(i)
CT	Part C services	Coverage available to \$6,400 per child per year, with aggregate benefit of up to \$19,200 per child over the total three-year period. (Not applicable to those with autism).  No cost-sharing is allowed on these services, unless provided through a high deductible plan	Section 38a-490a, Section 38a-516a
IN	Covers early intervention services for	Payments for early intervention services	IC 5-10-8-7.3

<sup>72</sup> § 27-20-50

<sup>73</sup> CAHI reports that 10 states in addition to Rhode Island have an Early Intervention mandate. Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013. See also The Early Childhood Technical Assistance Center; State Policies on the Use of Private Insurance for Early Intervention Services accessible at <http://ectacenter.org/topics/finance/statelegis.asp> which identifies 8 states in addition to Rhode Island with an Early Intervention mandate.

<sup>74</sup>See Vermont Department of Children and Families, description of IDEA Part C - Early Intervention Services for Infants and Toddlers, accessible at: [http://dcf.vermont.gov/cdd/cis/IDEA\\_Part\\_C\\_early\\_intervention](http://dcf.vermont.gov/cdd/cis/IDEA_Part_C_early_intervention).

State	Services Included	Dollar Limit	Notes
	children under age 2 if otherwise covered services under the policy.	may not count against any lifetime caps.	
MA	Requires coverage for medically necessary early intervention services for children under age 3 delivered by certified early intervention specialists, as defined in the early intervention operational standards by the department of public health and in accordance with applicable certification requirements.	No cost-sharing allowed, except if prohibition on co-payments, coinsurance or deductibles would cause plan to lose federal tax exempt status.	c. 175 § 47C; c. 176A § 8B; c. 176B § 4C; c. 176G § 4
NH	Coverage for Early Intervention Therapy Services up to child's third birthday.	Coverage of up to \$3,200 per child per year not to exceed \$9,600 by the child's third birthday.	415:6-n
NM	Requires coverage for children, from birth through three years of age of early intervention services as part of an individualized family service plan, delivered by certified and licensed personnel working in early intervention programs that are approved by the department of health.	Maximum annual benefit of \$3,500. Cost cannot apply against maximum lifetime limit or annual limits within policy.	NMAC – R 7.30.8
NY	Requires local early intervention program administrators to seek commercial insurance reimbursement for early intervention services delivered to children whose commercial insurance policies are subject to New York State law. State law subrogates municipalities to covered children's insurance policies for reimbursement of services delivered through the Early Intervention Program, and provides the following protections for family insurance policies when used for early intervention services:	Payment for early intervention services cannot be applied to the lifetime and annual monetary caps on the child/family's insurance policy. Cost-sharing is covered by county and state.  May have visit limitations but cannot reduce number of services otherwise available under the plan (e.g., if the policy covers 10 visits of physical therapy, and the county is reimbursed for 10 visits of physical therapy used for the purposes of early intervention, the child/family will continue to have 10 visits available for health care purposes - such as services required after surgery or an accident).	§ 3235-a.
VA	Available to infants and toddlers that are eligible for Part C of the IDEA. Occupational Therapy Speech Therapy Physical Therapy Assistive Technology Services and Devices  In order for these services and devices to be covered, they must be listed on the child's IFSP and they must meet the medically necessary requirements of the benefit.	Requires coverage of Part C services up to \$5,000 annually and exempts these costs from counting against any lifetime caps in a family's policy.	Effective July 1, 1998, the Code of Virginia §38.2-3418.5

It is possible that some of the services provided as early intervention services will be included as EHB under the category of habilitative services. Rhode Island may consider maintaining this mandate until a final ruling regarding EHB is made by HHS. Depending on whether early intervention services are included as an EHB, and to what extent, the State may want to reconsider this mandate, balancing the overall benefits of this mandate with the impact of the mandate on insurance premiums as well as the direct state cost for providing this coverage with for individuals purchasing subsidized coverage through HealthSource RI.

Cost Impact: BCBSRI estimated in 2013 that the cost impact of the early intervention services mandated equaled \$0.27 pmpm.<sup>75</sup> The estimate here jumps slightly to \$0.29 pmpm when inflated for 2014. Although Rhode Island has a broader mandate with no age limit, Connecticut’s cost estimate is the same as that of BCBSRI, while Massachusetts reports a much higher cost of \$0.89 pmpm.

*Enteral Formula*

Since 2009, Rhode Island has required insurers to provide coverage of non-prescription enteral formulas, up to \$2,500 per year, for treatment of malabsorption caused by specific diseases including Crohn’s disease, ulcerative colitis, gastroesophageal reflux, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.<sup>76</sup> Examples of non-prescription enteral nutrition<sup>77</sup> products include Ensure, Isosource and Boost. It is seen as a medically effective service, particularly for those with Crohn’s disease.

Several states have mandates related to foods and formulas for medically necessary metabolic disorders<sup>78</sup>, but many are quite different than Rhode Island’s mandate. Massachusetts mandate is the same as Rhode Island, although as shown in Table Six below, Massachusetts had more recently updated the annual limit for coverage. Given the prohibition on annual limits within the ACA, Rhode Island insurers have modified their implementation of this mandate by removing the annual limit. The cost impact of removing the annual limit is not consequential.

**Table Six: States With Similar Enteral Formula Mandates**

State	Mandate	Coverage Limit	Statutory Citation
CT	Includes provisions of low calorie foods as well as specialized formulas for those with inherited metabolic diseases. Formulas are only available to children under age 12.	n/a	38a-4921
DE	Must include coverage for medical formulas and foods and low protein modified food products for the treatment of inherited metabolic diseases, if such products are medically prescribed as medically necessary for the therapeutic	n/a	18S 3571

<sup>75</sup> Note that this estimate assumes no annual limit to early intervention services.

<sup>76</sup>§ 27-20-56

<sup>77</sup> Enteral nutrition is also known as “tube-feeding” and is used when an individual cannot take food orally.

<sup>78</sup> CAHI reports 33 states in addition to Rhode Island with this category of mandates. Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013.

State	Mandate	Coverage Limit	Statutory Citation
	treatment of inherited metabolic diseases and administered under the direction of a physician		
MA	Requires coverage for nonprescription enteral formulas for home use when medically necessary for the treatment of mal-absorption caused by Crohn's disease, gastro-esophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.	\$5000 (increased limit from \$2500 in 2008)	c. 175 sec 47I; c. 176A sec 8L; c. 176B sec 4K; c. 176G sec 4D; c. 32A sec 17A
MD	Mandatory coverage of medically necessary low protein, modified medical food products	n/a	15-807
MT	Must cover treatment of inborn errors of metabolism, including clinical services, medical supplies, prescription drugs, nutritional management and medical foods.	Durational limits, caps, deductibles, coinsurance & copayments may apply of terms same as other illness.	MCA Sec 32-22-131
NJ	Must cover low protein modified food product formulated to have < or = to 1 gram of protein per serving used under physician direction to treat inherited metabolic disease; and medical food to treat disease of condition with established nutritional needs to be taken enterally under physician direction		C.17B:26-2.1o (individual) C17B:27-46.1r (group)

Requiring insurers to provide enteral formula eases the cost burden of appropriate nutrition for a small subset of individuals with little impact to the overall premium. The exclusion of enteral formula from the EHB will not likely impose a significant cost burden to the State for individuals receiving subsidized coverage through HealthSource RI.

Cost Impact: BCBSRI reports an estimated premium impact of \$0.01 in 2010, which inflates to \$0.02 pmpm in 2014. BCBSRI's estimates fall within the range seen in other states - with a low of no additional premium cost in Maryland to \$0.29 pmpm in Connecticut.

#### *Hearing Aids*

Rhode Island mandates coverage of hearing aids every three years, with a coverage limit of \$1500 per ear for individuals under age 19 and \$700 per ear for individuals 19 and older.<sup>79</sup> Because of the ACA prohibition for annual limits on EHB services, this mandate is changed to a \$700/\$1,500 maximum per hearing aid, per ear, with no time limit. In addition to covering hearing aids as mandated, BCBSRI also provides coverage for cochlear implants in its commercial coverage.

<sup>79</sup>§ 27-20-46); enacted 1/1/06.

Hearing aids for children potentially fall within the EHB category of pediatric care. There is no EHB category that would similarly require coverage of hearing aids for adults. In addition to Rhode Island, there are 19 other states with hearing aid mandates.<sup>80</sup> As shown in Table Seven, most require coverage only for children, or cover adults into their early 20s. Only Arkansas and New Hampshire also require coverage of hearing aids for adults. Medicare does not include hearing aids within its benefit package. There is significant literature that hearing is an important part of a child’s development. Into adulthood, there is no question of the importance of hearing as a key communication tool in every part of our lives.

**Table Seven: Select State Hearing Aid Mandates**

State	Children’s Ages	Adults Covered	Devices Included	Dollar Limit	How Often	Note
AR	No limit	Yes	Hearing Aid	\$1400 per ear	Every 3 years	Insurer must offer as an optional rider; if employer elects, then must provide to employee (Arkansas Code Ann. Sec 23-19-1401)
CT	12 and under	No	Hearing Aid	\$1000	Every 2 Years	Classifies hearing aids as DME (Sec 38a-490b)
CO	Under 18	No	Hearing Aid	n/a	Every 5 years	May be sooner if new hearing aid needed b/c alternations to existing one can’t meet child’s needs (Colorado Rev. State. Sec 10-16-104)
DE	Under 24 (as long as dependent)	No	Hearing Aid	\$1000 per ear	Every 3 years	18 Sec 3357
MA	Under 21	No	Hearing Aid	\$2000 per ear	Every 3 years	Law explicitly excludes cochlear implants (ch. 32A sec 23; ch. 175 sec 47U; ch. 176A sec 8U; ch. 176B sec 4U; ch. 176G sec 4n0)
MD	Under 18	No	Hearing Aid	\$1400 per ear	Every 3 years	15-838
MN	Under 18	No	Hearing Aid	n/a	Every 3 years	Limited to hearing loss due to congenital

<sup>80</sup> Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013. See also American Speech-Language-Hearing Association; State Insurance Mandates for Hearing Aids; accessible at:

[http://www.asha.org/advocacy/state/issues/ha\\_reimbursement/](http://www.asha.org/advocacy/state/issues/ha_reimbursement/)

State	Children's Ages	Adults Covered	Devices Included	Dollar Limit	How Often	Note
						malformation not treated but other covered services (Minn stat. sec 62Q.675)
NH	No limit	Yes	Hearing Aid	\$1500 per hearing aid	Every 5 years	NH Stat Ann. sec 415-6p; sec 415:18-u
NJ	15 and under	No	Hearing Aid	\$1000 per ear	Every 2 years	Must be medically necessary and prescribed by physician or audiologist (a number of states require this) (17B:26-2.1aa; 17B:27-46.1gg; 17B:27A-7.14; 17B:27a-19.180)
NM	Under 18	No	Hearing Aid	\$2200 per ear	Every 3 years	Will cover until under age 21 if still in school ;(13-7-10; 59A-22-34.5; 59A-23-7.8; 59A-46-38.5; 59A-47-37.10)
WI	Under 18	No	Hearing Aid; Cochlear Implants	n/a	Every 3 years	Sec 609.86; Sec 632.895(16)

It is not clear whether the final EHB rules will include a requirement of providing hearing aids for children, and no EHB category is likely to include hearing aids for adults. Rhode Island should review the final ruling by HHS regarding EHBs to fully understand the potential for this benefit to be reduced or eliminated by insurers without the State mandate, and the cost implications to the State of continuing this mandate, both to the cost of insurance premiums in the State and direct costs to the State of providing this benefit to individuals receiving subsidized coverage through HealthSource RI.

Cost Impact: BCBSRI estimates that the cost of providing hearing aids to both adults and children was \$0.11 in 2010. Inflated to 2014, the current pmpm attributable to this mandate is \$0.14.<sup>81</sup> This estimate is understandably higher than that in Connecticut (\$0.01), Massachusetts (\$0.04) and Maryland (no premium impact) where Rhode Island is the only one of those four states to also require provision of hearing aids to adults.

#### *Home Health*

Rhode Island requires health insurers, except for BCBSRI, to provide home health services when medically necessary to reduce the length of a hospital stay or to delay or eliminate an otherwise

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<sup>81</sup> It is important to note that although the changes made to this mandate to accommodate the ACA are not expected to affect costs, the 2010 estimate was made before such changes were made.

medically necessary hospital admission.<sup>82</sup> The mandate provides that minimum home health care coverage shall not exceed six home or office physician's visits per month, and shall not exceed three nursing visits per week and will provide for home health aide visits up to twenty (20) hours per week. Home health services can include a broad range of health care and supportive services in the home including physical or occupational therapy as a rehabilitative service, respiratory service, speech therapy, medical social work, nutrition counseling, prescription drugs and medication, medical and surgical supplies, such as dressings, bandages, and casts, minor equipment such as commodes and walkers, laboratory testing, x-rays and E.E.G. and E.K.G. evaluations.

Home health services are typically used by individuals that are recovering from illness or injury, the disabled, or those with a chronic or terminal illness.<sup>83</sup> Allowing for home health services can both delay the need for long term care or other institutional care and allow for a quicker transition from a hospital back to a home setting. Estimating the clinical effectiveness of home health care is challenging however because of the variety of services delivered under as a home health service. Research has shown that the provision of well defined, quality home health care services can provide significant clinical benefits. Studies have found a reduction in mortality and admissions to hospitals with the provision of home health services.<sup>84,85</sup> Other studies have documented a decrease in the rate of decline of functional status.<sup>86</sup>

Nearly half of the states require some home health services.<sup>87</sup> A sample of other states' home health mandates are included as Table Eight.

**Table Eight: Select State Home Health Mandates**

State	Service	How Often	Note
CA	"Home health care" means the continued care and treatment of an insured person who is under the direct care and supervision of a physician but only if (i) continued hospitalization would have been required if home health care were not provided, (ii) the home health treatment plan is established and approved by a physician within 14 days after an inpatient hospital confinement has ended and such	100 visits in any calendar year or in any continuous 12-month period for each person covered under the policy. A visit of four hours or less	May be subject to an annual deductible of not more than \$50 for each person covered under a policy, and may be subject to a

<sup>82</sup>§ 27-18-3

<sup>83</sup> Visiting Nurses Associations of America, Home Health Care. Accessed 7/3/2011:

<http://vnaa.org/vnaa/g/?h=html/homehealthcareoverview.html>

<sup>84</sup> Elkan R, Kendrick D, Dewey M, Hewitt M, Robinson J, Blair M, et al. Effectiveness of home based support for older people: systematic review and meta-analysis. *BMJ*. 2001 Sep 29;323(7315):719-25.

<sup>85</sup> Hyde CJ, Robert IE, Sinclair AJ. The effects of supporting discharge from hospital to home in older people. *Ageing*. 2000 May; 29(3):271-9.

<sup>86</sup> Mann WC, Ottenbacher KJ, Fraas L, Tomita M, Granger CV. Effectiveness of assistive technology and environmental interventions in maintaining independence and reducing home care costs for the frail elderly. A randomized controlled trial. *Arch Fam Med*. 1999 May-Jun;8(3):210-7.

[http://www.orcotech.org/papers/home\\_monitoring/99\\_Mann\\_effectiveness\\_of\\_envrionmental\\_interventions.pdf](http://www.orcotech.org/papers/home_monitoring/99_Mann_effectiveness_of_envrionmental_interventions.pdf)

<sup>87</sup> CAHI reports that 20 states in addition to Rhode Island have a home health mandate. Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013.

State	Service	How Often	Note
	<p>treatment plan is for the same or related condition for which the insured person was hospitalized, and (iii) home health care commences within 14 days after the hospital confinement has ended. "Home health services" consist of, but shall not be limited to, the following: (i) part-time or intermittent skilled nursing services provided by a registered nurse or licensed vocational nurse; (ii) part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a registered nurse or a physical, speech or occupational therapist; (iii) physical, occupational or speech therapy; and (iv) medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent such charges or costs would have been covered under the policy if the insured person had remained in the hospital.</p>	<p>by a home health aide shall be considered as one home health visit.</p>	<p>coinsurance coverage of not less than 80 percent</p>
CT	<p>Home health care including (1) part-time or intermittent nursing care and home health aide services; (2) physical, occupational, or speech therapy; (3) medical supplies, drugs and medicines; and (4) medical social services.</p>	<p>Coverage can be limited to 80 visits per year and for terminally ill, no more than \$200 for medical social services</p>	<p>Coverage can be subject to an annual deductible of no more than \$50 and a coinsurance of no less than 75%, except that a high deductible plan used to establish a medical savings account is exempt from the deductible limit.</p>
MA	<p>No group medical benefits contract shall be delivered or issued or renewed for delivery by an insurance company, to any group of persons in this Commonwealth and no employees health and welfare funds shall be promulgated or renewed to any group of persons in this Commonwealth unless persons covered under such group contract or fund will be eligible for benefits for expenses arising from the provisions of home care services. As used in this subdivision, the words Services shall include, but not be limited to, nursing and physical therapy. Additional services such as occupational therapy, speech therapy, medical social work, nutritional consultation, the services of a home health aide and the use of durable medical equipment and supplies shall be provided to the extent such additional services are determined to be a medically necessary component of said nursing and physical therapy.</p>		

State	Service	How Often	Note
	Benefits for home care services shall apply only when such services are medically necessary and provided in conjunction with a physician approved home health services plan.		
MD	Mandatory home health care coverage for enrollees who would have otherwise required institutionalization	40 visit per year up to 4 hours per visit	
PA	Mandatory coverage for a medically necessary home health care visit within 48 hours after a mastectomy. 40 P.S. s 1583:		
VT	Insurers shall provide optional coverage for home health care. The coverage shall consist of at least 40 visits by a home health agency in any calendar year, or in any continuous period of 12 months, for each person covered under the policy or contract. Each visit by a member of a home health care agency, other than a home health aide, shall be considered one home health care visit, and four hours of home health aide service shall be considered one home health care visit. Coverage shall be provided for maternity and childbirth, but such coverage may be provided subject to a waiting period of nine months. Coverage may be subject to a co-insurance provision of not less than 80 percent of reasonable charges and a deductible provision of \$50.00 annually; however, if less restrictive benefits are provided by the basic hospital or medical coverage, as the case may be, these lesser restrictions shall apply to the home health care coverage. (Added 1975, No. 205 (Adj. Sess.), § 1.)		

While home health services are not specifically included within a category of EHBs, some rehabilitative services can be provided as home health services. It is likely that insurers would continue to provide these cost-effective services even without a mandate. There is no significant difference between fully-insured and self-insured plans regarding this benefit provision suggesting that it is cost-effective and clinically relevant. The State will need to review the final HHS ruling on EHBs to determine whether these services are included and, to the extent they are not, balance the benefit of providing home health services with the premium impact of including these services, as well as the potential direct cost to the State for paying for this benefit for individuals who receive subsidized coverage through HealthSource RI. Given that home health services are often used as individuals' transition between care settings, the State cost of providing these services may be significant if home health is not included as an EHB.

Cost Impact: Rhode Island insurers did not provide a cost estimate of the home health mandate. However, the cost of a home health mandate was estimated in Connecticut, Massachusetts and Maryland and ranged from a low of \$0.45 in Maryland in 2012 to a high of \$7.39 in Massachusetts in 2009. It is important to note, however, that there are significant differences among the states regarding service provision and visit limits for this benefit.

Importantly, Massachusetts law does not limit the number of visits at all. Although the methodology calls for using Massachusetts estimates whenever possible, for this particular mandate it may more accurate to use the estimate provided for Connecticut which is \$1.79 pmpm. Although the exact description of visits and limitations also are different between Connecticut and Rhode Island, the “no limit” provision in Massachusetts law has significant cost implications which, if used to estimate Rhode Island’s costs, would unduly increase the estimated cost impact of this mandate.

*Human Leukocyte-Antigen Testing*

Rhode Island is one of five states<sup>88</sup> that require insurers to cover one human leukocyte antigen testing per lifetime,<sup>89</sup> which is utilized to identify A, B, and DR antigens for use in bone marrow transplants and to identify potential matches.<sup>90</sup> Enacted in 1998, the mandate requires that testing be performed in an American Association of Blood Banks (or its successors) accredited facility that is licensed under the Clinical Laboratory Improvement Act, 42 U.S.C. § 263a.

As shown in Table Nine below, all of the states with this mandate use similar language to that within Rhode Island’s statute. The mandate assists individuals in need of bone marrow transplants by paying for testing of potential donors for a match. Without the payment of the testing, a potential donor may not undergo the test and will not be discovered. While California does not have a mandate requiring insurers to provide for testing, the state does mandate the employers provide a paid leave and health coverage when an employee is absent due to providing bone marrow for a transplant.<sup>91</sup>

**Table Nine: Antigen Testing for Bone Marrow Transplants**

State	Services Included	Dollar Limit	Statutory Citations
CT	Effective January 1, 2012, requires coverage of expenses arising from human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens for utilization in bone marrow transplantation.	Cost-sharing cannot be more than 20% of the cost of the testing. Policies may limit individuals to one test per lifetime.	<a href="http://www.cga.ct.gov/2011/fc/2011HB-05032-R000821-FC.htm">http://www.cga.ct.gov/2011/fc/2011HB-05032-R000821-FC.htm</a>
MA	Mandates coverage for the cost of human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability. Such coverage is required to cover the costs of testing for A, B, or DR antigens, or any combination thereof, consistent with the guidelines, criteria, and rules or regulations established by the Department of Public Health.	Mandate does not require insurers to cover costs associated with donor recruitment.	<a href="http://www.mass.gov/ocabr/business/insurance/doi-regulatory-info/doi-regulatory-bulletins/2001-doi-bulletins/2001-doi-bulletins-15.html">http://www.mass.gov/ocabr/business/insurance/doi-regulatory-info/doi-regulatory-bulletins/2001-doi-bulletins/2001-doi-bulletins-15.html</a>
MO	Language nearly identical to Rhode Island’s. Requires coverage of cost of antigen testing for A, B,	Limits cost of reimbursement for testing	<a href="http://www.moga.mo.gov/statutes/C300-">http://www.moga.mo.gov/statutes/C300-</a>

<sup>88</sup> The CAHI report does not include this as a mandated benefit; it is possible that there are more states than the five we identified with this mandate.

<sup>89</sup> This testing is also referred to as histocompatibility locus antigen testing.

<sup>90</sup> § 27-20-36

<sup>91</sup> California Labor Codes Section 1508 through 1512. The requirement applies to employer with 15 or more employees.

State	Services Included	Dollar Limit	Statutory Citations
	or DR antigens. Requires informed consent by individual being tested.	to \$75.	<a href="http://399/3760001275.HTM">399/3760001275.HTM</a>
NH	Requires insurers to provide coverage to NH residents and who meet criteria for testing as established by the Match Registry (the National Marrow Donor Program), coverage for laboratory fee expenses up to \$150 arising from human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for utilization in bone marrow transplantation. Requires testing to be performed in a facility that is accredited by the American Association of Blood Banks or its successors, or the College of American Pathologists, or its successors, or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists, and is licensed under the Clinical Laboratory Improvement Act of 1967, 42 U.S.C. section 263a, as amended. Requires informed consent.	Limits cost of reimbursement for testing to \$150; no cost-sharing is allowed.	<a href="http://www.gencourt.state.nh.us/rsa/html/XXXVII/415/415-6-m.htm">http://www.gencourt.state.nh.us/rsa/html/XXXVII/415/415-6-m.htm</a>

This service is unlikely to be contained in any final rules regarding EHBs. If the mandate remains outside of the EHB, the State would need to consider whether to keep the mandate not only in terms of the impact on the monthly premium, but also on the direct cost to the State of providing this benefit for those who receive subsidized coverage through HealthSource RI, even if it is likely to be minimal.

Cost Impact: BCBSRI estimated that the cost of HLA testing was \$0.03 in 2010. When inflated to 2014 dollars the estimated cost impact of this mandate is \$.0.04 pmpm. Massachusetts' cost estimate is somewhat lower, at \$0.0049 in 2009.

### *Infertility Services*

Rhode Island law requires insurers to provide coverage for diagnosis and treatment of infertility for married women age 25-42 who have been unable to conceive or sustain pregnancy for two years.<sup>92</sup> Under the law, co-insurance cannot be more than 20 percent and insurers can place a lifetime limit of \$100,000 on the benefit. Because the ACA prohibits the use of lifetime limits of an EHB in Base-Benchmark plans, qualitative limits are being used instead. "BCBSRI's approach includes substituting the \$100,000 lifetime maximum with a maximum number of in-vitro fertilization cycles that would be substantially equivalent to the dollar maximum."<sup>93</sup> Practically, this change equates to 8 cycles per lifetime which is "substantially equivalent" to the lifetime maximum contained in the Base-Benchmark plan. Including Rhode Island, 15 states

<sup>92</sup>§ 27-20-20; the mandate was initially enacted in 1989 and was most recently amended in 2006.

<sup>93</sup> BCBSRI Insurance filing.

have mandates regarding infertility services,<sup>94</sup> although each state’s mandate is unique and some are quite limited, as shown in Table Ten. Infertility services are not covered by state Medicaid programs.

**Table Ten: State Infertility Service Mandates**

State	Women’s Age	Mandated Services	Dollar or Service Limitation	Note
AR	No limit	<p>Insurers that provide maternity benefits must also cover in vitro fertilization (IVF), including cryopreservation. Other infertility treatment may also be included at the insurer’s option. HMO’s are exempt from the law.</p> <p>IVF procedures must be performed at a facility licensed or certified by the state and conform to the American College of Obstetricians and Gynecologists’ (ACOG) and the American Society of Reproductive Medicine (ASRM) guidelines.</p> <p>Limits preexisting condition to 12 months.</p>	\$15,000 lifetime max; cost-sharing allowed at same level as other maternity benefits.	<p>Law exempts HMOs.</p> <p>To receive services, there must be at least a 2-year history of unexplained infertility OR the infertility must be associated with: endometriosis; DES exposure; blocked or surgically removed fallopian tubes that are not the result of voluntary sterilization; or abnormal male factors contributing to the infertility. The patient’s eggs must be fertilized with her spouse’s sperm.</p> <p>Prior to receiving IVF, the patient must show that has been unable to obtain successful pregnancy through any less costly infertility treatments covered by insurance.</p>
CT	Under 40	Limits coverage for IVF, GIFT, ZIFT <sup>95</sup> and low tubal ovum transfer to individuals who have been unable to conceive or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures, unless the individual’s physician determines that those	Lifetime maximum coverage of 4 cycles of ovulation induction; 3 cycles of intrauterine insemination.	<p>Infertility means the condition of a presumably healthy individual who is unable to conceive or sustain a successful pregnancy during a one-year period.</p> <p>Limits coverage to individuals who have maintained coverage under a policy for at least 12 months.</p>

<sup>94</sup> Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013; see also [http://www.resolve.org/family-building-options/insurance\\_coverage/state-coverage.html](http://www.resolve.org/family-building-options/insurance_coverage/state-coverage.html).

<sup>95</sup> GIFT and ZIFT are alternative treatments that are similar to IVF except that eggs and sperm are placed in the fallopian tube either together (ZIFT) or separately (GIFT) instead of being implanted directly in the uterus as occurs with IVF. WebMD description of assisted reproduction, accessible at: <http://www.webmd.com/baby/healthtool-assisted-reproduction>.

		<p>treatments are likely to be unsuccessful.</p> <p>Requires infertility treatment or procedures to be performed at facilities that conform to the American Society of Reproductive Medicine and the Society of Reproductive Endocrinology and Infertility Guidelines.</p>	<p>2 cycles of IVF, GIFT, ZIFT or low tubal ovum transfer, with not more than 2 embryo implantations per cycle. Each fertilization or transfer is credited as a cycle towards the maximum.</p>	<p>Religious organizations are exempt.</p>
IL	Not specified	<p>Group insurers and HMOs that provide pregnancy related coverage must provide infertility treatment including, but not limited to: diagnosis of infertility; IVF; uterine embryo lavage; embryo transfer; artificial insemination; GIFT; ZIFT; low tubal ovum transfer.</p> <p>Coverage for IVF, GIFT and ZIFT is provided if the patient has been unable to attain or sustain a successful pregnancy through reasonable, less costly, infertility treatments covered by insurance.</p> <p>The procedures must be performed at facilities that conform with ACOG and ASRM guidelines.</p>	<p>Each patient is covered for up to 4 egg retrievals. However, if a live birth occurs, two additional egg retrievals will be covered, with a lifetime maximum of six retrievals covered.</p>	<p>Infertility means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.</p>
LA	n/a	<p>The law does not require insurers to cover fertility drugs, IVF or other assisted reproductive techniques, reversal of a tubal ligation, a vasectomy, or any other method of sterilization.</p>	n/a	<p>Prohibits the exclusion of coverage for the diagnosis and treatment of a correctable medical condition, solely because the condition results in infertility.</p>
MD	Not specified	<p>Individual and group insurance policies that provide pregnancy-related benefits must cover the cost of 3 IVFs per live birth.</p>	<p>Lifetime maximum of \$100,000.</p>	<p>History of infertility for 2 years or associated with: endometriosis; DES exposure; blocked or surgically removed fallopian tubes; abnormal male factors contributing to the infertility.</p> <p>The patient's eggs must be fertilized with her spouse's sperm.</p> <p>The patient has been unable to</p>

				<p>obtain successful pregnancy through any less costly infertility treatments covered by insurance.</p> <p>Employers with &lt;50 or religious are exempt</p>
MA	No age specified	<p>All insurers providing pregnancy-related benefits shall provide for the diagnosis and treatment of infertility including: artificial insemination; IVF; GIFT; sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any; ICSI; ZIFT.</p> <p>Insurers shall not impose any exclusions, limitations or other restrictions on coverage of infertility drugs that are different from those imposed on any other prescription drugs.</p>	No limit	<p>Infertility means the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year</p>
NY	21-44	<p>Group policies must provide diagnostic tests and procedures that include:</p> <ul style="list-style-type: none"> <li>• hysterosalpingogram;</li> <li>• hysteroscopy;</li> <li>• endometrial biopsy;</li> <li>• laparoscopy;</li> <li>• sono-hysterogram;</li> <li>• post coital tests;</li> <li>• testis biopsy;</li> <li>• semen analysis;</li> <li>• blood tests and</li> <li>• ultrasound</li> <li>• Every policy that provides for prescription drug coverage, shall also include drugs (approved by the FDA) for use in the diagnosis and treatment of infertility.</li> </ul>		<p>Prohibits the exclusion of coverage for the diagnosis and treatment of a correctable medical condition, solely because the condition results in infertility.</p> <p>The law abides by the ASRM definition of infertility -- the inability to achieve a pregnancy after trying for 12 months (if under 35) and 6 months (if over 35).</p> <p>Patients must be covered under their insurance policy for at least 12 months before receiving infertility coverage.</p> <p>Excludes coverage for IVF, GIFT, and ZIFT; reversal of elective sterilizations; sex change procedures; cloning or experimental medical or surgical procedures.</p>
TX	Not specified	Requires group insurers to offer coverage of IVF. Employers may choose whether or not to include infertility coverage as part of their	No limit	<p>Coverage is for the policyholder or spouse; and the patient's eggs must be fertilized with her spouse's sperm. The patient and spouse</p>

		<p>employee health benefit package.</p> <p>If an employer chooses to offer the benefit, the IVF procedures must be performed at medical facilities that conform to ACOG and ASRM guidelines.</p>		<p>must have a history of infertility of at least five continuous years or associated with endometriosis, DES, blockage of or surgical removal of one or both fallopian tubes or oligospermia; and the patient has been unable to attain a pregnancy through less costly treatment covered under their policy;</p> <p>Religious employers are exempt</p>
NJ	Under 46	<p>Group insurers and HMOs that provide pregnancy related coverage must provide infertility treatment including, but not limited to:</p> <ul style="list-style-type: none"> <li>• artificial insemination;</li> <li>• assisted hatching;</li> <li>• diagnosis and diagnostic testing;</li> <li>• fresh and frozen embryo transfers;</li> <li>• 4 completed egg retrievals per lifetime;</li> <li>• IVF, including IVF using donor eggs and IVF where the embryo is transferred to a gestational carrier or surrogate;</li> <li>• ICSI;</li> <li>• GIFT;</li> <li>• ZIFT;</li> <li>• medications;</li> <li>• ovulation induction; and</li> <li>• surgery, including microsurgical sperm aspiration.</li> </ul> <p>The procedures must be performed at facilities that conform with ACOG and ASRM guidelines.</p>	No limit	<p>Infertility means a disease or condition that results in the abnormal function of the reproductive system such that: a male is unable to impregnate a female; a female under 35 years of age is unable to conceive after two years of unprotected sexual intercourse; or one year if the female is 35 years of age and over; the male or female is medically sterile; or the female is unable to carry a pregnancy to live birth.</p> <p>Infertility does not mean a person who has been voluntarily sterilized regardless of whether the person has attempted to reverse the sterilization.</p> <p>The patient has been unable to obtain successful pregnancy through any less costly infertility treatments covered by insurance. Employers with fewer than 50 and religious employers are exempt</p> <p>Cryopreservation is not covered.</p> <p>Nonmedical costs of egg or sperm donor are not covered.</p> <p>Infertility treatments that are experimental or investigational are not covered.</p>

It is very difficult to measure the effectiveness of infertility mandates. While it is one of the highest cost mandates, it also provides a service that would otherwise be very expensive for couples to afford on their own.

Given its high impact on premiums and the potential large cost to the State of providing this coverage to those who receive subsidized coverage through HealthSource RI, the State will want to undertake a delicate calculation of the benefits of providing infertility services balanced with the real impact of continuing to mandate this benefit on the State budget. In addition, given the evolving science of infertility services, it is important for the State to continually review the mandate to ensure that it appropriately includes evidence-based treatments.

Cost Impact: As noted above, infertility mandates vary significantly from state to state as do the estimated costs. The average pmpm estimates provided by BCBSRI and Neighborhood Health Plan of Rhode Island were used and inflated to 2014 dollars. Based on that calculation, it is estimated that the infertility mandate costs \$1.29 pmpm in Rhode Island.

*Lyme Disease*

Rhode Island is one of three states that mandate insurers to provide coverage for diagnostic testing and long-term antibiotic treatment of chronic Lyme disease when determined medically necessary and ordered by a physician in accordance with Chapter 37.5 of Title 5 (Lyme Disease Diagnosis and Treatment).<sup>96</sup> The mandate further prohibits insurers from denying treatment solely because it may be characterized as unproven, experimental or investigational in nature.

Lyme disease is spread through bacteria received from tick bites. Lyme disease is common in New England and other areas where there are large deer populations.<sup>97</sup> Each of the three states has a slightly different mandate. Connecticut’s is more restrictive than Rhode Island’s in that it includes limits on treatment, without further physician recommendation. Minnesota is broader in that it covers treatment generally; it is not limited to prescription drugs. Connecticut and Minnesota also mandate coverage of treatment of Lyme disease as described in Table Eleven below.

**Table Eleven: Lyme Disease Mandates in CT and MN**

State	Mandate	Effective Date	Notes
CT	Requires coverage for Lyme disease treatment including not less than 30 days of intravenous antibiotic therapy, 60 days of oral antibiotic therapy, or both, and requires further treatment if recommended by a board certified rheumatologist, infectious disease specialist or a neurologist licensed in accordance with Chapter 370. (sec 38a-492h)	January 2000	Has specific limits on initial provision of benefits; but overall requires the benefits to continue as long as needed if medically necessary.
MN	Requires every health plan to cover treatment for diagnosed Lyme disease	1996	This is a broad mandate that allows for any necessary Lyme disease treatment; it is not exclusive to prescription therapies. (62A.265)

<sup>96</sup> § 27-20-48; enacted in 2004.

<sup>97</sup> See Center for Disease Control (CDC), Reported cases of Lyme disease by state or locality- 2002-2012; accessible at: [http://www.cdc.gov/lyme/stats/chartstables/reportedcases\\_statelocality.html](http://www.cdc.gov/lyme/stats/chartstables/reportedcases_statelocality.html)

The State will need to weigh the costs and benefit of this service if it is not included in the final ruling by HHS regarding EHB resulting in the State needing to fully fund the costs of the benefit for individuals receiving subsidized coverage through HealthSource RI.

Cost Impact: BCBSRI calculated the impact of the Lyme Disease mandate at \$0.02 pmpm in 2010. Inflated to 2014 dollars, the expected impact of this mandate on premiums in Rhode Island increases slightly to \$0.03 pmpm. This is significantly lower than Connecticut's 2014 estimate of \$0.34 pmpm.

### *Off-label Prescription Cancer Drugs*

First enacted in 1994, Rhode Island mandates that insurers cover off-label use of prescription drugs for treatment of cancer, even if the drug has not been approved by the FDA for that purpose, if the drug is recognized for treatment for a particular condition in standard reference compendia or the medical literature.<sup>98</sup> Prescribing physicians may be required to submit documentation supporting the proposed off-label use or uses at the insurer's request. The mandate further states that the insurer must cover any other medical services associated with the administration of the drug. Nothing in the mandate prevents cost sharing for these drugs.

Nearly two-thirds of the states have similar mandates.<sup>99</sup> In some states, the mandate includes the convening of an expert group to determine if the off-label use of a particular drug is appropriate.

The State may want to maintain this mandate as there is nothing similar in federal law requiring off-label use of prescription drugs. However, in making a final decision on whether to maintain this mandate, it is important to consider that if it is not included as part of the EHB, then the State would be required to cover the full cost of the mandate for anyone receiving subsidized coverage through HealthSource RI. Given the high estimated pmpm in Connecticut, this is one area where Rhode Island may consider conducting its own actuarial analysis of the cost of the mandate to identify a more exacting estimate of the State's potential costs.

Cost Impact: Rhode Island insurers did not provide estimates of the cost of this mandate. Connecticut did provide an estimate of \$3.48 pmpm in 2014, and for purposes of providing the Legislature with a sense of the impact of this mandate, the same estimate is used for Rhode Island.

### *Prostate Screening*

Enacted in 2000, Rhode Island mandates coverage for prostate screening and laboratory tests for cancer for any non-symptomatic covered individual, in accordance with the current American Cancer Society guidelines. Nearly two thirds of the states (35) require coverage of prostate cancer screenings. Like Rhode Island, many of these states specifically tie their mandate to American Cancer Society Guidelines.

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<sup>98</sup> § 27-55-2.

<sup>99</sup> Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013.

Most state laws require annual coverage of prostate screenings for men ages 50 and over and for high-risk men, ages 40 and over.<sup>100</sup> Prostate cancer is common and a frequent cause of cancer death. Prostate cancer is second only to non-melanoma skin cancer and lung cancer as the leading cause of cancer and cancer death, respectively, of men in the United States. The lifetime risk of developing prostate cancer is 16 percent, but the risk of dying of prostate cancer is only 2.9 percent. Prostate cancer grows slowly and often is detected in autopsies of men that die of other causes before the cancer becomes clinically evident. In fact, prostate cancer is detected in autopsies of one-third of men under the age of 80 and in two-thirds of older.<sup>101</sup>

PSA testing revolutionized prostate cancer screening. Although PSA was originally introduced as a tumor marker to detect cancer recurrence or disease progression following treatment, it became widely adopted for cancer screening by the early 1990s for men 50 and older. Prostate cancer screening is controversial because evidence suggests that detecting prostate cancer early may not reduce an individual's chance of dying from prostate cancer, and may instead lead to overtreatment of tumors that are not life threatening which may lead to both harmful side effects of the treatment and potential complications. In addition, the PSA test may give either false-positive or false-negative results, creating unnecessary anxiety and unnecessary biopsies.<sup>102</sup>

While the ACA requires coverage of preventive health services with no cost sharing for all USPSTF recognized preventive services, prostate cancer screening is not included. The absence of prostate cancer on the list is due to the Task Force's conclusion that the screening is not evidence-based and leads to unnecessary treatment of prostate cancer in many men.<sup>103</sup> Rhode Island should monitor the ongoing debate as to the appropriateness of prostate screenings to determine whether this mandate can continue to be considered evidence-based, and if so, how to balance that benefit with the potentially significant impact to premiums and directly to the State of providing this service to individuals receiving subsidized coverage through HealthSource RI.

Cost Impact: Rhode Island insurers did not conduct a specific cost estimate for the prostate screening mandate. Both Connecticut and Maryland have conducted cost estimates for prostate screening. Maryland's estimate was \$3.16 pmpm in 2012, which is much higher than Connecticut's estimate of \$0.11 for 2010, which if inflated to 2014 dollars using national estimates totals \$0.14 pmpm. For purposes of this report, it is estimated that the impact to the premium based on Connecticut's experience is \$0.14 pmpm. Given the ongoing debate about efficacy of prostate screening, it is important to note here that these cost estimates do not include any additional medical costs that may occur based on false positives or unnecessary treatment of prostate cancer.

### *Second Surgical Opinions*

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<sup>100</sup> High risk refers to African-American men and/or men with a family history of prostate cancer.

<sup>101</sup> See American Cancer Society, Key Statistics About Prostate Cancer; accessible at <http://www.cancer.org/cancer/prostatecancer/detailedguide/prostate-cancer-key-statistics>

<sup>102</sup> See National Cancer Institute, PSA Test Fact Sheet, accessible at:

<http://www.cancer.gov/cancertopics/factsheet/detection/PSA>.

<sup>103</sup> Ibid.

Under Rhode Islands’ second surgical opinion mandate, a policy that covers surgical operations must also cover a second surgical opinion, regardless of whether the surgery is performed on an inpatient or outpatient basis.<sup>104</sup> For the service to be covered, the individual must notify the insurer prior to seeking the second surgical opinion and may be limited to specific physicians approved by the insurer.

There are nine states in addition to Rhode Island that require second surgical opinions<sup>105</sup>, a sample of which are described in Table Twelve. In addition to state mandates, Medicare and a number of state Medicaid programs provide coverage for second surgical opinions for non-emergency services and other procedures.

There are limited data showing that second opinions save dollars by preventing unnecessary surgeries.<sup>106</sup> The Choosing Wisely campaign recently put a renewed focus on second surgical opinions with its release of a list of surgeries that may be potentially unnecessary and the importance of obtaining a second opinion prior to common surgeries such as back surgeries, cardiac surgery for angioplasty, stents or pacemakers, hip and knee replacements, and hysterectomies.<sup>107</sup>

**Table Twelve: State Second Surgical Opinion Mandates**

State	Services Included
CA	<p>At request of insured or contracting health professional, plan that covers hospital, medical, or surgical expenses must authorize a second opinion by an appropriately qualified health care professional. Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following: (1)If the insured questions the reasonableness or necessity of recommended surgical procedures; (2)If the insured questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition; (3)If clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and the insured requests an additional diagnosis; (4)If the treatment plan in progress is not improving the medical condition of the insured within an appropriate period of time given the diagnosis and plan of care, and the insured requests a second opinion regarding the diagnosis or continuance of the treatment; (5)If the insured has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.</p> <p>(c)If an insured or participating health professional who is treating an insured requests a second opinion pursuant to this section, an authorization or denial shall be provided in an expeditious manner. When the insured’s condition is such that the insured faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the insured’s life or health or could jeopardize the insured’s ability to regain maximum function, the second opinion shall be rendered in a timely fashion appropriate to the nature of the insured’s condition, not to</p>

<sup>104</sup> § 27-39-2

<sup>105</sup> Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013.

<sup>106</sup> See, for example, Ruchlin HS, Finkel M and McCarthy EG, The efficacy of second-opinion consultation programs: a cost-benefit perspective. *Med Care*, 1982 Jan,20(1):3-20.

<sup>107</sup> Why you should get a second opinion before getting surgery, USA Today, June 19, 2013, accessible at: <http://www.usatoday.com/story/news/nation/2013/06/19/surgery-second-opinion-interactive/2439275/>

State	Services Included
	<p>exceed 72 hours after the insurer's receipt of the request, whenever possible. Each insurer shall file with the Department of Insurance timelines for responding to requests for second opinions for cases involving emergency needs, urgent care, and other requests by July 1, 2000, and within 30 days of any amendment to the timelines. The timelines shall be made available to the public upon request.</p> <p>(d) If an insurer approves a request by an insured for a second opinion, the insured shall be responsible only for the costs of applicable copayments that the insurer requires for similar referrals.</p> <p>(e) If the insured is requesting a second opinion about care from his or her primary care physician, the second opinion shall be provided by an appropriately qualified health care professional of the insured's choice who is contracted with the insurer.</p> <p>(f) If the insured is requesting a second opinion about care from a specialist, the second opinion shall be provided by any provider of the same or equivalent specialty, of the insured's choice, within the insurer's provider network, if the insurance contract limits second opinions to within a network.</p> <p>(g) The insurer may limit second opinions to its network of providers if the insurance contract limits the benefit to within a network of providers and there is a participating provider who meets the standard specified in subdivision (b). If there is no participating provider who meets this standard, then the insurer shall authorize a second opinion by an appropriately qualified health professional outside of the insurer's provider network. In approving a second opinion either inside or outside of the insurer's provider network, the insurer shall take into account the ability of the insured to travel to the provider.</p> <p>(h) The insurer shall require the second opinion health professional to provide the insured and the initial health professional with a consultation report, including any recommended procedures or tests that the second opinion health professional believes appropriate. Nothing in this section shall be construed to prevent the insurer from authorizing, based on its independent determination, additional medical opinions concerning the medical condition of an insured.</p> <p>(i) If the insurer denies a request by an insured for a second opinion, it shall notify the insured in writing of the reasons for the denial and shall inform the insured of the right to dispute the denial, and the procedures for exercising that right.</p> <p>(j) If the insurance contract limits health care services to within a network of providers, in order for coverage to be in force, the insured shall obtain services only from a provider who is participating in, or under contract with, the insurer pursuant to the specific insurance contract under which the insured is entitled to health care service benefits.</p> <p>(k) This section shall not apply to any policy or contract of disability insurance that covers hospital, medical, or surgical expenses and that does not limit second opinions, subject to all other terms and conditions of the contract.</p> <p>(l) This section shall not apply to accident-only, specified disease, or hospital indemnity health insurance policies.</p>
MD	Health insurers must cover a second opinion when required by a utilization review program, and must provide outpatient coverage for a service for which a hospital admission is denied.
MO	<ol style="list-style-type: none"> <li>1. A health maintenance organization shall allow enrollees to seek a second medical opinion or consultation from the health maintenance organization's choice of other primary care physicians and specialty physicians at no additional cost to the enrollee beyond what the enrollee would otherwise pay for an initial medical opinion or consultation.</li> <li>2. If an enrollee chooses to seek a second medical opinion, and if the health maintenance organization does not employ or contract with another physician with the expertise necessary to provide a second medical opinion, then the health maintenance organization shall arrange for a referral to a physician with the necessary expertise to provide a second opinion or consultation and ensure that the enrollee obtains the covered benefit at no greater cost to the enrollee than if</li> </ol>

State	Services Included
	the benefit were obtained from participating physicians.
NJ	<p>Payment for second surgical opinion services</p> <p>A second surgical opinion program shall provide for payment for the second surgical opinion services of an eligible physician and for essential laboratory and X-ray services incidental thereto, either as a benefit under the group policy or, at the insurer's option, by a separate arrangement with the group policyholder. The program may be limited to eligible physicians who have agreed to participate in the insurer's second surgical opinion program. If the benefits are provided by the group insurance policy, the amount shall be reasonably related to amounts payable under the group policy for covered surgical procedures.</p> <p>- See more at: <a href="http://statutes.laws.com/new-jersey/title-17b/section-17b-27/17b-27-46-4#sthash.UJxQcnny.dpuf">http://statutes.laws.com/new-jersey/title-17b/section-17b-27/17b-27-46-4#sthash.UJxQcnny.dpuf</a></p>
NY	<ol style="list-style-type: none"> <li>1. A second surgical opinion by a "qualified physician", as that term is used in the law, requires the opinion be given by a board certified specialist who by reason of his specialty is an appropriate physician to consider the surgical procedure being proposed. The original recommendation for surgery must be given by the insured's surgeon, who need not be board certified or by another board certified specialist.</li> <li>2. The obtaining of the second surgical opinion must be at the option of the insured, except that in group and master group cases a mandatory program may be considered for approval by the Department.</li> <li>3. The benefit of a second surgical opinion by a qualified physician on the need for surgery shall be applicable to all in-patient surgical procedures of a non-emergency nature covered by the policy. The benefit shall be payable only if the patient is examined in person by the physician rendering the second surgical opinion and a written report is submitted to the insurer.</li> <li>4. The second surgical opinion can be rendered by a board certified specialist selected from a panel of specialists designated by the insurer or the insurer may provide the insured a list of board certified specialists in the area, or, refer the insured to the local Medical Society, local chapter American College of Surgeons, County Health Department or hospital for a list of board certified specialists.</li> <li>5. If a board certified specialist renders a second surgical opinion and also performs the surgery, no second surgical opinion benefit will be payable under the contract.</li> <li>6. The benefit payment for the second surgical opinion should be an amount which is reasonably related to the amounts payable under the policy for covered surgical procedures and may include reimbursement for ancillary services, such as x-rays and laboratory tests.</li> <li>7. The second surgical opinion benefit shall be added to all new and existing policies and contracts as required by the law without a premium increase. The anticipated savings in hospital and medical costs payable by the insurer should more than offset the cost of the second surgical opinion program.</li> <li>8. Insurers should collect and maintain experience data concerning the second surgical benefit, including at least a tabulation of cases confirmed and not confirmed for surgery, so that an on-going evaluation of the program can be made by the insurer and the Insurance Department.</li> </ol>
WV	Each managed care plan must, upon the request of an enrollee, provide access by the enrollee to a second opinion regarding a diagnosis or treatment plan requiring a serious or complex procedure, from a qualified participating provider.

Given that it seems as if this provides a benefit to consumers and saves insurers from paying for unnecessary surgeries, Rhode Island should consider maintaining this as a mandated benefit regardless of whether it is ultimately included as part of the EHB.

Cost Impact: No cost estimates could be found for this mandated benefit although significant research suggests that the cost more than pays for itself.

### *Cranial Prostheses (Wigs)*

Under Rhode Island law, if a policy covers any other prosthesis it must also provide coverage for expenses for scalp hair prosthesis (wigs) worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia.<sup>108</sup> Coverage is limited to \$350 per covered member per year, exclusive of any deductible. Because the ACA prohibits annual limits on an EHB in a Base-Benchmark Plan, BCBSRI changed its handling of this benefit by including a \$350 maximum for each prosthesis. Changing the mandate in this manner is not expected to add any additional costs.

Alopecia (hair loss or baldness) is a side effect of some cancer treatments, including chemotherapy and radiation. Hair loss is often the most severe side effect of chemotherapy, negatively affecting the quality of life for many cancer patients.<sup>109</sup>

In addition to Rhode Island, nine states also have a similar mandate; a sample of these mandates is included in Table Thirteen.<sup>110</sup> Like Rhode Island, most other states limit coverage for hair loss due to cancer or cancer treatment and have coverage of \$350. New Hampshire and Oklahoma provide broader coverage, requiring coverage of wigs for other diseases as well as hair loss related to cancer treatment.

**Table Thirteen: State Mandated Coverage of Wigs**

State	Services Included	Dollar or Service Limitation	Note
CT	Coverage for wig worn for hair loss caused by chemotherapy treatment.	Yearly benefit of at least \$350	Prescribed by licensed oncologist
DE	Coverage for wigs that are medically necessary due to alopecia aerate	Yearly benefit of \$500	Same limitations as other prostheses
MA	Coverage for scalp hair prostheses worn for hair loss caused by the treatment of any form of cancer or leukemia,	\$350 maximum per year	Subject to same limitations and guidelines as other prostheses  Only required if the policy provides coverage for any other prostheses  Treating physician states in writing that hair prostheses are medically necessary
MD	Coverage for one hair prosthesis worn for hair loss caused by chemotherapy or radiation treatment for cancer	May not exceed \$350	

<sup>108</sup> § 27-20-54; enacted in 2007.

<sup>109</sup> American Society of Clinical Oncology, Hair Loss or Alopecia, accessible at <http://www.cancer.net/navigating-cancer-care/side-effects/hair-loss-or-alopecia>

<sup>110</sup> Health Insurance Mandates in the States 2012, Council for Affordable Health Insurance (CAHI) 2013.

State	Services Included	Dollar or Service Limitation	Note
MN	Coverage for scalp hair prostheses for hair loss caused by alopecia areata	\$350 per benefit year maximum	Subject to cost-sharing requirements that apply to similar items under the policy
NH	Coverage for scalp hair prostheses worn for hair loss caused by alopecia areata, alopecia totalis or alopecia medicamentosa resulting from the treatment of any form of cancer or leukemia or permanent scalp hair loss due to injury	\$350 annual maximum for alopecia medicamentosa	Treating physician must determine, in writing, that it is medically necessary. Only required if policy covers other prostheses Subject to same annual deductibles, copayments or coinsurance limits
OK	Coverage for wigs or other hair scalp prostheses worn for hair loss caused by chemotherapy or radiation treatment for cancer and other conditions	Up to \$150 per year	Subject to same annual deductibles, copayments or coinsurance limits as all other covered benefits

The State will need to weigh the costs and benefit of this service if it is not included in the final ruling by HHS regarding EHB resulting in the State needing to fully fund the costs of the benefit for individuals receiving subsidized coverage through HealthSource RI.

Cost Impact: BCBSRI estimates the 2014 cost of providing this benefit is \$0.05 pmpm. Maryland law only allows one hair prosthesis per lifetime and estimates the cost at \$0.00pmpm while Massachusetts law is similar to Rhode Island with a 2009 estimate of \$0.018.

### C. State Mandated Providers

In addition to mandating certain health benefits, Rhode Island has enacted a number of laws generally requiring that insurers include certain types of providers within their networks and pay for their services. As further detailed in Table Fourteen, these laws require insurers include osteopaths, first nurse assistants (in surgery), nurse practitioners and nurse psychiatrists, midwives, licensed marriage and family therapists and licensed mental health counselors, optician and ophthalmologists in their networks. In addition, plans must include as an employer option the ability to include acupuncturists.

In one case, the State mandates that a particular service be provided only by a particular provider type. Specifically, the State requires that ABA services (discussed above as part of the autism mandated benefits), may only be provided by an ABA analyst or a psychologist.

According to the insurers, these provider mandates typically have little overall impact on the growth of the premium, as they are often focused on providing benefits with lower cost professionals. However, that may not always be the case and cannot be assumed. Where available, estimated costs for these provider mandates are included in Table Fourteen.

### Table Fourteen: Provider Mandates in Rhode Island

Provider Type	Description of Service	Statute	Year Enacted	Other States with Mandate	PMPM Cost Estimate
Acupuncturist	Plans must offer services of a doctor of acupuncture services as provider of acupuncture services as an optional rider to a policy	27-41-54	1999	12	\$3.12
Midwife	Plans must provide coverage for the services of licensed midwives.	27-41-36	2002	12	\$0.29
First Nurse Assistant	Plans must cover services rendered by a registered nurse first assistant (assist in OR)	27-20-35.1	2002	5	\$0.04
Licensed Marriage/Family Therapist	Plans must provide coverage for the services of licensed therapists in marriage and family practice	27-41-40	2002	17	
Nurse Practitioner	Plans must provide coverage for services of certified nurse practitioner, practicing collaboratively. Nurse practitioner may be a primary care provider.	27-41-39	2009	29	
Nurse (Psychiatric)	Plans must provide coverage for services of psychiatric and mental health nurse clinical specialists, if would be paid for if provided by another provider and not duplicative	27-41-39	2009	14	
Optician	For any insurance plan calling for expenditure of public funds, <sup>111</sup> health plans must	5-35.2-6	2008	2	

<sup>111</sup> Because the language in the statute refers specifically to public funds, this statutory provision may require a technical correction to include HealthSource RI, where the mandate currently specifies Medicaid/RIteCare and Medicare.

Provider Type	Description of Service	Statute	Year Enacted	Other States with Mandate	PMPM Cost Estimate
	allow opticians opportunity to apply for credentials and cannot be discriminated against				
Optometrist	Cannot discriminate against an optometrist; if health plan provides service within an optometrists scope of practice must allow optometrist to provide that service	40.1-3-15		40	
Osteopath (D.O)	Cannot discriminate against an osteopath	40.1-3-15		22	
Professional Counselor	Plans must provide coverage for services of licensed counselors in mental health	27-41-40		18	
Psychologist	Autism services should be provided by an ABA analyst or a psychologist	27-20-11	2012	43	

#### IV. Recommendations for Reviewing Rhode Island Mandates

Unlike the majority of states, Rhode Island does not have a statutorily required process to review current or new mandates. Today 29 states have processes in place for the systematic review of mandated health benefits. Some states look prospectively at proposed mandates, while others look both at proposed mandates and retrospectively at current mandates to understand their impact.<sup>112</sup>

Based on research of other state review processes, a set of criteria and a process to guide the State in its ongoing review of mandated benefits that incorporates the ACA's Essential Health Benefits (EHB) requirements<sup>113</sup>, is recommended below. This review also would consider

<sup>112</sup> California Health Benefits Review Program, Other States' Health Benefit Review Programs; September 20, 2013; accessible at [http://www.chbrp.org/docs/Survey\\_and\\_Analysis\\_of\\_Other\\_States\\_Health\\_Benefit\\_Review\\_Programs\\_2013\\_FINAL\\_092013.pdf](http://www.chbrp.org/docs/Survey_and_Analysis_of_Other_States_Health_Benefit_Review_Programs_2013_FINAL_092013.pdf)

<sup>113</sup> For 2014 and 2015, EHBs are state defined based on the state's selection of a benchmark plan, and may also include state-mandated benefits to the extent included in the benchmark plan, whether or not they would fall into one of the essential health benefits categories. When referring to EHBs here, however, we are referring to the ten categories of benefits included within the ACA. This proposal assumes that the

proposed additional mandates in a manner that balances breadth of coverage with individuals', employers', and governments' ability to afford that coverage.

In July 2011, the Institute of Medicine (IOM) released recommendations to the Secretary of Health and Human Services for a framework for considering EHBs. While not ultimately accepted by the Secretary, the recommendations provide a useful framework for considering mandated benefits within a state.<sup>114</sup> Under the framework, the IOM recommended that benefits be looked at both specifically and in the aggregate, and that they be updated on an ongoing basis. The IOM recommended that a target premium be set and the total package of proposed benefits be measured against that target. In addition, the IOM laid out a number of principles to guide decision-making as summarized in Table Thirteen.

**Table 13: IOM Criteria for Defining and Updating EHB<sup>115</sup>**

Content of Specific EHB Services	Content of the Aggregate EHB Package	Defining and Updating the EHB
<ul style="list-style-type: none"> <li>• Be safe</li> <li>• Be medically effective and evidence-based</li> <li>• Demonstrate meaningful improvement over current services/treatments</li> <li>• Be a medical service, not primarily serving an educational or social function</li> <li>• Be cost-effective</li> </ul>	<ul style="list-style-type: none"> <li>• Be affordable</li> <li>• Maximize the number of people with insurance coverage</li> <li>• Protect the most vulnerable</li> <li>• Encourage better care practices</li> <li>• Advance stewardship of resources by maximizing use of high-value services and minimizing use of low-value services</li> <li>• Address the medical concerns of the greatest importance to enrollees</li> <li>• Protect against the greatest financial risks due to</li> </ul>	<ul style="list-style-type: none"> <li>• Be transparent – rationale for decisions should be publicly available</li> <li>• Be participatory – enrollees should have role in defining priorities for coverage</li> <li>• Uphold expectations of equity and consistence</li> <li>• Demonstrate sensitivity to value – the covered service must provide a meaningful health benefit</li> <li>• Respond to new information</li> <li>• Be attentive to stewardship of resources</li> <li>• Encourage innovation</li> <li>• Be data driven, i.e. based on</li> </ul>

ten categories will be further defined over time to be consistent nationally. However, given that this approach is not yet in place and may not be implemented, it will be important for Rhode Island to consider over time what the ultimate impact of EHBs is on Rhode Island's review of state mandated benefits. Also it is important to remember that the EHB construct is applicable in the individual and small group marketplace. Until 2016, that includes employers with 50 or fewer employees. Beginning in 2016, it will include employers with 100 or fewer employees. However, there will always be some fully insured employers with more than 100 employees or self-insured employees that are not required to meet the EHB requirements (though the insurance needs to be comprehensive enough to count as creditable coverage).

<sup>114</sup> Ulmer, C; Ball, J; McGlynn E, and Bel Hamdounia, S; editors, Essential Health Benefits: Balancing Coverage and Cost; Committee on Defining and Revising an Essential Health Benefits Package for Qualified Health Plans, Board of Health Care Services, Institute of Medicine, National Academy of Science, 2012.

<sup>115</sup> Table initially developed by KerriAnn Wells in earlier report. See Wells, KerriAnn, Essential Health Benefits: Selecting and Supplementing a Benchmark Plan in Rhode Island, Prepared for the Office of the Health Insurance Commissioner, May 2012.

Content of Specific EHB Services	Content of the Aggregate EHB Package	Defining and Updating the EHB
	catastrophic events or illnesses	objective clinical evidence and actuarial reviews

With this framework in mind, the State should implement a standardized process both for (i) ongoing review of its existing state mandated health benefits and provider mandates (retrospective review) every three years and (ii) initial review of proposed mandated benefits and proposed provider mandates (prospective review), that considers the impact of each mandate individually and in terms of the impact of mandates on the aggregate benefit package. Ideally the retrospective review would be completed within the next year with an eye towards helping to inform HHS regarding its EHB decision-making before new EHB criteria are established by CMS for 2016 plans. Rhode Island has an opportunity now to establish its own version of Essential Health Benefits that fits the needs of Rhode Island, rather than deferring to the federal government’s perspective of what is good public policy in Rhode Island. In addition, based on the findings above, it is recommended that the initial retrospective review focus on the three mandates that are not included within EHB that have the highest estimated cost – off label prescription drug use, home health services and infertility services.

Prospective reviews should be completed within six months of referral of a pending mandate to OHIC. Allowing for both prospective and retrospective review on an ongoing basis provides the State with a process that combines the strength of estimating a proposed impact up front, while also evaluating the specific and cumulative impact of an individual mandate and a set of mandates. It is important that this proposed process be codified in State legislation.

*Key Principles of Mandates*

In considering whether the State should mandate specific benefits, four key principles can guide the review process as follows:

- Mandated benefits should, to the extent possible, be consistent with practices in the self-insured market (particularly State and municipal employee coverage) and the Medicaid program
- Mandated benefits should be based on medical evidence
- Mandated benefits should consider the cost impact; including both the impact of having or not having the benefit from the perspective of the State, payers and consumers
- Mandated benefits should not duplicate federal mandated benefits

*Designated Reviewer*

Having a designated reviewer responsible for ongoing retrospective mandate reviews and review of proposed mandates is a key component of any mandated benefit review process. Typically, designated reviewers are either a state agency or a commission brought together for the review of benefits.<sup>116</sup> Under either approach, the designated reviewer would be responsible for engaging appropriate stakeholders in the mandate review process. In Rhode Island, the

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<sup>116</sup> While most states designate a state agency with the responsibility for reviewing mandated benefits, a number of states utilize ongoing Commissions/Councils that are responsible for review of mandated benefits. In those cases, the Commissions include state officials in their official capacity, as well as a variety of stakeholders.

responsibility for mandated benefit reviews would likely sit within OHIC. As the State agency responsible for oversight of health insurance in the State, the responsibility to review mandated benefits and provide the Legislature with its findings and recommendations falls squarely within the role of OHIC. OHIC would also seek input from other state agencies, as appropriate. To ensure appropriate resources to fulfill this responsibility, the statute should provide OHIC with authority and funding to utilize an independent consultant and/or independent actuarial support to assist in analysis of mandated benefits where determined necessary by the OHIC Commissioner.

To ease the burden on the State related to the cost of conducting reviews of mandated benefits, proponents or advocates of the particular benefit could be encouraged to provide specific documentation upon introduction of legislation to consider a mandate that describes why the mandate is needed, whether the mandate falls within a category of EHB, who the proposed mandate will help, and the estimated cost impact. OHIC should not be obligated to conduct its own review until it determines that complete documentation has been provided. Under this approach, the State still will be required to conduct an independent review, but having some of the initial work done by the proponent should relieve the State of some burden associated with mandated benefits reviews.

As part of OHIC's independent review, OHIC shall be required to solicit input and feedback from stakeholders regarding the particular mandated benefit and the impact of adding another mandate to the required benefit package as a whole. At a minimum, stakeholders should include consumers, payers (State and insurers), relevant provider groups, and other state agencies. Stakeholders should also be consulted for retrospective reviews. Where appropriate, advocates of a particular existing mandate should be given the ability to provide evidence in support of continuing the specific mandate.

#### *Review Categories*

All proposed mandates and current mandates that are not squarely within an EHB category, or otherwise required by federal law, should be reviewed for medical efficacy, impact on cost, quality, providers, consumers and overall public health, as well as political considerations. Legislators may want to consider the inclusion of a sunset provision applicable to each exiting and newly enacted mandated requiring the law to be eliminated after three years unless a review provides evidence of its continued cost effectiveness and clinical relevance. For current mandated benefits falling within an EHB category, a review may only be necessary if there is a specified need for such review.<sup>117</sup>

#### Medical efficacy

Given that the overall purpose of a mandated benefit is to ensure that consumers have access to appropriate medical care, it is essential that mandated benefits be medically effective. In considering whether a mandated benefit meets medical efficacy standard, OHIC could consider:

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<sup>117</sup> We make this recommendation as we believe that the state's limited resources should be focused on review of mandated benefits over which the state can make a direct impact. However, we do recognize that there may be occasion for a state to review an EHB in order to be part of a national policy debate and want to leave the opportunity for that to occur, as appropriate.

- whether treatment falls within an Essential Health Benefit;
- the effect in prevention or treatment of disease or disability;
- recognition by the medical community that the treatment is effective and efficacious; and;
- demonstration of effectiveness by peer reviewed scientific literature.

As part of the medical efficacy review, OHIC also should consider the overall impact of the mandate on the quality of care provided. For reviews of proposed mandates, the impact of a mandate on the quality of care will be tied closely to the medical efficacy standards described above. For retrospective review of current mandates, OHIC should look at available performance measurement data to determine the impact of a particular mandate on quality of care.

### Cost

Another key aspect of review of a proposed or current mandated benefit is the impact of adding that benefit to the cost of insurance. It is important to consider that the cost of each mandate on its own may be minimal (pennies per month) but in the aggregate mandates often have a substantial impact on insurance premiums. While the impact on the premium reflects the direct and indirect cost of the mandate, it also is important to consider other potential impacts in reviewing proposed or current mandates, including the economic cost of the disease.

Specifically, when reviewing the cost of a mandate, the State should consider:

- general cost of the mandate;
- costs to specific stakeholders (consumers, insurers, employers and state, including whether the State will be liable for full cost of coverage for those individuals who receive subsidized coverage through HealthSource RI);
- the impact of the mandate on total cost of care, and on administrative costs;
- cost of not passing the mandate (substitute for more expensive treatment) and economic cost of the disease, where possible to determine (such as employment, education, jail recidivism);and
- how the additional cost of the mandate would be funded (e.g., is there a corresponding premium savings or benefit reduction to offset any additional cost).

For existing mandates, during retrospective review the State should obtain actual claims data from insurers to provide the actual cost impact of the mandate.

### Social Impact

An important aspect of the review of any current or proposed mandated benefits is to understand how the mandate will impact consumers. To that end, it is recommended that OHIC's review of mandated benefits include consideration of the impact of the mandate on utilization, demand for and availability of service, and the impact on such factors without the mandate.

Specifically, OHIC's review should include:

- Utilization, the impact of mandate on use of treatment (including potential to increase if proposed mandate, or actual impact if current mandate)
- Insurance Coverage – that is, is this service typically already covered by employers, including self-insured?
- Demand for services – that is, how relevant is the mandate to Rhode Island given the prevalence of a particular disease in the State<sup>118</sup>
- Availability – that is, are there providers in the State available to provide the particular service and how would the mandate impact the number and type of providers within the State?
- Need
  - Whether there are alternatives to provide coverage
  - How does lack of coverage impact consumers’ ability to afford and receive care
  - Whether individuals are avoiding care because of lack of coverage

### Public Health

The overall public health of its residents is a cornerstone responsibility of State government. It is therefore important to ensure that any mandate review includes consideration of the impact of a mandate on the public’s health. Specifically, mandate reviews should consider the impact of a current or proposed mandate on the State’s overall efforts to reduce morbidity and mortality across all sub-populations within Rhode Island as well as considering whether and how a mandate impacts health disparities.

### *Legislative Oversight*

For both retrospective and prospective review of mandates, it is important to establish an effective process for communications between OHIC and the Legislature, and for oversight by the Legislature of OHIC’s review activities. If the Legislature decides to enact a provision for the sunset of existing mandates, OHIC should perform its analysis and report its findings and recommendations to the Legislature well in advance of the sunset date, so that legislators can fulfill their proper oversight role and responsibilities.

### *Funding*

Conducting these retrospective and prospective mandate reviews will require additional resources in addition to OHIC staff. It is important to address this factor at the start as many of the mandated benefits review programs in other states identify lack of financial resources and mandate bill variability as ongoing issues.<sup>119</sup>

Given the lack of available general fund dollars, it is recommended that the State leverage the existing process of assessing health insurers for certain costs in order to fund these mandate

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<sup>118</sup> For example, consideration of a Lyme disease mandate in Rhode Island is relevant where incidence of Lyme disease is higher in the Northeast, then compared to Colorado which has no confirmed cases of Lyme disease. Center for Disease Control (CDC), Reported cases of Lyme disease by state or locality- 2002-2012; accessible at: [http://www.cdc.gov/lyme/stats/chartstables/reportedcases\\_statelocality.html](http://www.cdc.gov/lyme/stats/chartstables/reportedcases_statelocality.html)

<sup>119</sup> California Health Benefits Review Program, Other States’ Health Benefit Review Programs; September 20, 2013.

reviews. The existing line item in the budget for OHIC's annual actuarial expenses can be used, as the majority of the cost of the work to be done in reviewing current and proposed mandates is an actuarial analysis of the mandates' costs. In the process of developing actuarial estimates of those costs, it also will be necessary to conduct policy reviews of each of the mandates that should be funded through the same mechanism and line item. This funding proposal is consistent with previously proposed State legislation that would fund mandated benefits review through an insurer fee.

Draft legislation incorporating these recommendations is included for the Legislature's consideration as Attachment One.

## V. Conclusion

Rhode Island currently has one of the most comprehensive set of benefits requirements of any state in the country. As shown in this report, the majority of the mandated benefits overlap with EHBs and/or federal mandates and are therefore required of individual and small group plans regardless of whether there is a State mandate. The estimated cost of these mandated benefits equal \$50.16 of a fully-insured premium, or approximately 11% of the average monthly small group premium in Rhode Island. Likewise, most of the provider mandates within the State are focused on providing alternative providers that are typically of lower cost. There are a small number of benefit mandates, however, that are potentially optional given the backdrop of the ACA. These mandates equal an estimated \$8.36 pmpm of a fully-insured premium, or approximately 2% of the fully-insured premium within the State's small group market, with the off-label use of prescription drugs, infertility and home health mandates making up the majority of those costs.

Conducting standardized reviews of proposed mandated benefits and reviewing the mandates as a whole every five years will provide the State with a greater understanding of the overall impact of mandates and will allow for a balancing of a particular mandate with the overall health policy goals of the State aimed at improving both the quality and efficiency of care.

## Attachment One

### Draft Legislation

- 1) Declaration: It is hereby declared that health benefits coverage, while providing important protection for consumers, is costly for individuals, businesses, and government employers and programs that pay for coverage. Mandated benefits have public health, social, financial and medical implications for patients, providers and health plans. It is in the public interest to authorize and require the Office of the Health Insurance Commissioner to conduct independent reviews of proposed and existing mandated benefits to provide the Legislature with adequate and independent documentation defining the social and financial impact and medical efficacy of proposed and existing mandates.
- 2) Definitions:
  - a. Carrier: a insurance company, health service corporation, hospital services corporation, medical services corporation or health maintenance organization authorized to issue health benefit plans in Rhode Island.
  - b. Commissioner: The Commissioner of the Rhode Island Office of the Health Insurance Commissioner
  - c. Mandated Health Benefit: a benefit that a carrier must provide as part of a health benefits plan based on Rhode Island law, unless the benefit it also required by federal law
  - d. Mandated Provider: a provider type that a carrier must include as part of a health benefits plan network based on Rhode Island law, unless the provider mandate is also required by federal law
- 3) Review of Mandated Benefits or Providers.
  - a. The Commissioner shall review existing benefit or provider mandates (retrospective review), and proposed benefit or provider mandates (prospective review) in accordance with the process established in subsections (b) and (c) of this section, and in accordance with the review criteria set forth in subsection (d) of this section.
  - b. Retrospective review process.
    - i. The Commissioner shall conduct retrospective review of all existing benefit or provider mandates every three years, or three years following the enactment of an existing mandate, whichever comes later.
    - ii. An existing mandate shall sunset 60 days following the Commissioner's report to the Legislature recommending the sunset of the mandate, unless the Legislature re-enacts the mandate.
    - iii. The Commissioner shall solicit information and comments from consumers, government and private-sector employers, relevant provider

associations, advocates for a particular mandate, other state agencies, including but not limited to EOHHS, DOH, BHDDH, DHS, the Lt. Governor's Office and HSRI, and other individuals and entities with relevant information concerning the mandate under review.

- iv. The Commissioner may, at her or his discretion, conduct a focused report on any existing mandate at any time, based on new research on medical efficacy of a mandate, or significant change in social or financial impact.
- c. Prospective review process.
  - i. When any bill is introduced in the Legislature that would require a carrier to provide a mandated health benefit or require a health plan to include a specific provider type to be covered the Chairperson of the Committee to which the bill is referred shall request the Commissioner to conduct an independent review of the proposed bill. The Commissioner shall conduct her or his review upon receipt by OHIC of adequate supporting documentation from the stakeholders seeking enactment of the bill, and upon a determination by the Commissioner that the supporting documentation is complete.
  - ii. Any such legislation shall be accompanied by supporting documentation detailing the public health, social and financial impact of the proposed mandate and its medical efficacy. If the proposed mandate will increase the cost of insurance premiums, the documentation must also include a proposal for how to fund the increased cost.
  - iii. The Commissioner shall solicit information and comments from consumers, government and private-sector employers, relevant provider associations, advocates for a particular mandate, other state agencies, including but not limited to EOHHS, DOH, BHDDH, DHS, the Lt. Governor's Office and HSRI, and other individuals and entities with relevant information concerning the proposed mandate under review.
  - iv. The Commissioner shall report his or her findings and recommendations to the committee with jurisdiction over the bill within six months following the Commissioner's determination that the supporting documentation is complete.
- d. The Commissioner's retrospective and prospective review must include a literature review and financial analysis, and must include consideration of stakeholder information and comments. The Commissioner's review shall include consideration of the following factors:
  - i. Public Health, including:
    1. impact of mandate on State's morbidity and mortality rates across sub-populations
    2. impact of mandate on health disparities
  - ii. Social Impact, including:

1. Utilization, including:
    - a. Impact of mandate on use of treatment
    - b. Encouragement of mandate on consumer use of appropriate treatment/service
  2. Whether the mandate is typically covered by insurers in the State, including the self-insured
  3. How relevant is the mandate to Rhode Island given the prevalence of a particular disease in the State
  4. Whether there are providers in the State available to provide the particular service and how the mandate would impact the number and type of providers within the State;
  5. Whether there are alternative ways for consumers to obtain coverage
  6. If and how lack of coverage impacts consumers' ability to afford and receive care
  7. Whether individuals are avoiding care because of lack of coverage
  8. Assessment of other states regarding coverage of the proposed mandated benefit and estimated costs, when available
- iii. Financial Impact, including:
1. General cost of the mandate
  2. Costs to specific stakeholders, including but not limited to cost to individual consumers, governmental and private sector employers, and public programs.
  3. Impact of mandate on total cost of care, and on administrative costs
  4. Cost of not passing the mandate
  5. How the additional cost of the mandate would be funded
- iv. Medical Efficacy, including:
1. Whether treatment falls within federally-defined Essential Health Benefits
  2. Effect in prevention or treatment of disease or disability
  3. Recognition by the medical community as effective and efficacious
  4. Demonstration by peer-reviewed scientific literature
  5. Impact of service on overall quality of care provided
- v. The effects of balancing the social, financial and medical input.
- e. The Commissioner may assess carriers for the cost of any review conducted under this Section, in accordance with RIGL § 42-14-10 (actuarial fund).

Effective date. This act shall take effect on passage.