October 16, 2006

Actuarial Analysis of the North Carolina Action for Children Proposed Children's Health Insurance Expansion

DRAFT VERSION — FOR DISCUSSION ONLY

MMC Marsh & McLennan Companies

Contents

1

Introduction

Mercer Government Human Services Consulting (Mercer) was engaged by Action for Children North Carolina (Action for Children) to review and consult on a proposed design for a children's health insurance coverage expansion in North Carolina. Mercer has assisted through strategic discussions with Action for Children staff and preparation of an actuarial cost analysis of the proposed benefits. This report presents the results of Mercer's actuarial cost estimates.

Developing cost estimates for the uninsured is a blend of art and science. The most common approach is to take a population with known costs and demographics and develop assumptions to model how the unknown population will compare. In making the leap from known to unknown, the actuary must consider several phenomena and develop assumptions to address questions such as those listed below:

- What are the costs associated with demographic differences between my known and unknown programs?
- What is the value of service differences between my known and unknown programs?
- Since the unknown population is uninsured, will costs be higher because of pent-up demand?
- Will the unknown population have a selection bias because it attracts a population with higher costs than the base population?
- What type of administrative costs will insurers require to manage the new program?

Along with cost estimates for the proposed program, in this report Mercer has highlighted many of the issues that produce uncertainty in the cost estimates, and describes the assumptions used to make the projections. Ultimately, estimates provided in this report are best interpreted as point estimates within a reasonable range of possible costs.

2

Action for Children's Proposed Expansion Program

This chapter will describe key elements of a health coverage program, why they are important elements for estimating the cost of the program, and describe the relevant characteristics of the Action for Children proposal as provided to Mercer for pricing.

Eligibility

Characteristics of the individuals who ultimately enroll in the expansion program are a large determinant of the program's cost. Consequently, understanding eligibility rules and other factors that influence enrollment are critical to estimating a program's cost. Expansion programs use eligibility rules to target the segment of the uninsured population they want to reach. Eligibility rules for programs that target low-income individuals are typically based on household income levels, using the Federal Poverty Guideline (FPG)[1] as a benchmark.

North Carolina children in households with income levels below 200 percent of FPG are currently eligible for health insurance coverage through Medicaid or North Carolina Health Choice, the state's SCHIP program. Action for Children's proposed expansion would provide subsidized comprehensive coverage for children in households with income between 200 and 300 percent of the FPG. Children above 300 percent FPG would be allowed to buy into the program by paying the premium in full.

To lessen the likelihood that the new program attracts enrollees who are currently covered through the private sector (a phenomenon known as "crowd out"), many expansion programs include a rule that in order to be eligible to purchase the product, the individual must have been without coverage for a period of time (6 or 12 months is typical). This type of rule is called a "bare provision." The Action for Children model includes a bare

[1] In 2006, the FPG for a family of four was $20,000 per year. See http://aspe.hhs.gov/poverty/06poverty.shtml for FPG levels for other household sizes (as accessed October 16, 2006).

period of 3 months (waived for newborns). This relatively short period of uninsured status required for eligibility reflects a greater emphasis on maximizing coverage, particularly in instances where loss of prior coverage is involuntary (e.g., loss of employment or employer ceases to offer health insurance). However, it should be noted that when compared to longer bare provision periods, a three-month period may produce a larger crowd out effect as more parents drop dependent coverage from their employer-sponsored policies, anticipating enrolling their children in the expansion program once three months have passed.

Premium Levels

A second element of plan design that plays an important role in enrollment and the price of the product is the level and style of premium subsidization. Action for Children has proposed a member premium structure that increases as the household income rises, as shown in the table below. The remainder of the premium cost would be borne by the State.

Income Band (Percent of FPG)	Enrollee Premium Share
200 – 233 %	25%
233 – 267 %	50%
267 – 300 %	75%
Over 300 %	100%

The advantage of a sliding scale premium structure is that it allows for more contribution by households with higher levels of disposable income, while still providing an affordable contribution to those at the lower end of the income scale. An alternate structure considered for this program was a one-percentage point gradation, where for each percentage point over 200 percent FPG, the member premium share would increase by one percent of total premium. This type of approach would produce a smoother slope of premium payment and would likely encourage higher participation at the lowest eligible income levels (e.g., below 225 percent FPG). However, this alternative was discarded for the initial proposal due to concerns about the administrative complexity associated with maintaining, collecting, and enforcing 100 different eligibility group/premium payment levels.

Covered Benefits and Member Cost Sharing

Decisions regarding covered services and member cost sharing are key strategic elements to achieving the goals of a coverage expansion program. Typically, an expansion package of services is designed such that it maximizes attractiveness for individuals who do not currently purchase health insurance coverage, but minimizes the potential for attracting purchasers who are already covered by existing market products.

"Cost sharing" refers to the amount the enrollee pays at the point of service, which may take the form of *deductibles*, percentage-of-charge *coinsurance*, or flat dollar amount

copayments. Cost sharing levels, like the package of covered benefits, affect the attractiveness of the product to potential buyers and the choices they make between remaining uninsured, choosing other market coverage, or choosing the new program. Cost sharing levels also affect the service utilization patterns of individuals who enroll in the plan, with higher cost sharing levels tending to discourage use.

The children's expansion program proposed by Action for Children is a comprehensive package of medical and prescription drug benefits. Preventive care and mental health/substance abuse are covered, as are the standard health insurance benefits of hospital services, physician services, laboratory and x-ray. Dental services and maternity benefits are not covered in this program, however.

The proposed cost-sharing requirements are similar in many ways to typical commercially-offered products. Certain services, such as doctor visits and prescriptions, have a fixed copay amount payable when the service is received, as shown below. Once $500 in copays are paid on behalf of a child during the calendar year ($1,000 limit per family), further copays in the calendar year are waived.

Covered Service	Copayment Amount
Primary Care Physician	$10 per visit (waived for preventive care)
Specialist Physician	$30 per visit
Outpatient Medical / Surgical	$30 per visit
Therapy Services	$30 per visit
Outpatient Behavioral Health	$30 per visit
Prescription Drugs (Generic / Brand / OTC)	$0 / $20 / $0 per prescription
Emergency Room	$10 per visit ($100 if non-emergent)

In addition to the copayments, the Action for Children proposal includes a member calendar year deductible that must be met prior to the program covering expenses. Mercer priced two versions of the deductible, as described below. Appendices A.1 and A.2 show a detailed list of covered benefits and the associated cost sharing requirements for Option 1 and Option 2.

Option 1: Deductible of $500, applies to all services except preventive care and prescription drugs

Under Option 1, the plan covers medical expenses only after a $500 calendar year deductible is paid ($1,000 per family). The deductible applies to all services except preventive care and prescription drugs, including those services with a fixed dollar copay.

For example, when a child makes his or her first illness-related visit to the primary care doctor during the year, the $10 copay is paid (and accumulates toward the $500 copay limit for the year). The remaining cost of the visit is also paid by the patient (and

accumulates toward the $500 deductible). If a prescription is received for a generic drug, the prescription is filled at no cost to the patient.

Option 2: Deductible of $500, applies to services without copayments (waived for preventive care)

Under Option 2, some services are subject to the $500 deductible while others have only the fixed dollar copayment. The deductible applies to all services that don't have a copayment, except Preventive Care, which is available at no out-of-pocket cost to the patient.

For example, when a child makes his or her first illness-related visit to the primary care doctor during the year, the $10 copay is paid (and accumulates toward the $500 copay limit for the year). The remaining cost of the doctor visit is paid by the plan. If a prescription is received for a generic drug, the prescription is filled at no cost to the patient. If a prescription for a laboratory test is received, the patient will pay the cost of the laboratory test, and that payment will accumulate toward the $500 deductible.

Option 1 and Option 2 differ only in how the $500 deductible is applied, but they will result in different premium levels and will affect families differently. Consider the family of a healthy child: a healthy child will likely not incur $500 in non-pharmacy expenses during a calendar year, so under Option 1 the only benefits received may be preventive care and some coverage of prescription drugs. Option 2 provides more benefits, as one or two doctor visits will still provide some plan-paid benefits. In a large population of children, typically 60-65% will not reach $500 in non-pharmacy medical expenses in a 12-month period, thus would see limited plan benefits from Option 1.

The option with the higher member cost sharing, Option 1, will have a correspondingly lower premium. Lower premiums should be attractive to parents of healthy children. The significant level of state premium subsidization proposed, however, may dilute the attractiveness of the lower premium to healthy families, when offset by high cost sharing at the point of service which is not subsidized by the state. This is particularly a concern for families at the lower end of the income range. In selecting an appropriate cost sharing structure to use for the expansion, it is important to consider the balance of premium versus out-of-pocket cost sharing, including the effects of the proposed subsidization strategy. Focus groups held with families of potential enrollees may help to clarify the trade-offs and the value associated with various aspects of the program.

Program Enrollment

Not everyone who is eligible for the program will enroll in it. Basing cost estimates on the eligible population without factoring in how the enrolled population may vary may significantly over- or under-estimate the program's cost. Who actually enrolls is heavily influenced by the product design and price, relative to the individual's other options. Pricing should reflect assumptions about the ultimate enrollees, including income levels, demographics, and general morbidity levels. In addition, proper estimates of the volume of enrollees are important to determining the viability of the program and the potential variability of program costs.

Assumptions regarding the anticipated enrollment levels associated with various policy options are important for several reasons. First, understanding the volume of individuals who will enroll is important in evaluating the stability of the risk pool and the economies of scale that may be achievable; both of these features factor into projecting the level of administrative and contingency costs that may be associated with the option. Second, the design of certain types of voluntary coverage programs, such as this one, may be subject to adverse selection, which is the tendency of sicker individuals to be more likely to enroll in coverage than healthier individuals. The lower the rate of participation of eligible individuals, the more significant the adverse selection may be on the cost of the program. Finally, expected enrollment levels are necessary for taking per enrollee cost estimates and generating an overall expected cost associated with the policy option.

For the Action for Children proposed expansion, Mercer analyzed the benefit package and proposed subsidy levels to determine a reasonable participation assumption. Participation levels are influenced by other factors as well, such as aggressiveness of program outreach and marketing and the complexity of the application and enrollment process. With the understanding that existing outreach and application processes will leverage existing Medicaid/North Carolina Health Choice mechanisms and the information that no application fee will be required, Mercer concluded that a 50 percent participation rate may be achievable for this program at the proposed member premium sharing levels. However, it is likely that this enrollment level may not be achieved during the first year, as often expansion programs take several years to "ramp up" to a mature enrollment level.

3

Cost Estimates

Mercer analyzed two benefit package options on behalf of Action for Children. Both options represent a comprehensive package of medical benefits with member cost sharing similar to that seen in commercial health insurance products. Both options have a $500 deductible and fixed dollar copayments for certain services. The two options differ only in the manner in which the $500 deductible applies. The proposed program is described in more detail in Section 2 of this report, and the benefit grids attached as Appendix A.1 and A.2 illustrate the benefit packages evaluated. All cost estimates presented in this chapter are on a Calendar Year 2008 basis.

Projected Costs if 50 Percent of Eligible Children Enroll

As noted in Chapter 2, given the proposed premium subsidy levels and moderate outreach to eligible families, it is reasonable to assume that over time the proposed program could enroll 50% of the target population. Mercer's actuarial analysis suggests that, at that level of program participation, the per capita premium cost (expressed per member per month, or "PMPM") for the proposed package could range from $123 - $139 for Option 1 or from $150 - $170 for Option 2. Depending on the enrollment pattern across the three income premium tiers, the member share of that cost could range from $49 - $58 for Option 1 or from $60 - $71 for Option 2.

According to Action for Children, there are approximately 37,000 uninsured children in North Carolina in households with income levels between 200 and 300 percent of FPG. If half of these eligible children enroll in the expansion program, annual subsidy expenditures could range from $16.0 – $18.5 million (Option 1) or from $20.0 – $22.5 million (Option 2).

The tables below illustrate the components of those costs and the resulting public subsidy amount for the midpoint of the ranges cited. Chapter 4 describes the development of these cost estimates.

Table 1: Expected Monthly Expenses Per Capita

Children from 200-300 Percent of FPG; Assuming 50 Percent Participation

Calendar Year 2008 Cost Basis

	Option 1	Option 2
Expected Medical Expenses	$125.74	$153.84
Expected Administrative Expenses	$5.24	$6.41
Total PMPM	$130.98	$160.25
Expected Enrollee Premium Contribution	$53.50	$65.50
Expected Per Capita Public Expense	$77.48	$94.75
Enrolled Children (Mature Enrollment)	18,500	18,500
Annual Public Subsidy Expenses	$17.2m	$21.0m

Table 2: Expected Monthly Medical Expenses Per Capita by Service Category

Children from 200-300 Percent of FPG; Assuming 50 Percent Participation

Calendar Year 2008 Cost Basis

Service Category	Option 1	Option 2
Inpatient Hospital Services	$ 23.46	$ 23.46
Outpatient Hospital Services	$ 27.98	$ 30.24
Professional Services	$ 67.81	$ 73.71
Pharmacy	$ 17.92	$ 18.48
All Other Services	$ 14.02	$ 15.50
Total Expenses Prior to Deductible	$151.19	$161.39
Deductible Value	($25.45)	($ 7.55)
Net Expected Medical Expenses	$125.74	$153.84

Note that although Option 1 and Option 2 differ only in the application of the deductible, the Total Expenses Prior to Deductible for Option 1 shown in Table 2 is lower than that for Option 2. This phenomenon occurs because the broader application of the deductible discourages utilization of certain types of medical services more than does the narrower application of the deductible.

Projected Costs if 100 Percent of Eligible Children Enroll

Action for Children requested that Mercer also develop cost estimates for a scenario in which 100 percent of eligible children enroll in the program. It should be noted that these cost estimates reflect the combination of a lower bound for per capita costs (as the risk pool is larger, with more healthy children participating) and an upper bound for enrollment. 100 percent participation is rarely, if ever, achieved, even in programs that require no premiums or other out-of-pocket cost sharing. Table 3 illustrates cost estimates at 100 percent participation. As with all point estimates presented in this report, these estimates represent points within ranges of reasonable results.

Table 3: Expected Monthly Expenses Per Capita

Children from 200-300 Percent of FPG; Assuming 100 Percent Participation

Calendar Year 2008 Cost Basis

	Option 1	Option 2
Expected Medical Expenses	$98.26	$123.07
Expected Administrative Expenses	$4.09	$5.13
Total PMPM	$102.36	$128.20
Expected Premium Contribution	$41.00	$52.00
Expected Per Capita Public Expense	$61.36	$78.20
Enrolled Children (Mature Enrollment)	37,000	37,000
Annual Public Subsidy Expenses	$27.6m	$34.7m

4

Pricing Methodology and Assumptions

This section describes certain pricing issues in more detail and discusses some of the key methodological aspects of the cost estimates presented in Section 3.

Base Data

Mercer used a standard actuarial modeling approach to developing the cost estimates shown in this report. That approach involves starting with base data from a comparable population and making adjustments for population and product differences. For these estimates, at the request of Action for Children, Mercer used summarized data already on hand for children enrolled in the North Carolina Medicaid program during State Fiscal Years 2002, 2003, and 2004. Mercer compared those data to relevant benchmarks, such as published utilization statistics for the North Carolina Health Choice program and utilization and unit cost statistics for children covered under employer-sponsored products. Those benchmarks were considered as part of the process of adjusting the Medicaid base data for product and population differences.

Demographic Adjustments

The distribution of ages of the children who would enroll in the expansion program is likely materially different than those enrolled in Medicaid; in particular, the program would likely include significantly fewer newborns. Adjustments were made to the base data to mimic an age distribution that is more like a commercial distribution, as shown in the table below. A second demographic adjustment is made to reflect the fact that the target population represents higher income levels that the population forming the base. A significant body of research exists that illustrates that higher income levels are associated with improved health status and changed patterns of health care utilization. Utilization benchmarks from NC Health Choice and children enrolled in private employer-sponsored insurance were used to refine these utilization adjustments.

Age Band	Medicaid Base	Modeled
< Age 1	11%	4%
1 - 5	34%	19%
6 - 13	39%	40%
14 - 20	16%	37%

Selection Effect

The term "selection effect" describes the cost impact that may be experienced if the individuals who enroll in a particular product are significantly different than the average eligible population. *Positive selection* refers to the effect of healthier than average individuals enrolling in a product, and *adverse selection*, or anti-selection, refers to the effect of sicker than average individuals enrolling in a product. In the pricing of a new type of product targeted to the currently uninsured population, the concern is generally the potential for adverse selection.

The potential for adverse selection is often evaluated as it is associated with program participation levels. If all eligible individuals choose to participate (100 percent participation level), no selection adjustment is necessary. However, very few programs, even with low out-of-pocket costs, will achieve 100 percent participation. For a new product targeting individuals with no coverage, those that choose to enroll and pay the associated premium will tend to be sicker individuals than those who choose not to enroll. Low participation levels would be expected to be associated with enrolled populations that are materially sicker than the average eligible population.

Mercer analyzed the benefit package and proposed subsidy levels to determine a reasonable participation assumption to use in the Action for Children modeling. Given the understanding that existing outreach and application processes will leverage existing Medicaid/North Carolina Health Choice mechanisms and the information that no application fee will be required, Mercer concluded that a 50 percent participation rate may be achievable for this program at the proposed member premium sharing levels. Mercer used subsidy/participation/selection models that draw on a variety of published research on take up rates and claims pattern analysis to develop an underlying claims load of 24 percent to represent adverse selection impact for this program at 50 percent participation. No load is applied to the cost estimates provided for the 100 percent participation scenario.

Participation levels and the resulting selection impact are significant areas of uncertainty in estimating costs for a new coverage program. At Action for Children's request, Mercer has used a 50 percent participation assumption and agrees that it is potentially achievable. Lower participation levels would be expected to produce higher per capita costs than those shown for 50 percent participation, but those higher per capita costs would be paid

on fewer children, likely producing lower budget requirements than those shown in this report.

Pent Up Demand

Depending on an expansion program's design, it is often appropriate to factor in costs for "pent-up demand," which represents the possibility that currently uninsured individuals will delay treatment of non-emergent conditions in anticipation of coverage under a new program. Typically, adjustments for pent-up demand are made for the initial months of a new program and phase out over time. As the Action for Children proposal does require that children be uninsured for a period of time before becoming eligible for the expansion program, Mercer factored pent up demand adjustments into the cost estimates provided in this report. The pent-up demand adjustments produced a net impact on the cost estimates of 4 percent.

Benefit Adjustments

Mercer adjusted the base data to reflect benefits present in the base that will not be covered under the proposed program. Specifically, dental services and maternity services will not be covered. In addition, utilization adjustments are made to certain service categories to reflect the decreased utilization associated with commercial-level cost sharing requirements. Finally, the dollar value of the patients' cost sharing responsibility was removed from the base, so that resulting premiums reflect only the plan share of cost.

Provider Reimbursement and Trend

The Action for Children proposal includes specifications that most health care providers be paid at Medicare reimbursement levels rather than Medicaid levels. As Medicaid reimbursement levels form the base data structure, adjustments were developed to approximate Medicare levels for the modeling. Specifically, Action for Children requested that hospitals, physicians (except for Preventive Care services), and other non-pharmacy services be reimbursed at Medicare payment levels. Pharmacy and Preventive Care services are to be reimbursed at Medicaid payment levels.

To estimate the impact of these reimbursement differences on physician services, Mercer reviewed published studies on the relationship between Medicaid and Medicare reimbursement for physicians, as well as Medicare physician reimbursement changes over the last several years. The analysis suggests that Medicare reimbursement rates could range from 4-6 percent higher than Medicaid rates for Calendar Year 2008.

To estimate Medicare payment levels for hospital inpatient services, Mercer identified approximately 40 of the diagnosis related groups (DRGs) most commonly associated with childhood inpatient admissions. FFY 2007 average per diems were developed for those DRGs using the Medicare DRG case rates for the 10 North Carolina hospitals with the highest volume of Medicaid and Health Choice admissions. Mercer was unable to readily

identify a reliable statistic describing how those Medicare-based hospital reimbursement levels would compare to North Carolina hospital reimbursement levels.

For other types of non-pharmacy services, such as hospital outpatient, laboratory, and radiology services, Mercer was unable to identify reliable benchmark relationships between North Carolina Medicaid and Medicare. For the purposes of these budget level cost projections, Mercer assumed that the relationship was similar to that experienced for physician services and applied a 5 percent upward adjustment to the Medicaid unit costs to proxy Medicare levels. If this proposal moves forward including Medicare level reimbursement, Mercer recommends that further analysis of this relationship be performed.

Finally, Mercer developed trend assumptions to project the base period utilization and reimbursement levels to the Calendar Year 2008 period. As the base period represents SFY 2002-2004, the modeling of non-inpatient costs relies heavily on the trend assumptions used. Mercer recommends that if the proposal moves forward and gains momentum, Action for Children should consider an updated analysis that relies on more recent base data.

Administration Assumption

The Action for Children proposed program would be administered and operated by the State, rather than contracted out to a health plan for administration. This proposal follows the current approach used in the North Carolina Medicaid program. Mercer assumed an administrative cost of 4 percent of premium to estimate the administrative costs that could be incurred under this program. This administrative level is typical of state-administered Medicaid programs. If instead of State administration, the program is administered by a health plan, the associated administration costs could increase materially.

5

Conclusion

Studies show that individuals without health insurance coverage tend to defer obtaining needed health care, due to the high cost associated with paying out of pocket for services. When uninsured individuals do seek medical care, they tend to be sicker and have worse health outcomes than those who seek preventive care regularly and seek acute care services when needed. Action for Children's proposal could provide a viable health coverage option for the estimated tens of thousands of uninsured North Carolina children, both through subsidized premiums for households with income between 200 and 300 percent FPG, as well as a full-cost buy-in for those at higher income levels.

Program design, including eligibility rules, covered benefits, and cost sharing design are critical elements to achieving desired enrollment levels of the targeted uninsured population. Action for Children has proposed a comprehensive, but not overly rich, benefit package with commercial-level cost sharing elements. These features, combined with a 3 month "bare period" requirement, should assist with minimizing the potential for shift from current coverage in private sector products to the new publicly-sponsored coverage plan. It is important to balance out-of-pocket cost sharing, which is not subsidized, with premium levels and eligibility rules, to ensure a balanced risk mix of enrollees in the program. The program will be able to cover more children at a more stable cost level if the program enrolls healthy children as well as children who are high users of medical services.

6

Appendix: Benefit Design Detail

Covered Services and Cost Sharing Summary
Option 1

Option Name: Coverage Expansion - Children Buy-in
Covered Population:
- Children; FPG Bands: 200-300% FPL (subsidized), 300%+ (full premium buy-in)

Annual Benefit Limit	**None**
Out of Pocket Annual Maximum	**$1,000/Child; $2,000/Family**
Deductible	**$500**

Category of Service	Covered Service	Co-Payment	Coinsurance	Deductible	Benefit Limit
Inpatient Non-Maternity Physical Health	Yes	$0	None	Ded applies, then 100% coverage	
Skilled Nursing Facility	Yes	$0	None	Ded applies, then 100% coverage	
Outpatient Physical Health	Yes				
Medical / Surgery	Yes	$30	None	Ded applies after copay	
PT, OT, & Speech Therapy	Yes	$30/visit for first 3 visits, may be waived afterwards with OK from medical home	None	Ded applies after copay	
Emergency Room	Yes	$10, $100 if determined non-emergent	None	Ded applies after copay	
Primary Care Physician	Yes	$10, none if EPSDT or preventive care	None	Ded applies after copay	
Specialist Physician	Yes	$30	None	Ded applies after copay	
Inpatient Non-Maternity Behavioral Health	Yes	$0	None	Ded applies, then 100% coverage	
Outpatient Behavioral Health	Yes	$30/visit	None	Ded applies after copay	6 visits allowed without diagnosis, 26 visits annually
Behavioral Health Other	No				
Pharmacy					
Generic	Yes	$0	None	Waived	
Brand	Yes	$20	None	Waived	
Brand Non-Formulary	Yes	$20	None	Waived	
Family Planning	Yes	$0	None	Ded applies, then 100% coverage	
Case Management	CCNC only	$0	None	Waived	
Home Health	Yes	$0	None	Ded applies, then 100% coverage	
Personal Care	Yes	$0	None	Ded applies, then 100% coverage	210 minutes per day, 60 hours per month
School Based Services	Yes	$0	None	Ded applies, then 100% coverage	
Lab & Radiology	Yes	$0	None	Ded applies, then 100% coverage	
Dental	No				
Vision/Hardware	Yes	$0	None	Ded applies, then 100% coverage	One exam annually; with prior approval, one set of lenses annually and one set of frames every 24 months
DME / Supplies	Yes	$0	None	Ded applies, then 100% coverage	
Preventive Care (EPSDT Services)	Yes	$0	None	Waived	
Ambulance	Yes	$0, $100 if determined non-emergent	None	Ded applies, then 100% coverage	
Maternity	No				

Covered Services and Cost Sharing Summary
Option 2

Option Name: Coverage Expansion - Children Buy-in
Covered Population:
- Children; FPG Bands: 200-300% FPL (subsidized), 300%+ (full premium buy-in)

Annual Benefit Limit	**None**
Out of Pocket Annual Maximum	**$1,000/Child; $2,000/Family**
Deductible	**$500**

Category of Service	Covered Service	Co-Payment	Coinsurance	Deductible	Benefit Limit
Inpatient Non-Maternity Physical Health	Yes	$0	None	Ded applies, then 100% coverage	
Skilled Nursing Facility	Yes	$0	None	Ded applies, then 100% coverage	
Outpatient Physical Health	Yes				
Medical / Surgery	Yes	$30	None	Waived	
PT, OT, & Speech Therapy	Yes	$30/visit for first 3 visits, may be waived afterwards with OK from medical home	None	Waived	
Emergency Room	Yes	$10, $100 if determined non-emergent	None	Waived	
Primary Care Physician	Yes	$10, none if EPSDT or preventive care	None	Waived	
Specialist Physician	Yes	$30	None	Waived	
Inpatient Non-Maternity Behavioral Health	Yes	$0	None	Ded applies, then 100% coverage	
Outpatient Behavioral Health	Yes	$30/visit	None	Waived	6 visits allowed without diagnosis, 26 visits annually
Behavioral Health Other	No				
Pharmacy					
Generic	Yes	$0	None	Waived	
Brand	Yes	$20	None	Waived	
Brand Non-Formulary	Yes	$20	None	Waived	
Family Planning	Yes	$0	None	Ded applies, then 100% coverage	
Case Management	CCNC only	$0	None	Waived	
Home Health	Yes	$0	None	Ded applies, then 100% coverage	
Personal Care	Yes	$0	None	Ded applies, then 100% coverage	210 minutes per day, 60 hours per month
School Based Services	Yes	$0	None	Ded applies, then 100% coverage	
Lab & Radiology	Yes	$0	None	Ded applies, then 100% coverage	
Dental	No				
Vision/Hardware	Yes	$0	None	Ded applies, then 100% coverage	One exam annually; with prior approval, one set of lenses annually and one set of frames every 24 months
DME / Supplies	Yes	$0	None	Ded applies, then 100% coverage	
Preventive Care (EPSDT Services)	Yes	$0	None	Waived	
Ambulance	Yes	$0, $100 if determined non-emergent	None	Ded applies, then 100% coverage	
Maternity	No				

Mercer Government Human Services
Consulting
3131 E. Camelback Road, Suite 300
Phoenix, AZ 85016-4536
602 522 6500