



2011-12

Out-of-Pocket Expenditures Report

May 2013

California Managed Risk Medical Insurance Board

Benefits and Quality Monitoring Division





California Managed Risk Medical Insurance Board

Healthy Families Program

MRMIB provides and promotes access to affordable coverage for comprehensive, high quality, cost effective health care services to improve the health of Californians.

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INTRODUCTION

Federal law¹ limits subscriber cost sharing including monthly premiums and copayments to no more than five percent (5%) of annual household income for children enrolled in the Children's Health Insurance Program (CHIP). The Healthy Families Program (HFP), California's CHIP, has assured compliance with these requirements by limiting the total amount of copayments incurred per family for health services to no more than \$250 per benefit year², regardless of family size. Subscribers are informed of this limitation through enrollment materials such as the welcome letter and the HFP Handbook. Plans also provide the information in the Evidence of Coverage or Certificate of Insurance, and must twice a year inform subscribers. On an annual basis, the Managed Risk Medical Insurance Board (MRMIB) collects data from its contracting health and dental plans on the number of subscriber families who met the copayment maximum for health services and compares the total out-of-pocket expenditures with family income to ensure compliance with the federal law.

The design of the HFP benefits package requires subscribers to pay a \$5 to \$15 copayment for certain health, dental and vision benefits at the time services are provided. There are no copayments for preventive health and dental services, immunizations, medical transportation, inpatient care, sealants, or restorative dental procedures. Services that require copayments include: physician office visits, emergency room visits not ending in hospital admittance, acupuncture, chiropractic and biofeedback services, prescription drugs, outpatient mental health and substance abuse services, eye examinations, prescription glasses, and root canals, crowns and bridges.

HFP families must keep records of their copayments for each benefit year and notify their health plans when they have reached the copayment maximum for health services. Once families demonstrate to their health plans that they have paid the \$250 maximum copay amount no further copayments are necessary for health services in the benefit year. Health plans are required to notify providers to stop charging copayments and reimburse families that demonstrate they have paid more than \$250 in health services copayments.

This report provides information on the families enrolled in the HFP who reached the \$250 maximum copayment amount from October 1, 2011 through September 30, 2012 (Benefit Year 2011-12). As a result of the transition of HFP subscribers to the Medi-Cal program in 2013, this is the last report regarding out-of-pocket expenditures MRMIB will publish.

¹ Title XXI of the Social Security Act Section 2103(e)(3)

² California Insurance Code Section 12693.615(a)

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DATA COLLECTION AND ANALYSIS

The data collected is used to identify which families have reached the \$250 copayment maximum for health services and then determine if the family exceeded the five percent federal limit. Each health plan reports annually on the number of HFP families that incurred at least \$250 in copayments in each benefit year. MRMIB also requires dental plans to report the amount of copayments incurred for dental services by those HFP subscribers that incurred at least \$250 in health services copayments. The medical and dental copayments and premiums paid by families that reach the \$250 copayment maximum for health services are added together to determine each family's total out-of-pocket expenditures. Total expenditures are then compared to household income to determine if the total out-of-pocket expenditures exceed five percent (5%) of household income. MRMIB reviews this data annually to ensure compliance with federal law.

Health plans reported using the following methods for collecting, reviewing, and reporting copayment data.

- Some plans reported tracking only paid copayments.
- Others track only incurred copayments. Incurred means a service was provided that required a copayment, but the subscriber may not have actually paid the copayment.
- Some plans report copayment information for covered services only while other plans provide MRMIB with copayment information for both covered and non-covered services, such as cosmetic procedures.
- The most common methods used to verify copayment information include running reports against claims data, having subscribers mail in receipts to initiate the tracking process, and tracking cards provided to the subscribers.

MAJOR FINDINGS

The number of families reaching the \$250 copayment maximum for health services has increased from benefit year 2010-11 to 2011-12. In benefit year 2011-12, 3,355 families reached the \$250 copayment maximum for health services compared to 3,155 families in benefit year 2010-11. However, the 3,355 families reaching the copayment maximum for health services account for less than one percent (0.50%), of the overall number of families enrolled in the HFP. Of the 3,355 families, 3,021 families exceeded the \$250 copayment maximum for health services. One family incurred out-of-pocket expenditures exceeding five percent of their annual income and was reimbursed for the amount paid

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above \$250. On average, families reaching the \$250 copayment maximum for health services spent 1.6 percent of their annual income on total cost sharing, premiums and copayments for health and dental services.

PROGRAM CHANGE

In November 2009, copayments and premiums were increased for families in Income Categories B and C, those with incomes over 150 percent of Federal Poverty Level (FPL). In September and October 2009, MRMIB sent letters to the families explaining the copayment and premium increases. The letters encouraged families to review the HFP website which addressed the \$250 maximum and provided instructions on how to inform their health plans. There were no program changes to premiums and copayments in benefit years 2010-11 or 2011-12.

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RESULTS OF DATA ANALYSIS

As of December 31, 2012, there were 671,143 families, representing 1,082,971 children, enrolled in HFP. The number of families and children is derived from enrollment data and may include families and children counted more than once due to families changing plans during the benefit year. During benefit year 2011-12, 3,355 families reached the \$250 copayment maximum for health services. Table 1 shows the number of families listed by health plan that reached the copayment maximum for health services.

Table 1. Families Reaching \$250 Copayment Maximum by Health Plan

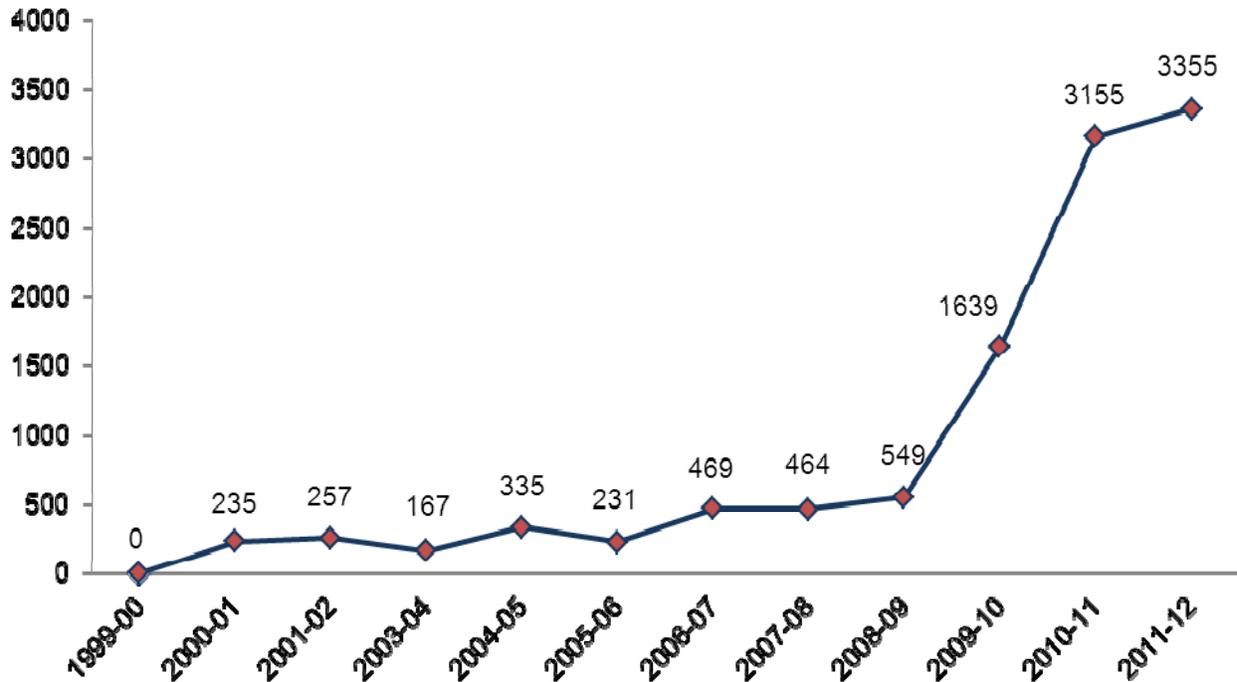
Health Plan	Total Families Who Reached \$250 Max Copay	Total Children in Families Who Reached \$250 Max Copay	Total HFP Families	Total HFP Children	Percentage of Health Plan's Families Who Reached the \$250 Max Copay
Kaiser Foundation Health Plan*	1,669	3,934	153,488	248,130	1.09%
Central California Alliance for Health	546	1,229	17,759	28,362	3.07%
Health Plan of San Joaquin	361	816	17,746	30,286	2.03%
CenCal Health	168	386	8,928	14,624	1.88%
Ventura County Health Care Plan	160	374	8,243	13,816	1.94%
Kern Health Systems	156	407	7,715	13,532	2.02%
Molina Healthcare	75	121	24,652	40,300	0.30%
Health Plan of San Mateo	54	120	5,042	7,662	1.07%
Health Net HMO	40	80	108,336	176,682	0.04%
Alameda Alliance	38	64	8,232	12,854	0.46%
Community Health Group	35	86	18,776	30,646	0.19%
Anthem Blue Cross HMO	14	28	104,946	163,695	0.01%
Contra Costa Health Plan	13	30	3,687	5,891	0.35%
CalOptima Kids	12	27	29,186	47,199	0.04%
Anthem Blue Cross EPO	9	18	57,958	95,126	0.02%
Partnership	4	13	2,057	3,233	0.19%
LA Care Health Plan	1	2	14,138	21,565	0.01%
Blue Shield HMO	0	0	3,273	4,533	0.00%
Community Health Plan	0	0	2,255	3,057	0.00%
Inland Empire Health Plan	0	0	43,661	73,995	0.00%
San Francisco	0	0	6,200	8,850	0.00%
Santa Clara	0	0	13,524	21,108	0.00%
Care 1 st	0	0	10,553	16,653	0.00%
Blue Shield EPO	0	0	788	1,172	0.00%
Totals for Families Who Reached \$250 Max Copay	3,355	7,735	590,889	953,603	0.57%
Total HFP	3,355	7,735	671,143	1,082,971	0.50%

* Kaiser's integrated deliver model provides for comprehensive reporting of subscribers' copayments

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There has been an upward trend over the last 12 years in the number of families that reached the \$250 copayment maximum for health services. Figure 1 below shows a significant increase in benefit years 2009-10 and 2010-11, as a result of the copayment and premium increase in November 2009. While the overall percentage of families that reached the HFP copayment maximum for health services has increased over the last 12 years, the number of families reaching the HFP copayment maximum for health services in benefit year 2011-12 is a small percentage, 0.50 percent, of the overall number of HFP families.

Figure 1. Total Number of Families Reaching the \$250 Copayment Maximum for Health Services by Year



In benefit year 2011-12, 3,355 families reached the \$250 copayment maximum for health services compared to 3,155 in benefit year 2010-11. Of the 3,355 families that reached the \$250 copayment maximum for health services, 3,021 families exceeded the copayment maximum for health services. Of the 3,355 families that reached or exceeded the copayment maximum for health services, the majority (78%) **did not** inform their health plan that they reached the copayment maximum for health services. Health Plans reported that 16 percent of the families notified their health plans and received reimbursements for health care services exceeding \$250. No data was reported for the remaining six percent of families.

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MRMIB contracts require HFP health plans to notify all subscriber families of the annual copayment maximum and the process for informing the health plan when a subscriber family reaches the maximum at least twice a year. Plans must also disclose the process to be used by subscribers to document that the annual copayment maximum has been reached. In addition, plans must work with network providers to offer extended payment plans whenever a family's copayments exceed \$25 in a month and to stop collecting copayments when the family reaches the \$250 maximum.

To assure that subscriber families are aware of the copayment limit, MRMIB has used a variety of communication strategies during the life of the program. This information is provided to families in their welcome letter, the HFP Handbook and on the HFP website. Health Plans must include the information in the Evidence of Coverage or Certificate of Insurance, must twice a year inform subscribers and also educate providers. In addition, Certified Application Assistants (CAAs) receive this information in their training and MRMIB has also included it in its CAA newsletters.

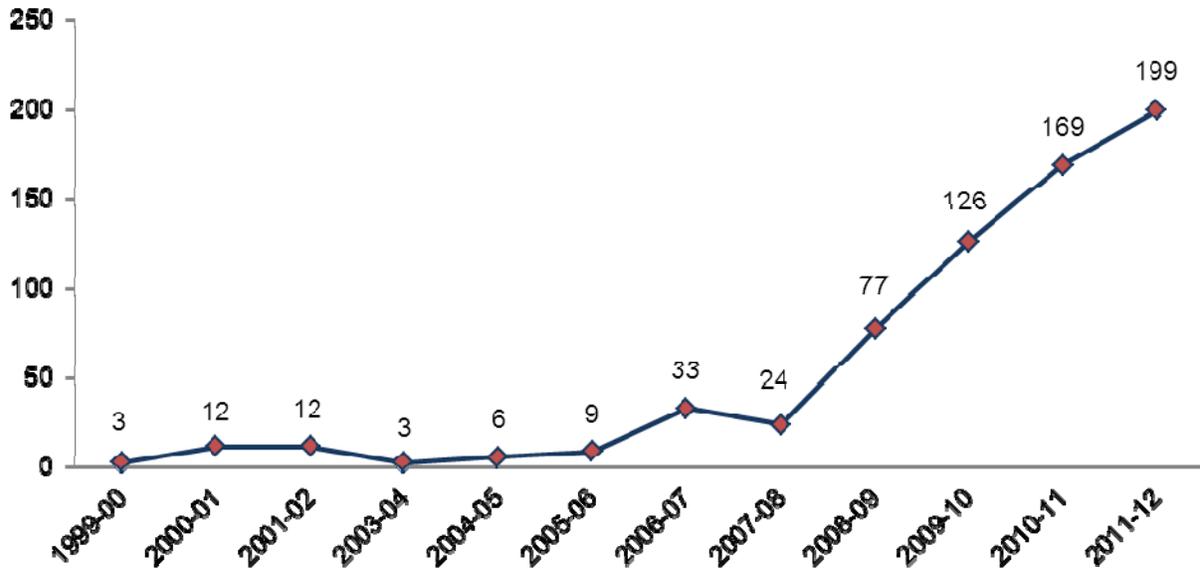
On average, families that reached the \$250 copayment maximum for health services spent 1.6 percent of their annual income on premiums plus health and dental copayments. Based on claims information submitted by HFP health plans, one family appears to have incurred six percent of their annual income on health care services for two (2) children. The family notified their health plan and was reimbursed for copayments above the \$250 limit.

Figure 2, on page 7 trends the last 12 years of families reaching the \$250 copayment maximum for health services who also incurred copayments for dental services. A list of families that reached the maximum copayment for health services is sent to their corresponding dental plan to obtain the total of the dental copayments. The dental copayments are included in the family's total out-of-pocket expenditures used to determine if the family exceeded the five (5%) percent federal limit. Of the 3,355 families that reached the \$250 copayment maximum for health services, 199 families also had dental copayments, an 18 percent increase from the prior benefit year.

When comparing Figure 1, Total Families Reaching the Copayment Maximum for Health Services and Figure 2, Total Number of Families Reaching the Copayment Maximum and had Copayments for Dental Services, we see the upward trend has been consistent. MRMIB would expect that with the increase in the number of families reaching the \$250 copayment maximum for health services, the number of families also incurring copayments for dental services would increase correspondingly.

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Figure 2. Total Number of Families Reaching the \$250 Copayment Maximum and had Copayments for Dental Services by Year



DEMOGRAPHIC COMPARISON

The following pages are comparisons of families reaching the \$250 copayment maximum for health services reported by the health plans, to the entire HFP population by the spoken language in the home, ethnicity, region, and FPL income categories.

Figure 3, on page 8 illustrates families that speak English in the home were the highest percentage of families who reached the \$250 copayment maximum for health services and they were a little more than half the HFP population, 55 percent. Similar results were observed in the prior three benefit years where families that speak English in the home were the highest percentage of families that reached the copayment maximum for health services and represented more than half the HFP population. The Chinese, Vietnamese and Korean speakers show a low percentage of families who reached the copayment maximum for health services. MRMIB annually measures utilization of services by HFP subscribers with selected measures from the Healthcare Effectiveness Data and Information Set (HEDIS)³ and conducts demographic statistical analysis for HEDIS measures derived from administrative data. Analysis contained in the 2011 HFP HEDIS Report also shows that for some measures, Asian language speaking families have significantly lower utilization rates. In particular, HEDIS measures of Appropriate

³ 2011 Healthy Families Program Healthcare Effectiveness Data and Information Set (HEDIS) Report http://www.mrmib.ca.gov/MRMIB/HFP/2011_HFP_HE_DIS.pdf

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Treatment for Upper Respiratory Infection, Appropriate Testing for Pharyngitis, Mental Health Utilization and Services for Alcohol and Drugs.

Figure 3. Percentage of Families Reaching the \$250 Copayment Maximum by Spoken Language

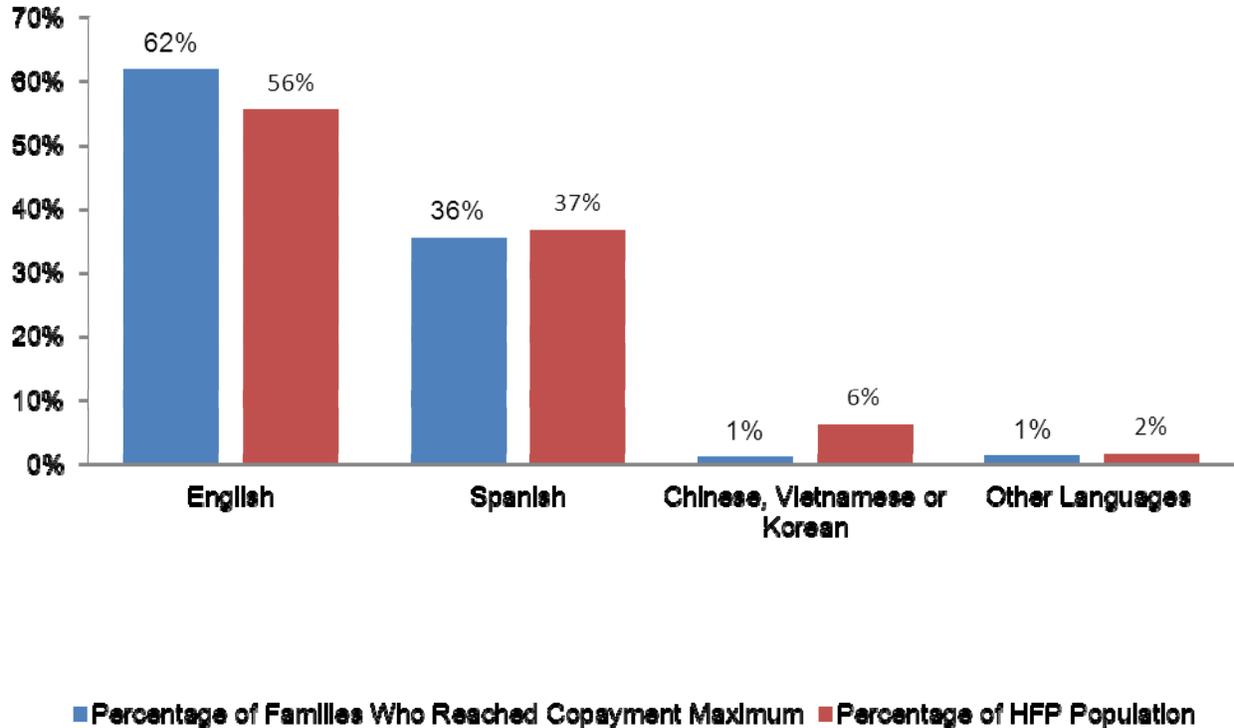
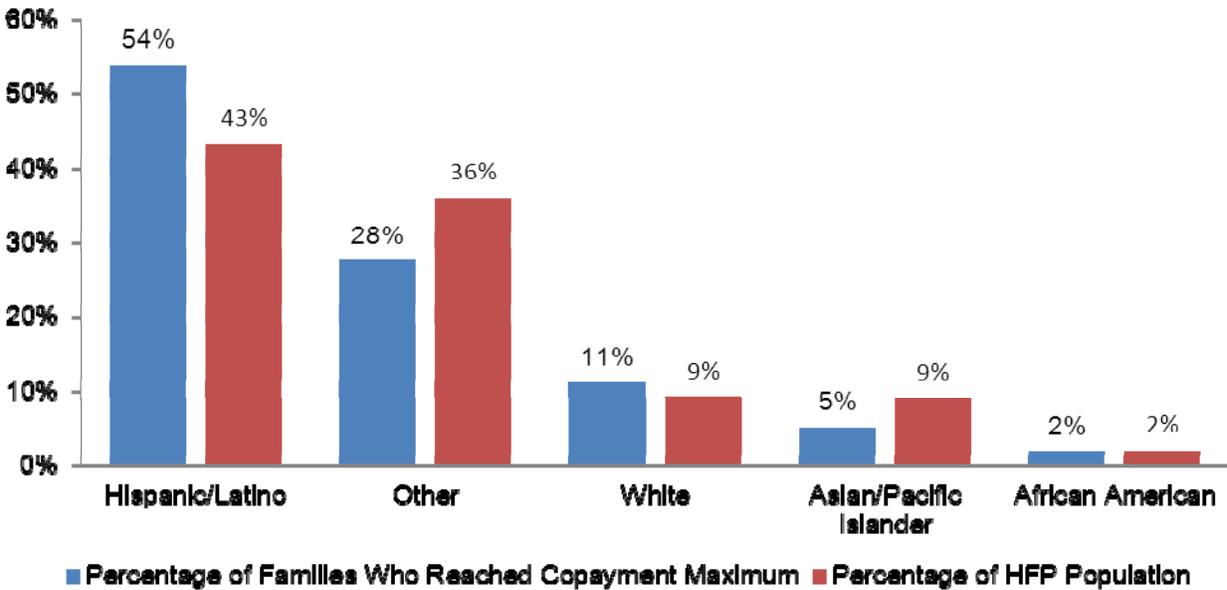


Figure 4, on page 9 shows the majority of families, 54 percent, reaching the \$250 copayment maximum for health services are Hispanic/Latino and that they are less than half of the HFP population, 43 percent. This is consistent with the two prior benefit years.

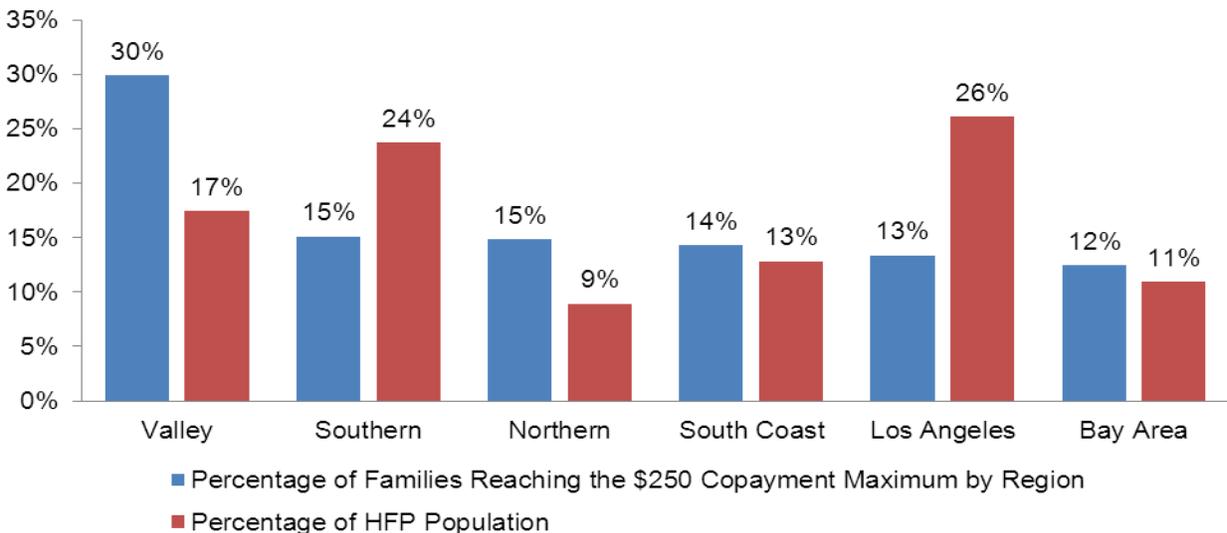
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Figure 4. Percentage of Families Reaching the \$250 Copayment Maximum by Ethnicity



In comparing regions, the Valley region continues to have the largest percentage (30%) of families reaching the \$250 copayment maximum for health services as displayed in Figure 5. Consistent with the prior three benefit years, the Valley region had the highest percentage of families reaching the copayment maximum for health services. Appendix A, the last page of this report, contains the HFP enrollment by region as of December 31, 2012.

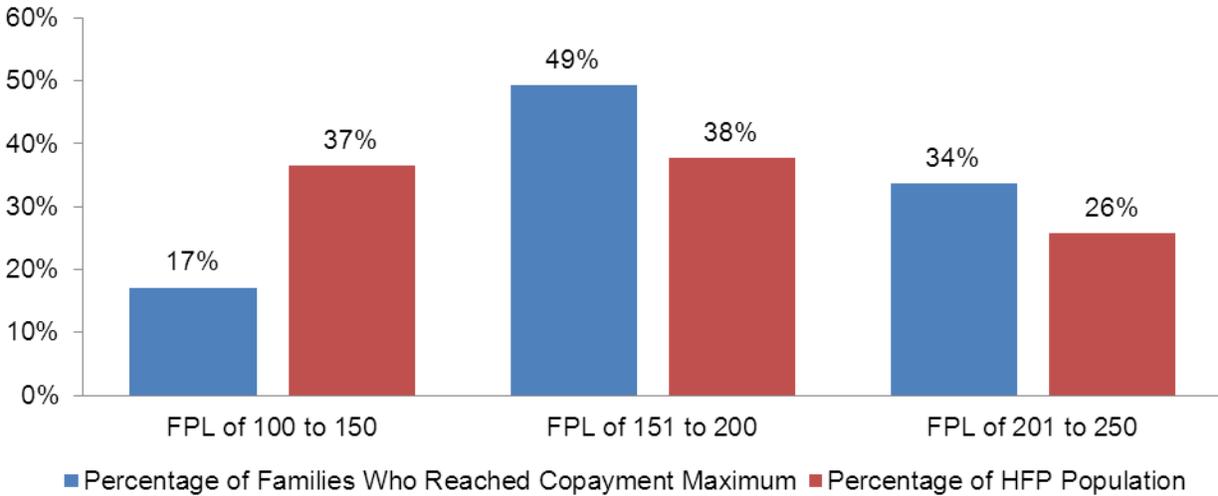
Figure 5. Percentage of Families Reaching the \$250 Copayment Maximum by Region



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Figure 6 shows families with incomes in the FPL category of 151 percent to 200 percent reached the \$250 copayment maximum for health services at a higher rate than those in the higher and lower income categories. This is consistent with the last five reporting years.

Figure 6. Percentage of Families Reaching the \$250 Copayment Maximum by Income Category



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LESSONS LEARNED

With the transition of HFP children to the Medi-Cal program underway in 2013, this is the final report MRMIB will publish on Out-of-Pocket Expenditures. However, strategies employed by MRMIB to limit cost sharing for low income subscribers and lessons learned may prove instructive to other state Children's Health Insurance Programs.

Despite numerous educational efforts by MRMIB and contracting health plans, the percentage of subscribers who notify their health plan when they reach the copayment maximum for health services continues to remain very low at 16 percent. As a result, we recommend further research to determine if other strategies should be employed to outreach to families.

There was also a significant difference the rates reported by those families with Asian language preferences. Therefore, other programs should conduct demographic analysis to determine if differences in spoken language and ethnicity are observed. Additional research may also be warranted to compare subscriber utilization with language spoken and ethnicity to determine if language per se represents a barrier or if this difference is attributable to lower utilization rates.

Lastly, health plan requirements should also be assessed. It may be necessary to require health plans to increase subscriber education and provide assistance in tracking their copayments. Other programs may also want to consider requiring health plans to track copayments and notify subscribers instead of relying on subscribers to self-report.

Map of California Regions

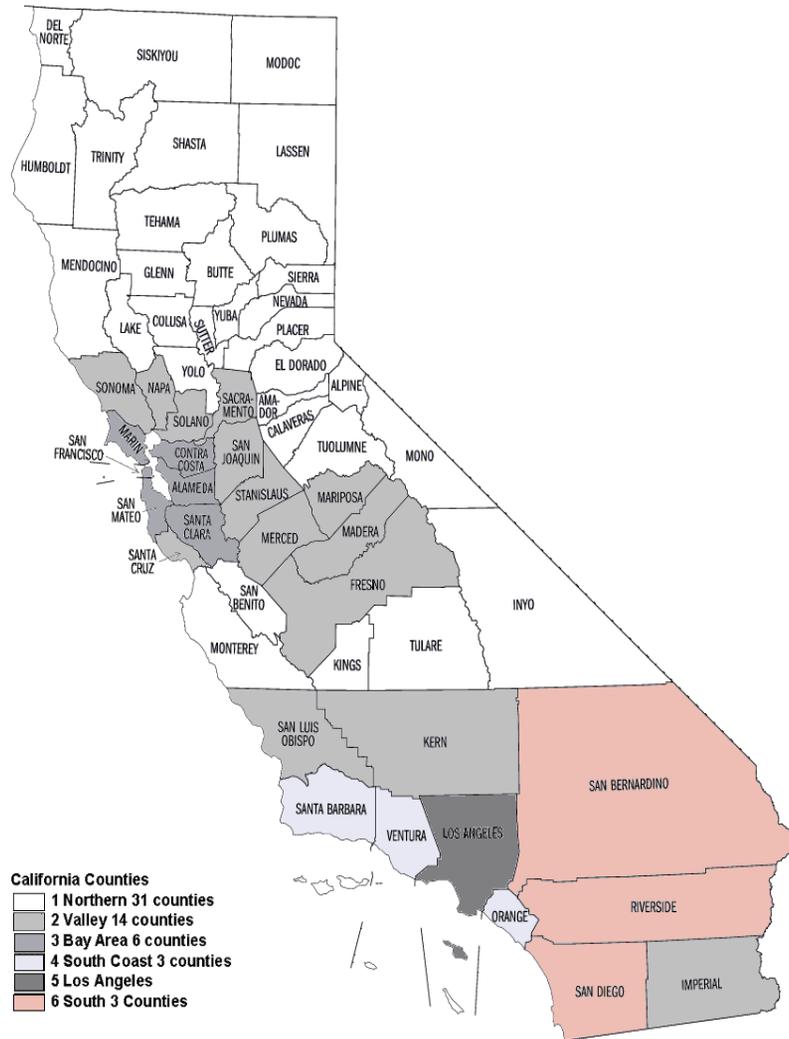


Table 2. HFP Enrollment by Regions and Counties as of December 31, 2012

Region	Counties	Total Unique Enrollment per Region	Percentage of Total Enrollment
Northern	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba	59,999	9%
Valley	Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus	116,840	17%
Bay Area	Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara	73,366	11%
South Coast	Orange, Santa Barbara, Ventura	86,024	13%
Los Angeles	Los Angeles	175,222	26%
Southern	Riverside, San Bernardino, San Diego	158,940	24%

California's Six Regions