REPORT OF THE
PANEL FOR THE DEVELOPMENT OF

An Essential Health Services Access Program And A Standard Health Services Program Pursuant To SB 506 Of 1992

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA AND
THE JOINT COMMISSION ON HEALTH CARE

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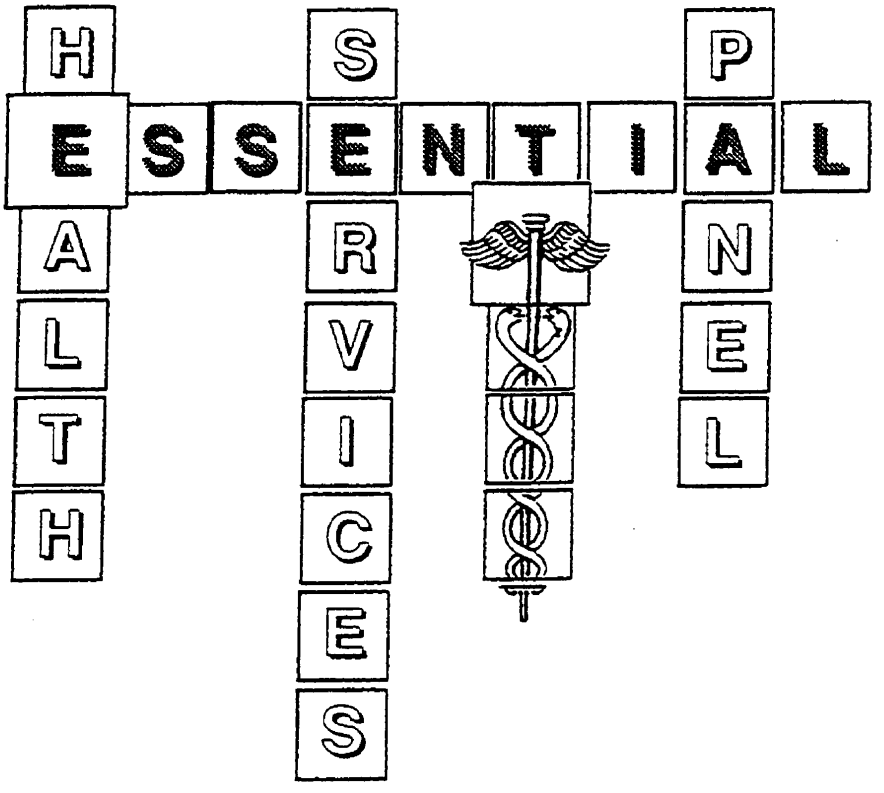
HEALTH
SERVICES
ESSENTIAL
PANEL

CONTENTS

REPORT OF THE ESSENTIAL HEALTH SERVICES PANEL

EXECUTIVE SUMMARY

Since 1988, concentrated efforts to address the health care crisis in Virginia have been the focus of the Joint Commission on Health Care and its antecedents. The commission has found that nearly one million Virginians are without health insurance and that thousands of others have limited health insurance. Designing programs to address lack of health care access and availability, while containing the ever-rising costs of health care, is the primary focus of the joint commission.

Established as an initiative of the Joint Commission on Health Care pursuant to SB 506 of 1992, the Essential Health Services Panel, a group of experts and citizens, was charged with assisting the joint commission by developing an essential health services access program and a standard health services program which includes all the essential health services plus additional, but not necessarily essential, services. The enabling legislation directed the panel to emphasize primary and preventive health care services and to concentrate on the specific services that must be made accessible to all Virginians, regardless of circumstances.

Among the panel's first tasks was defining an essential health services access program, essential health services, and determinative principles for identifying those health services considered essential. An essential health services access program was defined as a government effort to ensure all citizens' access to minimum health services. The panel determined that "essential health services" means those **age-appropriate, preventive, diagnostic, and treatment services required to maintain good health and to return individuals to good health.**

Determinative principles for identifying essential health services were also recognized as:

- Appropriate and effective for the prevention, diagnosis, or treatment of disease, injury, or congenital conditions (clinical effectiveness test)
- Good value for the dollar spent (cost effectiveness test)
- Contributing to the quality of life or providing comfort care for the terminally ill (quality of life test)
- Chosen for the individual or family without regard for the individual's or family's ability to pay (paternalistic test)
- Consideration of consistency with the health services common to most current health benefit plans and public health programs (equity test)
- Defined in terms of health services, not providers (health services test)

Over the panel's short, but active, history, much material and data were presented. Current efforts in other states, including Arizona, Florida, Hawaii, New York, Ohio, Connecticut, Michigan, Minnesota, South Carolina, Washington, and Maine, were summarized. For example, in Oregon, following an extensive process which included community meetings, public hearings, and a significant telephone survey, the Oregon Health Services Commission, a panel of health care providers, identified 17 categories of care encompassing 709 condition-treatment pairs. The Oregon methodology also included research and expert testimony on the effectiveness of treatments, a formula that considered cost and benefit of treatments, public values, and independent commissioner judgment. The Oregon plan, because it is Medicaid specific, required a federal waiver. The Health Care Financing Administration denied the Oregon waiver application in August 1992, stating that Oregon's plan violated the Americans with Disabilities Act; however, Oregon officials submitted a revised application and Oregon was granted a waiver in March 1993.

On the opposite extreme from the Oregon Plan, the Washington Basic Health Plan includes physician services, inpatient and outpatient hospital services, proven preventive and primary care services, prenatal, postnatal, and well-child care, and other services determined to be necessary for basic health care. The administrator will design and revise the benefits.

The two major public health benefits programs--Medicare and Medicaid--each also defining its covered services, were reviewed. Medicare is a federal health insurance program for the elderly and the disabled; Medicaid is a federally-established, state-administered program which is jointly funded by the federal and state governments. States do have some flexibility in designing their Medicaid programs; however, many of the Medicaid rules are federally mandated. In reviewing these programs, the panel noted that Virginia's Medicaid program provides generous services to recipients, with tightly controlled reimbursement for providers.

Information on certain other countries' health care programs was also provided, particularly the Canadian system. The Canadian health care system has been touted by many experts as a model for the United States. The components of the Canadian system are: all residents are covered for necessary physician and hospital care; each province administers the program for its residents; direct patient payments to providers are prohibited; no copayments or deductibles are allowed; physicians' fees are negotiated annually; and lump-sum budgeting and controls on acquisition of technology mean lower administrative costs for hospitals.

The provincial programs must comply with five conditions: (i) universal coverage for all legal residents; (ii) comprehensive coverage of all medically required services; (iii) reasonable access to services with no deductibles, copayments or additional fees; (iv) portability; and (v) public, nonprofit administration. Provider participation is not mandatory; however, because of the availability of free care, full-time private practice is seldom feasible.

One of the Canadian requirements is that the services be "comprehensive." Based on available materials, most, if not all, of the provincial programs cover preventive/primary care, including family physicians and other general practitioners; apparently unlimited outpatient primary care, e.g., prenatal care; comprehensive childhood immunizations;

mammograms; some dental services; and drugs and appliances as necessary. The Canadian system also covers emergency care, inpatient hospital care, outpatient hospital care, and diagnostic tests and specialty care. Physicians determine priority for specialty surgical procedures; hospital "gatekeepers" manage the hospital-based high technology diagnostic equipment; diagnostic tests and specialty care patients are classified as "emergent, urgent, or elective" by physicians ("emergent" patients are to be seen first; however, there are no definitions of these terms and each physician subjectively determines the classification). High technology diagnostic testing and specialty care appear to be rationed through the fee structure and limitations on technology dissemination; there are waiting lists.

The panel repeatedly evaluated the services on a staff-developed matrix in detail, directing that provider/site specific coverage should be eliminated. In August, presentations from representatives of business, insurance, consumer, and provider organizations and other interested parties were heard as well as an overview of health insurance policies/plans and the Board of Health's perspective. Two public forums were held in November and December. Statements concerning copayments, deductibles, and other means of limiting services and containing costs noted that, if a cost-effective administrative structure existed, such limitations might not be needed. Many individuals testified concerning mental health services as "essential" services for the citizens of the Commonwealth.

A three-round Delphi survey was conducted of the panel's members concerning services considered to be "essential." Ranking for the Delphi survey was based on the following relative value scale:

MUST have
SHOULD have
Important
Moderately Important
Not Particularly Important

The panel collectively reviewed and ranked the services listed on the Delphi survey over a series of meetings; the ranked services were retained on the essential/MUST have list, moved out of the MUST have ranking for further discussion, or designated for exclusion.

There were many different reasons for the panel's collective rankings. For example, some matrix services were considered to be included under retained broader categories and certain terminology, such as maternity care/obstetrics, was deemed redundant (maternity care was retained). All provider/site specific services, such as optometry services and rural health clinic services, were marked for possible exclusion. This notation does not, however, mean that health services identified as "essential" could not be delivered by the specific provider or at the specific site. Further, some matrix services did not, in the judgment of the panel, meet the established determinative principles.

Definitions were developed as follows:

"Medical emergency" means a condition or chief complaint manifested by acute symptoms of sufficient severity which, without immediate and necessary medical attention, could reasonably be expected to result in (i) serious jeopardy to the mental or physical health of the individual,

or (ii) danger of serious impairment of the individual's bodily functions, or (iii) serious dysfunction of any of the individual's organs, and (iv), in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Medically necessary" means a service acknowledged as acceptable medical practice by an established United States medical society for the treatment or management of pregnancy, illness, or injury which (i) is the most appropriate and cost-effective service to be provided safely to the patient, (ii) is consistent with the patient's symptoms or diagnosis, and (iii) is not experimental or investigative in nature. The fact that a physician prescribes a service does not automatically mean such service is medically necessary and will qualify for coverage.

Subject to appropriate utilization review and payment authorization, "covered inpatient hospital care" for individuals age 18 and over shall be limited to 21 days of hospitalization in a 12-month period, whether incurred for one or more hospital stays in the same or a different hospital. For individuals up to the age of 18, "covered inpatient hospital care" also includes primary care provider-certified, medically necessary inpatient hospitalization beyond the 21-day limitation, upon appropriate utilization review and payment authorization.

The panel's consensus was that the essential health services plan(s) should focus on improving the health status of Virginians at reasonably low costs, with some incentives for patient responsibility, and that the plan(s) should provide incentives for employers to maintain or expand their commitment to health care benefits. The panel also opined that a tightly managed plan, which encourages physician participation, would facilitate containment of costs while enhancing primary care. Repeatedly, the panel noted that the list of essential health services will need to be reviewed on an ongoing basis as new treatments and diagnostic tools are developed and outcomes assessment, standards of practice, patterns of care, and medical technology evolve. Therefore, if the essential health services plan becomes the basis for legislative action, the panel strongly recommends the establishment of a mechanism for continuous review and modification of the essential health care access services, especially to maintain currency, cost effectiveness, and treatment efficacy.

In deliberating on the various uses and cost limitations or cost containment devices, the panel was advised of managed care provisions, caps on expenditures, stop-loss provisions, fee schedules, rating bands, risk spreading, state subsidies, tax credits, etc. Twenty-seven other states, it was noted, have adopted conceptually similar legislation.

The panel discussed the availability of information sufficient for health insurance comparison shopping, the viability of developing limitations on the essential health services, and the merit of examining several different approaches or plans for essential health services. To assist the consumer in comparison shopping for health coverage, the panel suggested that a set of standardized health plans (two or three policies/plans/programs) covering the essential health services list be developed and statutorially required to be offered by insurers (e.g., those insurers operating in the small business market).

The panel further suggested that comparison shopping would be easier and more meaningful for the consumer, if such plans were regulated by

the Commissioner of Insurance, with standardized format and definitions, and if insurers were required to publish the premiums for these essential health services products.

The panel concluded that providing the Advisory Commission on Mandated Health Insurance Benefits, the Joint Commission on Health Care, and the General Assembly with a list of essential health services and standard health services as well as a selection of proposed flexible plans for limiting costs would increase the potential uses of their report.

To develop a selection of proposed flexible plans for limiting costs, a pricing study group was assembled, consisting of panel staff and representatives of Blue Cross and Blue Shield of Virginia, Kaiser Permanente, and the Department of Medical Assistance Services. Optima and Southern Health Services also assisted in this effort. The participating organizations agreed to collaborate with the panel in developing cost estimates for the essential health services program, using various assumptions regarding limitations, deductibles, co-insurance or co-payments, premium cost sharing, maximums, and the pricing of specific services, etc.

In devising these estimates, the price or cost of alternative essential health service programs was estimated by using available data and assuming the package of designated services will cover the same populations as the respective plans. Certain assumptions were also made regarding the level and types of managed care delivery systems which will be recommended in order to price the programs.

As described to the panel, possible uses of Virginia's essential health services access plan might be for: the Governor's Child Health Program; a reinsurance pool as part of small business insurance reform; a state-subsidized insurance plan for small employers who are not otherwise able to obtain or afford coverage for employees; an alternative to a state-mandated benefits plan for individuals and families or employers who cannot afford the cost of current policies, but who can pay for an affordable benefit package; an approach to expanded coverage for children using Medicaid administrative mechanisms and state-only funds; a state-subsidized insurance plan for individuals and families who are otherwise uninsurable or cannot afford coverage; and direct provision of services, using existing state facilities and contract providers to deliver some or all of the services outside of an insurance product.

In the event state-subsidized plans or programs implementing direct provision of services are developed for utilization of the essential health services access plan, the panel suggests that the value of sliding fee scales to contain costs and promote patient responsibility be examined.

In October, the panel developed a draft report, including a list of "MUST HAVE" or essential health services, as well as lists of "SHOULD HAVE" or standard health services. A set of flexible plans was also developed for the consideration of the Joint Commission on Health Care. The draft report was transmitted to the Advisory Commission on Mandated Health Insurance Benefits for review and evaluation.

Pursuant to the requirements of SB 506, public forums were held in November and December. In December, the panel revised its draft report in response to the recommendations received from the Advisory Commission on Mandated Health Insurance Benefits.

Conceivably, Virginia's unique approach to the issue of the uninsured--establishing a panel of experts and citizens to objectively evaluate and determine essential health care services, submitting the draft for review by a knowledgeable organization (the advisory commission), and revising and transmitting the plan to the legislative Joint Commission on Health Care for consideration--could lay the groundwork for "bellwether" changes in the Commonwealth's health care system, with national ramifications. Throughout its study, however, the panel reiterated that, in the final analysis, the ultimate authority and responsibility for determining the purpose/use of any essential health services plan rests with the Joint Commission on Health Care and the General Assembly.

SERVICES DETERMINED TO BE ESSENTIAL (MUST-HAVE)

—Emergency Services:

* Pre-hospital emergency medical services including ambulance
* Emergency hospital services (emergency room and inpatient services)
* Upon primary care provider certification, emergency room care for medical emergencies (refer to definition of "medical emergency")
* Acute medical detoxification
* Severe mental health crisis services, with ambulatory treatment preferred; includes inpatient treatment only on referral by primary care provider

—Primary Care for all medically necessary care and Preventive Care as outlined in the then current guidelines (all services to be reviewed and revised annually) of the American Academy of Pediatrics (AAP) for children and in the then current guidelines of the American Academy of Family Physicians (AAFP) for adults (19 years and older; individuals 65 and over not included--assumed to be covered by Medicare) as follows:

* 18 preventive health visits from birth to age 18, inclusive (to be reviewed and revised annually consistent with the then current guidelines of the American Academy of Pediatrics)

--Documented child health history
--Physical examination
--Developmental/behavioral assessment
--Anticipatory guidance
--Immunizations, including (as of the July 1991 AAP guidelines) diptheria-tetanus-pertussis (DTP), oral poliovirus (OPV), measles-mumps-rubella (MMR), and Haemophilus influenzae type b (HIB)
--Laboratory services

* On the recommendation of the primary care provider, one preventive health visit every 1-3 years **(no more than one per year)** from age 19 to age 39 inclusive (to be reviewed and revised annually consistent with the then current guidelines of the American Academy of Family Physicians)

--Documented health history
--Physical examination

--Primary and Preventive Care, age 19 to age 39, cont'd.

--Laboratory/diagnostic procedures including nonfasting or fasting blood cholesterol **(at least every five years)** and Papnicolauo smear **(annually for women who are, or have been, sexually active; every three years, at the discretion of the primary care provider, for women having three or more consecutive satisfactory normal annual examinations)**; **for high-risk groups**, fasting plasma glucose, rubella antibodies, VDRL/RPR, urinalysis for bacteriuria (frequency has not been determined; however, dipsticks combining leukocyte esterase and nitrite tests should be used to detect asymptomatic bacteriuria), chlamydial testing, gonorrhea culture, counseling and testing for HIV, hearing, tuberculin skin test, electrocardiogram, mammogram **(women aged 35 and older with a family history of premenopausally diagnosed breast cancer in a first-degree relative)**, colonoscopy **(persons with a family history of familial polyposis coli or cancer family syndrome)**
--Counseling on diet, exercise, substance use, sexual practices (including sexually transmitted diseases and family planning), injury prevention, dental health, and other primary preventive measures
--Immunizations, including, as of August 1991, tetenus-diphtheria booster **(every 10 years)**, and, **for high-risk groups**, hepatitis B vaccine, pneumococcal vaccine, influenza vaccine **(annually)**, and measles-mumps-rubella vaccine

* On the recommendation of the primary care provider, one preventive health visit every 1-3 years **(no more than one per year)** from age 40 to age 64, inclusive (to be reviewed and revised annually, consistent with the then current guidelines of the American Academy of Family Physicians)
--Interval and family health history
--Physical examination
--Laboratory/diagnostic procedures including nonfasting or fasting blood cholesterol **(at least every five years)**, Papnicolauo smear **(annually for women who are, or have been, sexually active; every three years, at the discretion of the primary care provider, for women having three or more consecutive satisfactory normal annual examinations)** and mammogram **(annually for all women beginning at age 50; every one to two years for women between ages 40 through 49)**; **for high-risk groups**, fasting plasma glucose, VDRL/RPR, urinalysis for bacteriuria, chlamydial testing, gonorrhea culture, counseling and testing for HIV, hearing, tuberculin skin test, electrocardiogram, fecal occult blood/sigmoidoscopy **(persons aged 50 and older who have first-degree relatives with colorectal cancer; a personal history of endometrial, ovarian, or breast cancer, or a previous diagnosis of inflammatory bowel disease, adenomatous polyps, or colorectal cancer)**, fecal occult blood/colonoscopy **(persons with a family history of familial polyposis coli or cancer family syndrome)**, and bone mineral content

--Primary and Preventive Care, age 40 to age 64, cont'd.

--Counseling on diet, exercise, substance use, sexual practices, injury prevention, dental health, and other primary preventive measures
--Immunizations, including tetanus-diphtheria booster **(every 10 years)**, and, **for high-risk groups**, hepatitis B vaccine, pneumococcal vaccine, influenza vaccine

—Outpatient Diagnostic Services/Testing/Treatment, upon referral by primary care provider:

* Outpatient radiation/chemotherapy treatment, when medically necessary and upon referral by primary care provider
* Laboratory
* Screening services
* X-ray or imaging
* Psychological testing

—Maternity Care (consistent with the then current guidelines of the American College of Obstetrics and Gynecology):

* Prenatal care, including diagnosis of pregnancy and, when medically indicated and, in accordance with the American College of Obstetrics and Gynecology guidelines, laboratory services and other diagnostic/testing procedures (e.g., amniocentesis, ultrasound, radiology, etc.)
* Inpatient hospital services, including anesthesia, complications of pregnancy, delivery by vaginal and caesarean section, labor and delivery room, medications, operating or other special procedure rooms, etc.
* Postpartum care

—Inpatient Hospital Care, subject to appropriate utilization review and payment authorization (for individuals 18 and over, limited to 21 days in a 12-month period, whether incurred for one or more hospital stays in the same or a different hospital; for individuals up to the age of 18, "covered inpatient hospital care" also includes primary care provider-certified, medically necessary inpatient hospital care extended beyond the 21-day limitation, upon appropriate utilization review and payment authorization):

* Room/board and ancillary services including anesthesia, casts, dressings, drugs and medications, equipment, general nursing, inhalation therapy, intensive care unit, laboratory and X-ray services, oxygen services, radiation therapy, short-term physical therapy, special diets, supplies, and use of operating room and recovery room
* Inpatient medical services, including primary, consultative, and specialty provider services
* Inpatient therapeutic blood services, including blood derivatives and their administration; whole blood when a volunteer blood program is not available
* Inpatient mental health services upon referral by the primary care provider, limited to 21 days annually
* Newborn care

—Outpatient Therapeutic Blood Services, including blood derivatives and their administration; whole blood when a volunteer blood program is not available

—Prescription Drugs, including prescription contraceptives:

* Limited to generic drugs as approved by the Virginia Voluntary Formulary Board, except when not available

—Durable Medical Equipment, when medically necessary

—Outpatient Medical and Surgical Specialty Care, including consultation, surgery, medication management visits for physical or psychiatric chronic/acute illnesses, and facility fees, when medically necessary and upon referral by the primary care provider

—Limited Outpatient Mental Health Counseling/Substance Abuse Treatment Services:

* 20 visits annually

—Prescription/Corrective Lenses for Children:

* Limited to one pair per year; limited frame selection

—Preventive and Acute Dental Care for Children:

* Regular examination (2/year)
* X-rays (where medically indicated)
* Prophylaxis (2/year)
* Topical fluoride (1/year)
* Sealants (permanent molars only, age 6-17)
* Fillings (excluding multisurface resins post. teeth)
* Temporary crowns (stainless steel and polycarbonate)
* Pulpotomy (with pre-authorization)
* Root canal (with pre-authorization)
* Space maintenance (early lost teeth, with pre-authorization)
* Oral surgery

--Extractions (for relief of pain, infection, or cystic lesions)
--Biopsy
--Removal of tumors, cysts, or neoplasms (medical or dental)
--Treatment of fractures of maxilla or mandible (medical or dental)
--Correction of congenital facial deformities

* Emergency care

--Palliative
--Trauma care
--Replacement crown
--Repair space maintainer
--Repair dentures (full or partial)

—Kidney and Cornea Transplants (only)

THE STANDARD HEALTH SERVICES PLAN

In order to arrive at the services to be included in the standard health services plan, the list of MUST HAVE or essential health services must be added to the SHOULD HAVE services list. The panel recommended the following services as add-ons to the essential health services list, the two lists to comprise the standard health services plan.

ADDITIONAL SERVICES (SHOULD HAVE LIST) TO BE INCLUDED WITH ESSENTIAL SERVICES IN A STANDARD PLAN

---**Allergy Treatments**, according to the guidelines and upon PCP referral

* skin testing
* injections

---**Audiology/Speech/Hearing Disorder Services**, upon referral by PCP

* Hearing aids and services

---**Adult Dental Services**

* Emergency examination
* X-rays (where medically indicated)
* Extraction (for relief of pain, infection or cystic lesions)
* Biopsy
* Removal of tumors, cysts or neoplasms
* Repair of dentures (complete or partial)
* Regular examination (2/year)
* Prophylaxis (2/year)
* Fillings
* Temporary crowns
* Pulpotomy (with pre-authorization)
* Root canal (with pre-authorization)
* Replacement of teeth, including complete/partial dentures

---**Case Management Services**, under direction of PCP

* Medical case management, performed by or under direction of PCP
* Social case management, under direction of PCP
* High cost illness case management, subject to guidelines based on outcomes

---**Inpatient Hospital Care**, from 21 to 365 days in a 12-month period, upon appropriate utilization review and payment authorization:

* Room/board and ancillary services including anesthesia, casts, dressings, drugs and medications, equipment, general nursing, inhalation therapy, intensive care unit, laboratory and X-ray services, oxygen services, radiation therapy, short-term physical therapy, special diets, supplies, and use of operating room and recovery room

---Inpatient Hospital Care, cont'd.

* Inpatient medical services, including primary, consultative, and specialty provider services
* Inpatient therapeutic blood services, including blood derivatives and their administration; whole blood when a volunteer blood program is not available
* Inpatient mental health services, upon referral by the primary care provider

---**Prescription/Corrective Lenses** for Adults:

* Limited to one pair per year; limited frame selection

---**Medically Necessary Post-hospital Alternatives** to Inpatient Hospital Care (as appropriate when approved by PCP as part of overall treatment plan to eliminate need for hospital admission or reduce inpatient hospital length of stay):

* Pre-authorized home health visits
* Hospice
* Nursing home care (skilled nursing care)

---**Rehabilitative Care**, upon referral by primary care provider:

* Mental health/substance abuse therapy
* Occupational therapy
* Physical therapy

---**Transplants** (heart, liver, others when medically effective)

REPORT OF THE ESSENTIAL HEALTH SERVICES PANEL TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA AND THE JOINT COMMISSION ON HEALTH CARE RICHMOND, VIRGINIA 1992

To: The Honorable L. Douglas Wilder, Governor of Virginia
and
The General Assembly of Virginia
and
The Joint Commission on Health Care

I. BACKGROUND OF THE STUDY

Establishment of the Panel

Since 1988, concentrated efforts to address the health care crisis in Virginia have been the focus of the Joint Commission on Health Care and its antecedents. The commission has found that nearly one million Virginians are without health insurance and that thousands of others have limited health insurance. Designing programs to address lack of health care access and availability, while containing the ever-rising costs of health care, is the primary focus of the joint commission.

Established as an initiative of the Joint Commission on Health Care pursuant to SB 506 of 1992, the Essential Health Services Panel was charged with assisting the joint commission by developing an essential health services access program and a standard health services program which includes all the essential health services plus additional, but not necessarily essential, services. The enabling legislation directed the panel to emphasize primary and preventive health care services and to concentrate on the specific services that must be made accessible to all Virginians, regardless of circumstances.

In its deliberations, this panel of experts and citizens, chaired by the Honorable J. Samuel Glasscock of Suffolk, was also directed to employ cost/benefit analysis and to consider the Commonwealth's health care system, relevant federal and state law, other states' and countries' programs, existing third-party plans (including Medicaid, Medicare, and insurance), and cost-containment mechanisms. As required by SB 506, the panel's draft report was presented to the Advisory Commission on Mandated Health Insurance Benefits. Following the review of the advisory commission and the panel's consideration of its recommendations, the panel revised and then transmitted its report to the Joint Commission on Health Care.

Defining an Essential Health Services Access Program

An essential health services access program may be defined as a government effort to ensure all citizens' access to a minimum set of health services, particularly those services meeting the basic health care needs of the otherwise uninsured. Focused primarily, but not exclusively, on primary and preventive health services, an essential health services package is also intended to contain costs, through the use of managed care and service limitations. In order to design an essential services program which is affordable to a large segment of the uninsured, a balance must be struck between the scope of the essential health services and willingness to pay.

State and Federal Roles

The McCarren-Ferguson Act grants to the states the authority to regulate private health insurance, including the definition of services that must or may be included in a policy sold as health insurance in the state. Two exceptions to this state role are provided through the Employee Retirement and Insurance Security Act (ERISA) and the federal Health Maintenance Organization (HMO) Act. ERISA exempts self-insured plans in which employers assume the costs and risks of covered services from state regulation. Thus, self-insured (or self-funded) companies are free to establish their own benefits. The federal HMO Act regulates those HMOs seeking and obtaining federally-qualified status, i.e., offering the services required by the federal HMO Act; however, states are not prohibited by federal law from regulating HMOs. Therefore, HMOs operating within a state having a state HMO act may meet the state requirements, rather than federal requirements.

The two major public health benefits programs--Medicare and Medicaid--also have defined lists of covered services. Medicare is a federal health insurance program for the elderly and the disabled; Medicaid is a federally controlled, state-operated program, jointly funded by the federal and state governments.

The legislative history of the health insurance industry, particularly related to the federal level and allowable regulation at the state level, suggests that states interested in expanding access must first define the specific services identified for expanded access. Just as the current definitions of mandated insurance benefits were developed through the political and legislative process, so too must essential health care access services be defined.

Possible Uses of an Essential Health Services Access Plan

Possible uses of Virginia's essential health services access plan might be for: the Governor's Child Health Program (components included in the essential services list); a reinsurance pool as part of small business insurance reform; a state-subsidized insurance plan for small employers who are not otherwise able to obtain or afford coverage for employees; an alternative to a state-mandated benefits plan for individuals and families or employers who cannot afford the cost of current policies, but who can pay for an affordable benefit package; an approach to expanded coverage for children using Medicaid administrative mechanisms and state-only funds; a state-subsidized insurance plan for individuals and families who are otherwise uninsurable or cannot afford coverage; and direct provision of services, using existing state facilities and contract providers to deliver some or all of the services outside of an insurance product. In the event state-subsidized plans or programs implementing direct provision of services are developed for utilization of the essential health services access plan, the panel suggested that the value of sliding fee scales to contain costs and promote patient responsibility be examined.

II. HEALTH CARE COVERAGE IN SELECTED COUNTRIES

Canada

The components of the Canadian system are: all residents are covered for necessary physician and hospital care; each province administers the program for its residents; direct patient payments to providers are

prohibited; no copayments or deductibles are allowed; physicians' fees are negotiated annually; and lump-sum budgeting and controls on acquisition of technology mean lower administrative costs for hospitals.

The provincial programs must comply with five conditions: (i) universal coverage for all legal residents; (ii) comprehensive coverage of all medically required services; (iii) reasonable access to services with no deductibles, copayments or additional fees; (iv) portability; and (v) public, nonprofit administration. Provider participation is not mandatory; however, because of the availability of free care, full-time private practice is seldom feasible.

One of the Canadian requirements is that the services be "comprehensive." Based on available materials, most, if not all, of the provincial programs cover preventive/primary care, including family physicians and other general practitioners; apparently unlimited outpatient primary care, e.g., prenatal care; comprehensive childhood immunizations; mammograms; some dental services; and drugs and appliances as necessary. The Canadian system also covers emergency care, inpatient hospital care, outpatient hospital care, and diagnostic tests and specialty Care. Physicians determine priority for specialty surgical procedures; Hospital "gatekeepers" manage the hospital-based high technology diagnostic equipment; diagnostic tests and specialty care patients are classified as "emergent, urgent, or elective" by physicians ("emergent" patients are to be seen first; however, there are no definitions of these terms and each physician subjectively determines the classification). High technology diagnostic testing and specialty care appear to be rationed through the fee structure and limitations on dissemination; there are waiting lists.

France, Germany, and Japan

In these countries, health insurance coverage is nearly universal. These countries are somewhat like the American system in the following ways: free choice of physician, coverage is obtained primarily through work, and coverage is provided by multiple third-party insurers. However, the differences are dramatic, e.g., compulsory insurance coverage for all residents; negotiated, standardized reimbursement rates; national regulation of benefits (including physician services, hospital care, laboratory tests, prescriptions, and some dental and optical care) and premiums (mandatory employee/employer contributions based on the average cost of a large population cross section); and cost/budget controls.

III. SIMILAR INITIATIVES IN OTHER STATES

Numerous other states have already adopted an essential health services list or are in the process of developing such a program. Many states are implementing essential-health-services-based pilot programs. Only two states, Maine and Hawaii, are operating on a statewide basis. The five general categories of initiatives using essential health service plans to achieve insurance coverage are:

- Subsidized insurance products for employer groups
- Privately-purchased insurance products for employers
- Expanded Medicaid eligibility for children
- State-subsidized insurance products for individuals
- Health insurance purchasing cooperatives (HIPC)

Each type of initiative has an essential health services list for coverage and can exclude certain services that might be covered in other plans.

These initiatives also differ in several other key dimensions. For example, the plans may differ on whether the state provides a direct subsidy to purchase the insurance, as in the case of subsidized insurance for employer groups or individuals. Another dimension of difference is whether the state administers the program, as in the case of Medicaid coverage for children or a health insurance purchasing cooperative. In an attempt to make the insurance more affordable, the states may, in some instances, only establish new rules for the marketing of insurance. In other cases, states use state tax revenues to establish a new social program to subsidize the purchase of insurance.

The following list, which is not intended to be inclusive, recounts states' experiences in implementing each type of initiative. Very brief summaries of the initiatives, emphasizing the use of an essential health services program, are presented.

Subsidized Insurance Products for Employer Groups

Recognizing that the largest percentage of uninsured individuals work in small companies, several states have concentrated their efforts on affordable products for the small-employer group. Some states provide direct payments to the employer or the individual, others provide subsidy payments to the insuring entity. Certain states organize their products to define a managed-care provider network to be used by those covered. Still others regulate the payment to providers to lower the cost of the product. The experiences of four states are highlighted below.

In **Arizona**, the Arizona Health Care Group is a demonstration program of the Arizona Health Care Cost Containment System (AHCCCS). Since January 1988, the existing prepaid managed care health plans under contract with the state for the Medicaid program have provided four specially designed, comprehensive insurance products to uninsured small businesses. More than 4,000 people from 1,300 businesses are enrolled.

In **Florida**, the Florida Health Access Corporation has been operating since May 1987. This nonprofit corporation organizes health care coverage for small uninsured firms having 19 or fewer employees, by pooling them together into a single organized buying group. The state subsidizes the portion of the premium covering claims from $15,000 to $115,000. By January 1991, about 2,000 small businesses were participating in the project, providing coverage for over 9,000 persons.

In **New York**, two pilots within the Employer Incentive Subsidy Program and three pilots within the Individual Subsidy Program constitute the state's demonstration program for the uninsured. Approximately 2,700 persons were enrolled in the Employer Incentive Subsidy Program, with some small group employers (20 or fewer employees who have not been provided group coverage since April 1991) receiving premium subsidies of up to 50 percent for employees and dependents enrolled in an approved health insurance plan. Within the Individual Subsidy Program, three pilots have enrolled approximately 3,700 people. The Individual Subsidy Program pilots are targeted at individuals and families with incomes under 200 percent of the federal poverty guidelines, with subsidies ranging from 90 to 95 percent of the premiums.

Since 1990, **Ohio** has funded a demonstration project in Cincinnati, the Health Care Account Project, to test an alternative approach to insurance. The plan includes a "medical spending account," which pays a limited amount for primary care services, and a catastrophic coverage component, which pays all the costs for covered services after the enrollee pays a deductible of at least $5,000 per individual or $10,000 per family. To be eligible, small firms must not have offered insurance to workers in the past 18 months. To receive subsidies, employees must work at least 16 hours per week and have incomes less than 200 percent of the federal poverty level.

Privately Purchased Insurance Products

An approach, placing less reliance on state funds, assumes that much of the high cost of small group coverage stems from inefficient insurance rules that encourage biased risk selection, excessive administrative costs, and gaps in coverage (when individuals in groups or groups are denied coverage). Connecticut has implemented the most notable example of the privately purchased insurance approach, which is currently undergoing development and changes.

Connecticut's "Small Employer Plan" is now being offered by 50 insurers for uninsured small employers with 25 or fewer full-time employees. Insurers must guarantee coverage to any firm, regardless of health status or history, and employers are guaranteed the right to renew their coverage. Participation is voluntary and there are no state subsidies to purchase the insurance.

Expanded Medicaid Eligibility for Children

A simple approach to coverage of uninsured children is expansion of Medicaid eligibility. All states must cover children in families with incomes up to 100 percent of the federal poverty level by the year 2002. This Medicaid expansion will not, however, extend to all children living in working poor families. Therefore, some states have developed solely state-funded essential health services programs to expand coverage to children through Medicaid, consisting of more limited services than those normally covered by the states' Medicaid programs. These programs have the advantage of built-in administration and process as the Medicaid eligibility and claims processing system are used and Medicaid payment levels are enforced. Three state programs are briefly described.

The Health Care Financing Administration awarded a demonstration project grant to **Florida** to establish the Healthy Kids Corporation, which will extend Medicaid coverage to children 6 through 18 years of age who live in families with incomes less than 130 percent of the federal poverty level. Low-cost commercial health insurance will be marketed through the Florida school system and the nonprofit "Healthy Kids Corporation." The insurance package will provide two options, consisting of a high (comprehensive) plan and a low (preventive and primary care only) plan. Medicaid reimbursement rates and providers who currently contract with Medicaid will be utilized under a state contract with an underwriting insurer. The demonstration began in early 1992.

In **Michigan**, the Michigan Child Caring Program--a public/private partnership between the Michigan Medicaid program and Blue Cross and Blue Shield--was initiated in January 1992 to extend Medicaid eligibility to children 6 through 18 years of age who are from families with incomes up to 185 percent of the federal poverty level.

Minnesota's Children's Health Plan provides insurance coverage for children with family incomes of up to 185 percent of the federal poverty level who are not eligible for Medicaid. This plan covers outpatient primary service only, including mental health services up to $1,000 per year. The program costs the state about $280 per enrollee per year.

State Subsidized Insurance Products for Individuals

Programs for individuals, rather than employees in small firms, typically involve an eligibility determination policy and process. Rather than focusing the changes in the workplace, these programs foster affordable, portable insurance for individuals without regard to their place of employment. In each case a minimum set of services is defined. The state may also become involved in organizing the insurance carriers, including their selection, approved premium levels, and eligibility rules. Other states have put their Medicaid program to work in providing expanded coverage for a limited set of benefits normally covered by Medicaid. Four states are briefly summarized.

In **South Carolina**, another demonstration project grant awarded by the Health Care Financing Administration, the Health Care Access Plan, will provide coverage to currently uninsured individuals with incomes below 150 percent of the federal poverty level who work in small firms that do not offer employee health insurance. For enrollees whose income is at or below 100 percent of the federal poverty line, employers will pay the entire premium, which will equal 27 percent of the projected claims cost (the current Medicaid match rate); for enrollees with incomes between 100 and 150 percent of the federal poverty level, employers will pay 75 percent of premium costs; and the remainder will be paid from demonstration project funds. In this managed care program, the available benefits are similar to those offered through the South Carolina Medicaid program. The project expects to enroll 2,750 individuals.

Since January 1989, **Washington**'s Basic Health Plan (BHP) demonstration program has provided state subsidies for the cost of health plan membership for individuals under age 65 who are not eligible for Medicaid and who have gross family incomes below 200 percent of federal poverty guidelines. After negotiating rates with a managed health care system, the state sets premiums; however, enrollees pay premiums according to a sliding-fee scale based on family size, age, income, and geographic region. The Basic Health Plan reached its statutory limit of 20,000 subsidized members about two years after beginning enrollment.

In addition, a new demonstration project, called BHP2, will seek enrollees not covered by the Basic Health Plan. This program will also use managed care providers; however, more extensive benefits than those available under BHP will be offered. Small employers will be solicited to participate in offering coverage through BHP2. Projected enrollment is 3,650 individuals.

Oregon has proposed an innovative, but controversial, strategy using Medicaid to fund health care for all Oregonians with incomes below 100 percent of the federal poverty level. Following an extensive process which included community meetings, public hearings, and a significant telephone survey, the Oregon Health Services Commission, a panel of health care providers, identified 17 categories of care encompassing 709 condition-treatment pairs.

The Oregon methodology also included research and expert testimony on the effectiveness of treatments, a formula that considered cost and benefit of treatments, public values, and independent commissioner judgment. Any necessary rationing would be accomplished by reducing benefits, rather than by restricting eligibility. The Oregon plan, because it is Medicaid specific, required a federal waiver. In August 1992, the Health Care Financing Administration denied the Oregon application for a waiver, averring that the proposed program would violate the Americans with Disabilities Act; however, Oregon officials submitted a revised application and the waiver was granted in March 1993.

The **Maine** Health Program is a state-sponsored insurance program for adults with incomes under 95 percent of the federal poverty level and for children with family incomes under 125 percent of poverty. The program offers all Medicaid services, except nursing home or pregnancy care. The program stopped enrolling additional adults in February 1992, because of the overwhelming demand for the program. The project now covers about 7,600 persons; slightly more than half are adults.

Health Insurance Purchasing Cooperative

A health insurance purchasing cooperative is a state-sponsored pool of people who have their choices of insurance and premiums negotiated by one authority. This authority--the cooperative--selects insurance companies and HMOs to participate, negotiates premiums, and sets contribution levels from the various participants. The authority also establishes rules for the marketing of insurance such as guaranteed issue, limits on preexisting condition clauses, and guaranteed renewability. Community rating is required for a defined set of benefits for all participating parties. Higher benefits may be offered and purchased, but the basic benefits must be community rated.

This newest form of essential health services coverage is being developed in **California**. The California agency responsible for administering the state employees health benefits program negotiates with insurers and provides promotional material to participants. In addition to all state employees, approximately 400,000 local employees already participate in the state employees health benefits program. The state is planning to convert the state employees health benefits program into a cooperative, in order to allow small employers to participate as well as the state and local employees.

IV. A SHORT STUDY HISTORY

Convened for its organizational meeting on July 13, 1992, the Essential Health Services Access Panel held nine meetings. During the first meeting, a review of the panel's charge, pursuant to SB 506, was presented, which noted the panel's statutory timelines as well as the considerations to be factored into its deliberations, such as cost/benefit analysis, the Commonwealth's present health care system, relevant federal and state law and programs, other states' and countries' programs, existing third-party plans, and cost-containment mechanisms.

The panel was also counselled on uses for essential health services programs and advised that the Joint Commission on Health Care and the General Assembly will share the ultimate responsibility for determining the

purpose of the essential health services plan. The panel's study plan noted that its draft report must be forwarded to the Advisory Commission on Mandated Health Insurance Benefits for review and comment. During this initial meeting, the panel engaged in extended discussion and expression of their individual perspectives. The panel's topics included how "essential" should be defined, how an assessment of cost/benefit should or could be made, and how to differentiate between essential services and standard services. Some of the suggestions were that the panel:

- Look first at what services the population needs, using its best objective judgment concerning net benefit from such services and bearing in mind the need for flexibility.

- Focus on various categories of services, e.g., preventive services (primary prevention), universal need, diagnostic services (disease prevention), and treatment, being reasonably specific in its proposal.

- Examine services from the perspective of what a basic health care plan should include and what is age appropriate, limiting its discussion to services for individuals between the ages of 0-65 (since Medicare covers older individuals).

- Take a balanced, rational approach, bearing in mind the long range goal of maintaining health/preventing disease while being sensitive to cost issues, including the costs of treatment and the costs of not treating.

- Avoid focusing on the uninsured and focus instead on identifying those services that should be available to everyone.

During the panel's next four meetings, much material and data was covered. An overview of the Governor's Child Health Program was presented in which it was noted that over 200,000 Virginia children belong to families that cannot afford basic health care, over 80 percent of whom have working parents. Because of the profound effects of poor health care on children, the Governor's Child Health Task Force determined that coverage for basic health needs for those children under the age of 18 whose family incomes are less than 200 percent of the federal poverty level was essential.

The panel examined the definitions, criteria, and services provided in certain other states' programs and conducted, using a staff-prepared matrix of other states' and programs' services, a detailed discussion of the possible definitions and criteria for Virginia.

"Essential health services" were defined as "**those age-appropriate preventive, diagnostic, and treatment services required to maintain good health and to return individuals to good health.**"

Determinative principles for identifying essential health services were also recognized as:

- Appropriate and effective for the prevention, diagnosis, or treatment of disease, injury, or congenital conditions (clinical effectiveness test)

- Good value for the dollar spent (cost effectiveness test)

- Contributing to the quality of life, or providing comfort care for the terminally ill (quality of life test)

- Chosen for the individual or family without regard for the individual's or family's ability to pay (paternalistic test)

- Consideration of consistency with the health services common to most current health benefit plans and public health programs (equity test)

- Defined in terms of health services, not providers (health services test)

The panel repeatedly evaluated the services on a staff-developed matrix in detail, directing that provider/site specific coverage should be eliminated. The panel received presentations from representatives of business, insurance, consumer, and provider organizations and other interested parties as well as an overview of health insurance policies/plans and the Board of Health's perspective. Statements concerning copayments, deductibles, and other means of limiting services and containing costs noted that, if a cost-effective administrative structure existed, such limitations might not be needed. Many individuals testified concerning mental health services as "essential" services for the citizens of the Commonwealth.

Over the first five meetings, the panel also received descriptions of the current efforts in other states, including Arizona, Florida, New York, Ohio, Connecticut, Hawaii, Michigan, Minnesota, South Carolina, Washington, and Maine and was presented with information on the health systems in Canada, France, Germany, Japan, and the United Kingdom.

A three-round Delphi survey was conducted of the panel's members concerning services considered to be "essential." Ranking for the Delphi survey was based on the following relative value scale:

MUST have
SHOULD have
Important
Moderately Important
Not Particularly Important

The panel collectively reviewed and ranked the services listed on the Delphi survey over a series of meetings; the ranked services were retained on the essential/MUST have list, moved out of the MUST have ranking for further discussion, or designated for possible exclusion.

There were many different reasons for the panel's collective rankings. For example, some matrix services were considered to be included under retained broader categories and certain terminology, such as maternity care/obstetrics, was deemed redundant (maternity care was retained). All provider/site specific services, such as optometry services and rural health clinic services, were marked for exclusion. This notation does not, however, mean that health services identified as "essential" could not be delivered by the specific provider or at the specific site. Further, some matrix services did not, in the judgment of the panel, meet the established determinative principles. Definitions of "medical emergency," "inpatient hospital services," and "medically necessary" were also developed to apply to the essential health services list.

The panel discussed the availability of information sufficient for health insurance comparison shopping, the viability of developing limitations on the essential health services, and the merit of examining several different approaches or plans for essential health services. The panel concluded that providing the Advisory Commission on Mandated Health Insurance Benefits, the Joint Commission on Health Care, and the General Assembly with a list of essential health services and standard health services as well as a selection of proposed flexible plans for limiting costs would increase the potential uses of their report. To assist the consumer in comparison shopping for health coverage, the panel suggested that two or three policies/plans/programs covering the essential health services list be developed and statutorially required to be offered by insurers, specifically those insurers operating in the small business market.

A pricing study group was assembled, consisting of panel staff and representatives of Blue Cross and Blue Shield of Virginia, Kaiser Permanente, and the Department of Medical Assistance Services. Optima and southern Health Services also assisted in this effort. The participating organizations agreed to assist the panel in developing cost estimates for the essential health services program, using various assumptions regarding limitations, deductibles, co-insurance or co-payments, premium cost sharing, maximums, and the pricing of specific services, etc. In developing these estimates, the price or cost of alternative essential health service programs was estimated by using available data and assuming the package of designated services will cover the same populations as the respective plans. Certain assumptions were also made regarding the level and types of managed care delivery systems which will be recommended in order to price the programs.

In discussing various uses and cost limitations or cost containment devices, the panel was advised of managed care provisions, caps on expenditures, stop-loss provisions, fee schedules, rating bands, risk spreading, state subsidies, tax credits, etc. Twenty-seven other states, it was noted, have adopted conceptually similar legislation.

The panel's consensus was that the essential health services plan(s) should focus on improving the health status of Virginians at reasonably low costs, with some incentives for patient responsibility, and that the plan(s) should provide incentives for employers to maintain or expand their commitment to health care benefits. The panel also opined that a tightly managed plan, which encourages physician participation, would facilitate containment of costs while enhancing primary care.

The panel reiterated that the list of essential health services will need to be reviewed on an ongoing basis as new treatments and diagnostic tools are developed and outcomes assessment, standards of practice, patterns of care, and medical technology evolve. Therefore, if the essential health services plan becomes the basis for legislative action, the panel strongly recommended the establishment of a mechanism for continuous review and modification of the essential health care access services, especially to maintain currency, cost effectiveness, and treatment efficacy.

V. THE ESSENTIAL HEALTH SERVICES PLAN

After extensive and difficult deliberation, the Essential Health Services Panel reached consensus on the services considered "essential."

Definitions applying to the essential health services list are:

"Medical emergency" means a condition or chief complaint manifested by acute symptoms of sufficient severity which, without immediate and necessary medical attention, could reasonably be expected to result in (i) serious jeopardy to the mental or physical health of the individual, or (ii) danger of serious impairment of the individual's bodily functions, or (iii) serious dysfunction of any of the individual's organs, and (iv), in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Medically necessary" means a service acknowledged as acceptable medical practice by an established United States medical society for the treatment or management of pregnancy, illness, or injury which (i) is the most appropriate and cost-effective service to be provided safely to the patient, (ii) is consistent with the patient's symptoms or diagnosis, and (iii) is not experimental or investigative in nature. The fact that a physician prescribes a service does not automatically mean such service is medically necessary and will qualify for coverage.

Subject to appropriate utilization review and payment authorization, "covered inpatient hospital care" for individuals age 18 and over shall be limited to 21 days of hospitalization in a 12-month period, whether incurred for one or more hospital stays in the same or a different hospital. For individuals up to the age of 18, "covered inpatient hospital care" also includes primary care provider-certified, medically necessary inpatient hospitalization beyond the 21-day limitation, upon appropriate utilization review and payment authorization.

SERVICES DETERMINED TO BE ESSENTIAL (MUST-HAVE)

—Emergency Services:

* Pre-hospital emergency medical services including ambulance
* Emergency hospital services (emergency room and inpatient services)
* Upon primary care provider certification, emergency room care for medical emergencies (refer to definition of "medical emergency")
* Acute medical detoxification
* Severe mental health crisis services, with ambulatory treatment preferred; includes inpatient treatment only on referral by primary care provider

—Primary Care for all medically necessary care and Preventive Care as outlined in the then current guidelines (all services to be reviewed and revised annually) of the American Academy of Pediatrics for children and in the then current guidelines of the American Academy of Family Physicians (AAFP) for adults (19 years and older; individuals 65 and over not included--assumed to be covered by Medicare) as follows:

* 18 preventive health visits from birth to age 18, inclusive (to be reviewed and revised annually consistent with the then current guidelines of the American Academy of Pediatrics)
  --Documented child health history
  --Physical examination

--Primary and Preventive Care, birth to age 18, cont'd.

--Developmental/behavioral assessment
--Anticipatory guidance
--Immunizations, including (as of the July 1991 AAP guidelines) diptheria-tetanus-pertussis (DTP), oral poliovirus (OPV), measles-mumps-rubella (MMR), and Haemophilus influenzae type b (HIB)
--Laboratory services

* On the recommendation of the primary care provider, one preventive health visit every 1-3 years **(no more than one per year)** from age 19 to age 39 inclusive (to be reviewed and revised annually consistent with the then current guidelines of the American Academy of Family Physicians)
--Documented health history
--Physical examination
--Laboratory/diagnostic procedures including nonfasting or fasting blood cholesterol **(at least every five years)** and Papnicolauo smear **(annually for women who are, or have been, sexually active; every three years, at the discretion of the primary care provider, for women having three or more consecutive satisfactory normal annual examinations); for high-risk groups**, fasting plasma glucose, rubella antibodies, VDRL/RPR, urinalysis for bacteriuria (frequency has not been determined; however, dipsticks combining leukocyte esterase and nitrite tests should be used to detect asymptomatic bacteriuria), chlamydial testing, gonorrhea culture, counseling and testing for HIV, hearing, tuberculin skin test, electrocardiogram, mammogram **(women aged 35 and older with a family history of premenopausally diagnosed breast cancer in a first-degree relative)**, colonoscopy **(persons with a family history of familial polyposis coli or cancer family syndrome)**
--Counseling on diet, exercise, substance use, sexual practices (including sexually transmitted diseases and family planning), injury prevention, dental health, and other primary preventive measures
--Immunizations, including, as of August 1991, tetenus-diphtheria booster **(every 10 years)**, and, **for high-risk groups**, hepatitis B vaccine, pneumococcal vaccine, influenza vaccine **(annually)**, and measles-mumps-rubella vaccine

* On the recommendation of the primary care provider, one preventive health visit every 1-3 years **(no more than one per year)** from age 40 to age 64, inclusive (to be reviewed and revised annually, consistent with the then current guidelines of the American Academy of Family Physicians)
--Interval and family health history
--Physical examination
--Laboratory/diagnostic procedures including nonfasting or fasting blood cholesterol **(at least every five years)**, Papnicolauo smear **(annually for women who are, or have been, sexually active; every three years, at the discretion**

--Primary and Preventive Care, age 40 to age 64, cont'd.

of the primary care provider, for women having three or more consecutive satisfactory normal annual examinations) and mammogram (**annually for all women beginning at age 50; every one to two years for women between ages 40 through 49); for high-risk groups**, fasting plasma glucose, VDRL/RPR, urinalysis for bacteriuria, chlamydial testing, gonorrhea culture, counseling and testing for HIV, hearing, tuberculin skin test, electrocardiogram, fecal occult blood/sigmoidoscopy (**persons aged 50 and older who have first-degree relatives with colorectal cancer; a personal history of endometrial, ovarian, or breast cancer, or a previous diagnosis of inflammatory bowel disease, adenomatous polyps, or colorectal cancer**), fecal occult blood/colonoscopy (**persons with a family history of familial polyposis coli or cancer family syndrome**), and bone mineral content
--Counseling on diet, exercise, substance use, sexual practices, injury prevention, dental health, and other primary preventive measures
--Immunizations, including tetanus-diphtheria booster (**every 10 years**), and, **for high-risk groups**, hepatitis B vaccine, pneumococcal vaccine, influenza vaccine

—Outpatient Diagnostic Services/Testing/Treatment, upon referral by primary care provider:

* Outpatient radiation/chemotherapy treatment, when medically necessary and upon referral by primary care provider
* Laboratory
* Screening Services
* X-ray or imaging
* Psychological testing

—Maternity Care (consistent with the then current guidelines of the American College of Obstetrics and Gynecology):

* Prenatal care, including diagnosis of pregnancy and, when medically indicated and, in accordance with the American College of Obstetrics and Gynecology guidelines, laboratory services and other diagnostic/testing procedures (e.g., amniocentesis, ultrasound, radiology, etc.);
* Inpatient hospital services, including anesthesia, complications of pregnancy, delivery by vaginal and caesarean section, labor and delivery room, medications, operating or other special procedure rooms, etc.
* Postpartum care

—Inpatient Hospital Care, subject to appropriate utilization review and payment authorization (for individuals 18 and over, limited to 21 days in a 12-month period, whether incurred for one or more hospital stays in the same or a different hospital; for individuals up to the age of 18, "covered inpatient hospital care" also includes primary care provider-certified,

--Inpatient Hospital Care, cont'd.

medically necessary inpatient hospital care extended beyond the 21-day limitation, upon appropriate utilization review and payment authorization):

* Room/board and ancillary services including anesthesia, casts, dressings, drugs and medications, equipment, general nursing, inhalation therapy, intensive care unit, laboratory and X-ray services, oxygen services, radiation therapy, short-term physical therapy, special diets, supplies, and use of operating room and recovery room
* Inpatient medical services, including primary, consultative, and specialty provider services
* Inpatient therapeutic blood services, including blood derivatives and their administration; whole blood when a volunteer blood program is not available
* Inpatient mental health services upon referral by the primary care provider and limited to 21 days annually
* Newborn care

—Outpatient Therapeutic Blood Services, including blood derivatives and their administration; whole blood when a volunteer blood program is not available

—Prescription Drugs, including prescription contraceptives:

* Limited to generic drugs as approved by the Virginia Voluntary Formulary Board, except when not available

—Durable Medical Equipment, when medically necessary

—Outpatient Medical and Surgical Specialty Care, including consultation, surgery, medication management visits for physical or psychiatric chronic/acute illnesses, and facility fees, when medically necessary and upon referral by the primary care provider

—Limited Outpatient Mental Health Counseling/Substance Abuse Treatment Services:

* 20 visits annually

—Prescription/Corrective Lenses for Children:

* Limited to one pair per year; limited frame selection

—Preventive and Acute Dental Care for Children:

* Regular examination (2/year)
* X-rays (where medically indicated)
* Prophylaxis (2/year)
* Topical fluoride (1/year)
* Sealants (permanent molars only, age 6-17)
* Fillings (excluding multisurface resins post. teeth)
* Temporary crowns (stainless steel and polycarbonate)
* Pulpotomy (with pre-authorization)

--Preventive and Acute Dental Care for Children, cont'd.

* Root canal (with pre-authorization)
* Space maintenance (early lost teeth, with pre-authorization)
* Oral surgery
  --Extractions (for relief of pain, infection, or cystic lesions)
  --Biopsy
  --Removal of tumors, cysts, or neoplasms (medical or dental)
  --Treatment of fractures of maxilla or mandible (medical or dental)
  --Correction of congenital facial deformities
* Emergency care
  --Palliative
  --Trauma care
  --Replacement crown
  --Repair space maintainer
  --Repair dentures (full or partial)

—Kidney and Cornea Transplants (only)

VI. THE STANDARD HEALTH SERVICES PLAN

In order to arrive at the services to be included in the standard health services plan, the list of MUST HAVE or essential health services must be added to the SHOULD HAVE services list. The panel recommended the following services as add-ons to the essential health services list, the two lists to comprise the standard health services plan.

ADDITIONAL SERVICES (SHOULD HAVE LIST) TO BE INCLUDED WITH ESSENTIAL SERVICES IN A STANDARD PLAN

---Allergy Treatments, according to the guidelines and upon PCP referral

* skin testing
* injections

---Audiology/Speech/Hearing Disorder Services, upon referral by PCP

* Hearing aids and services

---Adult Dental Services

* Emergency examination
* X-rays (where medically indicated)
* Extraction (for relief of pain, infection or cystic lesions)
* Biopsy
* Removal of tumors, cysts or neoplasms
* Repair of dentures (complete or partial)

---Adult Dental Services, cont'd.

* Regular examination (2/year)
* Prophylaxis (2/year)
* Fillings
* Temporary crowns
* Pulpotomy (with pre-authorization)
* Root canal (with pre-authorization)
* Replacement of teeth, including complete/partial dentures

---**Case Management Services,** under direction of PCP

* Medical case management, performed by or under direction of PCP
* Social case management, under direction of PCP
* High cost illness case management, subject to guidelines based on outcomes

---**Inpatient Hospital Care,** from 21 to 365 days in a 12-month period, upon appropriate utilization review and payment authorization:

* Room/board and ancillary services including anesthesia, casts, dressings, drugs and medications, equipment, general nursing, inhalation therapy, intensive care unit, laboratory and X-ray services, oxygen services, radiation therapy, short-term physical therapy, special diets, supplies, and use of operating room and recovery room
* Inpatient medical services, including primary, consultative, and specialty provider services
* Inpatient therapeutic blood services, including blood derivatives and their administration; whole blood when a volunteer blood program is not available
* Inpatient mental health services, upon referral by the primary care provider

---**Prescription/Corrective Lenses** for Adults:

* Limited to one pair per year; limited frame selection

---**Medically Necessary Post-hospital Alternatives** to Inpatient Hospital Care (as appropriate when approved by PCP as part of overall treatment plan to eliminate need for hospital admission or reduce inpatient hospital length of stay):

* Pre-authorized home health visits
* Hospice
* Nursing home care (skilled nursing care)

---**Rehabilitative Care**, upon referral by primary care provider:

* Mental health/substance abuse therapy
* Occupational therapy
* Physical therapy

---**Transplants** (heart, liver, others when medically effective)

VII. ADDENDUM TO PLANS

In its original form, the staff-developed matrix, used by the panel for opening discussion on essential health services, included many public health and ancillary services, ranging from environmental health services and dietary instruction to transportation and child care. In the panel's discussions, the "essentialness" of effective school health programs, general health education programs, and public health programs was addressed. Further, the panel observed that adequate transportation, child care, and other ancillary services are required for access to health care to be a reality.

The panel noted that children's educational success is directly related to their health. In Virginia, many school divisions offer only minimal school health services. The panel emphasized that, in this era of rising health care costs and significant socioeconomic-related health problems such as substance abuse and sexually transmitted diseases (STDs), health promotion education--in the schools--must play a crucial role in modification and prevention of at-risk behavior among children and young people. Certain members felt strongly that school health services should be enhanced and that the role of the schools as delivery sites for primary and preventive health care should be expanded.

Similarly, health promotion services serve the critical role of modifying and preventing at-risk behavior among adults through education on stress management, disease management, substance use, nutrition, etc. The panel commented on the Department of Health's excellent efforts in health promotion, which have been concentrated on risk reduction and prevention. Other public health services are also, in the panel's opinion, critical to Virginians' good health, e.g., environmental health services such as lead abatement, water quality control, and food inspection; STD contact tracing; and disease prevention and surveillance.

Although the available health care services vary widely among the various local and district health department offices in the Commonwealth, certain services are offered on a statewide basis, e.g., family planning, immunizations, HIV testing and counseling, and children's specialty services.

The panel stressed that, in its opinion, health promotion and primary care services available to the public on a sliding fee basis or at low or no cost through health department programs as well as primary and critical care services available through various free clinics and ancillary services provided by other public or private community efforts must be integrated, to the extent possible, into any program to provide health care to uninsured Virginians. Therefore, although not considered appropriate for inclusion in either of the plans, certain public health and ancillary services are important. Services thus designated as IMPORTANT, but **not** MUST HAVE or SHOULD HAVE were:

---Health Education:

* Assistance in management of stress and related health problems
* Dietary instruction
* Personal health care seminars

---Public Health Services:

* Child care necessary to receive services
* Communicable disease prevention and control
* STD screening clinic services
* Community health promotion and education
* Community health protection
  --Environmental health
  --Occupational health and safety
* Public health information and referral
* Public health nursing
* Public health outreach for infectious disease control
* Translation and communication
* Transportation to receive services

VIII. OTHER FINDINGS AND LEGISLATIVE OPTIONS

Experiences in other states and the latest research strongly indicate that the key to a successful essential health services access program is affordable health insurance. While development of a list of essential health services intrinsically helps to reduce the cost of coverage by establishing a circumscribed set of services, other mechanisms also exist to make coverage affordable.

Some suggestions for enhancing the affordability of insurance coverage using the essential health services list are offered in this chapter to provide the joint commission and General Assembly with flexible options; available mechanisms for using the essential and standard health services lists are also described.

Ways of enhancing the affordability of insurance include, but are not limited to:

- Placing additional **limits on covered benefits**;
- Reducing insurance administrative costs by creating **risk pools for individuals and groups**;
- Creating rules for purchasing the essential services that **prescribe who pays** the premium costs;
- Using existing systems or creating new **delivery systems** having managed care networks and techniques;
- Instituting **rules for insurance** that forbid or discourage actions that limit the availability or the affordability of insurance.

Each method of enhancing the affordability of insurance can be used alone or in various combinations with other cost containment mechanisms. Because these mechanisms are legislative in purview and beyond the scope of its authority, the panel is not recommending one or more combinations as packages to implement an essential health services access program. Nevertheless, in fulfilling its charge to assist the joint commission and the General Assembly, the panel has enumerated findings

and legislative options that could be pursued in Virginia to make an essential health services access program work.

The Price of the Virginia Essential Health Services Access Program

With the collaboration of the Department of Medical Assistance Services, Blue Cross and Blue Shield of Virginia, and Kaiser Permanente and the assistance of Optima and Southern Health Services, the panel has estimated the insurance cost of the essential "MUST HAVE" list of services. The estimates are shown in the table on page 21 along with the actual cost of essential insurance packages already being marketed or subsidized in several other states.

The price of insurance packages depends upon the assumptions used to estimate costs regarding:

- Deductibles
- Coinsurance or copayments
- Payments to providers
- Managed care networks and managed care techniques

Therefore, for the purpose of making estimates, four prototype plans were developed.

All plans are assumed to cover the "MUST HAVE" list of essential services. All plan types are assumed to have a one million dollar lifetime maximum.

A representative range of plan designs was selected, including unbridled fee for service, preferred provider network, and health maintenance organization; however, other types of plans are possible. TYPE I is a baseline plan for comparison purposes. To guard against risk selection based on plan design, similar cost sharing provisions were used for the TYPE II and TYPE III plans. The components of the four plans are:

TYPE I: No deductible, no coinsurance, no copayment, participating provider fee schedule, with unbridled fee-for-service provider network.

TYPE II: A $400 inpatient hospital deductible per admission is required, with 30 percent coinsurance after hospital deductible; $15 per provider visit for 4 annual visits, with 30 percent coinsurance for all outpatient visits, lab tests, X-rays, and prescriptions. The maximum out-of-pocket expenditure per year is $5,000 per individual and $15,000 per family. Participating preferred provider or HMO network payments are made to providers. A moderately restrictive preferred provider network or open-ended HMO network is used, in conjunction with a primary care provider case manager.

TYPE III: State-qualified HMO requirements must be met. A $400 hospital deductible per admission is required; $20 per outpatient visit, lab tests and X-rays; $10 per prescription. The maximum out-of-pocket expenditure per year is $5,000 per individual and $15,000 per family. Providers are paid in an HMO. HMO enrollment with primary care provider case manager is required.

TYPE IV: Federally-qualified HMO requirements must be met, including no deductibles, no limitations on inpatient hospital days; $20 per outpatient visit, lab tests, and X-rays; $10 per prescription. The maximum out-of-pocket expenditure per year is $5,000 per individual and $15,000 per family. HMO enrollment with primary care provider case manager is required.

The TYPE I plan would be the most expensive plan for the list of essential "MUST HAVE" services. In the TYPE I plan (see table, next page), the estimated monthly per person cost of the Virginia essential health services program (the "MUST HAVE" list of services) ranges from $126 - $187 for an individual and $353 - $527 for a family.

In contrast, the TYPE II plan utilizes restrictive preferred provider network, significant cost sharing, and a primary care provider case management system, with resulting reduced costs. The range of costs for a TYPE II plan is $73 - $132 monthly premium cost for an individual and $207 - $371 for family coverage.

The TYPE III plan delivers the essential health services with significant patient cost sharing in a state-qualified HMO. The monthly premiums are estimated to range from $109 - 123 for an individual and $ 296 - 334 for family coverage. TYPE IV, federally qualified, HMO coverage, would have estimated monthly premiums of $128 - $143 for individuals and $397 - $443 for family coverage.

Because little is known about the demographics of the population to be covered in terms of geographic location, age, and health status, there are difficulties in estimating a single price and the cost ranges are important. Therefore, ranges are presented to emphasize the provisional nature of the price estimates. Further, it is important to understand that substantial out-of-pocket limitations are positive factors in the containment of annual premium ranges. For many individuals and families, however, out-of-pocket limitations constituting significant sums may mean medical indigency and, in at least some cases, eligibility for Medicaid. The fact is that, if an insured individual or family cannot afford the out-of-pocket expense, health care still may not be obtained in a timely manner.

The estimates for Virginia are comparable to the actual experience of several other states with the pricing of essential health services plans, i.e., the Arizona Health Care Group (option A), Florida Health Access program (both high and standard options), and the Washington Basic Health Plan (with no premium subsidy). Each of these plans costs approximately $100 per month for individuals and $300 for families. These actual costs are at the high end of the estimated ranges. The table also shows the premiums for the state employee program, Key Advantage. Representing relatively generous coverage, its premiums are $171 for individuals and $479 for family coverage, well above the high range for the TYPE II plan.

Limits on Covered Benefits

A direct method for reduction of health insurance costs is to set maximum volume levels for the use of covered services, i.e., after some threshold level for certain services, coverage ceases. Some volume limits have already been included by the panel in the essential health services list. For example, the list contains a 21-day limit on inpatient hospital

MONTHLY COSTS
for
ESSENTIAL HEALTH SERVICES PLANS

January 1, 1992

Insurance Product	Individual [1]	Family
Virginia Essential Health Services Plan (Estimated) [2]		
Type I [3]	$ 126 - 187	$ 353 - 527
Type II [4]	73 - 132	207 - 371
Type III [5]	109 - 123	296 - 334
Type IV [6]	128 - 143	397 - 443
Arizona Option A	99.72	318.63
Florida Health Access		
High Option	105.44	289.25
Standard Option	98.00	269.14
Washington Basic Care		
0 - 74% of poverty	7.50	22.50
200% or more of poverty	95.00	290.00
Key Advantage for State Employees	171.00	479.00

1 *Adult, Age 35.*

2 *Central Virginia, costs would be higher in Northern Virginia. Excludes marketing and administrative costs.*

3 *Broad provider network, no cost sharing, no managed care.*

4 *Preferred provider network, cost sharing, primary care provider, managed care.*

5 *State-licensed health maintenance organization, deductible, copayments, primary care provider, managed care.*

6 *Federally-qualified health maintenance organization, no deductibles, no hospital maximum, primary care provider, managed care.*

days, limits on the medically necessary frequency of primary and preventive services in accordance with the recommendations of national specialty societies, and a limit of one pair of eye glasses per year for children.

Additional limits on service volumes or increased copayments could be established. During discussions of additional limits on service volumes, the panel stated that the essential health services list already incorporates as many limitations as would be possible and still remain "essential."

Specific mechanisms discussed by the panel included:

- Maximum of 10 inpatient days per year
- Maximum of $14,000 per hospital stay
- Maximum of four annual medical visits per person
- Maximum of two annual medical specialty care visits per person
- Maximum of 10 prescribed medicines per year
- Increased or variable copayments for services (e.g., 50/50 copayment)

Three important impediments to establishing volume limitations relate to marketability, cost shifting, and service utilization. For example, volume limitations, such as those listed in the first four bullets above, present a drawback for insurance plans marketed on a voluntary basis to previously uninsured small employers. Small employers often want more complete coverage; therefore, while volume limits may render insurance more affordable, such limits can be perceived as providing meager coverage, thereby making a plan difficult to sell.

Further, while volume limitations might avoid costs for the plan, the costs of obtained services, whether covered or not, will be incurred by some party--the patient, the employer, the public (Medicaid or other assistance), or the provider as uncompensated care. Such limits could be an indirect mechanism of shifting some health care costs to providers. For hospitals, setting limits on covered days or dollar limits per stay could result in the facilities bearing the expenses above the limits. Many primary care or specialty physicians whose patients have coverage for two to four visits might be reluctant to refuse to see their patients or to bill their patients for additional visits and might continue to provide free care or care at reduced out-of-pocket cost. However, because limits are an indirect way of shifting costs, they can result in unequal burdens among providers and lead to unwanted provider conduct; volume limits also provide poor incentives for continuity and coordination of care.

Finally, service limitations can have unintended effects on utilization of services. Limitations on prescription drugs, for example, may increase inpatient hospitalization as a result of inadequate outpatient drug therapy, subsequent health deterioration, and the consequent need for hospital admission to stabilize the patient. Limitations on drugs in Medicaid programs have resulted in hospital admissions just to obtain free prescriptions for patients.

Certain essential health services included in the panel's list have been excluded from other states' basic insurance plans. Therefore, another means of designing a more affordable insurance plan would be to eliminate certain services from the list of essential services. Services might be recognized as essential, yet nonetheless excluded from coverage for the sake of affordable insurance.

Examples of services listed in the essential health services plan which were excluded from some other state plans are:

- Vision care
- Transplants
- Mental health care
- Durable medical equipment
- Dental care
- Alcohol and substance abuse treatment

Although affordability could emanate from volume limitations or service exclusions, the savings are difficult to estimate. Nevertheless, an informed approximation would indicate significant coverage cost savings from these devices.

Rough estimates of the cost impact from volume limits or service exclusions were made by the pricing study group. A reduction in the maximum 21-day inpatient hospitalization per calendar year to a maximum of 10 days per calendar year would reduce the premium costs by 5-8 percent. A $14,000 per stay maximum in addition to a 21-day limitation would lower premiums by 5-10 percent. Eliminating mental health/substance abuse services would lower costs by 5-7 percent. Eliminating prescription drug coverage would lower the premium by 12-18 percent. A combination of volume limitations and service exclusions would decrease the range of monthly premiums by approximately 40 percent to $70 to $105.

As an alternative to volume limitations or service exclusions, the panel emphasized that the complete list of essential health services could be delivered at much lower cost in a managed care setting. As the accompanying table indicates, premiums can be lowered by 40 to 50 percent by a Type II plan (preferred provider network or open-ended HMO network in conjunction with a primary care provider case manager). Given the disadvantages discussed previously regarding volume limitations or service exclusions, the Panel strongly advocated cost-effective methods of delivery for the complete essential health services list.

Risk Pools

Private health insurance coverage in the small group employee market has been declining for nearly 15 years, while individuals are increasingly finding the costs of health insurance prohibitive. In 1990, although almost 100 percent of large employers offered health care benefits, only about 36 percent of firms with 25 or fewer employees provided health insurance.

Much of the small business market decline can be traced to federal interference in the private insurance market with the enactment of the Employment and Retirement Income Security Act and the subsequent marked growth in self-insurance among large employers. In the past, HMOs, Blue Cross/Blue Shield plans, and some commercial insurers created large pools of individual and group insureds, using community rating to spread the risk of covered services over these sizeable populations. Today, only federally qualified HMOs perform the same large scale community rating function. Insurers compete to identify and attract the best risks. Industry practice is to divide the risks into ever smaller groups for experience rating purposes. Groups and individuals are being denied coverage or levied significantly increased premiums to reflect changes in health status. These practices create unnecessary administrative costs, make the small group and individual markets nonfunctional, and push more people into the ranks of the uninsured. To address these issues, some critics have recommended that states recreate insurance pools as structures for community rating. Examples of insurance risk pools are a health insurance purchasing cooperative (HIPC), a health insurance network (HIN), and risk pools for individuals and groups.

A **health insurance purchasing cooperative (HIPC)** is a state-chartered, not-for-profit organization, with exclusive geographic territory (whole state, region or local area), designed to organize, offer, and administer affordable health insurance options, using community rating for a basic set of services. Each HIPC would negotiate premiums and select a menu of accountable health plans to be paid on a capitation basis, i.e., enrolling people at risk. Clear, concise, standardized information in booklet form would be provided to permit individuals and employees to make choices among plans. The HIPC would also collect information on outcomes of care and patient satisfaction to assist people in making choices annually among plans and to provide strong incentives to plans to keep people healthy and satisfied.

Persons carrying individual coverage and uninsured small businesses might be required to join the HIPC. For example, to make coverage more available and affordable, all individuals, except employees of very large companies, might be encouraged or required to join a HIPC. Employers might be required to make health insurance contributions to the HIPC equal to the lowest cost plan offered to employees, or employers might be granted tax deductions limited to the amount of contribution for the lowest cost plan. Risk adjustments for differences in enrollees' health status would be made to ensure that plans enrolling high-cost individuals would be paid higher premiums than plans enrolling low-cost individuals; therefore, biased selection would be minimized.

A **health insurance network (HIN)** is a state-licensed organization with voluntary enrollment, used to create large, community-rated pools of participating employer groups. Like HIPCs, HINs help to make coverage more available and affordable by pooling employer groups; however, participation is voluntary and no limits are placed on the number of organized HINs. Health insurance networks allow employer groups to pool their purchasing power, thereby obtaining the cost advantages enjoyed by large businesses. Regional and statewide small business associations and other groups forming HINs would be granted exemptions similar to those enjoyed by self-funded employers (through ERISA) by the state, i.e., exemptions to the mandated benefit laws, the health insurance premium

taxes, and other conflicting state law. Further, the insurance commissioner could be granted authority to regulate HINs.

A **high risk reinsurance pool** is a public or private entity, directed by a public board, which establishes and collects premium assessments, pays high-risk covered medical claims, and selects a contractor to administer the pool. Health plans may or may not be required to join the pool. A high-risk pool creates a system for community rating, particularly for high cost individuals. Greater affordability comes from cross-subsidies among insurers and reducing the incentives to select risks. As part of a strategy to spread the risk of service coverage, 26 states have implemented high-risk reinsurance pools. These pools provide mechanisms to avoid risk selection and to ensure that no particular insurance company will bear a disproportionate share of high risk individuals. Insurance companies can "cede," or transfer to the risk pool, individuals whose claims experience surpasses an established threshold. Once ceded, the individual's claims are paid by the high-risk pool. Participating insurance companies are usually assessed a contribution to fund the payment of the high-risk claims. Thus, the cost of high-risk coverage is shared among all participating health plans and, ultimately, among all subscribers through premium adjustments via participating plans' assessments.

Risk pool assessment methods are frequently controversial among insurers. High-risk pools are often ceded individuals whose health expenses are the most costly. Therefore, high-risk pools tend to have financial difficulties from time to time and some states subsidize their pools. Some employer groups with favorable risk experience would have higher premiums than they might have had otherwise, others would have lower premiums; all would be insulated from marked swings in insurance premiums caused by unfavorable risk experience. To protect against marked increases at implementation, a maximum increase of 15 percent per year attributable to the reinsurance pool and community rating might be allowed.

Insurance Rules

All risk pools would be accompanied by new rules for marketing insurance--perhaps the most conspicuous changes to enhance the affordability of essential health services coverage. The National Association of Insurance Commissioners, the Blue Cross and Blue Shield Association, and the Health Insurance Association of America all support such changes. More than 22 states, including Virginia, have already passed some or all of these reforms. The recommended reforms change enrollment and underwriting practices, renewal practices, and premium rating practices. While little evidence currently exists that the changes will significantly impact insurance affordability, these reforms may serve as important precursors to more profound changes.

Guaranteed availability or guaranteed issue requires any insurer in the state serving the small group insurance market (usually defined as three to 25 or 50 employees) to provide coverage, using some form of community rating. Four approaches to guaranteed issue with community rating are:

- Insurance companies simply voluntarily agree to be guaranteed-issue carriers.

- Guaranteed-issue is required in conjunction with a voluntary reinsurance association (see below).
- Guaranteed-issue is required in conjunction with a mandatory reinsurance association (see below).
- Guaranteed-issue is required in conjunction with an allocation program, whereby high-risk groups are allocated among all carriers in a state according to a formula.

Voluntary agreement to guarantee issue is administratively simple for the state. However, some insurers indicate the need for an "even-playing field." Many insurance carriers complain that, if guaranteed issue is required, they could not community rate without some mechanism to share risk among carriers. Insurers threaten to leave the market without some pooling mechanism. To resolve these concerns, a reinsurance association may be created by the state--which presents the important question of whether participation in such a reinsurance pool should be voluntary or mandatory. Large insurers may not feel the need to participate in a reinsurance association and may advocate voluntary participation. On the other hand, smaller insurers may feel more vulnerable to the increased risks of guaranteed issue and may support mandatory participation in order to ensure the availability of funds to cover substantial claims. An allocation program which randomly assigns high risks to each carrier in the state in proportion to their business in the state--similar to the mechanism for assigning high risk drivers for automobile insurance--is yet another approach.

Limitations on Preexisting Condition Clauses--Insurance policies have limits on coverage for medical conditions that existed prior to enrollment in the insurance. In the small employer group market, such provisions have been tantamount to no insurance coverage for affected individuals, because the clauses say that coverage will never be provided for a preexisting condition. Prohibiting or limiting preexisting condition clauses increases access to coverage, because insurance companies have used these clauses to limit coverage to only the healthiest people, leaving others, particularly the chronically ill, without coverage.

Guaranteed Renewability--Insurers have always had complete freedom to cancel insurance. Problems result when the insurance is cancelled because an employee's or individual's health status change has increased the number of submitted claims. Reform provisions guaranteeing renewability obligate insurers to renew insurance each year and, in combination with guaranteed availability provisions, require the issuance of insurance, upon a group application

Premium Rating Limits--Although guaranteed availability, preexisting condition limits, and guaranteed renewability increase the availability of insurance, these reforms have little effect on accessibility. Freedom to set premiums can result in high charges, with insurers using premiums to force out unwanted groups.

To address the concern of exorbitant premiums, premium rating would limit the range of premiums for similar groups, thus tying similar groups' premiums together in a modified community rating system and spreading high risks across a broader base. Usually the limit is defined as the average of the insurers' highest and lowest premium, plus or minus 35 percent, for a similar group. Premium rating limits allow market-wide cost increases, while limiting increases related to specific health risks.

Adjustments based on age, sex, and geographic location might be allowed. Further, premium differences (for example, up to 15 percent) might be permitted for various industries.

Financing the Cost of Insurance--The question of affordability of health insurance must be answered in the context of the population for whom the insurance is to be affordable. The panel emphasized in its deliberations that when health care services are provided, someone pays or absorbs the costs--employers, individuals, other payers, providers, or government. The three potential payers for an essential health services plan are employers, individuals, or the state or some combination thereof. In addition, subsidies might be created, as they are today, through discounts from providers for those in the plan.

Market Reforms and Continued Provider Discounts--As seen by the above discussion, states may enhance affordability without increasing their costs by adopting insurance reform measures and using an essential health services plan to define the basic services covered by small employer group insurance.

The insurance could be voluntarily offered and purchased; employers could set their own and their employees' contribution levels. Experiences in other states suggests that a purely voluntary system results in only modest improvements in insurance coverage. Increased availability of insurance through insurance market rule changes may not be enough to make the insurance sufficiently affordable for employers to purchase.

The state could regulate the payment levels to providers, with special requirements established for employers or individuals to be eligible to purchase the insurance. Then, for those so qualified, provider rates might be discounted. For example, Medicaid or Medicare payment rates might be used. Steep discounts would shift the costs of the insurance to providers; providers might shift these costs to other payers. Some providers might, however, welcome an insurance mechanism for previously uninsured persons. In any case, unless the provider discount is freely agreed to, the current practice of cost shifting, although already somewhat constrained, would surely continue.

Tax Credits

Positive incentives to individuals and employers to purchase insurance can be provided through tax credits. Tax credits are an indirect means to use state funds to enhance affordability by allocating a fixed credit for eligible individuals (eligibility usually based on income) or employers (small groups) to reduce their tax burden. A tax credit for a fixed amount per employee when combined with other reforms can leverage limited state resources by partially subsidizing small group employers.

The tax credit can also be refundable to poor persons who pay no taxes in order to provide an actual subsidy to purchase insurance. A tax credit for poor families with children exists in federal law and was expanded this year. State matching credits would have low administrative costs (the tax system is already in place) and could provide assistance for purchasing insurance. Thus, if an individual or family purchases insurance, they can get a dollar reduction in taxes paid. While the federal government has the biggest impact on the availability of tax deductions for

health insurance costs through federal wage taxes (7.65 percent) and federal income taxes (15 - 31 percent), states can resolve tax disincentives by making health insurance costs deductible. Most uninsured people, because they lack access to group coverage, must first earn income, pay social security payroll taxes and state and federal income taxes on that income, and then use after-tax dollars to purchase insurance. Thus, the tax system causes the cost of insurance to be 25 to 30 percent higher for individuals without access to employment-based group insurance.

Individual or Employer Mandates

Requirements that employers "pay or play" (contribute to a state-operated program or provide insurance) have been enacted in some states; however, only Hawaii, through an exemption to the ERISA preemption, has a workable mandate on employers to provide insurance. Alternatively, a mandate might be placed on individuals. Some observers challenge the entire employment-based insurance system in the United States and question why individuals and families should not be responsible for their insurance coverage, with government subsidies for low-income people. Placing the responsibility on the individual would enhance the portability of insurance and reduce the burden on employers to manage and pay for insurance.

The state could require all uninsured citizens (those with employment-based coverage would automatically meet the mandate) to purchase insurance for an essential set of services, providing tax or other subsidies for the poor. The program could be phased in, beginning with a subset of essential services, such as primary and preventive care services, or high cost services that might be covered by a reinsurance pool.

Medicaid Changes and Buy-ins

Most Medicaid programs cover only a portion of those below the federal poverty level. Because Medicaid offers federal matching dollars and most states can increase their eligibility levels to get those matching dollars, coverage could be expanded through Medicaid. Most states find expanded Medicaid eligibility too costly, because of Medicaid's comprehensive services, including long-term care and the federal requirement that services be "comparable" for like recipients.

The administrative structure of the Medicaid program, its ability to qualify people for coverage, enroll them, and pay their bills at Medicaid payment levels can be used as an alternative for providing coverage of essential services. Therefore, all state funds would have to be used since federal matching dollars would not be available for this type of coverage (i.e., the services would not be comparable). Although Medicaid's already existing administration could be used to reduce the costs of the state's expanded coverage for the low-income uninsured, in times of fiscal restraint, state dollars are difficult to find.

Under so-called "buy-in" programs, however, eligible individuals and their employers would be permitted to pay premiums to the state to administer Medicaid coverage for an essential set of benefits. The combination of a circumscribed set of essential benefits, Medicaid claims processing and administration, and Medicaid payment rates to providers would, thereby, reduce the cost of insurance to the uninsured.

Several states have developed such programs as described in an earlier section of this report. Three federally sponsored demonstration programs to test such concepts are now operating in Washington, South Carolina, and Maine. Federal legislation has been offered to permit all states to undertake Medicaid changes and receive federal matching funds.

Delivery Systems

The essential health services list emphasizes primary and preventive care and establishes an important role for the primary care provider. As a result, the traditional fee-for-service delivery system, which emphasizes multiple sources of generalist and specialist care, may not be the most affordable essential health services delivery system. Traditional fee-for-service delivery can lead to:

- Fragmented sources of service delivery that communicate with each other poorly and often provide duplication of services or even contraindicated services

- Incentives to provide unnecessary, ineffective, and even harmful care

- Excessive provision of high-cost services to the exclusion of primary and preventive services

One imperative of an essential health services access program is to ensure that the most important services--those that are both medically and cost effective--are provided to the otherwise uninsured. Thus, a delivery system that tolerates or even encourages wasteful provision of nonessential services should be avoided if the program is to be affordable.

Managed Care

The term, managed care, has been used for some time to describe a diverse--and still evolving--set of alternative delivery systems (to traditional fee-for-service medicine). The best known examples are health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

Health maintenance organizations provide care at risk on a capitated (per person) payment basis, require enrolled patients to use specified providers or to pay entirely out of pocket, and have formal utilization review and quality assurance programs. HMOs must accept payment prospectively for a comprehensive set of services including health education and primary and preventive services, without regard to the volume of service use. Using economic incentives and utilization review to determine medical necessity for specialty services, HMOs can contain costs while employing or contracting with diverse providers.

Thus, HMOs encourage the provision of services that keep patients healthy and prevent problems before they happen. To achieve these goals, nearly all HMOs rely heavily upon primary care physicians and other providers to be care managers.

A preferred provider organization selectively contracts with a particular set of hospitals, physicians, and other providers using explicit criteria, provides financial incentives for patients to use only the selected

providers, and maintains utilization review and quality assurance programs. PPOs may or may not be at risk for covered services. As financial incentives for using the network, care received inside the PPO network is often virtually free and the patient is required to pay some of the out-of-pocket cost when not using a preferred provider. PPOs use criteria to select providers that emphasize quality care and cost consciousness; frequently, patients are required to name a primary care provider and to obtain that provider's approval for specialty care.

The emphasis on primary and preventive care as well as the many requirements for primary care provider referrals to access certain services included in the essential health services plan are more reflective of managed care plans than traditional fee-for-service plans. Since managed care plans are more suited to reinforcing the primary and preventive care emphasis of the essential health services plan and have grown rapidly in Virginia in the last few years, with nearly all major insurers having managed care provider networks, a viable option would be to offer the essential health services program only through a managed care arrangement.

Direct Provision of Services

The Commonwealth of Virginia is already heavily involved in directly providing services to low-income families and the uninsured through four major programs--local health departments, community service boards for mental health and substance abuse services; free and community health clinics; and the state teaching hospitals. Because these entities already play a critical role in care for the uninsured and may be able to the provide affordable care, they must be preserved and protected in the context of an essential health services program.

Local/district health departments will, potentially, be able to assist in providing low cost drugs (as is already done for one program). Prescription contraceptives and family planning services are offered throughout the state by health departments (including Norplant). Primary care is delivered via local/district health departments in some areas (and will be emphasized in the future), for example, primary care is available to AIDS/HIV patients through a pilot project in the Lynchburg area. The community services boards already provide, through federal funds and some state appropriations, important mental health and substance abuse services to low-income people and others. Although care should be taken to avoid displacing federal funds with state moneys, the community services boards should be supported in their important role in the delivery of mental health and substance abuse services on the local level.

The state's network of community health clinics is an invaluable resource. These clinics could be enhanced by participation in the essential health services program as primary care providers.

The bulk of state indigent care funds go to the state teaching hospitals. To the extent an essential health services program provides more coverage for people who otherwise would have relied upon the teaching hospitals, it will be important to create mechanisms that provide a smooth transition from the current system. The teaching hospitals may be of assistance as principal sources of highly specialized care, e.g., concentration of transplant services in the state's teaching hospitals, whenever possible, may reduce transplant costs, while providing excellent quality of care.

IX. OTHER CONSIDERATIONS

Portability

In its examination of other countries' programs, the panel remarked that the most striking difference from our country's health care system was the portability of health coverage. The panel strongly urged the joint commission and the General Assembly to provide a mechanism for guaranteed portability of coverage for all Virginians. This one provision would relieve many individuals from concerns about job "lock-in" and fear of loss of health coverage through job changes and would be an enormous step towards Virginia "universal coverage."

Technology Assessment

Another important consideration, in the opinion of the panel, is the use of information technology to collect and analyze health care data in order to initiate strong quality assurance/outcomes analysis activities, e.g., technology assessment/outcomes analysis. Available information systems, present statewide telecommunications networks, and existing patient/recipient databases should be leveraged to avoid duplication and to contain administrative costs.

The panel supported the concept of implementation of a patient level data base. Such data will be useful in comparison shopping for health care by employers and private citizens and determining who is being served by various plans/programs and the level of utilization and the effectiveness of services. Therefore, this data could also be of assistance in establishing standards of practice and in improving utilization review.

Standards of Practice

Further, the panel suggested that, although practice standards could play an important role in containing costs and maintaining the quality of health care, practice parameters relating to the demography of the population served--economic, racial, sociological--are important elements of practice patterns that must be factored into practice standards.

The panel used the terms "medically necessary," "utilization review," and "primary care provider certification" frequently to indicate mechanisms for assuring that services are not inappropriately or unnecessarily used. The panel noted repeatedly that services must be delivered or ordered for an individual patient according to that patient's specific needs. Such terms as "at-risk individuals," "medically necessary," "medically appropriate," etc., may need to be addressed with greater specificity. Practice standards and utilization review based on specific practice standards may be appropriate mechanisms for avoiding overutilization of services simply because they are covered.

Continuous and Ongoing Review

As stated earlier, the panel resolutely believed that the essential health services access list should be subjected to continuous and ongoing review to accommodate changes in medical knowledge, technology, practice patterns, and the Virginia and national health care system. The potential of the patient level data base for generating new insights into the medical

efficacy of various procedures, technologies, and levels of care also creates an exciting opportunity for fine tuning of the essential health services list.

Further, although the essential health services list is tied to the practice guidelines of the American Academy of Pediatrics and the American Academy of Family Practice, revisions of these guidelines should be scrutinized carefully to maintain the "essential" quality of the list. For these reasons, the panel firmly supported the establishment of some body to conduct this necessary review.

Public/Private Cooperation

The panel suggested that any effort to reform the health care system through insurance or otherwise must involve all constituencies. It was the panel's profound belief that progress in health care reform can only be achieved through public/private cooperation and consensus.

X. CONCLUSIONS

The essential health services plan can be an important tool for standardizing covered services within the health insurance market. Prerequisite to establishing many innovative or reform measures, covered services must be standardized. By defining basic coverage, the essential health services plan may be useful in risk pools, including health insurance purchasing cooperatives (HIPCs), health insurance networks (HINs), and high risk pools for ceding high volume individuals.

The costs of the defined services can be estimated to provide the Commonwealth with informed options for other reforms, such as tax credits, tax deductions, and administrative and direct delivery alternatives.

As described to the panel, possible uses of Virginia's essential health services access plan might be for the Governor's Child Health Program; a reinsurance pool as part of small business insurance reform; a state-subsidized insurance plan for small employers who are not otherwise able to obtain or afford coverage for employees; an alternative to state-mandated benefits plan for individuals and families or employers who cannot afford the cost of current policies, but who can pay for an affordable benefit package; an approach to expanded coverage for children using Medicaid administrative mechanisms and state-only funds; a state-subsidized insurance plan for individuals and families who are otherwise uninsurable or cannot afford coverage; and direct provision of services, using existing state facilities and contract providers to deliver some or all of the services outside of an insurance product.

Conceivably, Virginia's unique approach to the issue of the uninsured--establishing a panel of experts and citizens to objectively evaluate and determine essential health care services, submitting the draft for review by a knowledgeable organization (the advisory commission), and revising and transmitting the plan to the legislative Joint Commission on Health Care for consideration--could lay the groundwork for "bellwether" changes in the Commonwealth's health care system, with national ramifications.

The panel offered this report with the hope that its work will be affirmatively received and will indeed assist the Joint Commission on Health Care and the General Assembly in their critical roles as the purveyors of health care reform.

Respectfully submitted,

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APPENDIX I

ENABLING LEGISLATION
SB 506 of 1992

Actions of the
ADVISORY COMMISSION
ON MANDATED INSURANCE BENEFITS

IMPLEMENTING LEGISLATION
HB 2353 of 1993

An Act to require the convening of a certain panel to assist the Commission on Health Care for All Virginians in the development of certain programs.

[S 506]

Approved APR 15 1992

Whereas, approximately $12 billion was spent on health care services in Virginia in 1991; and

Whereas, in the nation and Virginia, health care access is inextricably tied to third party coverage, including private insurance, employer-based insurance, Medicaid, Medicare, and Champus; and

Whereas, almost one million Virginians are uninsured, and an estimated 500,000 Virginians may be underinsured; and

Whereas, inequities among private and public benefits coverage are numerous in our present system, with some individuals provided a broad "menu choice" of benefits and others having much less coverage; and

Whereas, the reduced mandated benefit plan, enacted as a recommendation of the Commission on Health Care for All Virginians in 1990, has not stimulated a significant response among uninsured businesses or individuals; and

Whereas, the employer-based/entitlement system has not contained costs or provided overall access and only systemic reforms will adequately address the deeply rooted issues; and

Whereas, a wide variety of health care services are provided dependent solely on the "category" of coverage, and no consensus has occurred among the private and public sectors as to which health care services should be made available to each Virginia citizen; and

Whereas, other states, such as Oregon, have developed innovative approaches to increasing access and containing health care costs which, although falling short of providing universal access, provide valuable insights for the development of a Virginia plan; and

Whereas, the Commission on Health Care for All Virginians has recommended that an essential health care services program and a standard health care program be developed as first steps towards design of a Virginia universal access program; now, therefore,

Be it enacted by the General Assembly of Virginia:

1. *§ 1. Panel to assist the Commission on Health Care for All Virginians.—A panel of experts and citizens shall be appointed to assist the Commission in the development of an essential health services access program and a standard health services program. Such panel shall consist of twelve members, six of whom shall be appointed as follows: three primary care physicians who may be family practitioners, internists, or pediatricians; one obstetrician/gynecologist; one physician/specialist; one citizen member who is knowledgeable about, but not involved in, the health care system in Virginia and who shall be appointed by the Chairman of the Commission of Health Care for All Virginians. Such members shall serve at the pleasure of the Chairman. The remaining six members shall be appointed by the Governor as follows: one expert in mental health; one nurse; one pharmacist with a background in clinical pharmacy; one medical ethicist who shall not be a physician; one health care provider regulated by a health regulatory board pursuant to the provisions of Title 54.1 of the Code of Virginia, who is not a physician; and one citizen member who is knowledgeable about, but not involved in, the health care system in Virginia. The appointees of the Governor shall serve at his pleasure. The Governor shall designate one of the twelve members as its convener and moderator. The panel shall be served by such staff as the Chairman shall determine to be appropriate, which may include legislative staff. All agencies of the Commonwealth shall provide such assistance to the panel as shall be deemed necessary by the Chairman.*

Utilizing a cost/benefit analysis, the panel shall develop the specific components of an essential health services program and a standard health services program. This essential health services program shall specify those services which must be made accessible to all Virginians regardless of circumstances, with particular emphasis on primary and preventive health care services. The program shall address, but need not be limited to, hospital services, physician services, diagnostic testing, mental health services, and emergency care. The panel shall also develop the specific components of a standard health services program which shall consist of the services included in the essential health

services program and additional, but not necessarily essential, services.

In its deliberations, the panel shall consider the diverse demography of the Commonwealth's health care system, the needs of underserved populations and areas, and the components of relevant federal and Virginia law and programs and may examine other states' and countries' programs. The panel shall also examine the efficacy of incorporating into the programs various elements of existing third-party plans, including Medicaid, Medicare, and private and public insurance plans. Cost-containment mechanisms shall also be evaluated and incorporated into the programs as appropriate. The programs shall fully address the role of the public health system, the medical schools, and other health education programs in its design.

By August 1, 1992, the panel shall complete the initial draft of the recommended programs and report this draft to the Advisory Commission on Mandated Benefits. The Advisory Commission shall review and comment on the programs and make such recommendations as it deems appropriate by September 30, 1992. The panel's review of such recommendations and any subsequent revision of its draft shall be completed by November 1, 1992.

Prior to final determination of the recommended programs, the panel shall conduct public forums throughout the Commonwealth which shall receive the widest possible publication and shall provide opportunity for consumers of health care to comment on the proposed components of the programs.

A final composite report, consisting of the panel's proposed programs, the Advisory Commission's comments and recommendations for revision of the initial draft, and a summary of public reaction to the programs, shall be submitted to the Governor, the General Assembly, and the Commission on Health Care for All Virginians by December 1, 1992, in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

The Chairman may assign other responsibilities for research and study related to the work of the Commission on Health Care for All Virginians to the panel as he shall deem appropriate.

This section shall expire on January 31, 1993.

2. That an emergency exists and this act is in force from its passage.

_____

President of the Senate

_____

Speaker of the House of Delegates

Approved:

_____

Governor

Szakal, 1992

Actions of the Advisory Commission on Mandated Insurance Benefits

on the Report of the Essential Health Services Panel

On December 14, 1992, the Advisory Commission on Mandated Insurance Benefits met to consider the Report of the Essential Health Services Panel (transmitted to the Commission in late October).

Following discussion of the essential health services lists in particular and the report in general, the advisory commission approved two motions on this matter:

1. The advisory commission accepted the Report of the Essential Health Services Panel (as transmitted to it in October) and commended the panel on its work.

2. The advisory commission recommended that the panel amend the essential health services list to incorporate the commission's recommendations on mental health and substance abuse services, i.e., that the panel consider conforming the essential health services list to the advisory commission's recommendation.

The panel was also requested to consider the advisory commission's other work and recommendations on health insurance mandates.

(OVER)

Advisory Commission on Mandated Insurance Benefits

Recommendations on Mental Health/Substance Abuse Services

The advisory commission recommended that the mandated benefits for mental health be revised to include benefits for partial hospitalization and outpatient treatment as follows:

Inpatient Hospitalization: Individual & Group	Twenty days per policy year for adults Twenty-five days per policy year for children (under the age of nineteen) Conversion of up to ten days of inpatient coverage at the option of the beneficiary at a conversion ratio of 1 hospital day/1.5 partial hospital day (or intensive outpatient program day) Coverage no more restrictive than for any other illness
Outpatient Visits: Group	Twenty outpatient visits with the first five visits subject to limitations/copayments/deductibles that are no more restrictive than those for any other illness; next fifteen visits subject to copayment of no greater than 50%

Outpatient Medication Visits must be covered on the same terms as outpatient treatment for any other illness and must not be counted towards outpatient mental health visits.

Coverage for mental health services must include services for alcohol and drug dependency.

An Act to amend and reenact §§ 38.2-3430, 38.2-3431 and 38.2-3432 of the Code of Virginia and to amend the Code of Virginia by adding in Article 5 of Chapter 34 of Title 38.2 a section numbered 38.2-3433, relating to accident and sickness insurance provisions.

[H 2353]

Approved APR 7 1993

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3430, 38.2-3431 and 38.2-3432 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Article 5 of Chapter 34 of Title 38.2 a section numbered 38.2-3433 as follows:

§ 38.2-3430. Sunset provisions.—The provisions of this article shall expire on ~~July~~ *April* 1, 1994.

§ 38.2-3431. Small employer market.—A. Each insurer proposing to issue *individual or* group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, each corporation providing *individual or* group accident and sickness subscription contracts, and each health maintenance organization or multiple employer welfare arrangement providing health care plans for health care services that offers coverage to the small employer *or primary small employer* market shall be subject to the provisions of this article if any of the following conditions are met:

1. Any portion of the premiums or benefits is paid by or on behalf of the small employer;

2. The eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium;

3. The small employer has permitted payroll deduction for the covered individual ; ~~whether or not such coverage is issued through a group policy of insurance~~ or any portion of the premium is paid by the small employer; or

4. The health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for the purpose of §§ 106, 125, or 162 of the United States Internal Revenue Code.

B. For the purposes of this article:

"Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commission that a small employer carrier is in compliance with the provisions of § 38.2-3432 based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

"Affiliated companies" means companies that are affiliated or that are eligible to file a consolidated tax return which shall be treated as one carrier; provided, however that any insurance company or health services plan that is an affiliate of a health maintenance organization located in Virginia or any health maintenance organization located in Virginia that is an affiliate of an insurance company, or a health services plan, may treat the health maintenance organization as a separate carrier and each health maintenance organization that operates only one health maintenance organization in a service area of Virginia may be considered a separate carrier.

"Carrier" means any person that provides one or more health benefit plans or insurance in this Commonwealth, including an insurer, a health services plan, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, a third party administrator or any other person providing a plan of health insurance subject to the authority of the Commission.

"Community rate" means the average rate charged for the same or similar coverage to all groups with the same area, age and gender characteristics.

"Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the policy, contract or plan covering the eligible employee.

"Eligible employee" means an employee who works for a small group employer on a full-time basis, has a normal work week of thirty or more hours, has satisfied applicable waiting period requirements, ~~is included as an employee under a health benefit plan of a small group employer,~~ and is not a part-time, temporary or substitute employee.

"Established geographic service area" means a broad geographic area of the

Commonwealth in which a carrier sells or has sold insurance policies on or before January 1994, or upon its subsequent authorization to do business in Virginia.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA or plan provided by another benefit arrangement. Health benefit plan does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; dental only or vision only insurance; specified disease insurance; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Initial enrollment period" means a period of at least thirty days.

"Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer after the initial enrollment period provided under the terms of the health benefit plan.

"Essential and standard health benefit plan" means health benefit plans developed pursuant to subsection D of this section.

"Preexisting conditions provision" means a policy provision that limits, denies, or excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, for a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received within twelve months of the effective date of coverage.

"Premium" means all moneys paid by a small employer and eligible employees as a condition of coverage *from a carrier* , including fees and other contributions associated with the health benefit plan.

"Primary small employer," a subset of "small employer," means any person actively engaged in business that, on at least fifty percent of its working days during the preceding year, employed no more than twenty-five eligible employees and not less than two unrelated eligible employees, the majority of whom are enrolled within this Commonwealth. Primary small employer includes companies that are affiliated companies or that are eligible to file a combined tax return. Except as otherwise provided, the provisions of this article that apply to a primary small employer shall apply until the earlier of the plan anniversary or one year following the date the employer no longer meets the requirements of this subsection.

"Rating period" means the twelve-month calendar period for which premium rates are determined by a small employer carrier and are assumed to be in effect.

"Small employer *"or "small employer* market" means any person *actively* engaged in business that, on at least fifty percent of its working days during the preceding year, employed less than fifty full-time employees and not less than two unrelated full-time employees, the majority of whom are employed within this Commonwealth. A small employer market group includes companies that are affiliated companies or that are eligible to file a combined tax return. *Except as otherwise provided, the provisions of this article that apply to a small employer shall continue to apply until the earlier of the plan anniversary or one year following the date the employer no longer meets the requirements of this section.*

"Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers or one or more primary small employers.

C. A late enrollee may be excluded from coverage for eighteen months. However, an eligible employee or dependent shall not be considered a late enrollee if all of the conditions set forth below in subdivisions 1 through 4 are met or one of the conditions set forth below in subdivision 5 or 6 is met:

1. The individual was covered under a public or private health benefit plan at the time the individual was eligible to enroll.

2. The individual certified at the time of initial enrollment that coverage under another health benefit plan was the reason for declining enrollment.

3. The individual has lost coverage under a public or private health benefit plan as a result of termination of employment or employment status eligibility, the termination of the other plan's entire group coverage, death of a spouse, or divorce.

4. The individual requests enrollment within thirty days after termination of coverage provided under a public or private health benefit plan.

5. The individual is employed by a small employer that offers multiple health benefit plans and the individual elects a different plan offered by that small employer during an open enrollment period.

6. A court has ordered *that* coverage be provided for a spouse or minor child under a covered employee's health benefit plan, the minor is eligible for coverage and is a dependent, and the request for enrollment is made within thirty days after issuance of such court order.

However, such individual may be considered a late enrollee for benefit riders or enhanced coverage levels not covered under the enrollee's prior plan.

D. The Commission shall adopt regulations establishing the essential and standard plans. Such regulations shall incorporate the recommendations of the Essential Health Services Panel, established pursuant to Chapter 847 of the 1992 Acts of Assembly. Every small employer carrier shall, as a condition of transacting business in Virginia with small employers, actively offer to primary small employers at least the essential and standard plans. All small employer carriers shall issue the plans to every primary small employer that elects to be covered under either one of the plans and agrees to make the required premium payments and to satisfy the following provisions:

1. Such plan may include cost containment features such as, but not limited to, utilization review of health care services including review of medical necessity of hospital and physician services; case management; selective contracting with hospitals, physicians and other health care providers; reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; or other managed care provisions. The essential and standard plans for health maintenance organizations shall contain benefits and cost-sharing levels which are consistent with the basic method of operation and benefit plans of federally qualified health maintenance organizations and of nonfederally qualified health maintenance organizations. The essential and standard plans of coverage for health maintenance organizations shall be actuarial equivalents of these plans for small employer carriers.

2. No law requiring the coverage or offering of coverage of a health care service or benefit shall apply to the essential health care plan or riders thereof.

3. Within 180 days after the Commission's approval of essential and standard health benefit plans, every small employer carrier shall offer and make available to small employers an essential and a standard health benefit plan.

4. Within 180 days after the Commission's approval of essential and standard health benefit plans, every primary small employer that elects to be covered under either an essential or standard health benefit plan and agrees to make the required premium payments and to satisfy the other provisions of the plan shall be issued such a plan by the small employer carrier.

5. All essential and standard benefit plans issued to primary small employers shall use a policy form approved by the Commission providing coverage defined by the essential and standard benefit plans. Coverages providing benefits greater than the essential and standard plans may be provided by rider. A small employer carrier shall submit all policy forms, including applications, enrollment forms, policies, subscription contracts, certificates, evidences of coverage, riders, amendments, endorsements and disclosure plans to the Commission for approval in the same manner as required by § 38.2-316. Each rider providing benefits greater than the essential and standard benefit plans may require a specific premium for the benefits provided in such rider. The premium for such riders shall be determined in the same manner as the permiums are determined for the essential and standard plans. The Commission at any time may, after providing notice and an opportunity for a hearing to a small employer carrier, disapprove the continued use by the small employer carrier of an essential or standard health benefit plan on the grounds that such plan does not meet the requirements of this article.

6. No small employer carrier is required to offer coverage or accept applications pursuant to subdivision D4 of this section:

a. From a primary small employer already covered under a health benefit plan except for coverage that is to commence on the group's anniversary date, but this subsection shall not be construed to prohibit a group from seeking coverage or a small employer carrier from issuing coverage to a group prior to its anniversary date; or

b. If the Commission determines that acceptance of an application or applications would result in the carrier being declared an impaired insurer.

A small employer carrier that does not offer coverage pursuant to subdivision 6 b of

this subsection may not offer coverage to small employers until the Commission determines that the carrier is no longer impaired.

7. Every small employer carrier shall uniformly apply the provisions of subdivision D 6 of this section and shall fairly market the essential and standard health benefit plans to all primary small employers in their established geographic service area of the Commonwealth. A small employer carrier that fails to fairly market as required by this subdivision may not offer coverage in the Commonwealth to new small employers until the later of 180 days after the unfair marketing has been identified and proven to the Commission or the date on which the carrier submits and the Commission approves a plan to fairly market to their established geographic service area.

8. No health maintenance organization is required to offer coverage or accept applications pursuant to subdivision D 4 of this section in the case of any of the following:

a. To primary small employers, where the policy would not be delivered or issued for delivery in the health maintenance organization's approved service areas;

b. To an employee, where the employee does not reside or work within the health maintenance organization's approved service areas; or

c. Within an area where the health maintenance organization demonstrates to the satisfaction of the Commission, that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees.

A health maintenance organization that does not offer coverage pursuant to this subdivision may not offer coverage in the applicable area to new employer groups with more than fifty eligible employees until the later of 180 days after closure to new applications or the date on which the carrier notifies the Commission that it has regained capacity to deliver services to small employers.

In the case of a health maintenance organization doing business in the small employer market in one service area of this Commonwealth, the rules set forth in this subdivision shall apply to the health maintenance organization's operations in the service area, unless the provisions of subdivision 7 of this subsection apply.

9. In order to ensure the broadest availability of health benefit plans to small employers, the Commission shall set market conduct and other requirements for carriers, agents and third-party administrators, including requirements relating to the following:

a. Registration by each carrier with the Commission of its intention to be a small employer carrier under this article;

b. Publication by the Commission of a list of all small employer carriers, including a potential requirement applicable to agents, third-party administrators, and carriers that no health benefit plan may be sold to a small employer by a carrier not so identified as a small employer carrier;

c. The availability of a broadly publicized toll-free telephone number for the Commission's Bureau of Insurance for access by small employers to information concerning this article;

d. To the extent deemed to be necessary to ensure the fair distribution of primary small employers among carriers, periodic reports by carriers about plans issued to primary small employers; provided that reporting requirements shall be limited to information concerning case characteristics and numbers of health benefit plans in various categories marketed or issued to primary small employers. Carriers shall maintain data relating to the essential and standard benefit plans separate from data relating to additional benefits made available by rider for the purpose of complying with the reporting requirements of this section; and

e. Methods concerning periodic demonstration by small employer carriers that they are marketing and issuing health benefit plans to small employers in fulfillment of the purposes of this article.

§ 38.2-3432. Small employer market subject to certain provisions.—A. Every *individual or* group policy, subscription contract or plan delivered, issued for delivery or renewal in this Commonwealth *or providing benefits to or on behalf of a small employer* pursuant to this article is subject to the following provisions:

1. Except in the case of a late enrollee, any preexisting-conditions provision may not limit, deny or exclude coverage for a period beyond twelve months following the insured's effective date of coverage and may only relate to conditions manifesting themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve months immediately preceding the effective

date of coverage or as to a pregnancy existing on the effective date of coverage.

2. A condition which would otherwise be covered pursuant to subdivision A 1 may not be excluded from coverage.

3. In determining whether a preexisting-conditions provision applies to an insured, all coverage shall credit the time the person was covered under previous individual or group ~~coverage of equal or greater value~~ *policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis* if the previous coverage was continuous to a date not more than thirty days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such coverage.

~~4. Subdivision A 3 shall not be applicable to any nonstock corporation that offers an open enrollment program under § 38.2-4216.1 until such time as all carriers in the small employer market in the Commonwealth shall be obligated to make available and guarantee issue policies in such market.~~

B. Coverage shall be renewable with respect to all insureds at the option of the employer except:

1. For nonpayment of the required premiums by the policyholder, contract holder or enrollee;

2. For abuse or misuse of a provider network provision;

3. For fraud or misrepresentation of the policyholder, contract holder or enrollee, with respect to their coverage;

4. When the employer is no longer actively engaged in the business in which it was engaged on the effective date of the coverage;

5. For failure to comply with contribution and participation requirements defined by the health benefit plan;

6. For failure to comply with health benefit plan provisions that have been approved by the Commission; ~~or~~

7. When *primary small employer* new business ceases to be written by an insurer in the small employer market, provided that the following conditions are satisfied:

a. Notice of the decision to cease writing new business in the *primary* small employer market is provided to the Commission and to either the policyholder, contract holder, enrollee or employer; ~~and~~

b. Writing new business in the *primary* small employer market in this Commonwealth shall be prohibited for a period of three years from the date of notice to the Commission pursuant to this subdivision. In the case of a health maintenance organization which ceases to do new business in the small employer market in one service area of the Commonwealth, the rules set forth in this subdivision shall apply to the health maintenance organization's operations in ~~the~~ *that* service area ~~.~~ ;

c. When a small employer carrier ceases to write new business and renew business in the primary small employer market, it may continue to participate in the market of small employers which are not primary small employers if it complies with the provisions of this article applicable to the small employer market. Nothing in this provision shall prohibit a small employer carrier from writing and renewing business in the primary small employer market if it has ceased writing and renewing business to small employers which are not primary small employers; and

d. Health benefit plans subject to this article shall not be canceled for 180 days after the date of the notice required under subdivision 7 a of this subsection and for that business of a small employer carrier which remains in force, any small employer carrier that ceases to write new business in the small employer market shall continue to be governed by this article with respect to business conducted under this article; or

8. Benefits and premiums which have been added by rider to the essential or standard benefit plans issued to primary small employers shall be renewable at the sole option of the small employer carrier.

C. If coverage is offered under this article, such coverage shall be offered and made available to all of the eligible employees of ~~an~~ *a small* employer and their dependents. No coverage may be offered to only certain eligible employees or their dependents and no employees or their dependents may be excluded *or charged additional premiums* because of health status.

D. If coverage to the small employer market pursuant to this article ceases to be written, administered or otherwise provided, such coverage shall continue to be governed by this article with respect to business conducted under this article that was transacted prior to the effective date of termination and that remains in force.

§ 38.2-3433. Small employer market premium and disclosure provisions.—A. New or renewal premium rates for essential or standard health benefit plans issued by a small

employer carrier to a primary small employer not currently enrolled with that same employer carrier shall be based on a community rate subject to the following conditions:

1. A small employer carrier may use the following risk classification factors in rating small groups: demographic rating, including age and gender; and geographic area rating. A small employer carrier may not use claim experience, health status, duration or other risk classification factors in rating such groups, except as provided in subdivision 2 of this subsection.

2. The premium rates charged by a small employer carrier may deviate above or below the community rate filed by the small employer carrier by not more than twenty percent for claim experience, health status and duration only during a rating period for such groups within a similar demographic risk classification for the same or similar coverage or the rates that could be charged to such groups under the rating system.

3. Small employer carriers shall apply rating factors including case characteristics consistently with respect to all primary small employers in a similar demographic risk classification. Adjustments in rates for claims experience, health status and duration from issue may not be applied individually. Any such adjustment must be applied uniformly to the rate charged for all participants of the primary small employer.

B. A small employer carrier shall not involuntarily transfer a primary small employer into or out of a class of business. A small employer carrier shall not offer to transfer a primary small employer into or out of a class of business unless such offer is made to transfer all primary small employers in the class of business without regard to case characteristics, claims experience, health status, or duration of coverage since issue.

C. In connection with the offering for sale of any health benefit plan to a primary small employer, each small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of:

1. The extent to which premium rates for a specific primary small employer are established or adjusted in part based upon the actual or expected variation in claims costs or actual or expected variation in health condition of the eligible employees and dependents of such primary small employer;

2. Provisions relating to renewability of policies and contracts; and

3. Provisions affecting any preexisting conditions provision.

D. Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices pertaining to its primary small employer business, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

E. Each small employer carrier shall file with the Commission annually on or before March 15 an actuarial certification certifying that it is in compliance with this article. A copy of such certification shall be retained by the small employer carrier at its principal place of business.

F. A small employer carrier shall make the information and documentation described in subsection D of this section available for review by the Commission upon request.

2. That the provisions of this act shall become effective on April 1, 1994.

Service Coverage Comparison
Essential "MUST HAVE" list

Major Service	Essential "MUST HAVE"	Key Advantage	Medicaid
Emergency Services	X	X	X
> Pre-hospital emergency medical services including ambulance services	X	X	X
> Acute medical detoxification	X	X	X
> Emergency hospital services	X	X	X
> Emergency room care for medical emergencies	X	X	X
> Severe mental health crisis	X	X	X
Preventive and Primary Care	X	X	X
> 18 preventive health visits from birth through age 17	X	X	X
> One preventive health visit every 1-3 years from age 18 to age 23	X		X
> One preventive health visit every 1-3 years from age 40 to age 64	X		X
Diagnostic Services/ Testing	X	X	X
> Laboratory	X	X	X
> Screening Services	X	X	X
> X-ray	X	X	X
> Outpatient radiation and chemotherapy treatment	X	X	X
> Psychological testing	X	X	X
Maternity Care	X	X	X
> Prenatal care, including diagnosis of pregnancy and laboratory services and other diagnostic/testing procedures	X	X	X
> Inpatient hospital services including anesthesia, complications of pregnancy, delivery by vaginal and caesarean section, labor and delivery room, medications, operating or other special procedure rooms.	X	X	X

	Essential "MUST HAVE"	Key Advantage	Medicaid
Inpatient Hospital Care, subject to Utilization Review, at least 21 days per year.	X	X	X*
> Room/ board and ancillary services; anesthesia, casts, dressings, drugs/meds, eqpt., nursing, inhalation therapy, ICU, laboratory, X-ray, oxygen services, radiation therapy, short-term physical therapy, special diets , supplies, OR and recovery room.	X	X	X
> Inpatient medical services, including primary, consultative and specialty provider services.	X	X	X
> Inpatient therapeutic blood services, blood derivatives and their administration. Includes whole blood when volunteer blood program not available.	X	X	X
> Newborn care when mother discharged before child	X	X	X
Outpatient Therapeutic Blood Serives. Includes blood derivatives and whole blood.	X	X	X
Prescription Drugs, including prescription contraceptives.	X	X (1)	X
Durable Medical Equipment	X	X	X (2)
> When medically necessary			
Outpatient medical and surgical specialty care	X	X	X
> upon referral by primary care provider	X	X	X
Limited mental health counseling and substance abuse	X	X	X (3)
> 12 counseling visits annually	X	X	
> 12 additional visits (total 26/year) with second opinion	X	X	
Preventive and acute dental care for children	X	X	X
> regular examinations	X	X	X
> X-rays	X	X	X
> Prophylaxis	X	X	X
> Topical flouride	X	X	X
> sealants	X	X	X
> fillings	X	X	X
> temporary crowns	X	X	X
> pulpomoty	X	X	X
> root canal	X	X	X

APPENDIX II

SERVICE COVERAGE COMPARISON

Many of Virginia's and other states' health plans and programs were reviewed in the development of the essential and standard health services plans. Certain services and all references to specific providers were excluded from the essential list. Further, some terms were excluded from the essential list; however, services subsumed by these terms or within the scope of specific providers may be included. For example, although no references to chiropractors and orthopedic surgeons are included, medically necessary outpatient specialty medical and surgical care are included; therefore, medically necessary treatment for low back pain would be included.

To clarify the terms and services included or excluded from the essential health services list, the following side-by-side comparison of three programs--Key Advantage, Medicaid, and the state-mandated benefits--was prepared. An X indicates that the service is covered.

	Essential "MUST HAVE"	Key Advantage	Medicaid
Preventive and acute dental care for children (continued)			
> space maintenance	X	X	X
> oral surgery	X	X	X
> extractions	X	X	X
> biopsy	X	X	X
> removal of tumors, cysts or neoplasms	X	X	X
> treatment of fractures of maxilla or mandible	X	X	X
> correction of congenital facial deformities	X	X	X
> Emergency dental care	X	X	X
> palliative	X		X
> trauma care	X	X	X
> replacement crown	X		X
> repair space maintainer	X	X	X
> repair dentures (full or partial)	X	X	X
Transplants (cornea & kidney)	X	X	X
Notes:			
X (1) contraceptives not covered			
X (2) preauthorized, strict circumstances			
X (3) no substance abuse			
X* 21 day limit per episode of illness			

Service Coverage Comparison Standard "SHOULD HAVE" List	"SHOULD HAVE"	Key Advantage	Medicaid		
Allergy treatments according to the guidelines and upon PCP referral	X	X	X		
> injections	X	X	X		
> skin testing	X	X	X		
Audiology/Hearing/Speech disorder services, upon referral by PCP	X	X	*X (4)*		
>hearing aids and services	X		X		
Case Management Services, under direction of PCP	X				
> medical case management, performed by or under direction of PCP	X				
> social case management, under direction of PCP	X	X	X		
> high cost illness case management, subject to guidelines based on outcomes	X	X	X		
Dental services	X	X	*(5)*		
> adult dental cleaning	X	X			
> dentures	X	X			
> diagnostic radiographs	X	X			
> extraction (for relief of pain, infection or cystic lesions)	X	X	*		
> biopsy	X		X		
> removal of tumors, cysts or neoplasms	X		X		
> repair of dentures (complete or partial)	X				
> examination	X	X			
> prophylaxis	X	X			
> fillings	X				
> temporary crowns	X				
> pulpotomy	X				
> root canal	X				
> replacement of teeth	X				

	"SHOULD HAVE"	Key Advantage	Medicaid		
Inpatient Hospital Care, subject to Utilization Review; limit days 22 through 360 per year	X	X	X		
> Room / board and ancillary services, anesthesia, casts, dressings, drugs/meds, eqpt., nursing, inhalation therapy, ICU, laboratory, X-ray, oxygen services, radiation therapy, short-term physical therapy, special diets, supplies, OR and recovery room.	X	X	X		
> Inpatient medical services; including primary, consultative and specialty provider services.	X	X	X		
> Inpatient therapeutic blood services, blood derivatives and their administration. Includes whole blood when volunteer blood program not available.	X	X	X		
Prescription / corrective lenses for adults	X		X		
Medically necessary post-hospital alternatives to hospital care	X	X	X		
> pre-authorized home health visits	X		X		
> hospice	X	X			
> nursing home care (skilled nursing)	X		X		
Rehabilitative care	X		X		
> occupational therapy w/ referral from PCP	X		X		
> physical therapy w/ referral from PCP	X		X		
Transplants; (Heart and Liver TBN)	X		X		
Notes:					
X (4) Medallion Plan					
(5) Virginia Medicaid covers only certain extractions and oral surgery cases					
**** under limited circumstances, related to decay caused by radiation therapy.***					

Other	"Essential" or "Standard"	Key Advantage	Medicaid
Radial keratotomy		X	X
Rest cures			
Cosmetic surgery			
Experimental or investigative medical and surgical procedures			
Autologous bone marrow transplants			
In vitro fertilization			
Chiropractor services or services for spine manipulation			X (6)
Services performed and billed by clinical psychologists, clinical social workers, professional counselors and psychiatric clinical nurse specialists		*	*
Hearing aids or examinations for these devices			X (7)
Services for surgical sexual transformation or sexual dysfunction			
Services for acupuncture			
Custodial, domiciliary care and services			
Services for marital and family counseling; educational, behavioral, vocational, recreational and coma-stimulation therapy.			
Sleep Therapy			
Treatment for Obesity, except for surgical treatment of morbid obesity			
Removal of corns, calluses or the trimming of nails			

	"Essential" or "Standard"	Key Advantage	Medicaid
Separate charges for local infiltration anesthesia and any anesthesia services conducted by the same doctor performing surgical or obstetrical services			
Stop-smoking aids or services of stop-smoking clinics			X (8)
Services by a home health agency			X
Services by a nursing facility / long term care			X
Telephone consultations, charges for not keeping appointments or charges for completing claim forms			
Notes:			
* *some coverages*			
X (6) qualified Medicare recipients only			
X (7) Children only; (EPSDT)			
X (8) Medications only, no clinical care provided			

Service Coverage Comparison Virginia Mandated Benefits	"Essential" or "Standard"	Key Advantage	Medicaid	Mandated (Virginia)
Reimbursement for services performed by practicioners other than physicians:	*			
Chiropractors		X		X
Optometrists				X
Professional Counselors				X
Psychologists				X
Clinical Social Workers				X
Podiatrists				X
Physical Therapists				X
Chiropodists				X
Podiatry services		X	X	X
Clinical Nurse Specialists				X
Speech Pathologists / Audiologists		*some*	X (9)	X
Opticians				X
Notes:				
X (9) screening examinations				
* *The Essential Health Services and Standard Health Services Plans are not provider specific.*				

Notes:				
Included in the Virginia Mandated required benefits are coverage of dependent children, dentists services, coverage of newborn children, coverage for mental, emotional or nervous disorders, coverge for pregnancy due to rape or incest.				
Coverge is to be provided for adoptive children, and exclusions or reductions in benefits are prohibited as are conversions on termination of eligibility.				
Virginia also requires the following benefits to be offered in policies:				
coverage for outpatient mental, emotional or nervous disorders, coverage for alcohol and drug dependence, coverage for obstetrical services, provide options for deductibles and coinsurance, coverage for mammograms and				
coverage for child health supervision services				