

# Healthy Families Program Benefit Design Options for Achieving Cost Savings

*A Preliminary Assessment of Options for HFP Benefit Changes Presented to the Managed Risk  
Medical Insurance Board*

3/08/2010

Prepared by Kelch Associates

In consultation with Mercer Government Human Services Consulting

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## I. Overview

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The California HealthCare Foundation contracted with Kelch Associates and Mercer Government Human Services Consulting (Mercer), to conduct an analysis of the benefit design in California's Healthy Families Program (HFP) and potential cost savings that might be achieved in HFP from benefit design changes. This preliminary report outlines benefit design options for California's Healthy Families Program (HFP) which provides low cost, comprehensive health care coverage to eligible low-income children.

This report includes benefit design options under federal law, benefit choices made by other states, comparison of existing HFP benefits with the specific benchmark plans permitted under federal law, and several other cost reduction options. These options are offered for initial consideration by the Managed Risk Medical Insurance Board (MRMIB). Following further discussion and direction from MRMIB at the March 17, 2010 Board meeting, Kelch Associates and Mercer will do additional analyses and research to revise and refine the benefit design options, including making recommendations on the options with the most potential for cost savings.

## Next Steps

1. General discussion and direction from the MRMIB at 3-17-10 board meeting on potential benefit design options and options for which further review and information is requested;

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2. Additional research, analysis and verification by Kelch Associates of benefit design details and options adopted by other states;
  3. Collaboration with MRMIB staff to analyze and identify benefit design changes for cost analysis and to apply the proposed framework for review of benefit design changes;
  4. Mercer cost and cost savings analyses for specific benefit design changes under consideration; and,
  5. Revised report developed by Kelch Associates in consultation with Mercer to provide specific findings and recommendations for benefit design changes and other cost savings options submitted by **March 31, 2010**.

## Project Scope

Federal law authorizes states to provide Children's Health Insurance Program (CHIP), (no longer SCHIP) coverage through the state's Medicaid program or through a separate state program using one of several benefit design options outlined in federal law and regulations. Since the inception of California's CHIP program, the Healthy Families Program (HFP) benefits have been provided through a separate CHIP program modeled on the state employees benefit package provided through the California Public Employees Retirement System (CalPERS).

MRMIB Board members have asked MRMIB staff to explore other benefit and premium options allowable under the Children's Health Insurance Program Reauthorization Act (CHIPRA) that could result in program savings. The purpose of the inquiry is to explore alternative benefit packages and analyze the various options, and any cost savings that may result from benefit design changes, to inform the ongoing discussions about potential HFP cost reductions in the context of the state budget.

To support MRMIB in this evaluation, the California HealthCare Foundation contracted with Kelch Associates, and separately with Mercer. Mercer will provide assistance with the cost modeling and actuarial analysis that may be required. Kelch Associates is tasked with the following:

- 1) Develop a framework for California to assess various HFP benefit options;
- 2) Identify and assess potential cost-saving options available in federal law with respect to benefit design, family share of cost, and potentially other benefit areas;
- 3) Explore experiences from other states that have used "Secretary-approved" benefit benchmarks and identify options and lessons for California; and,

- 4) Work with Mercer in completion of an actuarial analysis of selected benefit design options identified by Kelch Associates.

Based on consultation with MRMIB staff, it was determined that the scope of work for this project would be limited to an evaluation of HFP medical benefits and not include a review of potential benefit changes for dental and vision coverage.

## Initial Evaluation

Kelch Associates has reviewed the federal CHIP benefit options and conducted preliminary analyses to identify areas for further study and evaluation, in collaboration with Mercer, in the following areas: 1) alternative benchmark benefit designs; 2) pharmacy benefit design changes that could reduce program costs; and 3) cost-sharing options compared to the maximum levels permitted under federal law.

No actuarial or cost estimation analysis has yet been conducted. Mercer is working with MRMIB staff on a review of the maximum cost-sharing that may be imposed in HFP and on identifying potential pharmacy cost saving options that have not already been implemented by contracting HFP plans.

This preliminary analysis found:

- Most state CHIP program benefits are modeled after state employee coverage or Medicaid;
- When states consider reductions in CHIP program costs, most states have reduced eligibility or increased family cost-sharing in the form of higher premiums or co-payments. There is so far little evidence of major benefit shifts or benefit eliminations in CHIP programs; and,
- Cost savings for HFP through benefit design changes may not be a matter of cutting entire benefit classes but may instead require imposing limitations and exclusions that might trim costs, along with targeted cost-sharing. Further analysis is required to identify benefit design choices with the highest cost savings potential.

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## II. Background

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The Healthy Families Program (HFP) is California's state and federally-funded Children's Health Insurance Program (CHIP), established pursuant to Title XXI of the federal Social Security Act. The Managed Risk Medical Insurance Board (MRMIB) administers HFP. HFP provides comprehensive health, dental and vision insurance to low-income children under age 19 with family incomes above the Medi-Cal income eligibility levels. Approximately two-thirds of the funding for HFP is provided by the federal CHIP. HFP provides services to eligible children through public and private health plans who provide services to HFP children for a fixed payment amount each month. As of January 2010, there were 878,000 children enrolled in HFP.

In the past several years, the HFP has been repeatedly slated for program and funding cutbacks, along with many other health and social service programs, as California continues to face sustained and massive budget deficits. In 2009-10, the Governor proposed elimination of HFP. The Legislature rejected the Governor's proposal to eliminate HFP but reduced funding by \$124 million General Fund (GF), necessitating implementation of a waiting list for HFP enrollment unless alternative funding was made available from other sources. The Governor vetoed another \$50 million (GF) from the program which created a total funding gap of about \$174 million GF. A temporary solution was enacted in AB 1422 (Bass), Chapter 157, Statutes of 2009, which included the following. 1) Authority for the First 5 California Children and Families Commission (First 5) to transfer funding for coverage of HFP children ages 0-5 (implemented by First 5 action to allocate up to \$81.4 million to HFP); 2) \$157 million from gross premiums taxes imposed on Medi-Cal managed care plans which yielded \$97 million in additional federal funds for HFP; and assumed savings from program changes to HFP, including increased family premiums and benefit co-payments, and additional changes to be adopted by MRMIB (which subsequently made changes to subscriber dental benefit plan choices.)

In January 2010, the Governor proposed further program reductions to HFP, including legislation to eliminate HFP eligibility for families with incomes from 200-250% of the federal poverty level

(FPL), for a reduction of \$41.9 million (\$10.5 million GF) in 2009-10, and \$252.4 million (\$63.9 million GF) in 2010-11. The Governor also proposed legislation to eliminate HFP vision coverage and increase monthly premiums for HFP families with incomes from 151-200% percent of poverty, effective July 1, 2010, for a combined reduction of \$65.8 million (\$21.7 million GF). Under the Governor's proposal, monthly premiums for families from 151-200% of FPL poverty would be increased by \$14 per child (to \$30 for one child; \$60 for two; and a family maximum of \$90 for three or more). Families under 150% FPL would not have a premium increase.

The Governor has proposed a series of further reductions if California fails to reform the state's relationship with the federal government and obtain \$6.9 billion in federal funding owed to California due to faulty reimbursement formulas and federal mandates. These are referred to as "trigger" reductions. Among the trigger reductions would be the total elimination of HFP July 1st of 2010, generating state savings of \$126 million.

Unlike Medi-Cal, HFP is not an entitlement program and MRMIB is required by statute to maintain enrollment and expenditures to ensure that expenditures do not exceed the amounts available for HFP. If sufficient funds are not available to cover the estimated cost of program expenditures, according to MRMIB regulations, the Board must institute appropriate measures to limit enrollment. Under the HFP regulations, if the Board finds that sufficient funds are not available to cover the estimated costs of the program, the program must establish a waiting list for new applicants. If the Board finds that the waiting list does not sufficiently limit expenditures, children must be disenrolled at the time of their Annual Eligibility Review.

### III. Framework for Evaluating Coverage Options

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MRMIB requested that Kelch Associates develop and recommend a framework for the decision process of evaluating the various coverage and benefit options available under federal law. Kelch Associates recommends that the State take into account the following issues and considerations in evaluating benefit design options for HFP:

- 1) Subscriber impacts -- How will the proposed benefit/program change affect HFP subscribers? Subscriber costs? Will cost increases or benefit changes impact enrollment? Quality of life impacts? Choice of and access to providers?
- 2) Feasibility -- Can the proposed benefit/program change be effectively implemented by MRMIB staff? Contracting health plans? Will the proposed change yield State General Fund savings

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through reduced health plan premiums and/or reduced program costs for contracting health plans?

- 3) Federal authority -- Is the benefit/program change allowable under federal law? Is federal approval required? What is the likely result of seeking federal approval?
- 4) Implementation costs -- What staff or administrative costs will result from the change? State staffing costs? Health plan or provider administrative costs? Will external experts or resources be needed to implement the proposed changes? Do the demand on staff resources or administrative costs of initial or ongoing implementation outweigh any potential for savings? Short versus long term?
- 5) Implementation timeline -- How long will it take to accomplish the benefit/program change? Anticipated timing for any required federal approvals or state statutory/regulatory changes? What will be the time horizon for savings? Can the benefit/program change be implemented to achieve and capture savings in the near term? Budget year 2010-11?
- 6) Unintended costs or consequences -- Will the benefit/program change result in unintended costs in other areas that reduce or eliminate the savings potential? For example, will elimination of a specific primary care service or benefit result in increased utilization of other services such as increased hospital or emergency room use?
- 7) Network or provider impact -- How will the benefit/program change affect health plan participation in the program? How will the benefit/program change affect provider participation?
- 8) History -- Has the benefit/program change been previously proposed and considered? What was the outcome or experience?

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## IV. CHIP Benefit Design Options Under Federal Law

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Under the enabling CHIP statute, states may provide expanded children's coverage through the state's Medicaid program, or establish a separate coverage program for CHIP-eligible children using one of several specified benefit plan options, or use a combination of Medicaid expansion and a separate CHIP program. Under Medicaid, states are federally mandated to cover certain benefits, including the Early Periodic Screening Diagnostic and Treatment (EPSDT) benefit. Under EPSDT, regular health, dental, hearing and vision screenings must be covered, as well as any medical services that a child is found to need, as long as it is the type of services that Medicaid covers. Under CHIP, states with stand-alone CHIP programs are not required to cover EPSDT and have more flexibility over the benefits package for children.

Under California's combination coverage approach, some children eligible for CHIP coverage are covered through California's Medicaid program (Medi-Cal) and HFP is California's separate program for children in families with incomes of up to 250% FPL who are not otherwise eligible for Medi-Cal.

The various benefit design options in federal law and regulation for a separate CHIP coverage program such as HFP are as follows:

- 1) Benchmark coverage, as defined;
- 2) Benchmark-equivalent coverage, as defined;
- 3) Existing comprehensive state-based coverage options applicable to Florida, New York and Pennsylvania; or
- 4) Secretary-approved coverage that is one of several options outlined in federal law and regulations.

Regardless of the type of health benefits coverage chosen by a state, all CHIP programs must provide the following minimum benefits:

- 1) Well-baby and well-child care services as defined by the State;
- 2) Age-appropriate immunizations in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP); and
- 3) Emergency services needed to evaluate, treat, or stabilize an emergency medical condition.

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## CHIPRA 2009 Benefit Changes

The Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009 extends and expands the State Children’s Health Insurance Program. CHIPRA requires states to include dental services (meeting new statutory standards or equivalent to one of three dental benchmark packages) in CHIP plans. In addition, CHIPRA would allow states the option to provide dental-only supplemental coverage for children who otherwise qualify for a state’s CHIP program, but have other health insurance without dental benefits.

CHIPRA also requires mental health parity for states that select a benchmark plan that includes coverage for mental health or substance abuse services. According to CMS, CHIPRA requires that state child health plans comply with the mental health parity requirements included in the Public Health Services Act “in the same manner” as such requirements apply to a group health plan.<sup>1</sup> Specifically, the mental health parity changes require the following coverage for mental health:

- 1) Financial requirements (e.g., co-payments) that are applied to mental health or substance use disorder benefits must be no more restrictive than the predominant financial requirements that are applied to substantially all medical/surgical benefits;
- 2) Treatment limitations (e.g., numbers of visits or days of coverage) that are applied to mental health or substance use disorder benefits must be no more restrictive than the predominant treatment limitations that are applied to substantially all medical/surgical benefits;
- 3) No separate financial requirements or treatment limitations can apply only to mental health or substance use disorder benefits; and,
- 4) When out-of-network coverage is available for medical/surgical benefits, it also must be available for mental health or substance use disorder benefits.

## CHIP Benefit Design Choices in Other States

According to the Centers for Medicare and Medicaid Services (CMS), six states, five territories and the District of Columbia adopted Medicaid expansions as their CHIP programs, 17 states adopted separate state child health plan coverage, and 27 states, including California, adopted combination

programs. Appendix A includes a description of the benefit designs in each state CHIP program.

According to the preliminary results of a 2008 survey of state CHIP programs (the latest available) conducted by the National Academy for State Health Policy (NASHP), and preliminary review of the CHIP state plan fact sheets posted on the CMS web site,<sup>2</sup> of the 44 states with separate CHIP programs, 4 states (AR, MN, OK, RI) only operate separate CHIP programs only for pregnant women under the “unborn” option in the CHIP regulations. This means that there are 40 states with separate CHIP programs covering low-income children for comparison purposes with HFP. Among separate CHIP programs, most of the benchmark CHIP plans are based on a state employees’ health plan, and most secretary-approved plans are modeled after Medicaid.<sup>3</sup> (Note: There are some discrepancies between the NASHP survey and the CMS posted state plans that will have to be resolved before the final report is submitted.)

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## Benchmark Coverage

Federal law defines benchmark coverage as coverage consistent with any of the following:

- 1) Federal Employees Health Benefit Plan (FEHBP). The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is offered to federal employees;
- 2) State employees plan. Coverage offered and generally available to state employees in the state;  
or
- 3) A health maintenance organization (HMO) plan. A health insurance coverage plan in the state offered through an HMO which has the largest insured, commercial non-Medicaid enrollment in the state.

## Benchmark Coverage in Other States

According to the preliminary NASHP survey, and review of state plans posted on the CMS web site, one state, New Hampshire, chose the federal employees FEHBP coverage as the benchmark, 18 states chose the state employee plan and 4 states (AL, CO, IN, and WI) chose the commercial HMO

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plan.

### Preliminary Analysis for HFP: Benchmark Coverage

Since the inception of HFP in 1997, California has by statute provided benefits to HFP children based on the CalPERS state employee benefit package as the benchmark coverage for health. HFP also has provided enhanced services beyond the benchmark package, including screening and initial treatment services through the Child Health and Disability Prevention (CHDP) program comprehensive dental and vision coverage and screening and initial treatment services through the Child Health and Disability Prevention (CHDP) program. In addition, HFP children with complicated medical conditions receive treatment of those conditions through the California Children's Services (CCS) program. MRMIB contracts for HFP medical care services with 24 public and private health plans, most of whom are licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene). HFP contracting health plans may offer certain optional benefits without additional payments from the state, including acupuncture, chiropractic, and biofeedback.

Kelch Associates consulted with the California Association of Health Plans to identify the HMO plan with the largest commercial enrollment in California and determined that the plan that most likely fits the federal definition is an HMO coverage plan offered by Kaiser Permanente to small employers, with an estimated enrollment of just over 157,000 lives.<sup>4</sup>

The most significant differences between HFP and the three benchmark benefit designs are in the area of cost-sharing. However, federal law limits cost-sharing in CHIP Appendix B compares the benefits offered (services covered) and the cost-sharing (co-payments, deductibles, etc.) in HFP with the three benchmark coverage options. The comparison is based on a thorough review of the evidence of coverage (EOC) documents for several of the largest HFP health plans and the EOC documents of the potential benchmark plans. EOCs are the detailed contractual disclosure documents that health plans provide to subscribers and enrollees of a particular benefit plan.

This detailed comparison shows that HFP covered health benefits and the benchmark health benefit plans are substantially similar, with some differences discussed below. Highlights of benefit differences include:

- Hearing Services – all benchmark benefit plans appear equal in coverage of routine hearing screenings. However, HFP coverage for hearing testing and examinations for the prescribing or fitting of hearing aids is the broadest coverage of the benefit plans reviewed. CalPERS coverage provides that the primary care/personal physician will provide hearing screening to

determine the need for an audiogram for hearing correction, as well as newborn hearing screening services, while HFP does not appear to have this restriction, potentially permitting referrals to specialists to conduct hearing screenings.

- Durable Medical Equipment – HFP appears to have the broadest coverage of DME among the plans reviewed.
- Mental Health and Alcohol and Drug Abuse Services – Mental health and substance abuse parity will be applicable to HFP at the beginning of the next benefit year, which is anticipated to be October 1, 2010. Meantime, the benefit designs in the other coverage options have already been adjusted for mental health parity.
- Home Health Care – The Kaiser small group employer plan and the FEHBP plan have reduced home health care coverage and limits on the number of visits covered compared to HFP.
- Skilled Nursing Care – The FEHBP excludes coverage for skilled nursing whereas all other benchmarks and HFP cover 100 days of skilled nursing.

## Benchmark-equivalent Coverage

Under federal law, benchmark equivalent coverage is health benefits coverage that has an aggregate actuarial value at least actuarially equivalent to the coverage under one of the benchmark packages listed above. Benchmark-equivalent coverage must meet the following federal requirements:

- 1) Be determined to be actuarially equivalent to one of the three products available as a benchmark option, (plan options listed above) supported by an actuarial opinion the state must provide to CMS;
- 2) Include at a minimum, the minimum benefits required in all CHIP programs as above (well-baby and well-child visits, immunizations and emergency care) plus the following additional categories of services:
  - a) Inpatient and outpatient hospital services;
  - b) Physicians' surgical and medical services; and
  - c) Laboratory and x-ray services.

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- 3) If the benchmark coverage package used by the State for purposes of comparison in establishing the aggregate actuarial value of the benchmark-equivalent coverage package includes coverage for prescription drugs, mental health services, vision services or hearing services, then the actuarial value of the coverage for each of these categories of service in the benchmark-equivalent coverage package must be at least 75% of the value of the coverage for such a category or service in the benchmark plan used for comparison by the State.

According to the preliminary NASHP survey, no other state has pursued a CHIP program with actuarially equivalent benchmark coverage. However, a review of the state CHIP plans posted on the CMS web site found the following:

- *Indiana* reports offering a benchmark-equivalent which is actuarially-equivalent to benefits in the FEHBP program;
  - *Colorado* reports offering a benchmark-equivalent that covers inpatient services; outpatient services; physician services; surgical services; dental services; vision services; prescription drugs; lab and radiology services; prenatal care and family planning services; inpatient and outpatient mental health services; outpatient substance abuse treatment services; durable medical equipment; home and community-based health care; case management services; physical and occupational therapy; hospice care; medical transportation; organ transplant and skilled nursing facility care;
  - *Illinois* reports offering a benchmark-equivalent consistent with the state employee plan; and
- 1) *New Hampshire* reports benchmark-equivalent coverage is provided. An actuarial analysis comparing the benefit package to the Federal Employees Health Benefit Program was conducted. Effective January 1, 1999, a State plan amendment modified the prescription benefit, mental health and substance abuse benefit, and dental benefit. An actuarial analysis submitted to CMS demonstrated that health benefit coverage under the amended Title XXI plan remains benchmark-equivalent;
- 2) *Utah* -- Utah offers benchmark-equivalent coverage. The State's plan includes an actuarial analysis comparing the benefit package to the benefit plan provided to Utah State

employees; and,

### Actuarial Equivalence Calculations

Actuarial equivalence is a general term used to describe two or more benefit designs that have approximately the same value.<sup>5</sup> In this context, “value” could mean several things but is commonly either the dollar value of average expected benefits paid out by a health plan or the average share of total health spending that is paid for the plan. Potential plan design differences considered when performing actuarial equivalence comparisons include cost-sharing features, differences in services covered, and major differences in utilization expected to result from differences in cost-sharing.<sup>6</sup> For example, higher cost-sharing can result in lower utilization. Provider network differences are not generally included in actuarial equivalence comparisons and the calculations generally assume the use of in-network services for non-emergency health care.

### CHIP Benefits Caveat

It is important to note that federal CHIP requirements result in a somewhat artificial distinction between “benefits” and “cost-sharing.” In most private coverage, a benefit plan design generally includes the combination of benefits (services covered) and cost-sharing, as well as the network of providers offered under the plan, and any utilization controls or limitations imposed. In today’s private market, the greatest variations among coverage products are based on the level of cost-sharing imposed, such as the copayments or coinsurance for specific covered services, annual deductibles and any out-of-pocket maximum limits.

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In CHIP, in order to financially protect low-income families and children federal law sets parameters and limitations on the cost-sharing elements of any plan based on the family income and specific fixed limits for various services, with an overall cap so that a family’s total out-of-pocket expenditures may not exceed 5% of family income.

### Preliminary Analysis for HFP: Benchmark-equivalent Coverage

Although an analysis to determine actuarial equivalence has not yet been performed, with the federal limitation on cost-sharing in HFP, Mercer believes that it is possible a less rich benefit package could meet the actuarial equivalence test for benchmark-equivalent coverage.

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For background in considering the design of a potential benchmark equivalent package, the following benefits are currently covered by HFP but are not mandatory under federal law for benchmark-equivalent coverage:

- 1) Medical transportation (Knox-Keene basic health care service -- elimination in HFP would require an exemption in law for participating HFP health plans, all of whom are Knox-Keene licensed plans. Knox-Keene requires coverage of emergency ambulance services as a basic health care service);
- 2) Physical, occupational and speech therapy (Knox-Keene basic health care service);
- 3) Family planning (Knox-Keene basic health care service);
- 4) Health education services (Knox-Keene basic health care service);
- 5) Durable medical equipment;
- 6) Skilled nursing services;
- 7) Acupuncture, chiropractic and biofeedback (optional at plan's discretion in HFP and not at state cost).

Because all three benchmark plans include prescription drugs, mental health and hearing services, these services would have to be included in a benchmark-equivalent at 75% of the actuarial value for those benefits in the benchmark plans. Mental health and substance abuse treatment coverage would also have to meet federal mental health parity requirements.

## Secretary-approved Coverage

Under federal law, states may apply for approval to the Secretary of the federal Department of Health and Human Services to offer CHIP coverage that meets specified requirements in federal law and regulation. Nearly half of the states with "Secretary-approved" coverage are providing the state's Medicaid benefits in the separate CHIP programs. Several states have Secretary-approved coverage that is really very similar to benchmark coverage such as the state-employees plan or the FEHBP benefit plan. Five states have "other" Secretary-approved coverage, but generally speaking the benefits in those programs have features unique to the individual state.

Secretary-approved coverage can be consistent with any of the following benefit options:

- 1) Coverage the same as the benefits offered in the Medicaid State plan -- According to NASHP, 17 states have been given approval to use the state's Medicaid benefits for the separate CHIP programs, and observers generally agree that it is the policy of CMS to approve proposals to use the Medicaid state plan benefits to define CHIP coverage. This benefit option would include the provision of the full EPSDT benefit for children;
- 2) Comprehensive coverage for children under a Medicaid Section 1115 demonstration project -- Massachusetts covers some CHIP-eligible children with the basic benefits package developed for the state's current Section 1115 health care reform waiver.
- 3) Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population -- There is no evidence of a state seeking or receiving approval to offer CHIP coverage pursuant to this option;
- 4) Coverage that includes benchmark coverage plus additional coverage -- Georgia offers a "Secretary-approved" plan meeting this description. The GA BlueChoice Health Care Plan, the state's HMO with the largest enrollment, is the benchmark plan. The benefit plan for GA PeachCare for Kids is the benchmark coverage with added services to bring the coverage to equal a Medicaid look-alike, with the exceptions of non-emergency transportation, targeted case management, services solely for persons over age 19, and some services that to be needed require a level of disability that would qualify the child for Medicaid.
- 5) Coverage that is the same as defined by the grandfathered existing comprehensive state-based coverage offered in Florida, New York and Pennsylvania -- In the CHIP regulations, CMS lists as one Secretary-approved option use of the grandfathered benefits currently offered in one of these three states whose comprehensive benefit package was cited by Title XXI as having sufficient coverage to meet the requirements for CHIP. The benefits in each state are summarized as follows:
  - *Florida* -- The Healthy Kids benefit package is the benefit package that existed prior to CHIP that was cited in the Title XXI legislation as acceptable child health coverage. This benefit package includes a full range of inpatient and outpatient services. Limitations are placed on psychiatric, rehabilitation and physical therapy

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inpatient admissions; alcohol and drug services; chiropractic services; podiatry services; outpatient rehabilitation services; and, durable medical equipment and remedial devices;

- *New York* -- The benefit package for enrollees in the separate child health program is the comprehensive benefit package offered under the State-funded CHPlus program that was in effect prior to the establishment of the State CHIP, plus several added benefits, including durable medical equipment, inpatient and outpatient mental health, speech therapies, and some non-prescription medications. The fourth state-plan amendment (SPA) submitted by NY added non-airborne pre-hospital emergency medical services provided by an ambulance service, and the state's fifth SPA added a hospice benefit;
  - *Pennsylvania* -- The benefit package is the PA CHIP benefit package that was implemented prior to SCHIP. Services include: inpatient hospitalization; outpatient services; physician services; surgical services; clinic services; prescription drugs; laboratory and radiological services; inpatient and outpatient mental health services; inpatient and outpatient substance abuse services; durable medical equipment; home and community-based health care services; nursing care services; dental services; case management; physical, occupational, and speech therapy; hospice care; and ambulance services when medically necessary.
- 6) Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison -- There is no evidence of a state seeking or receiving approval to offer CHIP coverage pursuant to this option; or,
- 7) Other -- There are four states with Secretary-approved "other" benefit plans:
- *Massachusetts* -- Children enrolled in the State's SCHIP Medicaid expansion program receive the Medicaid benefit package. What Massachusetts refers to as 'direct coverage' enrollees receive the benchmark benefits coverage (HMO with the largest commercial enrollment in the State). MassHealth Healthy Start enrollees receive the Basic Benefit Level, as approved by the Secretary under the Massachusetts 1115 section Medicaid demonstration project;
  - *Oregon* -- The separate child health program offers Secretary-approved coverage that is the same as coverage offered under the State's Medicaid program. The State's

benefit package is based on the Oregon Health Plan Prioritized List of Health Services, a modified Medicaid benefit package as allowed under Oregon's section 1115 Medicaid demonstration waiver for its entire Medicaid population. Medically necessary services are defined in the Prioritized List;

- *Texas* -- According to the NASHP survey, Texas offers a Secretary-approved benefits plan with a basic set of health care benefits focused on primary health and that contain the cost of the benefit package. The benefit package includes well-baby and well-child services, immunizations, emergency services, inpatient and outpatient care, prescription drugs, diagnostic services, durable medical equipment, and inpatient and outpatient mental health and substance abuse treatment and services. The State offers a three-tiered dental benefit. Each tier of dental benefits includes preventive services up to \$250. The limit on the amount of therapeutic services available varies (ranging from \$280 to \$565) depending upon when an individual re-enrolls in the program at the end of a 12-month enrollment period; and,
  
- *Wyoming* -- Secretary-approved basic benefits as in Wyoming statute, and as determined by a health benefits committee appointed by the Governor. Benefits include: inpatient; outpatient; physician; surgical; clinic and other ambulatory care; prescription drugs; laboratory and radiological; prenatal care and pre-pregnancy family services and supplies; inpatient and outpatient mental health; durable medical equipment and medically-related or remedial devices; disposable medical supplies (therapeutic); home and community-based care; nursing care; abortion only to save the mother's life or pregnancy is a result of rape/incest; dental; inpatient, residential, and outpatient substance abuse treatment; case-management services; care coordination; physical and occupational therapy, and services for speech, hearing, and language disorders; hospice care; eye exams for prescriptive lenses; and medically necessary transportation. Families at or below 200 percent of the FPL have comprehensive dental and vision services. Families above 200 percent of the FPL receive preventative dental services with an annual limit of \$150, and do not receive vision services. There is a \$200,000 annual limit on benefits and a \$1,000,000 lifetime limit on benefits.

### Preliminary Analysis for HFP: Secretary-approved coverage

Depending on direction from MRMIB, further study can be conducted on any of these potential benefit options, additional information gathered, and, as appropriate, Mercer can conduct a cost analysis to determine whether adoption of the alternative benefit designs would result in a cost savings in the HFP program.

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## V. Options for HFP Enrollee Cost-sharing

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Cost-sharing is a common feature of private health coverage around the country and a major element of difference among the numerous health coverage options available to purchasers. However, in the CHIP program, federal law sets specific maximum cost-sharing limits in recognition of the low incomes of families and children eligible for CHIP programs. CHIP cost-sharing can be in the form of monthly premiums; deductibles, an amount that families must pay before coverage begins; and / or co-payments at the time of service. When states have faced fiscal and economic challenges, CHIP enrollee cost-sharing has been one area of cost savings through increases in the out-of-pocket obligations for the families of children enrolled. For example, in 2009, 15 states made changes to reduce CHIP coverage, including California, and 14 of those increased monthly premiums.<sup>7</sup>

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*In 2009, 15 states made changes to reduce CHIP coverage, including California, and 14 of those increased monthly premiums.*

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### Federal CHIP Cost-sharing Limits

Federal CHIP law permits state to impose cost-sharing for some beneficiaries and some services.<sup>8</sup> States that cover low income children through a Medicaid expansion must follow Medicaid rules for nominal cost-sharing and rules specific to CHIP Medicaid expansion programs pursuant to the Deficit Reduction Act of 2005.

States with separate CHIP programs may charge premiums or enrollment fees within the maximum total limit imposed. For all individuals enrolled in CHIP, the total aggregate amount of all cost-sharing cannot exceed 5% of family income (on a quarterly or monthly basis as specified by the state). Enrollees may also be charged service-related cost-sharing, but such cost-sharing is limited to: (1) nominal amounts defined in federal Medicaid regulations for the subgroup with income below 100% FPL, and (2) slightly higher amounts defined in CHIP regulations for families with income between 100%-150% FPL, including no more than \$5 per visit for services provided by a managed care organization, except that the co-payment for non-emergency use of the emergency room can be up to twice the basic co-payment, or no more than \$10.<sup>9</sup> For a family with income above 150% FPL, cost-sharing may be imposed in any amount, provided that cost-sharing for higher-income children is not less than cost-sharing for lower-income children and subject to the out-of-pocket limit of 5%

of family income.<sup>10</sup> Preventive services, as defined by CMS, are exempt from any cost-sharing for all CHIP enrollees regardless of income.

## Cost-sharing in Other State CHIP Programs

According to a December 2009 survey of Medicaid and CHIP programs conducted by the Kaiser Commission on Medicaid and the Uninsured (Kaiser Commission), 34 states impose premiums or an enrollment fee in their children's health coverage programs, and nine states, including California charge premiums to families with incomes below 150% FPL.<sup>11</sup> According to the Kaiser Commission, other states impose premiums and cost-sharing for CHIP programs as follows:

- In states with premiums, the median premium for two children in a family of three earning 200% percent of FPL (\$36,620 per year for a family of three in 2009)<sup>12</sup> is \$480 per year, \$40 per month, or 1.3 percent of family income.
- The monthly premium ranges in other states for two children in a family based on family income as a percent of poverty are as follows:
  - 101% of FPL from \$8 to \$15;
  - 151% of FPL from \$10 to \$61;
  - 201% of FPL from \$15 to \$115;
  - 250% of FPL from \$30 to \$183;
  - 300% of FPL from \$20 to \$172; and,
  - 350% of FPL from \$90 to \$152.
- 12 states impose "lock-out" periods on children in families that do not pay the required premium, preventing such children from re-entering the program for a specific period of time after being disenrolled;
- 20 states require co-payments for non-preventive physician visits, emergency room care, and/or in-patient hospital care for children in families with income at 200% FPL; and,
- 24 states require a co-payment for prescription drugs for children.

## Preliminary Analysis for HFP: Cost-sharing

In the current HFP, monthly family premiums are determined based on family size and health plan. Current premiums are set at \$4 to \$14 per family for those at 150% of FPL and below (premium Category A); \$13 to \$48 per family for those at 150-200% FPL (premium Category B); and \$21 to \$72 per family for those at 201-250% FPL (Premium Category C). Starting November 1, 2009, co-payments for families in Premium Category A remain unchanged at \$5 per copayment for services as

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below, but co-payments for families in premium categories B and C were increased as follows:

- 1) Co-payments for non-preventive health, dental, and vision services increased from \$5 to \$10 per visit;
- 2) Co-payments for generic prescription drugs increased from \$5 to \$10 per script;
- 3) Co-payments for brand name prescription drugs increased from \$5 to \$15 per script, unless no generic is available or the brand name drug is medically necessary (\$10); and,
- 4) Co-payments for emergency room services increased from \$5 to \$15 per visit, unless the child has to stay in the hospital which will result in waiver of the co-payment.

In January 2010, the Governor proposed to eliminate eligibility for HFP entirely for children in families with incomes of 200-250% FPL and to increase premiums for families with incomes of 150-200% FPL to \$30 for one child; \$60 for two; and a family maximum of \$90 for three or more. The Governor's 2010 proposed premium increases would put HFP premiums at the higher end of premiums charged by other states.

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*The Governor's 2010 proposed premium increases would put HFP premiums at the higher end of premiums charged by other states.*

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To determine the maximum amount of premiums and copayments that can be charged under the federal law, Mercer is working with MRMIB staff to review previous staff calculations and to assist in determining the level of both premiums and co-payments that may be imposed under the 5% of income overall family limit in federal law.

One caution for California is that moving to cost-sharing in HFP that is at or near the 5% maximum could result in additional CMS requirements and potential administrative cost increases for both MRMIB and contracting HFP plans. Currently, as is the case with most private insurance, HFP families must keep track of their out-of-pocket costs and notify the health plan they are enrolled in when they reach the maximum. However, according to MRMIB staff, CMS has previously expressed concerns that the higher the cost-sharing imposed on families the more likely CMS will be to require MRMIB and contracting health plans to more directly track and monitor individual family out-of-pocket costs.

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## VI. Pharmacy Benefit Design Changes

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The cost of providing pharmacy benefits has risen significantly during the last decade, surpassing the cost increases experienced by employers for any other category of medical services.<sup>13</sup> As a consequence, most health plans have some clinical/formulary management programs.<sup>14</sup> Most HMOs exert considerable control over pharmacy utilization through both provider education and plan design, including the use of formularies. HFP is providing services through licensed health plans and the ability to achieve pharmacy savings will depend on the extent to which HFP health plans are already implementing pharmacy cost controls. Pharmacy benefit changes that might be considered to reduce program costs in HFP include:

- Establishment of a carve-out for pharmacy services that relies on a single program-wide pharmacy benefit manager (PBM) to manage and pay claims for prescription drugs;
- Utilization of program-wide drug formularies such as are used in the Medi-Cal program;
- Differential coverage and co-payments for generic and brand-name prescriptions;
- Negotiation of rebates from pharmaceutical companies;
- Implementation of utilization controls, such as prior authorization and fail-first or step therapy requirements; and,
- Implementation of or more aggressive Maximum Allowable Cost (MAC) pricing for ingredient costs (primarily for generic or multi-source brand drugs).

In evaluating the cost savings potential of various pharmacy benefit changes in HFP, the first step will be analysis of the pharmacy cost controls already implemented by the contracting HFP health plans. It is likely that HFP health plans have already implemented a range of pharmacy cost controls which could include the use of their respective PBMs and/or specific utilization controls. Mercer is working with MRMIB staff to review cost data submitted to MRMIB by HFP health plans and to supplement the information with a survey of HFP health plans to identify pharmacy cost control measures plans are using, use of rebates and cost trends in drug utilization for HFP enrollees. The information resulting from this analysis will permit Mercer to evaluate the feasibility and the potential cost savings of various pharmacy benefit changes in HFP.

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## VII. Other Potential Cost Savings for Consideration

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One additional area previously identified by MRMIB staff for potential cost savings to HFP and to its contracting health plans would be a provision that in some way limits the amount HFP health plans must pay non-contracting hospitals for emergency services (both inpatient and outpatient) provided to HFP enrollees who are treated in an out-of-network hospital emergency room and admitted to the hospital as an inpatient. A similar limit applies in Medi-Cal managed care where health plans may pay Medi-Cal rates to out-of-network providers consistent with the federal Rogers' amendment. If this is an area of interest for MRMIB, further analysis can be conducted.

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<sup>1</sup> Centers for Medical and Medicaid Services. *Letter to State Health Officials: SHO 09-014: CHIPRA #9*. November 4, 2009..

<sup>2</sup> State plans and state plan amendments, along with a state plan fact sheet which summarizes the main features of each State's CHIP program, are posted on the CMS web site and can be obtained online at:

[www.cms.hhs.gov/NationalCHIPPolicy/StatePlan/](http://www.cms.hhs.gov/NationalCHIPPolicy/StatePlan/)

<sup>3</sup> Herz, EJ, Peterson, CL, Baumrucker, EP. *State Children's Health Insurance Program (CHIP): A Brief Overview*. Congressional Research Service. March 18, 2009.

<sup>4</sup> Kaiser has higher enrollment in both the CalPERS and FEHBP program benefit plans but this is the HMO benefit plan with the highest commercial enrollment.

<sup>5</sup> Critical Issues in Health Reform: Actuarial Equivalence. American Academy of Actuaries. May 2009. Obtained online at: [www.actuary.org/pdf/health/equivalence\\_may09.pdf](http://www.actuary.org/pdf/health/equivalence_may09.pdf)

<sup>6</sup> Ibid.

<sup>7</sup> Cohen Ross, D., Jarlenski M., Artiga S. and Marks C. *A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009*. Kaiser Commission on Medicaid and the Uninsured. December 2009. Obtained online at: [www.kff.org/medicaid/upload/8028.pdf](http://www.kff.org/medicaid/upload/8028.pdf)

<sup>8</sup> Congressional Research Service. *State Children's Health Insurance Program: A Brief Overview*. March 18, 2009.

<sup>9</sup> 42 Code of Federal Regulations, Chapter IV, Subpart 457, Section 457.555.

<sup>10</sup> Ibid.

<sup>11</sup> Ibid.

<sup>12</sup> Department of Health and Human Services. 2009 poverty guidelines remain in effect until updated poverty guidelines are published in March 2010. Obtained online March 5, 2010 at

[www.cms.hhs.gov/MedicaidEligibility/07\\_IncomeandResourceGuidelines.asp](http://www.cms.hhs.gov/MedicaidEligibility/07_IncomeandResourceGuidelines.asp)

<sup>13</sup> Mercer Human Resources Consulting. *Navigating the Pharmacy Benefits Marketplace*. Prepared for the California HealthCare Foundation. January 2003.

<sup>14</sup> Ibid.

**Appendix B**  
**Benchmark Health Benefit Packages Comparison Chart**  
(Based on review of 2010 Evidence of Coverage Documents and 2009-10 HFP EOC)

<b>Health Benefit Description</b>	<b>Healthy Families Program</b>	<b>CalPERS Blue Shield HMO</b>	<b>CalPERS Kaiser HMO</b>	<b>Commercial HMO: Kaiser Small Employer Plan</b>	<b>Federal Employees Basic Option EPO Blue Cross/ Blue Shield</b>
<b>Annual Cost-sharing Maximum Per Year:</b> - For one family member - For any one member in family of two or more - For an entire family of two or more members.	\$ 250 \$ 250  \$ 250	\$ 1,500 \$ 3,000  \$ 3,000  Prescription drug copayments do not apply to member annual maximum per year. Prescription drug maximum cost-sharing per year: \$ 1,000	\$ 1,500 \$ 3,000  \$ 3,000  Prescription drug copayments do not apply to member annual maximum per year. Prescription drug maximum cost-sharing per year: \$ 1,000	\$ 3,000 \$ 3,000  \$ 6,000  Deductible for brand name drugs: \$ 250 per member per year	\$ 5,000 \$ 5,000  \$ 5,000  Coinsurance for non-formulary or brand name drugs do not apply to annual maximum cost-sharing.
<b>Hospital Services</b>  <b>Inpatient:</b> room and board, nursing care, surgery, anesthesia, X-rays, lab tests, drugs and medically necessary services.  <b>Outpatient:</b> diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility.	No inpatient copay  No copay for outpatient except \$5/10 per visit for physical, occupational and speech therapy performed on an outpatient basis	No inpatient copay  No copay for outpatient except \$ 15 per visit for physical, occupational and speech therapy performed on an outpatient basis	No inpatient copay  No copay for outpatient except \$ 15 per visit for physical, occupational and speech therapy performed on an outpatient basis	\$ 400 per inpatient day  \$ 200 per outpatient surgery or procedure  \$ 10 per outpatient X-ray, mammogram, EKG, EEG and lab encounter except \$ 50 per MRI, CT, and PET scan.	\$ 150 per inpatient day up to \$ 750 maximum allowance and \$ 500 penalty if hospital pre-certification not done.  \$ 75 per outpatient day for any medical, surgical, physical therapy, diagnostic, radiology imaging.  <u>Reduced cost note:</u> “Never Events” not paid for by both subscriber and plan.

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<b>Physician Services</b>  Office Visits Home Visits Hospital Visits Surgery Anesthesia/Assistant surgeon Radiation & chemotherapy Dialysis Allergy Visits Members <24 mos.	\$ 5/10 per visit \$ 5/10 per visit No copay No copay No copay No copay No copay \$ 5/10 per visit No copay	\$ 15 per visit \$ 15 per visit No copay No copay No copay No copay No copay \$ 15 per visit No copay	\$ 15 per visit \$ 15 per visit No copay No copay No copay No copay No copay \$ 15 per visit No copay	\$ 30 per visit No copay No copay No copay No copay \$ 30 per visit No copay \$ 30 per visit \$ 30 per visit	\$ 25/35 per visit \$ 25/35 per visit No copay \$ 100 per surgeon No copay \$ 25/35 per visit \$ 25/35 per visit \$ 25/35 per visit \$ 25/35 per visit
<b>Diagnostic X-ray and Laboratory Services **</b> Inpatient and outpatient	No copay	No copay	No copay	\$ 10 per outpatient X-ray, mammogram, EKG, EEG and lab encounter except \$ 50 per MRI, CT, and PET scan.	No copay
<b>Physical, Occupational, Speech Therapy **</b>  Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility, or home. Plans may require periodic evaluations as long as therapy, which is medically necessary, is provided.	No copay for inpatient or hospice therapy.  \$ 5/10 per visit for outpatient and home care therapy.	No copay for inpatient or hospice therapy.  \$ 15 per visit for outpatient and home re therapy.	No copay for inpatient, hospice or home care therapy.  \$ 15 per visit for outpatient therapy.	No copay for inpatient, hospice or home care therapy.  \$ 30 per visit for outpatient therapy.	No copay for inpatient, hospice or home care therapies.  \$ 30 per visit for outpatient and skilled nursing facility therapy.

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<b>Maternity Care</b> Prenatal and postnatal care, inpatient and newborn nursery care and one postpartum visit	No copay	No copay	No copay	No copay	No copay
<b>Emergency Services</b> 24-hour emergency department visits for emergency services. No copay if admitted directly to the hospital as an inpatient.	\$5/15 per ER visit	\$50 per ER visit	\$50 per ER visit	\$ 100 per ER visit \$ 30 per urgent care center visit	\$ 75 per ER visit \$ 350 per urgent care center visit
<b>Hearing Services</b>  Routine hearing screening tests, covered as part of periodic health exam (see above)  Testing and examinations for the prescribing or fitting of hearing aids.  Hearing aids	No copay for routine hearing screening.  No copay for testing and exams for hearing aids.  No copay for hearing aid(s).  <u>Reduced coverage note:</u> surgery to implant a hearing aid is not covered.	No copay for routine hearing screening.  No copay for testing and exams for hearing aids.  \$ 1,000 hearing aid allowance every 36 mos. for both ears  <u>Reduced coverage note:</u> hearing aid(s) covered up to \$1,000/36 mos.	No copay for routine hearing screening.  No copay for testing and exams for hearing aids.  \$ 1,000 hearing aid allowance every 36 mos. for both ears  <u>Reduced coverage note:</u> hearing aid(s) covered up to \$1,000/36 mos.	No copay for routine hearing screening.  Testing and exams for hearing aids not covered (surgery to implant a cochlear implant is covered with no copay)  Hearing aids are not covered; however, surgery to implant a cochlear hearing aid device is covered with no copay.	No copay up to age 22 for routine hearing screening.  30% coinsurance for testing and exams for hearing aids.  Hearing aid(s) covered as prosthetic device with 30% of plan allowance coinsurance. Surgery to implant covered.  <u>Reduced coverage note:</u> Hearing aid(s) limited to \$1,000 per ear, per year for children < 22.

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<p><b>Preventive Services</b>  Routine services as recommended by the American Academy of Pediatrics for children up to the age of 22:</p> <ul style="list-style-type: none"> <li>- Routine physical exams including newborns</li> <li>- Routine vision and hearing tests</li> <li>- Laboratory tests</li> <li>- Immunizations --  Human Papillomavirus (HPV)  Meningococcal vaccine  Rotavirus vaccine  H1N1 Influenza vaccines</li> <li>- Related office visits</li> <li>- Sexually transmitted disease (STD) testing and counseling</li> <li>Confidential HIV testing and counseling</li> <li>Family planning services</li> <li>Health education services</li> </ul>	<p>No copay for all listed routine preventive services.</p> <p>No copay for family planning services.</p> <p>No copay for health education services.</p>	<p>No copay for all listed routine preventive services.</p> <p>No copay for family planning services.</p> <p>No copay for health education services.</p>	<p>No copay for all listed routine preventive services.</p> <p>No copay for family planning services</p> <p>No copay for health education services.</p>	<p>No copay age &lt;24 mos. and \$ 30 per visit age &gt;24 mos. for all listed routine preventive services except where noted below:</p> <p>\$10 per lab encounter</p> <p>No copay age &lt;24 mos. and \$ 30 per visit age &gt;24 mos. for related office visits.</p> <p>\$ 10 per lab encounter for STD testing.</p> <p>\$ 10 per lab encounter for HIV testing.</p> <p>\$ 30 per visit for family planning services.</p> <p>No copay for group session and \$ 30 per individual visit for health education services.</p>	<p>No copay age &lt;22 years for all listed routine preventive services.</p> <p>\$ 25 primary care MD/\$ 35 specialty MD per visit for family planning services.*</p> <p><u>Reduced Coverage Note for Family Planning Services:</u>  Abortions not covered except when life of mother would be endangered or if fetus is result of rape or incest.</p> <p>No copay for health education services.</p>

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<p><b>Prescription Drugs</b></p> <p>30-day supply of prescription drug, including one cycle of tobacco cessation drug:</p> <ul style="list-style-type: none"> <li>• Generic</li> <li>• Brand name (unless No copay generic equivalent available or brand name is specified by prescribing MD)</li> </ul> <p>90-day supply of maintenance drug through mail order program:</p> <ul style="list-style-type: none"> <li>• Generic</li> <li>• Brand name (unless no generic equivalent available or brand-name is specified by prescribing MD)</li> </ul>	<p>\$5/10 generic</p> <p>\$5/15 brand name</p> <p>\$ 0/10 generic</p> <p>\$0/15 brand-name</p>	<p>\$5 generic</p> <p>\$15 brand name</p> <p>\$ 45 non-formulary</p> <p>\$10 generic</p> <p>\$ 25 brand-name</p> <p>\$75 non-formulary</p> <p><u>Added benefit note:</u> Maintenance drugs after 3 months non-mail order: \$10 generic, \$ 25 brand- name, \$ 75 non-formulary. \$ 1,000 annual maximum.</p>	<p>\$5 generic</p> <p>\$15 brand name</p> <p>\$ 45 non-formulary</p> <p>\$10 generic</p> <p>\$ 25 brand-name</p> <p>\$75 non-formulary</p> <p><u>Added benefit note:</u> Maintenance drugs after 3 months non-mail order: \$10 generic, \$ 25 brand-name, \$ 75 non-formulary. \$ 1,000 annual maximum.</p>	<p>\$ 10 for up to a 100-day generic supply</p> <p>\$ 250 deductible for brand name drugs per calendar year. After drug deductible met \$ 35 for up to a 100-day supply</p> <p>\$ 10 for up to a 100-day supply generic</p> <p>\$ 250 deductible for brand-name drugs per calendar year. After drug deductible, \$ 35 for up to a 100-day supply</p>	<p>\$ 10 for up to a 34-day generic supply</p> <p>\$ 35 for up to 34-day supply brand-name drug up to a 34-day supply</p> <p>50% coinsurance or \$ 45 minimum for up to 34-day supply non-formulary or non-brand-name</p> <p>\$ 30 generic</p> <p>\$ 105 brand-name 50% coinsurance or \$ 135 minimum for non-formulary or non-brand-name</p>

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<b>Medical Transportation</b>  Emergency ambulance transportation to a hospital, and medically necessary non-emergency transportation to transfer a member from a hospital to another hospital or facility, or facility to home.	No copay	No copay	No copay	\$ 75 per trip	\$ 100 per day ground transportation \$ 150 per day air or sea transportation
<b>Mental Health</b> <u>Basic Mental Health Services</u> provided by the Plan or Plan subcontractor for diagnosis and treatment of a mental health condition.  Inpatient  Outpatient  Outpatient and inpatient services are provided without limit for serious mental illnesses (SMIs).	No inpatient copay.  \$5/10 per outpatient visit  <u>Reduced coverage note:</u> Limited to 30 inpatient days and 20 outpatient visits per year. Parity scheduled to be implemented 1/1/2011.	No inpatient copay  \$15 per outpatient visit  <u>Added coverage note:</u> Mental and Substance Abuse Parity implemented; number of covered days or visits is unlimited.	No inpatient copay  \$15 per outpatient visit  <u>Added coverage note:</u> Mental and substance abuse parity implemented; number of covered days or visits is unlimited.	\$ 400 per inpatient day  \$ 30 per individual outpatient visit and \$ 15 per group outpatient visit  <u>Added coverage note:</u> 1) Up to 20 additional group visits that meet Medical Group criteria \$ 15 per group visit; and, 2) Visit and day limits do No copay for SMI and SED illnesses.	Mental health coverage same as for other illnesses or conditions (parity).
<b>Mental Health</b> <u>Serious Emotional Disturbance (SED)</u>	No inpatient copay  Services provided by County Mental Health for SED condition.	No inpatient copay  \$15 per outpatient visit	No inpatient copay  \$15 per outpatient visit	No inpatient copay	Mental health coverage same as for other illnesses or conditions (parity).

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<p><b>Alcohol and Drug Abuse (also known as Chemical Dependency or Substance Abuse Services)</b></p> <p><b>Inpatient:</b> As medically appropriate to remove toxic substances from the system.</p> <p><b>Outpatient</b></p>	<p>No inpatient copay</p> <p>\$5/10 per outpatient visit and limited to 20 visits per year.</p>	<p>No inpatient copay</p> <p>No outpatient copay</p> <p><u>Added coverage note:</u> Mental and Substance Abuse Parity implemented; number of covered days or visits is unlimited.</p>	<p>No inpatient copay</p> <p>No outpatient copay</p> <p><u>Added coverage note:</u> Mental and Substance Abuse Parity implemented; number of covered days or visits is unlimited.</p>	<p>\$ 400 per inpatient day</p> <p>\$ 30 per individual outpatient visit and \$ 5 per group outpatient visit</p> <p><u>Added coverage note:</u> Transitional residential recovery covered up to 60 days per year with \$ 100 copay per admit</p>	<p>Alcohol and drug coverage same as for other illnesses or conditions (parity).</p>
<p><b>Home Health Care</b></p>	<p>No copay except \$5/10 per visit for physical, occupational and speech therapy</p>	<p>No copay except \$ 15 per visit for physical, occupational and speech therapy</p>	<p>No copay except \$ 15 per visit for physical, occupational and speech therapy</p>	<p>No copay</p> <p><u>Reduced coverage note:</u> Up to 100 visits per calendar year.</p>	<p>\$ 25 per visit</p> <p><u>Coverage reduction note:</u> Limited to 25 visits per calendar year.</p>

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<p><b>Durable Medical Equipment</b></p>	<p>No copay</p> <p>Medical equipment appropriate for use in the home, which primarily serves a medical purpose, is intended for repeated use, and is generally not useful to a person in the absence of illness or injury.</p> <p>(no specific list provided in EOC)</p>	<p>No copay</p> <p>Medically necessary durable medical equipment, prostheses and orthoses for activities of daily living, and supplies needed to operate DME, oxygen and oxygen equipment and its administration; blood glucose monitors as medically appropriate for insulin dependent, non-insulin dependent and gestational diabetes; apnea monitors; and ostomy and medical supplies to support and maintain gastrointestinal, bladder or respiratory function.</p> <p>When authorized as durable medical equipment includes other covered items specifically mentioned</p>	<p>No copay</p> <p>DME for use in the home in accord with DME formulary guidelines.</p> <p>DME for home use is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home.</p> <p>Coverage is limited to the standard item of equipment that adequately meets medical needs. The following diabetes blood-testing supplies and equipment and insulin-administration devices are covered: blood glucose monitors and their supplies (test strips and lancets) and insulin pumps and supplies to operate the pump.</p> <p>(no specific list in EOC)</p>	<p>50% coinsurance.</p> <p>For diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)</p> <p>Infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other drugs)</p> <p><u>Reduced coverage note:</u> EOC states that most DME is not covered due to restricted DME formulary.</p>	<p>30% coinsurance.</p> <p>Durable medical equipment (DME) is equipment and supplies that are:</p> <p>Prescribed by the attending physician</p> <p>Medically necessary</p> <p>Primarily and customarily used only for a medical purpose</p> <p>Generally useful only to a person with an illness or Injury</p> <p>Designed for prolonged use</p> <p>Serve a specific therapeutic purpose</p> <p><u>Reduced coverage note:</u> EOC contains specific list of covered DME that does not appear to include DME items covered through HFP and CalPERS.</p>

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<b>Skilled Nursing Care</b>	No copay  Coverage is limited to 100 days each year	No copay  Coverage is limited to 100 days each year	No copay  Coverage is limited to 100 days each year	No copay  Coverage is limited to 100 days each year	Not covered  <u>Reduced coverage note:</u> No skilled nursing facility coverage as long term care coverage is a separate supplemental benefit.
<b>Acupuncture</b>	Optional coverage by plan: 1) HPSJ covers unlimited visits with \$5/10 copay; 2) Kaiser no coverage; 3) Anthem Blue Cross covers 20 visits per year with \$5/10 copay	Not covered	Not covered	Not covered	\$ 25 primary care MD/\$ 35 specialty MD per visit for unlimited number visits
<b>Chiropractic</b>	Coverage is optional and all plans currently cover 20 visits per year with \$5/10 copay per visit	Not covered	Not covered	Not covered	\$ 25 per visit  Coverage is 20 visits per year; 1 set of X-rays per year.
<b>Biofeedback</b>	Coverage is optional: 1) HPSJ covers 8 visits per year with \$5/10 copay per visit; 2) Kaiser does not provide coverage 3) Anthem covers unlimited visits with \$ 5/10 per visit.	Not covered	Not covered	Not covered	Not covered

