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## **Plan & Benefit Options Under the State Children's Health Insurance Program**

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with

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## **PLAN AND BENEFIT OPTIONS UNDER THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

The new state Children's Health Insurance Program (CHIP) has granted states broad flexibility to define the scope of covered benefits available to eligible children. They may utilize Medicaid, other subsidized insurance programs for children, existing private plans, or design entirely new arrangements. Moreover, different benefit packages may be selected for different targeted groups of children. Because of the significant amount of federal and state resources being devoted to CHIP, states presumably will want to assure that the program provides the target population reasonable access to services they are likely to require.

The purpose of this issue brief is to assist states in evaluating the various plan and benefit choices relative to the needs of uninsured children. A brief overview of the five types of coverage that are permissible under Title XXI is presented along with a short discussion of the range of the potential benefit packages that could be offered. This is followed by an examination of each of the five coverage options:

- Medicaid,
- benchmark coverage,
- benchmark-equivalent coverage,
- Secretary-approved coverage, and
- direct services under a waiver.

Information for this issue brief was obtained through interviews with health economists and actuaries, federal HCFA staff, and selected CHIP program officials. It was also based on a review of CHIP proposals and a comparative analysis of benchmark plans in selected states. This issue brief on plan and benefit selection is the second in an ongoing series of issue briefs and fact sheets on children's health insurance. The next topic to be addressed will be cost-sharing options under CHIP.

## POTENTIAL PLAN AND BENEFIT OPTIONS UNDER CHIP

### *Brief Overview of the Coverage Options Available*

States have been given considerable latitude in fashioning a benefit plan for CHIP participants. They may choose to enroll eligible children in the state Medicaid program or they may offer a separate health insurance program with benefits that are either the same or actuarially equivalent to one of three benchmark plans.<sup>1</sup> Benchmark plans are the Blue Cross / Blue Shield standard preferred provider plan offered to federal employees, a health plan generally available to state employees, or the HMO plan with the largest commercial enrollment. For a plan to be actuarially equivalent to one of these three plans, it must have the same aggregate actuarial value as the benchmark plan selected. Also it must provide the same coverage for physician services, inpatient and outpatient hospital services, laboratory and x-ray services, and well-child care and coverage that is equal to at least 75 percent of the actuarial value of the coverage provided for prescription drugs, mental health services, and vision and hearing services. However, the amount of coverage may be adjusted downward if there are greater cost-sharing requirements under the actuarial benchmark plan than would be allowed under CHIP.<sup>2</sup>

States have two additional options as well. One is to design their own health benefits plan and submit it to the Secretary for approval. The only statutory criterion for approval is that the plan

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<sup>1</sup> Three state children's health insurance programs -- Florida's Healthy Kids, New York's Child Health Plus, and Pennsylvania's Caring Foundation for Kids -- were granted special authority as approved CHIP programs.

<sup>2</sup> States that choose the Medicaid option must adhere to the Medicaid statute with respect to cost sharing. Medicaid law allows very limited use of cost sharing -- premiums and deductibles may not be charged for child beneficiaries and co-payments are limited to nominal amounts. States that choose to establish a state child health insurance program can implement cost-sharing provisions as long as they do not apply cost sharing to preventive services. Medicaid rules regarding cost sharing would apply for children in families with income at or below 150 percent of poverty. For children in families with income above 150 percent of poverty, the total amount of all cost sharing cannot exceed five percent of the family's annual income. The next issue brief by the MCH Policy Research Center will discuss cost-sharing options.

provide appropriate coverage for the population of targeted low-income children proposed to be covered under the plan. The other option is to seek a waiver from the Secretary for permission to exceed the 10 percent limit on federal payments for direct service, outreach, and administrative purposes to offer coverage in the form of direct services furnished by community providers. This coverage, however, must meet the requirements of benchmark or benchmark-equivalent coverage and, on an average per-child basis, must not cost more than benchmark coverage.

Little guidance has been provided by HCFA to states about what is needed for approval of a specially designed plan, a direct service program, or even a benchmark-equivalent plan. It is clear, however, that states have the option to offer different benefit plans to meet the needs of different target groups of children. Such groups may be identified on the basis not only of income but also of age or disability status.

### **Potential Benefits Package**

The range of benefit packages that could be made available under Title XXI is enormous. At one extreme, a state could enroll CHIP-eligible children into Medicaid, providing access to generous benefits for enabling services, mental health and other therapies, and even long term care. At the other, a state could offer these children access to coverage that is substantially more restrictive than might be available under the most popular HMO plan or state employees' benefit plan. With respect to mental health treatment, for example, Medicaid coverage could include all medically necessary office- and community-based interventions, whether for acute or chronic care needs, while a benchmark-equivalent plan could restrict coverage to as few as 10 or 15 mental health visits per year, after accounting for CHIP's cost-sharing ceiling, and exclude coverage for children with neurological and conduct disorders. Similarly, Medicaid could cover all medically necessary ancillary therapies -- physical therapy, occupational therapy, and also speech and language therapy -- while a benchmark-equivalent plan could conceivably omit coverage for all of these therapies.

## ANALYSIS OF PLAN AND BENEFIT DESIGN ISSUES

### The Medicaid Option

The obvious threshold decision for states with regard to plan selection is whether to provide Medicaid coverage to some, if not all, groups of CHIP-eligible children. A state could choose to enroll all CHIP-eligible children in Medicaid and, if state financing is an issue, set the upper income eligibility level at an amount below what is statutorily allowed.<sup>3</sup> A state also could provide Medicaid coverage to all CHIP participants in families with incomes up to a certain eligibility level, perhaps 133 or 150 percent of poverty, and enroll higher income participants in a state health insurance plan that provided benchmark or actuarially equivalent coverage.<sup>4</sup> In fact, numerous options are possible. In addition to making Medicaid coverage available to all children up to a certain family income level, a state could also make Medicaid coverage available to all CHIP-eligible children determined to have a disability or all those in a certain age group. States would not have to use different insurers for children covered by different benefit packages; they could administer all CHIP benefit packages through the Medicaid administrative structure and, where managed care is in place statewide, use the same insurers to furnish whatever package the child was entitled to.

With its more extensive coverage of numerous non-physician services, outreach, and case management and its requirement to provide children with all federally allowable, medically necessary services, Medicaid has clear advantages for all poor and near-poor children whose families have few resources to pay out-of-pocket for uninsured services. Medicaid also has definite benefits for children with disabilities who are more likely to require coverage for case management services,

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<sup>3</sup> More information about the eligibility options under CHIP can be found in our earlier issue brief. Fox HB, et al.: *Eligibility Options Under the State Children's Health Insurance Program*. Washington, D.C.: Maternal and Child Health Policy Research Center, December 1997.

<sup>4</sup> At a minimum, states probably would want to provide Medicaid coverage to all children ages 14 to 19 living in families with incomes up to 100 percent of poverty, since these adolescents are scheduled to become eligible for Medicaid on a phase-in basis ending in year 2002.

long-term ancillary therapies, assistive devices, and home care, and for adolescents, who are more likely to require access to a wide array of traditional and non-traditional mental health services.

States that choose Medicaid, in addition to having an easier and less costly CHIP start up, would have the fiscal advantage of maximizing federal revenues for expenses that might otherwise be borne by the state. Medicaid would provide a 75 percent federal matching rate for unlimited outreach, eligibility determination, data analysis, contract monitoring, and other administrative expenses associated with extending Medicaid coverage to CHIP-eligible children.<sup>5</sup> Medicaid, because of its generous benefit package, also would permit states to claim federal matching funds at the enhanced-CHIP matching rate, or the regular Medicaid matching rate if CHIP funds are depleted, for the cost of furnishing covered health care services through various state-financed programs -- including the Title V program for children with special health care needs, the children's mental health services program, the early intervention program, and the special education program. Reimbursement for the services could be required under a managed care contract, or it could be handled directly by the state under a separate capitation or fee-for-service arrangement.

The Medicaid option also offers other advantages for families and states. It would relieve families from having to pay premiums and meet cost-sharing requirements for their child's care. It would provide states with a consistent level of federal funds when CHIP allocations drop beginning in the year 2002. And, where the alternative under consideration in a state is a privately administered benchmark or benchmark-equivalent plan, it would enable different age children in families at the same income level to be covered by the same insurer.<sup>6</sup>

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<sup>5</sup> States selecting the Medicaid CHIP option may elect to claim administrative costs at the Title XXI enhanced federal financial participation (FFP) rate and then revert to Medicaid's regular 75/25 administrative rate if they reach the 10 percent limit, or they may elect to claim all administrative costs at the regular Medicaid administrative rate. States selecting the non-Medicaid CHIP option may only elect to claim the Title XXI enhanced FFP rate to cover joint Medicaid-CHIP outreach activities. Health Care Financing Administration guidance dated December 8, 1997 and January 23, 1998.

<sup>6</sup> For a more detailed discussion of the advantages of the Medicaid option, see Mann C: *Why Not Medicaid? Using Child Health Funds to Expand Coverage through the Medicaid Program*. Washington, D.C.: Center on Budget and Policy Priorities, November 20, 1997; and Weil A: *The New Children's Health Insurance Program: Should States Expand Medicaid?* Washington, D.C.: The Urban Institute, October 1997.

However, states have to consider the additional costs related to choosing the Medicaid option. By creating an entitlement, a state would have to enroll all eligible children into Medicaid and when its federal allotment had been spent, it would be dependent on federal matching funds at its regular Medicaid matching rate.<sup>7</sup> Whether a state should assume that its CHIP allotment would be depleted is unclear, however. States may find that they have sufficient federal funding. Those with low rates of uninsurance among children in fact may not be able to identify enough children who would be eligible for CHIP, rather than Medicaid, to exhaust their CHIP allotment.<sup>8</sup>

In addition, because of Medicaid's generous benefit package, a state would expect to incur higher per-child service costs under the Medicaid option. Yet, the actual cost differential would depend on each state's historic Medicaid experience and the particular benchmark benefit package it was considering. Research shows that Medicaid programs vary widely in average per-child costs -- from \$740 per child in Idaho to \$2,635 per child in Maryland<sup>9</sup> -- but that private insurance costs for a single child would vary almost as much.<sup>10</sup> Moreover, when Medicaid is compared to benchmark or benchmark-equivalent coverage privately administered by a health insurance purchasing cooperative, it may be that the private sector's higher insurance and administrative costs

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<sup>7</sup> For some states the difference between the regular Medicaid matching rate and the enhanced CHIP rate would be relatively small. In Mississippi, for example, the Medicaid and CHIP rates are 77 percent and 84 percent, respectively -- a difference of only seven percentage points. In fact, in 12 states the difference between the regular and enhanced rate is nine percentage points or less. Health Care Financing Administration notice dated September 10, 1997.

<sup>8</sup> A forthcoming report by the Urban Institute will estimate the number of children eligible for CHIP rather than Medicaid and whether states will be able to fully access their CHIP allotment.

<sup>9</sup> *Medicaid Expenditures and Beneficiaries, National and State Profiles and Trends, 1990-1995*. Washington, D.C.: The Urban Institute, November 1997. Several states were not included in our analysis, either because they were operating under an 1115 waiver (Arizona, Hawaii, Minnesota, Oregon, Rhode Island, and Tennessee) or because their per-child costs were judged by the Urban Institute to be overstated (Massachusetts).

The variation in per-child Medicaid expenditures reflects state differences in beneficiary composition, health care costs, provider payment policies, utilization controls, and managed care penetration.

<sup>10</sup> For example, in 1997, annual per-child costs among state health insurance programs in Colorado, Florida, New York, Pennsylvania, and Washington ranged from \$452 in Washington to \$1,008 in New York. Information obtained by Fox Health Policy Consultants through telephone conversations with plan administrators.

would offset much of the savings that could be accrued from a reduced benefit package.<sup>11</sup> An actuarial report for the state of California found that private coverage available through a health insurance purchasing cooperative would actually be more expensive than Medicaid, because Medicaid's administrative costs would be lower and because its capitation rates for CHIP-eligible children would reflect historically lower payments to providers and also would be adjusted downward from current rates to account for the expected lower service utilization of this population.<sup>12</sup>

### **Benchmark Coverage Options**

Any state that opts not to use Medicaid for all CHIP participants will probably assess each of the benchmark coverage options and consider whether to provide any of these benefit packages and, if so, to which children. A state could make benchmark coverage available to all CHIP-eligible children or only those in certain income or age groups, such as those with incomes above 150 percent of poverty or those older than age six. Just as a state could elect to insure some groups of targeted children under Medicaid and others under a different coverage arrangement, it could also elect to offer different benchmark benefit packages to different target groups of children. The benchmark benefit package or packages might be privately administered through a health insurance purchasing cooperative or whichever insurer offered the particular package, or they might be administered through the same structure as Medicaid and even rely on the same managed care contractors.

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11 Administrative costs for Medicaid coverage cannot be easily compared to those for private coverage sold directly by an HMO or other health insurer. Administrative costs for Medicaid were 4.4 percent of vendor payments in 1996. (Personal communication with Miles McDermott, Health Care Financing Administration, December 11, 1997.) However, this figure does not include the administrative costs (claims payment, general administration, and risk and profit) incurred by the health insurers with which most states contract. Average costs related to plan administration by private insurers have been estimated to have been about 14 percent of claims paid in 1990. (Thorpe KE: Inside the Black Box of Administrative Costs. *Health Affairs*. 11:41-55, 1992.)

12 Trapnell GR: *Estimated Cost of a Child Health Program in California*. Annandale, VA: Actuarial Research Corporation. September 10, 1997.

Offering different benchmark plans would be a reasonable strategy to pursue only in states where the benefits available under the three plans -- the federal employees' Blue Cross / Blue Shield preferred provider plan, the state employees' plan, and the most popular HMO plan -- were substantially different. Most states choosing the benchmark option, however, would want to select just one. The federal employees' Blue Cross / Blue Shield plan would provide coverage for most, though not all of the items and services authorized under Title XXI but many benefits have day or visit limits, as Table I shows. The HMO and state employees' plans tend to be more restrictive, though they are likely to vary substantially from state to state. Based on our analysis of the HMO and state employees' plans in five selected states, we found that HMOs provide more generous coverage of preventive and primary care and that the state employees' plans provide more generous coverage for specialized or chronic care services, as Tables II and III show. Specifically, the HMOs have more coverage for prenatal care and family planning services and somewhat more coverage for dental care and outpatient mental health care. State employees' plans, by contrast, offer more durable medical equipment, home and community-based care, nursing services, ancillary therapies, and both inpatient and outpatient substance abuse treatment. Still, both types of plans typically set day and visit limits, annual or lifetime maximum dollar amounts, and numerous condition exclusions for these services. Mental health and ancillary therapy benefits generally could not be accessed by children with certain types of chronic mental health conditions or developmental problems. A state could choose, however, to augment its chosen benchmark plan.

Using the state Medicaid agency rather than health insurance purchasing cooperatives to administer benchmark coverage would make sense in states that already were enrolling Medicaid children into managed care statewide and wanted to achieve the same level of program and fiscal oversight for CHIP. The Medicaid agency could provide a comparable, or possibly lower, cost administrative structure for outreach, enrollment, premium collection, quality assurance, and

complaint resolution.<sup>13</sup> In addition, the Medicaid agency could more easily facilitate the coordination of insurance mechanisms that Title XXI requires<sup>14</sup> and avoid potential duplication of Medicaid agency functions in the private sector. Although benefit packages would vary, this arrangement would assure that children of different ages or incomes could be enrolled with the same insurer.

### **The Benchmark-Equivalent Option**

States also have the option of offering benchmark-equivalent coverage, which could theoretically be either more or less generous than benchmark coverage. The benchmark-equivalent option is likely to be of greater interest, however, to states looking to offer a narrower benefit package to CHIP participants. It might be a state that wanted to expand access to an existing publicly or privately funded health insurance program for children, a state that wanted to avoid covering a particular service, or a state with limited resources and a particularly large uninsured child population. As with the benchmark plan option, a benchmark-equivalent plan could be privately administered or administered through Medicaid, using Medicaid managed care contractors.

States considering the benchmark-equivalent option would first select the benchmark plan for which it would provide documentation of actuarial equivalence. A state that wanted to offer a

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<sup>13</sup> Program administrative costs would likely run at least five percent of total premium costs regardless of whether a Medicaid agency or health insurance purchasing cooperative assumed the administrative functions. A health insurance purchasing cooperative would have a higher administrative cost rate under CHIP than when selling coverage to small businesses because of greater costs associated with outreach, enrollment, and premium collection and also because the premium charge for an individual child is lower than for an individual adult. The Medicaid agency would have a higher administrative cost rate than it does when children are enrolled into managed care but not required to make a premium contribution. However, a Medicaid agency's administrative costs might be lower if it had already established a mechanism for premium collection. Information provided to Fox Health Policy Consultants in telephone conversations with Gordon Trapnell, President, Actuarial Research Corporation and Jack Rodgers, Director, Health Policy Economics Group, Price Waterhouse.

<sup>14</sup> Title XXI requires that the state must coordinate its CHIP program with other public and private health insurance programs in the state so that only eligible targeted low-income children are covered.

very restrictive benefit package presumably would choose either the lowest option among the plans offered to state employees or the HMO plan with the largest commercial enrollment; provide only 75 percent of the actuarial value of the benchmark-coverage for prescription drugs, mental health, hearing services, and vision services; and take full advantage of the option to consider the value of any deductible, co-insurance, and co-payment requirements not permitted under CHIP. Other states, however, might choose to make only minor modifications to benchmark coverage, perhaps reducing some benchmark benefits and augmenting others. Since benchmark coverage, compared to Medicaid, is already limited, severely restricting benefits may mean that children's acute and chronic care needs could not be met and other publicly funded programs would be utilized for basic health care in addition to wrap-around services.

The task of providing documentation of actuarial equivalence is fairly complex<sup>15</sup> but is far from an exact science and is, to a some extent, subject to manipulation. A state's actuarial report to HCFA must provide data not only for pediatric coverage as a whole, but for at least four discrete services. Obtaining cost and utilization data for children from any benchmark plan is apt to be very difficult.<sup>16</sup> Actuaries, therefore, will be more likely to use existing models derived from large claims databases to establish the actuarial value of the benchmark plan selected and to test a state's proposed plan against the benchmark coverage. Since most existing databases probably cannot distinguish children from adults, however, actuaries will have to make critical assumptions about the composition of insured family units.

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<sup>15</sup> Title XXI stipulates that the actuarial report must be prepared by a member of the American Academy of Actuaries using generally accepted actuarial principles and methodologies, a standardized set of utilization and price factors, a standardized population that is representative of privately insured children of the age of children who are expected to be covered. These same principles and factors must be used in comparing the value of different coverage and categories of services. The actuarial value should not take into account differences in coverage based on the method of delivery (HMO or FFS) or cost control or utilization methods used.

<sup>16</sup> Insurers monitor the premium/loss ratio for their plans (that is, the ratio of premiums paid to claims incurred) but typically do not track individual services or even identify the family member for which the claims were paid.

### *Secretary-Approved Plan Option*

States also have the option of crafting their own plan and submitting it to the Secretary for approval. Under this option, as under the benchmark-equivalent option, coverage could be either more or less generous than a benchmark coverage. The option would seem to be particularly attractive, however, to states that want to be innovative in their plan design and avoid having to prepare an actuarial report. A state could structure a unique pediatric benefit package for all CHIP-eligible children. A particular target group of children -- such as children in families with below a certain income threshold, perhaps 150 percent of poverty; children with disabilities; or adolescents -- or for all CHIP-eligible children. A wide range of financing, delivery, and administrative arrangements are possible under this option. For example, the complete benefit package could be offered as regular insurance, or basic medical and hospital services could be insured and other benefits could be furnished as wrap-around services paid for on a fee-for-services basis (as Medicaid often does) or through a separately capitated plan.

Designing a special pediatric plan might help to assure that federal and state funds were used most effectively -- providing targeted groups of children access to the type and extent of services they are likely to require and from public and private providers who have historically served them. For example, through a Secretary-approved plan adolescents might be given coverage for case management, peer group counseling, or substance abuse prevention and treatment services in addition to routine medical care. Children with disabilities might be given coverage for assistive technologies, extended home health care, long-term ancillary therapy services, and alternative community-based mental health services, or family support. The benefit package proposed by a state might be less comprehensive than Medicaid's but still very generous and uniquely structured to meet the needs of children and adolescents.

### **Direct Services Coverage Option**

Yet another option available to states is to secure a waiver from the Secretary to exceed the 10 percent limit on federal payments for outreach, administrative, and direct service purposes in order to provide direct services as a cost-effective alternative to benchmark coverage.<sup>17</sup> A state could choose this option for all CHIP-eligible children or only for those in certain targeted groups. It could, for example, furnish grants to community-based providers serving adolescents, children with disabilities, or children living in rural communities or on Indian reservations.

This option would be appropriate for children who had traditionally been well served through rural, school-based, or specialty clinics and hospital-based centers and who, because of special language or service needs would find it difficult to receive care under mainstream insurance. In such instances, direct grants to traditional providers would seem to make sense. Providers could primarily serve targeted groups of low-income children but they could serve others as well. Yet, if demands were great, grant funds could run out before the year's end and the state, without federal matching support, might be required to provide additional funding.

## **SUMMARY AND CONCLUSIONS**

The plan and benefit options available to states under CHIP are numerous, each with different coverage and cost implications. The most comprehensive option by far is Medicaid. Among the three benchmark options, the federal employees' standard Blue Cross/Blue Shield plan offers the most generous set of services, but still this option provides only limited coverage of mental health and substance abuse, nursing care, and ancillary therapy services. Although benefits offered in the HMO and state employees' plans would vary considerably by state, a state employees' plan is likely

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<sup>17</sup> It may be that a state also will be able to request a waiver of the 10 percent limit to provide direct services as a supplement to its chosen benefit plan. HCFA currently is preparing guidance interpreting the direct service waiver provision.

to offer more specialized or chronic care services and an HMO plan more preventive and primary care services. With respect to the benchmark-equivalent option, coverage could be even more restrictive, though it would not have to be. Under the Secretary-approved option, the breadth of coverage could vary considerably depending on the state's intent. The direct services option, given all of the available choices, is likely to be used only as a gap-filling measure for certain target groups.

Faced with the variety of plan and benefit options available, many states will need to weigh the financial tradeoffs of extending eligibility to more uninsured children with a narrower benefit package versus covering fewer children with a more comprehensive set of services -- though they may compromise with combined approaches. The evaluation of CHIP benefits across all of the plan options will require careful scrutiny given the types of limitations that are typically applied to specialized benefits and the exclusions that exist for children with certain types of health problems.

States will also need to evaluate the cost and efficiency of using their existing Medicaid administrative and managed care systems to provide new CHIP benefit packages against other private or public-private arrangements. Other considerations that states are likely to factor into plan and benefit selection are the preferences of pediatric health professionals and families with uninsured children. The extent to which states are able to not only reduce uninsurance but also to assure children access to appropriate benefits will be an important test of the success of CHIP.

**TABLE I  
FEDERAL EMPLOYEES' HEALTH PLAN BENEFIT PACKAGE**

<b>Services Authorized Under Title XXI</b>	<b>FEHBP (BCBS-PPO)</b>	<b>Services Authorized Under Title XXI</b>	<b>FEHBP (BCBS-PPO)</b>
Inpatient services	Covered in full	Nursing care services	Covered up to 25 visits/yr for 2 hours/day for home health care
Outpatient services	Covered in full	Abortion	Covered in full
Physician services, including preventive care and immunizations	Covered in full	Dental services	Covered except for orthodontia
Surgical services	Covered in full	Inpatient substance abuse treatment services	Covered for 1 treatment program up to 28 days/lifetime for all SA svcs
Clinic services, including health center services and other ambulatory care services	Not specified	Outpatient substance abuse treatment services	Covered for 1 treatment program up to 28 days/lifetime for all SA svcs
Prescription drugs	Covered in full	Case management services	Not specified
Over-the-counter medications	Not Covered	Care coordination services	Not covered
Lab and radiology services	Covered in full	Physical, occupational, and speech therapy	Covered up to 50 visits/yr for PT, 25 visits/yr for OT and ST combined
Pregnancy-related services	Covered in full	Hospice care	Covered for home hospice care with no stated limits and inpatient hospice care up to 5 days
Outpatient mental health services	Covered up to 25 visits/yr	Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services	Not covered
Inpatient mental health services	Covered up to 100 days/yr	Medical transportation	Covered in full
DME and prosthetic devices	Covered except for hearing aids	Enabling services (e.g., translation, transportation, and outreach services)	Not covered
Disposable medical supplies	Covered only if needles and syringes	Any other health care services or items	eyeglasses, eye exams, hearing screening
Home and community-based health care services	Not covered		

**Source:** Information was obtained by Fox Health Policy Consultants through an analysis of health plan materials in December 1997.

**TABLE II  
BENEFIT PACKAGES BY THE LARGEST COMMERCIAL HMO  
IN FIVE SELECTED STATES\***

<b>Services Authorized Under Title XXI</b>	<b>AL</b> (United HealthCare)	<b>CT</b> (BlueCare)	<b>NM</b> (Presbyterian)	<b>OR</b> (Regence, BCBS, HMO Oregon)	<b>WI</b> (PrimeCare)
Inpatient services	Covered except for intentional self-inflicted injury	Covered in full	Covered in full	Covered in full	Covered in full
Outpatient services	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Physician services, including preventive care and immunizations	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Surgical services	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Clinic services, including health center services and other ambulatory care services	Not specified	Not specified	Not specified	Not specified	Not specified
Prescription drugs	Covered in full	Not covered**	Covered in full	Not covered**	Covered in full
Over-the-counter medications	Not covered	Not covered	Not covered	Not covered	Not covered
Lab and radiology services	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Prenatal care and pre-pregnancy family planning services and supplies	Covered in full	Covered in full	Covered, except for contraceptives	Covered in full	Covered in full
Outpatient mental health services	Covered up to 20 visits/yr, except for neurological disorders (autism, developmental delays, mental retardation), conduct and impulse control disorders.	Covered up to 40 visit/yr in comb w/SA benefit and 120 partial days/yr and covered in full for certain disorders (schizophrenia, autism, and schizoaffective, major depressive, bipolar, paranoia and other psychotic, obsessive-compulsive, panic, and pervasive developmental disorders)	Covered up to 20 visits/yr, except for learning or behavioral problems and any long-term tx	Covered up to \$2,500/24 months, except for chronic or long-term tx. Max. coverage of \$12,500/24 months for all MH svcs	Covered up to \$2,000/yr and \$3,000/yr for transitional tx of character disorders, autism, development delay, mental retardation, Max coverage of \$7,000/yr for all MH/SA svcs
Inpatient mental health services	Covered up to 20 visits/yr in comb w/SA benefit, except for chronic conditions	Covered up to 60 days/yr and covered in full for certain disorders (schizophrenia, autism, and schizoaffective, major depressive, bipolar, paranoia and other psychotic, obsessive-compulsive, panic, and pervasive developmental disorders)	Covered up to 30 days/yr and 30 partial days/yr	Covered up to \$10,500/24 months incl residential tx and partial hosp. Max coverage of \$12,500/24 months for MH svcs	Covered up to \$7,000/yr in comb w/SA benefit

<b>Services Authorized Under Title XXI</b>	<b>AL</b> (United HealthCare)	<b>CT</b> (BlueCare)	<b>NM</b> (Presbyterian)	<b>OR</b> (Regence, BCBS, HMO Oregon)	<b>WI</b> (PrimeCare)
Durable medical equipment and other medically related or remedial devices	Covered, except for hearing aids and equipment repair and replacement	Covered up to \$2,000/yr	Covered, except for hearing aids and equipment repair and replacement	Covered, except for hearing aids	Covered, except for hearing aids and equipment repair and replacement
Disposable medical supplies	Not covered	Covered only for diabetes	Not covered	Not covered	Covered only for diabetes
Home and community-based health care services	Covered up to 60 visits/yr for home health care	Covered in full	Not covered	Covered in full	Covered up to 40 visits/ yr home health care
Nursing care services (in office, home, school, and other settings)	Not covered	Covered for home health care only	Covered up to 60 days/yr for home health care only	Covered in full	Not covered
Abortion if necessary to save the life of the mother or if pregnancy is the result of rape or incest	Not specified	Not specified	Covered in full	Not specified	Not specified
Dental services	Covered only for injury	Covered only for injury	Not covered	Covered only for injury	Covered in full
Inpatient substance abuse treatment services and residential substance abuse treatment services	Covered only for detoxification for 3 days/episode	Covered up to 45 days/yr	Covered up to 30 days/yr and 30 partial days/yr	Covered up to \$8,500/24 months incl residential tx or partial hosp. Max. coverage of \$10,500/24 months for all SA svcs	Covered up to \$7000/yr in comb w/MH benefit
Outpatient substance abuse treatment services	Covered only for detoxification for 3 days/episode	Covered up to 40 visits/y in comb w/MH benefit	Covered up to 30 visits/yr, except for long-term tx	Covered up to \$2,000. Max. coverage of \$10,500/24 months for all SA svcs	Covered up to \$2000/yr and \$3000/yr for transitional tx in comb w/MH benefit Max, coverage of \$7,000/yr for all MH/SA svcs
Case management services	Not specified	Not specified	Not specified	Not specified	Not specified
Care coordination services	Not covered	Not covered	Not covered	Not covered	Not covered
Physical, occupational, and speech therapy	Covered up to 60 sessions/episode, except ST for non-organic conditions	Covered up to 60 sessions/episode	Covered up to 60 sessions/yr	Covered up to 30 sessions/yr	Covered up to 60 sessions/episode, except ST for non-organic conditions
Hospice care	Covered in full	Covered, except medical-social services up to \$200	Covered in full	Covered up to \$15,000/lifetime	Covered in full

<b>Services Authorized Under Title XXI</b>	<b>AL</b> (United HealthCare)	<b>CT</b> (BlueCare)	<b>NM</b> (Presbyterian)	<b>OR</b> (Regence, BCBS, HMO Oregon)	<b>WI</b> (PrimeCare)
Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services	Not covered	Not covered	Not covered	Not covered	Not covered
Medical transportation	Covered in full	Covered up to \$500/trip by land and \$4,000/trip by air only for emergencies	Covered only for emergencies	Covered in full	Covered in full
Enabling services (i.e., translation, transportation, and outreach services)	Not covered	Not covered	Not covered	Not covered	Not covered
Any other health care services or items	eye exams, hearing screening	eye exams, hearing screening	eye exams, hearing screening, diabetes education	eye exams, hearing screening, diabetes instruction	eye exams, hearing screening

\* Information on this table pertains to the most popular plan offered by the largest HMO company in the state in 1997. The company was identified for us by the state insurance commissioner and the plan was identified by the HMO (which also verified its position as the largest company). The state insurance commissioner was unable to identify the HMO plan with the largest commercial enrollment. Presumably this plan could only be identified through a survey of all HMOs doing business in the state (as was done in Colorado).

\*\* Employers have the option of purchasing a prescription drug plan separately.

**Source:** Information was obtained by Fox Health Policy Consultants through an analysis of health plan materials, supplemented by telephone interviews with health plan staff in December 1997.

**TABLE III  
STATE EMPLOYEES' BENEFIT PACKAGES IN FIVE SELECTED STATES\***

<b>Services Authorized Under Title XXI</b>	<b>AL</b> (BCBS)	<b>CT</b> (BlueCare)	<b>NM</b> (Presbyterian)**	<b>OR</b> (BCBS)	<b>WI</b> (DeanCare)
Inpatient services	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Outpatient services	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Physician services, including preventive care and immunizations	Covered in full	Covered in full	Covered in full	Covered, but preventive visits limited to 8 up to age 2, then once every 3 yrs	Covered in full
Surgical services	Covered, except for congenital anomalies and tonsillectomy within 270 days of enrollment.	Covered in full	Covered in full	Covered, except only for one procedure performed through same incision	Covered in full
Clinic services, including health center services and other ambulatory care services	Not specified	Not specified	Not specified	Not specified	Not specified
Prescription drugs	Covered in full	Covered in full	Covered in full	Covered, except for contraceptive drugs or devices for any purpose	Covered in full
Over-the-counter medications	Covered for certain drugs	Not covered	Not covered	Not covered	Not covered
Lab and radiology services	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Prenatal care and pre-pregnancy family planning services and supplies	Covered in full	Covered, except for contraceptive drugs and devices	Covered in full	Covered, except for contraceptive drugs and devices	Covered in full
Outpatient mental health	Covered up to 20 visits/yr	Covered up to 40 visit/yr or \$2,000/yr in comb w/SA benefit, except for chronic mental illness, congenital and/or organic disorders (incl autism and mental retardation), unless for acute behavioral conditions amendable to brief psych intervention	Covered up to 60 visits/yr in comb w/SA benefit, except for developmental disorders	Covered up to \$2,500/24 months, except for mental retardation, learning disabilities, developmental delay, personality disorders, mental illness for which there is no effective cure. Max. coverage of \$12,500/24 months for all MH/SA svcs	Covered up to \$1,800/yr and \$2,700/yr for transitional svcs, in comb w/SA benefit

<b>Services Authorized Under Title XXI</b>	<b>AL</b> (BCBS)	<b>CT</b> (BlueCare)	<b>NM</b> (Presbyterian)**	<b>OR</b> (BCBS)	<b>WI</b> (DeanCare)
Inpatient mental health	Covered up to 30 days/yr in comb w/SA benefit. Max. coverage of \$10,800/yr and \$25,000/lifetime	Covered up to 60 days/yr, except for eating disorders	Covered up to 60 visits/yr	Covered up to \$10,500/24 months incl residential tx and partial hosp. Max. coverage of \$12,500/24 month for all MH/SA svcs	Covered up to 30 days/yr or \$6300/yr, in comb w/SA benefit
Durable medical equipment and prosthetic devices	Covered, except for hearing aids	Covered, except for hearing aids, insulin injectors, orthopedic equipment	Covered, except for hearing aids and equipment repair and replacement	Covered, except for equipment w/ mechanical or electrical features, and only if illness or injury occurred while in plan; hearing aids covered every 24 months up to \$300	Covered, except for hearing aids
Disposable medical supplies	Covered in full	Not covered	Covered only for diabetic supplies	Covered only for diabetic supplies	Covered only for diabetic supplies
Home and community-based health care services	Not covered	Covered for home health care	Not covered	Covered up to 180 visit/yr for up to 2 hours/day in comb w/nursing care benefit	Covered up to 50 visits/ yr, in lieu of SNF, in comb w/nursing care benefit
Nursing care services (in office, home, school, and other settings)	Covered in full for out-of-hospital private duty nursing	Not covered	Covered up to 4 hours/day periods for home care	Covered, except for private duty nursing, up to 180 visits/yr for up to 4 hours/day in comb w/home health benefit	Covered up to 50 visits/ yr in comb w/home health benefit
Abortion if necessary to save the life of the mother or if pregnancy is the result of rape or incest	Not specified	Covered in full	Covered in full	Not specified	Not specified
Dental services	Covered for up to \$750/yr, except for orthodontia	Covered only for injury or impacted teeth	Covered only for injury	Not covered	Covered except for orthodontia
Inpatient substance abuse treatment services and residential substance abuse treatment services	Covered up to 30 visits/yr in comb w/MH benefit. Max. coverage of \$9,600/yr and \$12,000/lifetime for all SA svcs	Covered for drugs up to 60 days/yr and for alcohol up to 45 days/yr. Max. coverage of 2 detoxification tx/lifetime	Covered up to 30 days/yr. Max coverage of 2 tx/lifetime	Covered up to \$8,500/24 months incl residential tx or partial hosp. Max. coverage of \$12,500/24 months for all MH/SA svcs	Covered up to 30 days or \$6300/yr, in comb w/MH benefit

<b>Services Authorized Under Title XXI</b>	<b>AL</b> (BCBS)	<b>CT</b> (BlueCare)	<b>NM</b> (Presbyterian)**	<b>OR</b> (BCBS)	<b>WI</b> (DeanCare)
Outpatient substance abuse treatment services	Covered up to 40 visits/yr. Max. coverage of \$9,600/yr and \$12,000/lifetime for all SA svcs	Covered up to 40 visits/yr or \$2000, in comb w/MH svcs	Covered up to 60 days/yr in comb w/MH benefit	Covered up to \$2,500/24 months. Max. coverage of \$12,500/24 months for all MH/SA svcs	Covered up to \$1800/yr and \$2,700/yr for transition svcs, in comb w/MH benefit
Case management services	Not specified	Not specified	Not specified	Not specified	Not specified
Care coordination services	Not covered	Not covered	Not covered	Not covered	Not covered
Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders	Covered for PT in full, but OT not covered and ST covered up to 30 sessions/yr only for organic impairment	Covered on "short-term" basis, but ST not covered for developmental delay	Covered, but ST not covered for learning disabilities	Covered up to 60 visits/yr, but ST covered only for illness or injury	Covered up to 50 visits/yr
Hospice care	Not covered	Covered in full	Covered up to \$7,500	Covered up to \$15,000	Covered in full
Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services	Not covered	Not covered	Not covered	Not covered	Not covered
Medical transportation	Covered in full	Covered only for emergencies	Covered only for emergencies	Covered up to 500 miles/year	Covered only for emergencies
Enabling services (e.g., translation, transportation, and outreach services)	Not covered	Not covered	Not covered	Not covered	Not covered
Any other health care services or items	eye exams	eye exams, hearing screening	eyeglasses, eye exams, hearing screening	eyeglasses, eye exams, hearing screening, diabetic instruction	eye exams, hearing screening

\* Information on this table pertains to the most popular state employees' health benefit plan in 1997. This plan was identified by the responsible agency in each state (e.g. state insurance commissioner's office, state employees' insurance or benefits board, or the controller's office).

\*\* The state employees' Presbyterian plan does not provide mental health coverage. State employees are covered under the state's public managed behavioral health plan (Metropolitan Clinic of Consulting - MCC) and information from this plan is included on the table.

**Source:** Information was obtained by Fox Health Policy Consultants through an analysis of health plan materials, supplemented by telephone interviews with health plan staff in December 1997.