Issues Involved in Designing a Basic Benefit Package and Determining Actuarial Equivalence

A Briefing Paper

A standard, or basic, benefit package is a plan of medical health insurance coverage that can be mandated by a governmental body. The plan may represent a minimum set of benefits to be equaled or exceeded by health insurance carriers. For certain populations or programs, it may be the only set of benefits that are offered. It generally consists of a list of health care services required to be covered, along with limitations on reimbursement such as cost sharing, maximum reimbursement, and exclusion of coverage for certain procedures or benefits.

Basic benefit plans are a key element in any health care reform proposal. Such standardized benefit plans can ensure a minimum level of coverage, control cost, and facilitate comparison among plans. The cost of a benefit can be a deciding factor in the public or private insurers' decision to include or exclude it in a policy. A detailed understanding of benefit packages with their limitations of coverage, cost-sharing characteristics, and anticipated utilization is necessary in order to be able to estimate or actuarialize program costs for covered services.

Actuarial equivalent is defined as "equal actuarial present value, determined as of a given date on the basis of the same set of actuarial assumptions."[1] In other words, a plan is equal or greater in value at this moment in time to another plan if similar pricing assumptions are used.

This paper addresses the design of a basic benefit package, while considering awareness of the needs of the target population and the values of the community providing the benefit plan. It will also address legal requirements of the benefit design in order to secure additional funding from the Federal government through Medicaid program expansion by looking at actuarially equivalent or benchmark plans.

Goals and Drawbacks of a Basic Benefit Plan

A basic benefit plan usually refers to some determination of the "minimum health services that should be generally and uniformly available in order to assure adequate health status and protection of the population from disease or that meet some other criteria or standard."[2] However, there is little agreement on what constitutes a "basic" benefit plan.

Goals of a basic benefit package include: 1) providing a uniform basis for measuring and comparing the cost of health care plans, 2) providing a benchmark level of benefits for comparison with other plans, 3) helping to control cost using cost-sharing and managed care, and 4) mandating coverage for certain services for public health or public policy reasons.

A challenge in designing a basic benefit package is the difficulty of achieving consensus on its design. Designating a basic set of benefits can have the potential to eliminate richer plans and discourage more imaginative approaches to benefit design. If too specific, it can generate controversy and debate over what will be covered. If too vague, it will be open to different

[1] The American Academy of Actuaries (May 1993). "Standard Benefits in Health Care Reform–The Impact and Cost". Public Policy Monograph. Washington, DC.

[2] Pepper Commission (1990). A Call for Action-US Bipartisan Commission on Comprehensive Health Care. Washington DC: US Government Printing Office

interpretations by different health plans, which could lead to benefit differences, adverse risk selection, and increased total cost of providing coverage.

It is difficult to predict a basic benefit package's cost because of the complexity of benefit design; inadequate or conflicting pricing data; the impact of adverse risk selection; increased use of healthcare because coverage becomes available (induced demand); the effect of managed health care; and trends over time in utilization, price, and population demographics.

Approaches to Benefit Plan Design

Target Population

Defining and fully characterizing the target population is critical in determining a basic benefit package. In the summer of 2000, a Task Force on Basic Benefit Plans was created within the Oregon Health Council. The Council held public discussions on the complex issues involved in defining a basic benefit plan. A summary of these issues is attached (see Attachment A).

With the OHP Medicaid expansion covering up to 100% FPL already, the Task Force focused on the uninsured working poor, those adults living in households with an income between 100-200% of the Federal Poverty Level (FPL). Children and pregnant women in this range would likely be covered under alternative funding through expansions of the State Children's Health Insurance Program (SCHIP) and Medicaid, which currently cover these individuals up to 170%FPL.

When extrapolating to an uninsured population, there is no previous, or at least clearly defined, past utilization information to use for future use predictions. This population often forgoes needed care or uses safety net clinics and hospital emergency rooms, making it difficult to make assumptions about the cost of services needed. [3] Expanding the coverage above 100% of FPL will require careful analysis of the population demographics with some extrapolation from the current OHP "new eligibles" health status and usage.

Benefit Design Focus

The Benefit Task Force focused on two types of approaches to benefit design: 1) *access promotion*, a system that encourages early diagnosis through routine health care in order to increase the potential for better outcomes of treatment and reduced costs, 2) *asset protection*, a system exemplified by a catastrophic plan, which uses co-payments and deductibles to shift some of the cost of low-cost care to the consumer, while providing the individual protection from losing their assets due to a severe illness or "catastrophic" event. Most HMO's have traditionally offered fairly rich and complete coverage of both preventative care and catastrophic expenses.

The Task Force reached the conclusion that a basic benefit plan for uninsured adults between 100-200% of FPL should stress *access promotion*. The issues around additional expenses such as co-pays for diagnostic tests, etc. were raised with the concern that many individuals of this population would not be able to afford even moderate expenses, resulting in their outcomes being no different than if they remained uninsured.

[3] Ayanian, J.Z. et al. (2000). "Unmet Health Needs of Uninsured Adults in the United States," JAMA 284(16): 2061-2068.

By focusing on access promotion, there would be enhanced coverage of preventive and early intervention health care, while limiting the coverage of high cost cases. This plan is consistent with the public health goal of encouraging preventive care. Minnesota, in its MinnesotaCare expansion, includes single adults without dependent children. Initially supported by state funds only, awaiting waiver approval, they have offered only outpatient services. Inpatient services for this target population were recently added but with a $10,000 limit.

Utilization of Health Care Services

Studies support that insurance coverage itself increases use of health care services, especially among the poor and the sick poor[4,5,6] with some leveling off after the initial "pent-up demand". This was found by the Washington Basic Health Plan (BHP) with a standard set of benefits with dollar amount restrictions on certain services. There was initial pent-up demand for care for those who had been without insurance for more than a year. However, overall, members in the BHP were not high users of care. Total expenditures were comparable to those for state employees and lower than those for Medicaid recipients.[7]

Restrictions on Health Care Services

Both public and private insurers can restrict the use of an insurance benefit package in efforts to curb costs. A benefit package can be designed to limit use of some providers, some types of services, or certain drugs. However, these restrictions have the potential to reduce access to needed care.

Adjusting eligibility standards of Medicaid and Medicare can restrict use of services as well. As costs go up for a particular federally mandated benefit package, most states have tightened eligibility requirements. Fixed benefits are provided to a population small enough not to exceed budget limitations. In contrast, the Oregon Health Plan attempted to contain costs by limiting the benefits provided to a fixed population via a prioritized list of covered services.

Determining What Benefits Will Be Included

Specific Benefits and Services

Most of the standard health care packages offered have similar benefits regarding hospital care, outpatient, and health care provider services. Dental, vision, mental health, and treatment of substance abuse are commonly not included in some packages in attempts to curtail insurance benefit package costs, although limited mental health and substance abuse coverage is mandated in Oregon. Prescription drugs, durable medical equipment (DME), home health, rehabilitation, experimental treatments, transplants and new technology are limited in many benefit packages to curtail costs. However, there is evidence that services such as mental health may decrease overall

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[4] Davis, K. &D. Rowland, (1983). "Uninsured and Underserved: Inequities in Health Care in the United States", *Milbank Memorial Fund Quarterly* 61:149-76. In J.H. Godderis & A.J. Hogan, ed., Improving Access to Healthcare-What Can the States Do? Kalamazoo, MI: WE Upjohn Institute.

[5] Newachek, P.W. (1988). "Access to Ambulatory Care for Poor Persons", *Health Services Research* 23:401-19. In J.H. Godderis & A.J. Hogan, ed., Improving Access to Healthcare-What Can the States Do? Kalamazoo, MI: WE Upjohn Institute.

[6] Wilinsky, G.R. & M. Berk, (1983). "Poor, Sick, and Uninsured", *Health Affairs*2( ): 91-95

[7] Martin, D.P., et al, 1997). "Health Care Utilization for the 'Newly Insured': Results from the Washington Basic Health Plan". *Inquiry* 34(2): 129-42.

health care costs because they contribute towards overall prevention of disease and increase livability.[8,9]

Risk issues

Some studies have described basic benefit packages as basic health services that one can anticipate most people will need during their lives.[10] This is a variation from the more traditional catastrophic insurance model that attempts to minimize risk by protecting assets. Predicting the utilization of the population can be a guide to determining the services necessary in a basic benefit plan. However, making any predictions incorporates an element of risk.

Dental benefit plans use actuarial predictions of utilization of dental services.[11] While medical care may not be as easily predicted as dental, it does raise the question of whether utilization data can be analyzed to better anticipate the needs of a population.

The American Academy of Family Practice (AAFP) describes their approach to basic care as "assured" rather than risk-based insurance. The AAFP model includes prenatal care, well-child care, and all services provided by an individual's primary physician. Their model would allow individuals to purchase services not included in the basic coverage and/or to obtain insurance for these services. To insure against financial ruin, a cap would be placed on out-of-pocket expenditure for services not covered by the basic benefits package at $5,000 per year for individuals and $8,000 a year for families. This catastrophic coverage includes provisions for a 20% co-payment up to a total expenditure for $10,000 for individual or family. The entire model is still in draft form, awaiting member input.

The Role of Community Values in Selecting Benefits

Making Health Policy 2000, a survey published by Oregon Health Decisions in August 2000, aimed to determine if Oregonians really want to extend health care to more people and the tradeoffs they deem acceptable in doing so. The report indicated continued support for rationing services and maintaining coverage when faced with budget shortfalls. Eliminating populations of people to maintain a full set of services a subset of the population was not favored. Most of the participants felt that prevention and timely treatment could save money.

The Basic Benefit Task Force analyzed a modified list of the Health Service Commission's original seventeen categories of care that were developed from community input to determine the original OHP Prioritized List of Health Services (see Attachment B-Health Service Categories). They determined that providing the coverage associated with only the top nine of these categories reduced the cost of the full OHP benefit package by approximately 25%. There was some concern by the Task Force over the complexities of administering a basic plan using the same condition/treatment pairs and limiting coverage to a higher level of the List. There was

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[8] Rosenheck, R.A., et al (1999). "Effect of Declining Mental Health Service Use on Employees of a Large Corporation". *Health Affairs* 18(5): 193-203.

[9] Olfson, M., et al (1999). "Mental Health/Medical Care Cost Offsets: Opportunities for Managed Care", *Health Affairs* 18(2): 79-90.

[10] American Academy of Family Practice (2000). "A Strategy to Provide Health Care Coverage for All: A Proposal for Discussion and Comment". Retrieved December 15, 2000 from the World Wide Web: http://www.aafp.org/unicov/.

[11] Bailit, H.L., et al (1979). "Controlling the Cost of Dental Care". *American Journal of Public Health* 69(7): 699-703.

much concern that the target population (uninsured working poor) needed most of the same services that were available under the OHP.

The Task Force felt the broader categories of care could be the basic framework for an affordable basic benefit plan. A matrix was developed to see how the full range of benefits available and cost sharing could be incorporated (see Attachment C), with ratings assigned to each category for expected cost-sharing from the individual. Treatable fatal conditions, maternity care and comfort care were assigned zero or low levels of contribution by an individual. Treatable non-fatal conditions were either medium or high contribution. The areas of least agreement were in preventive care and family planning, as well as in the areas of mental health, chemical dependency, and dental services. The Task Force debates centered on differences in philosophy of definition of health care services and what basic health coverage should include versus what could be better handled through a community-based program.

Mandated Coverage Requirements and a Basic Benefit Package

When discussing Medicaid benefit packages, the issue of mandated coverage arises. There are coverage requirements in the Social Security Act that dictate eligibility for benefits by specific categories. These "categorically needy" have mandated benefits that states must provide in order to receive federal matching funds. The Oregon Health Plan goes beyond the required benefits and provides a package 22% richer than the mandated benefits.

Waivers of these eligibility and benefit requirements offer states a way to gain flexibility in benefit packages and include more of the uninsured. Massachusetts expanded coverage through a Medicaid waiver, offering a basic option for "new eligibles" (i.e. non-categorical needy), called "MassHealth." It was an attempt to target services to the needs of the expansion population. While the mandated services were still offered, some of the optional services were dropped including adult foster care, hospice, nursing facility services, and other transportation services beyond emergency ambulance.

Actuarial equivalence is health benefit coverage that is equal or greater in value to another benefit package. This is based on assumptions about predicted use and current costs. Traditionally, insurers would anticipate a population's usage of services based on age and sex. In a new approach, Washington State, in determining the premium for their "uniform benefits package" of the Basic Health Plan, incorporated previous utilization data using the following parameters:[12]

- Scope of services
- Utilization and cost
- Cost sharing
- Delivery system makeup (HMO, traditional, etc.) and their effectiveness
- Estimated administrative expenses
- Medical inflation and utilization trends
- Population characteristics and composition

[12] Washington Health Service Commission (1995). Report to Governor Lowry and the Washington State Legislature-Volume 1: Executive Summary. State of Washington

The State Children's Health Insurance Program (SCHIP) addition to the Social Security Act offers the states an option to provide "benchmark coverage." This is health benefit coverage that is actuarially equivalent to commercial HMO, federal or state employee standard benefit packages instead of the Medicaid benefit package. SCHIP requires one of three benchmarks: 1) the standard Blue Cross/Blue Shield preferred provider option service benefit plan offered to federal employees, 2) the State employees basic benefit option, or 3) the basic plan option of the largest (determined by number of insured non-Medicaid covered lives) commercial HMO in the state.

Healthy New York is that state's product sold to eligible small businesses who don't provide health insurance coverage for their employees and eligible working uninsured individuals. The benefits are described as a "scaled down" comprehensive benefit package. It is designed to be an alternative actuarial equivalent plan. Certain mandates of the Medicaid package are not part of the "scaled down" version in order to keep the overall cost down. This includes elimination of home health care, chiropractic care and outpatient treatment of alcoholism and substance abuse. There is no coverage for mental health and the prescription drug benefit is subject to a $3,000 dollar maximum per year. The state is still waiting approval by HCFA for any further expansion beyond what state funds alone can allow. The federal government is requesting more information to determine if the expansion plan is "budget neutral", not adding any increased cost by the change in benefit structure.

Recently, Governor John Kitzhaber charged the Oregon Health Services Commission with the task of designing a basic benefit package that would be actuarially equivalent to the mandated benefits of Medicaid. This package could then be a means of expanding some level of coverage that could qualify for federal match under the current Oregon Health Plan. Alternatively, a Medicaid waiver approach could include a basic benefit package that is actuarial equivalent to the benchmark plans as outlined in the SCHIP legislation.

Attachment D is a comparison of the Medicaid's mandated services and benefits with those covered under the Federal Employees Basic Option under Blue Cross/Blue Shield, Oregon's PEBB basic option, and one of the larger statewide HMO's, Kaiser Permanente. This is a beginning attempt at looking at equivalent coverage. In 1995, when an employer-mandate expansion of the OHP was under consideration, the Benefit Design Task Force did a similar type of comparison of basic benefits coverage available within the state at the time. The more recent Basic Benefit Task Force matrix could be further defined along these lines for comparison, as could other states' basic options.

Conclusion

Designing a basic benefit package for a particular target population requires detailed knowledge of the specific population, their need of services, the community's values regarding how to frame the basic benefit package, and awareness of the mandates and requirements imposed by the Federal government to gain additional financial assistance. Since our target expansion population is the low-income uninsured, traditional approaches to benefit design, such as the protection of assets, have to be weighed against the concept of access promotion. Costs are more difficult to predict since utilization data are less available. By extrapolating from the Medicaid population and what we do know about the uninsured, multiple models of basic benefit packages could be analyzed in terms of actuarial equivalence. Benchmarking these against federal mandates or

other actuarially equivalent plans could help to determine feasibility of obtaining federal matching dollars. The Oregon Health Plan's Prioritized List was a means of "rationally"[13] distributing healthcare resources, in a structurally simple and technically straightforward approach. This framework or the benchmark-equivalent models could be used to extend coverage in a cost-effective and access promotion manner, incorporating the values that Oregonians continue to support.

This is one of a series of papers discussing issues related to universal health coverage for low-income uninsured Oregonians. This work is supported by a grant from the Health Resources and Services Administration. As more information is gathered, the papers will change. Views and ideas expressed within these papers are not intended to reflect those of any particular group, unless so noted, but are intended to inform and stimulate discussion and debate on critical health care coverage strategies. For the most recent revision, please visit the grant team's Web site: http://www.ohppr.org/hrsa/index_hrsa.htm, or call 503/418-1067 to request the paper in an alternate format.

[13] Nerenz, D.R., et al (1992). "Benefit Package Considerations in a State Health Plan". In J.H. Godderis & A. J. Hogan, ed., Improving Access to Healthcare-What Can the State Do? Kalamazoo, MI: WE Upjohn Institute.

ATTACHMENT A
Points for Consideration when Defining a Basic Benefit Plan

Services

Preventive care
Comprehensive primary care
Ancillary care
Urgent and emergent hospital and surgical care
Elective hospital and surgical care
Mental health integration
Cafeteria plan of extras
Condition-treatment pairs
Experimental v. Non-experimental

Financial considerations

Incentives
Cost Sharing
Encourage self-reliance
Tiered subsidy
Affordability
Avoid crowd-out
Cost reimbursement
Tax credits
Private buy-into public programs, such as Medicaid

Systems issues

Utilize existing administrative structure v. new administrative structure
Portability
Recognize and address barriers to care

General considerations

Equity
Accountability
Sustainability
Flexibility
Evidence-based
Cost-effective
Public/private partnership
Public input

ATTACHMENT B
Health Service Categories

The following ranked list of health services categories is the result of category weights and Health Service Commission judgment. They are ranked from most important to least important. The groupings of condition/treatment pairs characterized by being acute or chronic, fatal or non-fatal (e.g., chronic nonfatal, one-time treatment improves quality of life). Note that the examples cited in parenthesis are intended to be illustrative—not comprehensive.

1. **Acute Fatal, treatment prevents death with full recovery:** appendectomy for appendicitis; repair of deep, open wound in neck; medical therapy for myocarditis.
2. **Maternity Care, including most disorders of the newborn:** obstetrical care for pregnancy.
3. **Acute Fatal, treatment prevents death without full recovery:** surgical treatment for head injury with prolonged loss of consciousness; medical therapy for acute bacterial meningitis; reduction of an open fracture of a joint.
4. **Preventive Care for Children:** immunizations; medical therapy for streptococcal sore throat and scarlet fever-reduce disability, prevents spread; screening for specific problems such as vision or hearing difficulties or anemia
5. **Chronic Fatal, treatment improves life span and quality of life:** medical therapy for Type I Diabetes Mellitus; medical and surgical treatment for treatable cancer of the uterus; medical therapy for asthma.
6. **Reproductive Services, excludes maternity and infertility services:** contraceptive management; vasectomy; tubal ligation.
7. **Comfort Care:** palliative therapy for conditions in which death is imminent.
8. **Preventative Dental Care, adults and children:** cleaning and fluoride applications.
9. **Proven Effective Preventive Care for Adults:** mammograms; blood pressure screening; medical therapy and chemoprophylaxis for primary tuberculosis.
10. **Acute Nonfatal, treatment causes return to previous health state:** medical therapy for acute thyroiditis; medical therapy for vaginitis; restorative dental service for dental caries.
11. **Chronic, Nonfatal, one-time treatment improves quality of life:** hip replacement; laser surgery for diabetic retinopathy; medical therapy for rheumatic fever.
12. **Acute Nonfatal, treatment without return to previous health state:** relocation of dislocated elbow, arthroscopic repair of internal derangement of knee; repair of corneal laceration.
13. **Chronic Nonfatal**, **repetitive treatment improves quality of life:** medical therapy for chronic sinusitis; medical therapy for migraine; medical therapy for psoriasis.
14. **Acute Nonfatal**, **treatment expedites recovery of self-limiting conditions:** medical therapy for diaper rash; medical therapy for acute conjunctivitis medical therapy for acute pharyngitis.
15. **Infertility Services:** medical therapy for anovulation; microsurgery for tubal disease; in-vitro fertilization.
16. **Less Effective Preventive Care for Adults:** dipstick urinalysis for hematuria in adults less than 60 years of age; sigmoidoscopy for persons less than 40 years of age: screening of non-pregnant adults for Type I Diabetes Mellitus.
17. **Fatal or Nonfatal, treatment causes minimal or no improvement in quality of life:** repair fingertip avulsion that does not include fingernail; medical therapy for gallstones without cholecystitis; medical therapy for viral warts.

ATTACHMENT C

Categories of Care (listed in priority given by Health Services Comm.)	Service Type							
	Inpatient services	Outpatient services	ER	MH/CD	Oral health	Rx	Other ancillary	Enabling services
Treatable Fatal Conditions	0 - L	0 - L	0 - L	0 - L	N/A	0, L, M	L	0 - L
Maternity Care	0 - L	0 - L	0	0	N/A	0 - L	0 - L	0 - L
Preventive Care	N/A	0 - L	N/A	0, M	0, M	L - M	L	0, M
Family Planning	0 - L	0 - L	H	N/A	N/A	0 - L	M	0, H
Comfort Care	L	0 - L	0 - L	0 - L	N/A	0 - L	0 - L	0 - L
Treatable Nonfatal Conditions	M - H	M - H	M - H	M	M - H	L, M, H	M - H	0, M
Self-limited Conditions	X	X	X	X	X	X	X	X
Infertility Services	X	X	X	X	X	X	X	X
Futile Care	X	X	X	X	X	X	X	X

Legend: 0 = No contribution
L = Low contribution
M = Medium contribution
H = High contribution
X = Not covered, full contribution
N/A = Not applicable

The above levels of contribution (0, L, M, H, or X) are approprate to ask of an individual living in a house- with income between 100-200% FPL. Different levels of contribution are listed for services of a specific type (columns) to be used in the treatment of conditions within certain categories of care (rows) as part of a basic benefit package emphasizing access promotion.

1. Outpatient services include office visits, lab, x-ray, and outpatient surgery.
2. Other ancillary services include DME, PT/OT, speech therapy, and hearing services.
3. Enabling services include transportation, interpretive services, and coordination of care.
4. The categories of care are based on the 17 categories ranked by the Health Services Commission (HSC) as part of their original prioritization methodology.
5. Treatable fatal conditions include the HSC categories: acute fatal, treatment prevents death with full recovery (HSC1), acute fatal, treatment prevents death without full recovery, (HSC3) and chronic fatal, treatment improves life span and quality of life (HSC5).
6. Maternity care (HSC2) includes obstetrical care for pregnancy and most disorders of the newborn.
7. Preventive care includes services for children (HSC4) and adults (HSC8) that have been rated as A or B by the US Preventive Services Task Force. Consider services under the oral health heading as including cleaning and fluoride for children and those at high risk who cannot provide self-care (HSC9). Less effective preventive services (HSC16) rated as C, D, or E by the Task Force are not included in any of these categories of care.
8. Family planning (HSC6) include contraceptive management, vasectomy, and tubal ligation.
9. Comfort care (HSC7) includes palliative therapy for terminal illness. Services covered under OHP include pain management, hospice care, symptom relief, and services under the Oregon Death with Dignity Act.
10. Treatable nonfatal conditions include the HSC categories: acute nonfatal, treatment causes return to previous health state (HSC10), chronic nonfatal, one-time treatment improves quality of life (HSC11), acute nonfatal, treatment without return to previous health state (HSC12), and chronic nonfatal, repetitive treatment improves quality of life (HSC13).
11. Self-limited conditions (HSC14) includes acute, nonfatal conditions where treatment expedites recovery (e.g. treatment for a viral sore throat).
12. Infertility services (HSC15) include medical therapy for anovulation, microsurgery for tubal disease, and in-vitro fertilization.
13. Futile care (HSC17) include fatal and nonfatal conditions where treatment causes minimal or no improvement in quality of life.

ATTACHMENT D
Benefit Comparison Chart

MEDICAID	**Oregon Health Plan (OHP)**	**Federal Employee Program** BlueCross / Blue Shield Standard Option PPO	**State Employee Program (PEBB)** Regence BC/BS PPO Basic Plan	**Largest HMO in Oregon** Kaiser Permanente Basic Plan
Mandated Basic Services (categorically needy)				
Cost-sharing restrictions for certain eligibility categories: (no fees, premium, or other charges allowed) – < age 18 – pregnant women – inpatients, nursing home patients, other institutional patients – emergency services – family planning and supplies – hospice patients	Depending on category of eligibility	Some copays, coinsurance.	No deductible, but coinsurance (usually 30% of first $1,000) some copays for specific services	No deductible, no coinsurance, some copays
Inpatient Hospital (other than services in a mental health institution, skilled, or intermediate nursing care facility)	Covered using prioritized list	Covered with unlimited days	30% of first $1,000 then 20% (50% if non-preferred provider	$50 copay per day up to $250 maximum per stay
Outpatient Hospital (includes emergency)	Covered using prioritized list	Emergency covered with $25 co-pay after a $200 deductible each year; $25 each day, per facility copay	30% of first $1,000 then 20% (50% if non-preferred provider	Emergancy: $50 copay in and out of area, waived if admitted
Physician Services (outpatient, hospital, skilled nursing facility, or elsewhere)	Covered using prioritized list	Inpatient care, outpatient surgical care with deductibles; home and office visits with co-pay	Inpatient, outpatient with 30% of first $1,000 then 20% (50% if non-preferred)	Inpatient care paid in full; outpatient with $10 copay
Pediatric and Family Nurse Practitioner Services	Covered as per physician services	Covered as per physician services	Covered as per physician services	Covered as per physician services

MEDICAID	**Oregon Health Plan (OHP)**	**Federal Employee Program** BlueCross / Blue Shield Standard Option PPO	**State Employee Program (PEBB)** Regence BC/BS PPO Basic Plan	**Largest HMO in Oregon** Kaiser Permanente Basic Plan
Mandated Basic Services (categorically needy) ***(continued)***				
Nurse Midwife Services	Covered as per physician services	Covered as per physician services	Covered as per physician services	Covered as per physician services
Prenatal Care for pregnant women (includes coverage for any conditions that might complicate the pregnancy, and extends 60 days after pregnancy ends)	Covered using prioritized list	Covered in full	30% of first $1,000 then 20% (or 50% if non-pref.)	Physician paid in full, facility charges and other services as any condition
Medical and Surgical Dental Services (done by a dentist for a medical condition)	Covered using prioritized list	Limited to certain procedures	Covered except for certain restrictions for TMJ treatment	Covered with some limitations
Nursing Facility for individuals age 21 or older (not mental institutions)	Covered	Limited days	20%(or 50% for non-pref.)	Skilled nursing home–paid in full
Family Planning Services and Supplies (limited to child-bearing age and minors)	Covered through clinic services and drug	Covered through clinic services and drug	Not covered	Covered (need to check detail)
Early/Periodic Screening, Diagnosis, and Treatment (EPSDT) for age< age 21	Covered using prioritized list	Covered up to age 22	Well-baby paid in full, then like office visit	$10 copay for well-baby/ well-child (0-12), well-teen (age 13-17)
Immunizations for Children	Covered	Covered up to age 22	Paid in full	Paid in full up to age 18
Rural Health Clinic Services (includes part-time visiting nurse if shortage area to a homebound patient, and usual ambulatory services)	Covered using prioritized list	Ambulatory services covered under outpt., services; ? visiting nurse?	Ambulatory services covered under outpt. services; ? visiting nurse?	Ambulatory services covered under outpt. services; ? visiting nurse?

MEDICAID	**Oregon Health Plan (OHP)**	**Federal Employee Program** BlueCross / Blue Shield Standard Option PPO	**State Employee Program (PEBB)** Regence BC/BS PPO Basic Plan	**Largest HMO in Oregon** Kaiser Permanente Basic Plan
Mandated Basic Services (categorically needy) *(continued)*				
Federally Qualified Health Center Services	Covered using prioritized list	Covered if provider is in network	Covered if provider is in network	Not covered, required to use only Kaiser facilities for coverage
Durable Medical Equipment (but not prosthetic devices)	Covered using prioritized list	Rental or purchase (up to plan)	Includes prosthetics	10% paid by patient
Diagnostic Services (laboratory/x-ray services); provided in a provider's office other than a hospital outpt. dept. or clinic	Covered	Covered	Covered	Covered
Transportation Services	Covered using prioritized list	Covered ambulance in medical emergency, during covered home health or inpt. care	Ambulance–20% coinsurance required	Ambulance–$50 copay per trip
Mandated (if including the medically needy)				
Ambulatory Services if <age 18 or if entitled to institutional services	Covered using prioritized list	See above under outpt., physician, children coverage	See above under outpt., physician, children coverage	See above under outpt., physician, children coverage
If State Providing Services in a mental institution or intermediate care facility for the mentally retarded–inpatient hospital, outpatient lab, nursing home, and physician services are covered for this group	Covered	No info	No info	No info

MEDICAID	**Oregon Health Plan (OHP)**	**Federal Employee Program** BlueCross / Blue Shield Standard Option PPO	**State Employee Program (PEBB)** Regence BC/BS PPO Basic Plan	**Largest HMO in Oregon** Kaiser Permanente Basic Plan
Mandated (if including the medically needy) *(continued)*				
Home Health if entitled to nursing facility services	Covered using prioritized list	See home health listed below	See home health listed below	See home health listed below
Optional Services under Medicaid				
Diagnostic Screening, Preventative Services	Diagnostics covered even below the line of the priority list	Diagnostic cancer tests covered in full; preventative screenings, routine physicals (every 3 years), adult immunizations	$10 copay for PAP, mammo-graphy, 20% (or 50%) for other diagnostic tests, physicals	$10 copay for physicals, PAP, mammography
Clinic Services (those provided by a facility not part of a hospital	Covered using prioritized list	If providers are in pref. provider network; if not, treated as non-pref.	If providers are in pref. provider network; if not, treated as non-pref.	Only if Kaiser-affiliated clinic
Nursing Facility Services for those over 65 in a mental health institution (also includes inpt. hospital, and intermediate care facility services for this population)	Covered	Info. unavailable	Info. unavailable	Info. unavailable
Intermediate Care Facility Services for the mentally retarded	Covered	Info. unavailable	Residential: 20% with limitations	Residential:$50 copay per day up to $250 max. per stay, 26 days for all members per 24 months
Inpatient Psychiatric Services for age < 21	Covered using prioritized list	$150 per day copay for up to 100 days	50% with limitations	$50 copay per day up to $250 max., 15 days for children per 24 months

MEDICAID	**Oregon Health Plan (OHP)**	**Federal Employee Program** BlueCross / Blue Shield Standard Option PPO	**State Employee Program (PEBB)** Regence BC/BS PPO Basic Plan	**Largest HMO in Oregon** Kaiser Permanente Basic Plan
Optional Services under Medicaid *(continued)*				
Vision (optometrist services and eyeglasses)	Covered	Optional, requiring additional buy-in	Not covered	$10 copay for exam; plan pays up to $200 max. benefit
Prescribed Drugs	Covered	$12 generic, $20 brand name by mail order; retail requires a 25% fee at time of purchase	40% (30 day supply at local pharmacy, 90 day via mail) with $1,000 yearly max. out of pocket	$10 generic drug, $15 formulary brand, $25 non-formulary drug
TB-Related Services for TB-infected persons	Covered	Covered under outpt. care and drug benefit	Covered similar to other conditions	Covered similar to other conditions
Prosthetic Devices (replacement, corrective, or supportive devices for a physical deformity, includes catheters)	Covered using prioritized list	Covered, with catheter supplies covered	Included in durable medical with 20% (or 50%) co-insurance	Included in durable medical with 20% (or 50%) co-insurance
Dental Services (except those for medical conditions)	Covered using prioritized list	Will pay a max. allowable charge, with patient required to make up difference, with kids under 13 more fully covered	Need to select a separate policy; options similar to Kaiser's, some with deductible for more choice	(Extra policy) No deductible no max. benefit; preventative and basic maintenance care paid in full; copay for crowns, bridges, and orthodontia not covered

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Optional Services under Medicaid *(continued)*				
Home Health and Community-Based Care to certain persons with chronic impairment (would otherwise require nursing home care)	Covered	25 visits per year limit	Home health visits up to 180 per year, with a 20% (or 50% if non-pref.) co-insuarance; includes home infusion for certain conditions	Paid in full
Private Duty Nursing	Covered using prioritized list	Not covered	Not outlined	Not outlined
Rehabilitation and Physical Therapy (includes physical and occupational therapy services	Covered using prioritized list	50 visit max./year for physical therapy, 25 for occupational therapy and speech, all with deductibles, inpatient facility co-pay	Outpt.: 60 visits max. per year with 20% (non-pref. 50%) coinsurance; inpt.: 30 days per year with 20% (or 50%) coinsurance	$10 copay per visit
Speech & Audiology (includes speech pathology care, audiological testing)	Covered using prioritized list	Speech: 25 visits	20% every 12 months for exam, hearing aid covered in full up to $500 max. every 36 months	Speech: 2 months if showing significant improvement; hearing aid covered up to $500 max. every 36 months

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Optional Services under Medicaid *(continued)*				
”Remedial” Care and/or Alternative Care –chiropractor	If diagnosis above line on prioritized list	Will cover acupuncture provided by a physician or physical therapist	40% paid by patient plan; pays up to $1,000 max. for all services per year	Kaiser-approved provider only, $15 copay per visit; plan pays up to $1,000 max. for all services per year
Additional Services Not Required				
Hospice	Covered	Covered	Paid in full up to a lifetime max. of $15,000	Paid in full
Mental Health	Covered using prioritized list	(Some new parity info.) Inpt.: $150 (if pref. provider hospital) per day, copay up to 100 days, patient responsible for all charges after for inpt. provider services; after deductible, pay 40% of the allowable charge	Inpt. and residential: 20% with limits (see above); outpt.: 20% copay, max. 52 visits in 24 months	Inpt. and residential: $50 copays up to $250 max. with specific day limits; Outpt.: $10 copay, 52 visits per 24 months
Alcohol/Chemical Dependency	Covered using prioritized list	Inpt. as any condition with life-time max. of one treatment program (28 day); outpt. as per any mental health outpt. care	Treated same as any condition	Treated same as any other condition
Allergy Injections	If diagnosis above line on prioritized list	Covered	Included as a therapeutic injection, 20% coinsurance	$5 copay per visit
Diabetes Supplies	Covered	Covered	Paid in full by the plan	Paid in full by the plan

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Additional Services Not Required *(continued)*				
Diabetes Education	Covered	Covered if provider in plan	? Info unavailable	Some coverage
Smoking Cessation	Covered using prioritized list	After deductible, will pay in full up to max. of $100 for one smoking cessation program per member per lifetime	? Info unavailable	Available