Benchmark Equivalent Coverage Analysis

Healthy Indiana Plan Demonstration

Prepared for:
Patricia Casanova
Indiana Medicaid Director

Prepared by:
Rob Damler
FSA, MAAA
Principal and Consulting Actuary

Christine Mytelka
FSA, MAAA
Consulting Actuary

111 Monument Circle
Suite 601
Indianapolis, IN 46024-5126
USA

Tel +1 317 639-1000
Fax +1 317 639-1001

milliman.com

March 26, 2013

Table of Contents

Appendices

BACKGROUND

This report was developed in response to a request from the Center for Medicare and Medicaid Services (CMS). In a February 15, 2013 letter, Diane Heffron requested a benefit analysis of the Healthy Indiana Plan (HIP) section 1115 demonstration.

CMS will use this benefit analysis to determine whether coverage provided under HIP as of December 1, 2009 represented "full benefits", "benchmark", or "benchmark-equivalent" coverage.

The performance of this benefit analysis will not obligate Indiana to expand Medicaid.

Details of CMS' request are included in Attachment A to this report. The report is structured in the same manner as the request.

SECTION 1 – BENEFIT ASSESSMENT TO SUBSTANTIATE NEWLY ELIGIBLE

The newly eligible FMAP is only available to states that, as of December 1, 2009, did not provide "full state plan benefits", "benchmark", or "benchmark-equivalent" coverage to low-income adults in the new adult coverage group, either through the Medicaid state plan or through a section 1115 demonstration.

As of December 1, 2009, the state provided coverage to uninsured custodial parents and caretaker relative adults (ages 19 through 64) with income above the AFDC income limit up to and including 200 percent of the federal poverty level (FPL) and uninsured non-custodial parents and childless adults (ages 19 through 64) with family income up to and including 200 percent of the federal poverty level (FPL).

Coverage was provided through the Healthy Indiana Plan (HIP) demonstration (Project Number 11-W-00237/5).

1. ENROLLMENT LIMIT

As of December 1, 2009, the demonstration Special Terms and Conditions restricted enrollment for non-custodial parents and childless adults to 34,000. There was no specific enrollment cap for custodial parents and caretaker relatives; although, the state was allowed to modify eligibility if funding was not available.

2. FULL BENEFITS

The benefits available under the HIP 1115 demonstration, as in effect December 1, 2009, did not include all benefits available under the state's approved Medicaid plan. For example, HIP did not cover maternity benefits, vision benefits, dental benefits, Medicaid rehabilitation option services, chiropractic benefits, hearing aids, non-emergency transportation benefits, and others. In addition, benefit limitations often differed from those in the state plan.

HIP benefits were subject to annual and lifetime limits of $300,000 and $1,000,000 respectively. In addition, enrollees were required to make monthly contributions to a POWER account. Those who did not make required contribution were dis-enrolled.

3. BENCHMARK COVERAGE

The benefits available under the HIP 1115 demonstration, as in effect December 1, 2009, did not represent "benchmark coverage", as described in subparagraph (A), (B), or (C) of section 1937(b)(1) of the Act.

The demonstration did not include the entire range of services offered under the three benchmark commercial packages, as in effect December 1, 2009.

The Standard BCBS PPO, as offered under the FEHBP

The demonstration did not include the entire range of service offered under the Federal Employees Health Benefit Program (FEHBP), as in effect December 1, 2009. The demonstration did not include maternity services, chiropractic services, vision services, or dental services.

In addition, HIP benefits were subject to annual and lifetime limits of $300,000 and $1,000,000 respectively. Although the FEBHP plan contains lifetime maximum benefits for specific services (for example wigs or substance abuse treatment), there is no overall lifetime maximum benefit limit.

The State Employee PPO

The demonstration did not include the entire range of service offered under the State employee PPO, as in effect December 1, 2009. The demonstration did not include maternity services, chiropractic services, vision services, or dental services.

In addition, HIP benefits were subject to annual and lifetime limits of $300,000 and $1,000,000 respectively. The State Employee PPO has no annual limit, but has a lifetime benefit limit of $2,000,000 per member.

The HMO with the largest insured non-Medicaid enrollment

The demonstration did not include the entire range of service offered under the Advantage HMO, as in effect December 1, 2009. The demonstration did not include maternity services, vision services, or dental services.

In addition, HIP benefits were subject to annual and lifetime limits of $300,000 and $1,000,000 respectively. The Advantage HMO does not have an overall lifetime maximum benefit limit.

4. BENCHMARK EQUIVALENT COVERAGE

The benefits available under the HIP 1115 demonstration, as in effect December 1, 2009, did not represent "benchmark coverage", as described in section 1937(b)(2) of the Act.

Inclusion of Basic Services

i. Inpatient and outpatient hospital
   The demonstration package covered most inpatient and outpatient hospital services. However, Maternity services were not covered under HIP.
ii. Physicians' surgical and medical services
   The demonstration package covered physician services.
iii. Lab and x-ray services
   The demonstration package covered lab and x-ray services.
iv. Emergency services, as required in 42 CFR 440.335(b)(5)
   The demonstration package covered emergency services, as required in 42 CFR 440.335(b)(5).

42 CFR 440.335(b)(5) requires benchmark benefit packages to include coverage of essential health benefits. Please note that « Maternity and newborn care » is listed as an essential health benefit under Section 1302(b)(1)(D) of the Patient Protection and Affordable Care Act.

HIP also provides only limited coverage of another essential benefit: "Rehabilitative and Habilitative services and devices" (ACA Section 1302(b)(1)(G)). For example, HIP does not cover hearing aids, safety glasses, athletic glasses, treatment for learning disabilities, or foot care.

Aggregate Actuarial Value

The study developed an aggregate actuarial value for the Healthy Indiana Plan demonstration and each of the three benchmarks. The actuarial values are illustrated in Table 1 below.

Table 1 Actuarial Value – Aggregate Plan Healthy Indiana Plan Demonstration compared with benchmarks	
Plan	**Actuarial Value**
Standard BCBS PPO	83%
State employee plan	86%
Largest HMO	83%
HIP Demonstration	75%

The aggregate actuarial value of the demonstration is lower than all three benchmarks. The difference is larger than the +/- 2% *de minimis* standard to be used on Affordable Insurance Exchanges.

Prescription Drugs, Mental Health, Vision, or Hearing services

The actuarial value of prescription drug, mental health, vision, and hearing benefits provided by the Healthy Indiana Plan demonstration was compared to each of the three benchmarks. The actuarial values are illustrated in Table 2 below.

Table 2 Actuarial Value for Specific Services Healthy Indiana Plan Demonstration compared with benchmarks				
Plan	**Drug**	**Mental health**	**Vision**	**Hearing**
Standard BCBS PPO	82%	73%	82%	89%
State employee plan	93%	83%	82%	78%
Largest HMO	82%	54%	82%	100%
HIP Demonstration	100%	100%	0%	100%

The actuarial value calculated for each service is illustrated net of service-specific cost sharing such as copays and coinsurance, but before application of global cost sharing such as deductibles and out of pocket maximums.

The benchmark plans all include at least a basic level of vision services that allows for coverage of eyeglasses when related to an injury or specific medical condition. The demonstration does not cover vision services under any circumstances. Under section 1937(b)(2)(C) of the Act, vision service coverage for benchmark equivalent plans is required to have an actuarial value that is at least 75% of the benchmark.

The benchmark plans all make subsidized optional dental and vision plans available to members, but these optional plans have not been included in our analysis.

Actuarial Value Calculation

Milliman has provided a certificate of actuarial value of the demonstration benefit package as part of this report. The analysis conforms to the following guidelines:

i. The study was performed in accordance with generally accepted actuarial principles and methodologies. All Actuarial Standards of Practice promulgated by the Actuarial Standards Board have been observed.
ii. The study uses a standardized set of utilization and price factors for the demonstration plan and the benchmarks. The utilization is representative of an adult population and Medicare pricing was used.
iii. The study uses a standardized population for evaluating the demonstration plan and the benchmarks. In order to be representative of the potential new adult coverage group, an adult non-Medicare population was used, with an age and gender distribution similar to that of the population that would be eligible for the new adult coverage group in Indiana. Coverage is assumed to be self-only (no family or dependent coverage).
iv. The demonstration was compared to the benchmarks using the same principles and factors in comparing the value of different coverage. The same actuarial cost model was used for all plans, modified only to reflect different plan provisions, such as benefits covered and cost sharing provisions.
v. The analysis does not take into account any differences in coverage based on method of delivery or means of cost control or utilization used.
vi. The analysis reflects cost sharing requirements for each plan.

Appendix B contains actuarial cost model summaries for the HIP demonstration and each benchmark plan.

Data

CMS suggested actual claims experience from the demonstration population be used as a data source for the average utilization and cost information needed to determine actuarial value. Milliman's preliminary analysis explored this option, and identified two issues with this approach:

- The enrolled demonstration population is not representative of those who would be eligible for the new adult coverage group under a Medicaid expansion. The demonstration population is significantly older, more female, and less healthy than the population eligible for the new adult coverage group.
- The demonstration claims data does not include utilization for essential health benefits that were not covered by the demonstration benefit package. For example, because HIP does not cover benefits such as maternity care or vision, utilization of such benefits in the demonstration claims data is zero. This does not allow us to estimate the actuarial value of these benefits for benchmark plans that offer these services.

The alternative we chose was to use ***Milliman Health Cost Guidelines*** data.

The ***Guidelines*** were first developed by Milliman in 1954, and have been updated and expanded annually since that time. An extensive amount of data is used in developing the Guidelines, including published and unpublished data. The ***Guidelines*** was developed from full medical experience (hospital, physician, supplies, prescription drugs) from over 21 million lives. This is supplemented by other sources for specific services, for example a database of inpatient admissions that represents 75% of the national total.

Base utilization levels in the ***Guidelines*** are consistent with a commercial major medical plan. The utilization is summarized by age and gender, and is easily adjusted to the approximate age and gender makeup of those eligible for the new adult coverage group. Utilization is available for every service that may be offered by a benchmark plan.

Methodology

The actuarial value of the HIP demonstration and each benchmark plan was developed using a common actuarial cost model. High level results from this model are illustrated in Appendix B. The summaries illustrate all the key elements by category of service: utilization, cost per service, per member per month cost, and cost sharing value. For each service, the model illustrates estimated utilization (column 1) and average allowed cost per service (2). These are multiplied to develop the total per member per month (3) cost of benefits for each service. Through column 3, the results are identical for the demonstration and three benchmark plans. The total per member per month cost of $280.52 represents the cost

of essential health benefit coverage for the standardized population at a Medicare reimbursement. This is the denominator for each aggregate actuarial value calculation.

Column 4 illustrates the value of member cost sharing. As an example, when the plan requires the member to contribute 20% coinsurance, the cost sharing will be approximately 20% of the total value in column 3. In cases where the benefit was not covered in December 2009, the cost sharing will be equal to the total value in column 3 (for example maternity benefits for the demonstration). Column 5 illustrates the net value provided by the plan. The net per member per month cost for all services is developed by adding the cost for each individual service.

Finally, cost sharing provisions that apply across multiple service categories, such as deductibles or out of pocket maximums, are reflected. After adjustment for global cost sharing, the net per member per month cost illustrates the value provided by the plan.

The actuarial value for each plan is developed by dividing the value of benefits provided by the plan by the total per member per month cost for covering all essential health benefits ($280.52).

Demographics

The cost models used standard utilization, developed based on the ***Milliman Health Cost Guidelines*** data, with adjustment for the estimated demographics of the new adult coverage group in Indiana. This group is aged 19 to 64, with age and gender distribution as illustrated in Table 3 below.

Table 3
Age/Gender Distribution - New Adult Coverage Group

Age Bracket	Male	Female
19-25	12%	11%
25-29	6%	6%
30-34	5%	6%
35-39	4%	5%
40-45	4%	6%
45-49	4%	4%
50-54	5%	4%
54-59	3%	4%
60-64	4%	6%

Those eligible for the new adult coverage group were estimated based on 2011 American Community Survey data from the U.S. census bureau. We selected individuals aged 19 – 64 who were not already covered by Medicare or Medicaid and had incomes below 138% of poverty guidelines. Also excluded were individuals in group quarters: college students, nursing home residents, and incarcerated individuals. We have found that college students often appear to have improperly low incomes because they have not been grouped with their parents. And finally, the estimated new adult coverage group also excludes adults who are currently eligible for Medicaid but enrolled: custodial adults with incomes below the AFDC income limits.

Pricing and Other Assumptions

Pricing in the models has been adjusted to Medicare levels for all plans. This is the pricing level used for the HIP demonstration. Pharmacy reimbursement has been assumed to be the Average Wholesale Price (AWP) less 18% for brand name drugs, and AWP less 65% for generics. A $2 dispensing fee has also been incorporated in the cost.

No adjustment has been made to reflect differing degrees of health care management, including utilization control, prior authorizations, or other delivery system variations.

Cost sharing provisions for each plan are reflected in the models.

Analysis of Results

In general, the benchmark plans covered a wider range of services, most notably maternity benefits.

Adjustments for the value of the cost sharing did not change the relative positions of the plans. Although the benchmark plans have higher copays and coinsurance, the demonstration has the highest deductible.

The remainder of this section discusses the actuarial value by category of service. Please refer to the actuarial cost model summaries in Appendix B.

Inpatient Facility benefits

As for all services, utilization (column 1), average allowed cost (2) and total per member per month cost (3) are the same for all plans. The total monthly value of these services before cost sharing is estimated as $46.09 for all plans.

The benchmark plans had relatively low cost sharing for this category of service:

- The FEHBP required a $200 copay per admission. The copay is waived for maternity admissions.
- The State employee plan required a $500 copay per admission.
- The HMO required a $250 copay per admission.
- The HIP demonstration did not cover maternity services. This is illustrated as 100% cost sharing for this service line. There are no other copay or coinsurance requirements for inpatient hospital services. However, these services were subject to the $1,100 deductible.

Outpatient Facility benefits

The total monthly value of outpatient facility services before cost sharing is estimated as $60.18 for all plans.

Cost sharing is reflected as follows:

- The FEHBP required 15% coinsurance
- The State employee PPO required $75 copays for emergency room services, $250 copays for outpatient surgery, and 20% coinsurance applied to other services.
- The HMO required $125 copays for outpatient surgery and emergency room visits, $35 copays for therapy, mental health, and substance abuse visits, and an additional $50 copay for certain types of imaging. Other services were subject to 20% coinsurance.
- The HIP demonstration required a $3 to $25 copay for emergency room services. Also, all costs other than preventive services were subject to the deductible.

Professional

The total monthly value of professional services before cost sharing is estimated as $76.41 for all plans.

Cost sharing generally reflected a mixture of copays and coinsurance and can be summarized as follows:

- The FEHBP required $20 copays for most office visits, and 15% coinsurance for other services. Cost sharing was waived for maternity services.
- The State employee PPO required $20 copays for office visits, and 20% coinsurance applied to other services. Cost sharing was waived for preventive services.
- The Advantage HMO did not cover chiropractic services. These are illustrated as 100% patient responsibility. In general, the HMO applied $20/$35 primary care/specialist copays to office visits, including mental health and substance abuse visits, with $50 copays for urgent care visits. 20% coinsurance applied to other services. Cost sharing is reduced for maternity services (only applies to the first prenatal visit).
- The HIP demonstration did not cover maternity or chiropractic services. These are illustrated as 100% patient responsibility. Also, all costs other than preventive services were subject to the $1,100 deductible.

Other

The total monthly value of professional services before cost sharing is estimated as $97.84 for all plans, mainly attributable to prescription drugs.

Prescription drug cost sharing provisions can be summarized as follows:

- When purchased retail, the FEHBP required 20% coinsurance for generics and 30% for brand drugs. Mail order purchases allowed for a 90-day supply: $10 for generics and $65 for brand name drugs. We have assumed an even mix of purchase types (mail order/retail).
- The State employee PPO required $10 copays for generic drugs, $20 for brand drugs.
- The Advantage HMO required $10 or $20 copays for generic drugs and $30 for brand drugs.
- The HIP demonstration had no copays for drugs. They were subject to the $1,100 deductible.

The HIP demonstration did not provide dental or vision benefits. The benchmark plans covered a minimal level of vision and dental benefits in order to cover accidental injury or glasses needed for a medical condition. The benchmark plans also subsidize stand-alone supplemental vision and benefit plans for members, but these are not valued as part of this analysis.

Global Cost Sharing Adjustments

The value of global cost sharing provisions, such as deductibles and out of pocket maximums, was developed using a claims probability distribution. Although average per member per month values are illustrated for each service, the majority of members do not incur any claims at all during a given month, and those members who do incur claims tend to incur costs that are higher than the average.

The deductible serves to shift a portion of first dollar costs from the plan to the member, reducing actuarial value. It has a greater impact for HIP demonstration members than for benchmark plan members. This is because:

- Except for preventive services, all demonstration services are subject to the deductible. The benchmark plans have many commonly provided services, most notably hospital, prescription drugs and office visits, that are not subject to the deductible because they are subject to copays instead.
- The demonstration's deductible is higher than for the other plans.

The out of pocket maximum serves to protect members who incur large costs, adding to the value of the plan. The value of this provision is largest for the State PPO, as their members only have to incur $2,000 in out of pocket expenses - $500 deductible plus $1,500 additional – before the out of pocket maximum kicks in. It is less valuable for the FEHBP, whose members need to pay $5,000 out of pocket before the maximum is reached. And it has almost no value at all for HIP demonstration members because after the $1,100 deductible has been paid, there are no additional opportunities for cost sharing (no other copays or coinsurance except for a minimal copay related to emergency services.)

SECTION II – BENEFIT ASSESSMENT TO SUBSTANTIATE EXPANSION STATE FMAP

In the previous section, the State of Indiana has determined that the Healthy Indiana Plan (HIP) section 1115 demonstration did not provide full benefits, benchmark benefits, or benchmark equivalent benefits. The State has not prepared a response to Section II due to the results of the analysis presented in Section I.

CERTIFICATE OF ACTUARIAL VALUE OF THE DEMONSTRATION PACKAGE

ACTUARIAL CERTIFICATION

The authors of this study, Robert Damler, and Christine Mytelka, are consulting actuaries with the firm of Milliman, Inc. We were retained by the State of Indiana, Office of Medicaid Policy and Planning, to perform a benchmark equivalent coverage analysis for the Healthy Indiana Plan (HIP) demonstration.

The study was performed in accordance with generally accepted actuarial principles and methodologies. All Actuarial Standards of Practice promulgated by the Actuarial Standards Board have been observed.

The study uses a standardized set of utilization and price factors for the demonstration plan and the benchmarks. The utilization is representative of an adult commercial population, and Medicare pricing was used.

The study uses a standardized population for evaluating the demonstration plan and the benchmarks. A non-Medicare adult population was used, with standard age and gender distribution. Coverage is assumed to be self-only (no family or dependent coverage).

The demonstration was compared to the benchmarks using the same principles and factors in comparing the value of different coverage. The same actuarial cost model was used for all plans, modified only to reflect different plan provisions, such as benefits covered, benefit limitations, and cost sharing provisions.

The analysis does not take into account any differences in coverage based on method of delivery or means of cost control or utilization used.

The analysis reflects the increase in actuarial value of benefits resulting from limitations on cost sharing.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

March 26, 2013
Date

Christine Mytelka, FSA, MAAA
Consulting Actuary

March 26, 2013
Date

LIMITATIONS

The information contained in this report has been prepared for the State of Indiana, Family and Social Services Administration and Office of Medicaid Policy and Planning (OMPP), to assist with submitting benefit information associated with the Healthy Indiana Plan 1115 demonstration to the Centers for Medicare and Medicaid Services (CMS). The data and information presented may not be appropriate for any other purpose.

The letter may not be distributed to any other party without the prior consent of Milliman. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for OMPP by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has relied upon certain data and information provided by the State of Indiana, Family and Social Services Administration and their vendors. The values presented in this letter are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented in our report will need to be reviewed for consistency and revised to meet any revised data.

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and OMPP approved May 14, 2010.

Appendix A

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

FEB 15 2013

Patricia Casanova
Director
Office of Medicaid Policy and Planning
Family and Social Services Administration
402 West Washington Street, PO Box 7083
Indianapolis, IN 46207-7083

Dear Ms. Casanova:

CMS recently issued Questions and Answers, which can be found at http://medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/ACA-FAQ-BHP.pdf, to provide states with more information about the availability of increased federal medical assistance percentages (FMAPs, or federal match) provided in the Affordable Care Act. We are writing to provide additional guidance to Indiana on the availability of the "newly eligible" and/or "expansion state" FMAP given that Indiana provided coverage to low-income adults through its Healthy Indiana Plan (HIP) section 1115 demonstration prior to the enactment of the Affordable Care Act. Specifically, we wanted to describe how we will work with you to determine whether demonstration populations will be eligible for the newly eligible, expansion state or regular FMAP, if your state decides to adopt the new adult coverage group. More guidance about the method states will use to distinguish among populations for purposes of applying the appropriate FMAP will be provided in forthcoming FMAP final regulations.

As you know, beginning in 2014 the Affordable Care Act authorizes two types of increased federal Medicaid matching rates for state expenditures for low-income individuals in the new adult group (that is, the group described by section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act)): the newly eligible FMAP and the expansion state FMAP. Under the statute, these two increased federal matching rates are only available to states that adopt the new adult group.

- The newly eligible FMAP is available to all states, including those identified as expansion states, for expenditures for individuals in the new adult group who would not be eligible for full state plan, benchmark, or benchmark-equivalent Medicaid benefits under state rules in effect as of December 1, 2009. This includes expenditures for individuals that would have been eligible for such coverage, but were not enrolled due to enrollment limitations under the demonstration.
- The expansion state FMAP is available to qualifying states for expenditures for certain nonpregnant childless adults (those who are enrolled in the new adult group and who the state may require to enroll in benchmark coverage), to the

> extent that such individuals do not qualify for the newly eligible FMAP. A qualifying state is a state that, as of March 23, 2010 (the date of enactment of the Affordable Care Act), had provided a specified level of health benefits coverage, which we refer to as "specified" coverage,[1] (whether through Medicaid or a fully state-funded program) statewide to both low-income parents and nonpregnant childless adults up to at least 100 percent of the federal poverty level (FPL).

The newly eligible and expansion state FMAP definitions reference different coverage dates and different scopes of benefits, thus requiring different analyses to confirm their application. To the extent that the definitions overlap for a particular population, so that either the newly eligible or the expansion state FMAP could apply in a state designated as an expansion state, expenditures would be matched at the higher applicable FMAP; being an expansion state will not be a disadvantage in terms of matching rates for that population. It is important to also note that the expenditures for some populations in the new adult group (for example, parents who were previously eligible for full state plan benefits) may be matched at your regular FMAP.

We will work with you and your staff to ensure that the correct FMAP is applied to expenditures for each population. When we approved the HIP demonstration, we did not explicitly designate the coverage offered under your accepted Special Terms and Conditions (STCs) as "benchmark" or "benchmark-equivalent" coverage, even though the coverage offered to demonstration beneficiaries may have met such standards. Therefore, to reach a final FMAP determination for your state, we are requesting that you provide certifications about eligibility and benefits in effect as of dates specified in the Affordable Care Act.

In particular, we request that you provide a benefit analysis that includes the information described in Attachment A to enable CMS to confirm whether coverage provided to each demonstration population as of December 1, 2009 represents "full benefits," "benchmark," or "benchmark-equivalent" coverage. (Additional information on the statutory benchmark standards that were in effect on December 1, 2009 can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/Benchmark-Standards-12-1-09.pdf). If the demonstration coverage is found not to have met a benchmark or benchmark-equivalent coverage standard, Indiana will qualify for the newly eligible FMAP for relevant populations. As noted above, Attachment A provides a guide for you and your staff to use to as you conduct your benefit analyses. Completion of the guide is not required as it is merely a form to use at your option; however, the type of information contained in it is needed for CMS to confirm your applicable FMAPs.

If the newly eligible FMAP is not available for a particular population, you may be able to claim the expansion state FMAP for certain nonpregnant childless adults covered in

---

[1] The standards for specified coverage are set forth in section 1905(z)(3) of the Act statewide; it is coverage that included inpatient hospital services, was not dependent on access to employer coverage, employer contribution, or employment, and was not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits authorized under a demonstration program authorized under section 1938 of the Act.

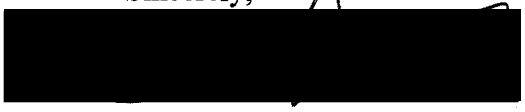
the new adult group. The benefit analysis described in Attachment A is necessary for you to establish Indiana's status as an expansion state so that we can apply the expansion state FMAP to appropriate expenditures. As noted above, status as an expansion state will not negatively affect your ability to claim the newly eligible FMAP. The expansion state FMAP will apply only when the newly eligible FMAP is not applicable for a particular population.

Attachment A provides additional detail about the methodology and data necessary to substantiate your analysis. For example, the state's benchmark equivalence analyses must be certified by a qualified actuary and must include information on the data, assumptions, and methodology used to calculate actuarial values, as described in Attachment A. We will use the benefit analyses information provided to determine the appropriate FMAP. Upon reviewing your benefit analyses, we may seek additional information and/or clarification.

Given that Indiana expanded coverage prior to the enactment of the Affordable Care Act, we encourage you to analyze your demonstration's benefits using the guide found in Attachment A and to submit your analyses to CMS. We understand that you may have not made a decision about whether and/or when to adopt the new adult coverage category and submission of your analysis will not obligate Indiana to any particular decision. Rather, providing this information will enable CMS to provide you with information about the FMAP(s) that might apply depending on the state's decision.

We are committed to reviewing your information and working with you and your staff to confirm the applicable FMAPs in a timely manner. We encourage you to submit your analysis to Allison Orris at Allison.Orris@cms.hhs.gov by April 15, 2013. Please work with your State Operations and Technical Assistance (SOTA) team, or contact Allison Orris if you have any questions.

Sincerely,



Dianne E. Heffron
Director
Financial Management Group

Attachment

Attachment A: Guide to Demonstration Benefit Analysis

cc:

Verlon Johnson, Associate Regional Administrator, Division of Medicaid and Children's Health Operations

Barbara Edwards, Director, Disabled and Elderly Health Programs Group

Jennifer Ryan, Acting Director, Children and Adults Health Programs Group

Attachment A - Guide to Demonstration Benefit Analysis

This Attachment provides a guide for the state to use to conduct the benefit analysis for purposes of determining which FMAPs may apply for adult populations provided coverage through section 1115 demonstrations prior to enactment of the Affordable Care Act. Use of this guide is not required; however, the information contained below will help CMS to confirm the applicable FMAPs. A separate analysis should be undertaken for each demonstration group, if different demonstration populations received different benefits under the demonstration and/or if different enrollment caps or limitations applied to different groups. CMS may request additional information to address specific questions; the below questions represent a uniform starting point for analysis.

Section I – Benefit Assessment to Substantiate Newly Eligible FMAP

The newly eligible FMAP is only available to states that did *not* provide "full state plan benefits," "benchmark" or "benchmark-equivalent" coverage to low-income adults either through the Medicaid state plan or through a section 1115 demonstration. To determine if demonstration-based coverage could have been designated as benchmark or benchmark-equivalent coverage, the following questions (based on section 1937 of the Act, as it was in effect on December 1, 2009, and our regulation at 42 CFR 440.330-340) should be considered as part of the state's analysis.

> According to our preliminary review, on December 1, 2009, the state provided coverage to uninsured custodial parents and caretaker relatives with income above the AFDC income limit up to and including 200 percent of the federal poverty level (FPL) and uninsured non-custodial parents and childless adults (ages 19 through 64) with family income up to 200 percent of the FPL through the Healthy Indiana Plan demonstration (Project Number 11-W-00237/5). If this is incorrect, please provide the correct demonstration name, project number and/or covered populations.

1. Was the demonstration, as in effect on December 1, 2009, authorized to limit enrollment?

> If applicable, please specify the enrollment cap authorized by the demonstration as of December 1, 2009, and the actual enrollment, as calculated per the reporting requirements specified under the demonstration, if different.

2. **Full Benefits:** Did the benefits available under the section 1115 demonstration indicated above, as in effect on December 1, 2009, represent "full benefits" meaning, with respect to each demonstration group, medical assistance for all services covered under the state's approved Medicaid state plan?

[If the answer to question 2 is "yes," skip to Section II to establish whether "expansion state" status is applicable.]

3. **"Benchmark Coverage":** Did the benefits available under the section 1115 demonstration indicated above, as in effect on December 1, 2009, represent "benchmark coverage" described in subparagraph (A), (B), or (C) of section 1937(b)(1) of the Act? Please answer the following questions to support this representation, and include any applicable citations to the demonstration's special terms and conditions (STCs) that were in effect on December 1, 2009:

3a. Did the demonstration benefit package include the entire range of services offered under any of the following three commercial products, as they were in effect on December 1, 2009? (States that are unable to locate health plan information from 2009 should contact CMS for technical assistance.)

i. The standard Blue Cross/ Blue Shield preferred provider option;
ii. A health benefits coverage plan that is offered and generally available to state employees in that state; or
iii. The health insurance coverage offered by a Health Maintenance Organization with the largest insured non-Medicaid enrollment of covered lives.

[If the answer to question 3a is "no," continue to question 4.]

4. **"Benchmark Equivalent Coverage":** Did the benefits available under the section 1115 demonstration indicated above, as in effect on December 1, 2009, represent "benchmark equivalent coverage" described in section 1937(b)(2) of the Act that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in (A), (B), or (C) of section 1937(b)(1) of the Act? Please answer the following questions to support this representation:

4a. Did the demonstration benefit package provide all of the following services?

i. Inpatient and outpatient hospital,
ii. Physicians' surgical and medical services,
iii. Lab and x-ray services, and
iv. Emergency services, as required in 42 CFR 440.335(b)(5)

4b. In addition to the services mentioned above, did the demonstration benefit package have an aggregate actuarial value that is at least actuarially equivalent to one of the three following commercial products:

i. The standard Blue Cross/ Blue Shield preferred provider option;
ii. A health benefits coverage plan that is offered and generally available to state employees in that state; or
iii. The health insurance coverage offered by a Health Maintenance Organization with the largest insured non-Medicaid enrollment of covered lives.

4d. If the commercial product selected for actuarial comparison contained prescriptions drugs, mental health services, vision or hearing services as of December 1, 2009, did the demonstration benefit package offer such coverage to have an actuarial value of at least 75 percent of the actuarial value of the coverage

for that category of service in the benchmark plan used for comparison by the state?

4e. Has the state obtained a certificate of actuarial value of the demonstration benefit package adhering to the requirements above, completed by an individual who is a member of the American Academy of Actuaries, and that meets the following elements?

i. Uses generally accepted actuarial principles and methodologies;
ii. Uses a standardized set of utilization and price factors;
iii. Uses a standardized population that is representative of the population involved;
iv. Applies the same principles and factors in comparing the value of different coverage (or categories of services);
v. Does not take into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
vi. Takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under this title that results from the limitations on cost sharing under such coverage. This is important especially since Medicaid typically has minimal or no cost sharing requirements (even if they may be more extensive in waiver plans) while the benchmark plans may have higher levels of cost sharing.

In conducting the foregoing analysis, it will be important to utilize a consistent methodology and provide CMS with sufficient data to substantiate the states' conclusions. Following the below guidelines will assure CMS' ability to validate states' analysis:

- The analysis should specify the source of data used to calculate the actuarial value of the plans. We recommend using recent actual claims experience from beneficiaries in the demonstration to conduct the analysis. If other data is used, the data should be for a comparable population (which may include age, gender, geography, and health and disability status amongst other factors); the report should also state why this data source was used.

- The methodology to calculate actuarial value and equivalence should also be specified in the analysis. The following factors should be considered in the methodology:
  - The methodology should use a standard set of prices or reimbursement rates for the different plans. In other words, the differences between the prices paid between the plans should not be considered as a source of difference in actuarial value between the plans.
  - The methodology should consider differences between the cost sharing requirements of the plans. The actuarial value should be based on the

value of the benefits paid by the plan rather than on the value of the allowed benefits of the plans.
    - The methodology should also consider other relevant differences between the plans. This should include differences in values that result from benefits offered in the demonstration plan and not in the benchmark plans and vice versa (benefits offered in the benchmark plans but not in the demonstration plan).

- When determining whether the demonstration plan, as in effect on December 1, 2009, and the benchmark plans are actuarially equivalent, we consider a plan that has an actuarial value equal to another plan's value plus or minus 2 percent to be actuarially equivalent. This standard, which we are adopting for benchmark equivalence comparisons for purposes of assigning the newly eligible FMAP only, is based on and consistent with the November 26, 2012 proposed rule "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation." The Center for Consumer Information and Insurance Oversight proposes to apply this +/- 2 percent *de minimis* standard to determine whether plans that will be offered on Affordable Insurance Exchanges are actuarially equivalent. Because measuring the actuarial value of plans may not be precise, particularly in cases where there are significant differences in the benefits and plan design between the demonstration plan and the benchmark plans, it is reasonable to allow for a range around the actuarial values of the plan rather than require a precise equality.

In communicating the results of this analysis, you should submit a report certified by an actuary (as described above) that contains at a minimum the following information:

- The data used in the analysis;
- The methodology used in the analysis;
- The actuarial values of the demonstration plan and the benchmark plans, and;
- An analysis of the differences in actuarial values of the demonstration plan and the benchmark plans if the demonstration plan is found not to be at least actuarially equivalent to the benchmark plans. This analysis should discuss the main reasons for the differences (for example, differences in services covered; differences in cost sharing and plan design; other key differences between the plans) as well as the relative contribution of the major differences between the plans.

Finally, as noted above, for demonstrations that have separate populations and benefit plans, an analysis should be provided for each population or plan. These analyses may be presented within the same report or in separate reports.

Section II – Benefit Assessment to Substantiate Expansion State FMAP

If, after completing the newly eligible benefit assessment described above, you determine that full benefits, benchmark benefits, or benchmark equivalent benefits were provided, and that the newly eligible FMAP is therefore not available for some or all demonstration

populations, you should answer the following questions in order to substantiate possible eligibility for the expansion state FMAP, if applicable.

In answering the questions below, please cite the applicable STC or state-based policy.

1. Did Indiana provide coverage to parents and childless adults up to at least 100 percent of poverty, as of March 23, 2010?

   If Indiana did provide coverage, please answer questions (a) through (c) below:

   a. What was the upper income level of coverage for parents as of March 23, 2010? How many people received such coverage?

   b. What was the upper income level for coverage of childless adults as of March 23, 2010? How many people received such coverage?

   c. If coverage was provided through a section 1115 demonstration, please provide the demonstration's name and project number; if through a state-only program, please identify the state-only program.

2. Was this coverage offered on a statewide basis?

3. What was the scope of coverage provided to these populations?

   a. Did the coverage include inpatient hospital services?

   b. Was the coverage dependent on access to employer coverage, employer contribution, or employment?

   c. Was the coverage limited to premium assistance, hospital-only benefits, a high deductible health plan, or a health opportunity account?

Appendix B

Indiana Medicaid

FEHB Plan - Standard Option
$300 Deductible / 15% Coinsurance

Net Medical Cost

Benefit	Admissions Per 1,000	Length of Stay	(1) Utilization Per 1,000	(2) Allowed Average Charge	(3) Per Member Per Month Claim Cost	(4) Per Member Per Month Cost Sharing Value	(5) Net Per Member Per Month Claim Cost	
Inpatient Facility								
Medical	22.3 Admits	4.10	91.4 days	$1,686.65	$12.85	$0.37	$12.48	
Surgical	18.6 Admits	4.23	78.7 days	3,746.96	24.58	0.31	24.27	
Psychiatric/Alcohol & Drug Abuse	5.1 Admits	15.58	79.5 days	271.85	1.80	0.09	1.71	
Maternity	19.4 Admits	2.77	53.7 days	1,422.64	6.36	0.00	6.36	
Skilled Nursing Facility	1.3 Admits	21.25	27.6 days	217.57	0.50	0.00	0.50	
	66.7 Admits	4.96	330.9 days		$46.09	$0.77	$45.32	
Outpatient Facility								
Emergency Room			209 cases	$682.75	$11.89	$1.19	$10.70	
Surgery			142 cases	1,934.79	22.90	3.43	19.47	
Radiology/Pathalogy/Lab			694 cases	203.70	11.78	1.76	10.02	
Psychiatric/Alcohol & Drug Abuse			63 cases	79.30	0.41	0.06	0.35	
Preventive			329 cases	54.83	1.50	0.23	1.27	
Other Outpatient Facility			582 cases	241.40	11.70	1.85	9.85	
					$60.18	$8.52	$51.66	
Professional								
Surgery			746 proced	$360.78	$22.43	$3.36	$19.07	
Maternity			50.0 proced	784.51	3.26	0.00	3.26	
Office/Home/Urgent Care Visits			2,693 visits	44.31	9.95	4.42	5.53	
Miscellaneous Medical			1,642 proced	51.98	7.12	1.19	5.93	
Preventive			1,394 proced	32.04	3.72	2.32	1.40	
Consults			862 visits	90.63	6.50	0.85	5.65	
Vision			0 visits	0.00	0.00	0.00	0.00	
Physical Therapy			723 visits	44.00	2.65	1.21	1.44	
Hearing and Speech Exams			21 visits	51.35	0.09	0.01	0.08	
Radiology/Pathalogy/Lab			4,832 proced	43.60	17.56	2.64	14.92	
Chiropractor			564 visits	19.82	0.93	0.93	0.00	
Outpatient Psychiatric/Alcohol & Drug Abuse			618 visits	42.68	2.20	1.03	1.17	
					$76.41	$17.96	$58.45	
Other								
Prescription Drugs			12,122 scripts	$90.84	$91.76	$16.51	$75.25	
Private Duty Nursing/Home Health			43 visits	175.90	0.63	0.09	0.54	
Ambulance			22 cases	737.04	1.35	0.14	1.21	
DME/Supplies/Prosthetics			370 proced	91.92	2.84	0.42	2.42	
Glasses/Contacts			10 cases	135.60	0.11	0.02	0.09	
Dental Benefits			133 cases	104.07	1.15	0.86	0.29	
Other - Total					$97.84	$18.04	$79.80	
Total Medical Cost					$280.52	$45.29	$235.23	
Starting Net PMPM Claim Cost for Services Subj to Ded.							$100.03	
Value of $300 Deductible							(9.87)	
Value of $4,700 Out-of-Pocket Maximum after deductible							8.02	
Value of $9,999,999 Annual Maximum							0.00	
Adjusted Net PMPM for Services Subject to Deductible							$98.18	
PMPM for Services Not Subject to Deductible							$135.20	
Total Medical Cost After Deductible and Coinsurance							$233.38	83.2%
				Prescription Drugs		$75.25	$91.76	82.0%
				Mental Health Services		3.23	4.41	73.2%
				Vision		0.09	0.11	81.8%
				Hearing		0.08	0.09	88.9%

Indiana Medicaid

State Employee PPO
$500 Deductible / 20% Coinsurance

Net Medical Cost

Benefit	Admissions Per 1,000	Length of Stay	(1) Utilization Per 1,000	(2) Allowed Average Charge	(3) Per Member Per Month Claim Cost	(4) Per Member Per Month Cost Sharing Value	(5) Net Per Member Per Month Claim Cost	
Inpatient Facility								
Medical	22.3 Admits	4.10	91.4 days	$1,686.65	$12.85	$0.93	$11.92	
Surgical	18.6 Admits	4.23	78.7 days	3,746.96	24.58	0.78	23.80	
Psychiatric/Alcohol & Drug Abuse	5.1 Admits	15.58	79.5 days	271.85	1.80	0.22	1.58	
Maternity	19.4 Admits	2.77	53.7 days	1,422.64	6.36	0.81	5.55	
Skilled Nursing Facility	1.3 Admits	21.25	27.6 days	217.57	0.50	0.05	0.45	
	66.7 Admits	4.96	330.9 days		$46.09	$2.79	$43.30	
Outpatient Facility								
Emergency Room			209 cases	$682.75	$11.89	$1.31	$10.58	
Surgery			142 cases	1,934.79	22.90	2.96	19.94	
Radiology/Pathalogy/Lab			694 cases	203.70	11.78	2.35	9.43	
Psychiatric/Alcohol & Drug Abuse			63 cases	79.30	0.41	0.09	0.32	
Preventive			329 cases	54.83	1.50	0.30	1.20	
Other Outpatient Facility			582 cases	241.40	11.70	2.34	9.36	
					$60.18	$9.35	$50.83	
Professional								
Surgery			746 proced	$360.78	$22.43	$4.49	$17.94	
Maternity			50.0 proced	784.51	3.26	0.65	2.61	
Office/Home/Urgent Care Visits			2,693 visits	44.31	9.95	4.57	5.38	
Miscellaneous Medical			1,642 proced	51.98	7.12	1.43	5.69	
Preventive			1,394 proced	32.04	3.72	0.74	2.98	
Consults			862 visits	90.63	6.50	0.83	5.67	
Vision			0 visits	0.00	0.00	0.00	0.00	
Physical Therapy			723 visits	44.00	2.65	0.53	2.12	
Hearing and Speech Exams			21 visits	51.35	0.09	0.02	0.07	
Radiology/Pathalogy/Lab			4,832 proced	43.60	17.56	3.52	14.04	
Chiropractor			564 visits	19.82	0.93	0.19	0.74	
Outpatient Psychiatric/Alcohol & Drug Abuse			618 visits	42.68	2.20	0.44	1.76	
					$76.41	$17.41	$59.00	
Other								
Prescription Drugs			12,122 scripts	$90.84	$91.76	$6.37	$85.39	
Private Duty Nursing/Home Health			43 visits	175.90	0.63	0.07	0.56	
Ambulance			22 cases	737.04	1.35	0.09	1.26	
DME/Supplies/Prosthetics			370 proced	91.92	2.84	0.57	2.27	
Glasses/Contacts			10 cases	135.60	0.11	0.02	0.09	
Dental Benefits			133 cases	104.07	1.15	0.31	0.84	
Other - Total					$97.84	$7.43	$90.41	
Total Medical Cost					$280.52	$36.98	$243.54	
Starting Net PMPM Claim Cost for Services Subj to Ded.							$73.66	
Value of $500 Deductible							(12.15)	
Value of $1,500 Out-of-Pocket Maximum after deductible							10.72	
Value of $2,000,000 Annual Maximum							0.00	
Adjusted Net PMPM for Services Subject to Deductible							$72.23	
PMPM for Services Not Subject to Deductible							$169.88	
Total Medical Cost After Deductible and Coinsurance							$242.11	86.3%
				Prescription Drugs		$85.39	$91.76	93.1%
				Mental Health Services		3.66	4.41	83.0%
				Vision		0.09	0.11	81.8%
				Hearing		0.07	0.09	77.8%

Company Name

Advantage HMO
$250 Deductible / 50% Coinsurance

Net Medical Cost

Benefit	Admissions Per 1,000	Length of Stay	(1) Utilization Per 1,000	(2) Allowed Average Charge	(3) Per Member Per Month Claim Cost	(4) Per Member Per Month Cost Sharing Value	(5) Net Per Member Per Month Claim Cost	
Inpatient Facility								
Medical	22.3 Admits	4.10	91.4 days	$1,686.65	$12.85	$0.46	$12.39	
Surgical	18.6 Admits	4.23	78.7 days	3,746.96	24.58	0.39	24.19	
Psychiatric/Alcohol & Drug Abuse	5.1 Admits	15.58	79.5 days	271.85	1.80	0.11	1.69	
Maternity	19.4 Admits	2.77	53.7 days	1,422.64	6.36	0.40	5.96	
Skilled Nursing Facility	1.3 Admits	21.25	27.6 days	217.57	0.50	0.00	0.50	
	66.7 Admits	4.96	330.9 days		$46.09	$1.36	$44.73	
Outpatient Facility								
Emergency Room			209 cases	$682.75	$11.89	$2.18	$9.71	
Surgery			142 cases	1,934.79	22.90	1.48	21.42	
Radiology/Pathalogy/Lab			694 cases	203.70	11.78	0.28	11.50	
Psychiatric/Alcohol & Drug Abuse			63 cases	79.30	0.41	0.18	0.23	
Preventive			329 cases	54.83	1.50	0.00	1.50	
Other Outpatient Facility			582 cases	241.40	11.70	1.35	10.35	
					$60.18	$5.47	$54.71	
Professional								
Surgery			746 proced	$360.78	$22.43	$0.00	$22.43	
Maternity			50.0 proced	784.51	3.26	0.04	3.22	
Office/Home/Urgent Care Visits			2,693 visits	44.31	9.95	5.81	4.14	
Miscellaneous Medical			1,642 proced	51.98	7.12	1.07	6.05	
Preventive			1,394 proced	32.04	3.72	0.00	3.72	
Consults			862 visits	90.63	6.50	0.35	6.15	
Vision			0 visits	0.00	0.00	0.00	0.00	
Physical Therapy			723 visits	44.00	2.65	2.11	0.54	
Hearing and Speech Exams			21 visits	51.35	0.09	0.00	0.09	
Radiology/Pathalogy/Lab			4,832 proced	43.60	17.56	0.00	17.56	
Chiropractor			564 visits	19.82	0.93	0.93	0.00	
Outpatient Psychiatric/Alcohol & Drug Abuse			618 visits	42.68	2.20	1.72	0.48	
					$76.41	$12.03	$64.38	
Other								
Prescription Drugs			12,122 scripts	$90.84	$91.76	$16.90	$74.86	
Private Duty Nursing/Home Health			43 visits	175.90	0.63	0.00	0.63	
Ambulance			22 cases	737.04	1.35	0.27	1.08	
DME/Supplies/Prosthetics			370 proced	91.92	2.84	1.42	1.42	
Glasses/Contacts			10 cases	135.60	0.11	0.02	0.09	
Dental Benefits			133 cases	104.07	1.15	0.39	0.76	
Other - Total					$97.84	$19.00	$78.84	
Total Medical Cost					$280.52	$37.86	$242.66	
Starting Net PMPM Claim Cost for Services Subj to Ded.							$28.94	
Value of $250 Deductible							(8.69)	
Value of $0 Out-of-Pocket Maximum after deductible							0.00	
Value of $9,999,999 Annual Maximum							0.00	
Adjusted Net PMPM for Services Subject to Deductible							$20.25	
PMPM for Services Not Subject to Deductible							$213.72	
Total Medical Cost After Deductible and Coinsurance							$233.97	83.4%
				Prescription Drugs		$74.86	$91.76	81.6%
				Mental Health Services		2.40	4.41	54.4%
				Vision		0.09	0.11	81.8%
				Hearing		0.09	0.09	100.0%

Indiana Medicaid

Healthy Indiana Plan Demonstration

Net Medical Cost

Benefit	Admissions Per 1,000	Length of Stay	(1) Utilization Per 1,000	(2) Allowed Average Charge	(3) Per Member Per Month Claim Cost	(4) Per Member Per Month Cost Sharing Value	(5) Net Per Member Per Month Claim Cost	
Inpatient Facility								
Medical	22.3 Admits	4.10	91.4 days	$1,686.65	$12.85	$0.00	$12.85	
Surgical	18.6 Admits	4.23	78.7 days	3,746.96	24.58	0.00	24.58	
Psychiatric/Alcohol & Drug Abuse	5.1 Admits	15.58	79.5 days	271.85	1.80	0.00	1.80	
Maternity	19.4 Admits	2.77	53.7 days	1,422.64	6.36	6.36	0.00	
Skilled Nursing Facility	1.3 Admits	21.25	27.6 days	217.57	0.50	0.00	0.50	
	66.7 Admits	4.96	330.9 days		$46.09	$6.36	$39.73	
Outpatient Facility								
Emergency Room			209 cases	$682.75	$11.89	$0.05	$11.84	
Surgery			142 cases	1,934.79	22.90	0.00	22.90	
Radiology/Pathalogy/Lab			694 cases	203.70	11.78	0.00	11.78	
Psychiatric/Alcohol & Drug Abuse			63 cases	79.30	0.41	0.00	0.41	
Preventive			329 cases	54.83	1.50	0.00	1.50	
Other Outpatient Facility			582 cases	241.40	11.70	0.00	11.70	
					$60.18	$0.05	$60.13	
Professional								
Surgery			746 proced	$360.78	$22.43	$0.00	$22.43	
Maternity			50 proced	784.51	3.26	3.26	0.00	
Office/Home/Urgent Care Visits			2,693 visits	44.31	9.95	0.00	9.95	
Miscellaneous Medical			1,642 proced	51.98	7.12	0.00	7.12	
Preventive			1,394 proced	32.04	3.72	0.00	3.72	
Consults			862 visits	90.63	6.50	0.00	6.50	
Vision			0 visits	0.00	0.00	0.00	0.00	
Physical Therapy			723 visits	44.00	2.65	0.00	2.65	
Hearing and Speech Exams			21 visits	51.35	0.09	0.00	0.09	
Radiology/Pathalogy/Lab			4,832 proced	43.60	17.56	0.00	17.56	
Chiropractor			564 visits	19.82	0.93	0.93	0.00	
Outpatient Psychiatric/Alcohol & Drug Abuse			618 visits	42.68	2.20	0.00	2.20	
					$76.41	$4.19	$72.22	
Other								
Prescription Drugs			12,122 scripts	$90.84	$91.76	$0.00	$91.76	
Private Duty Nursing/Home Health			43 visits	175.90	0.63	0.00	0.63	
Ambulance			22 cases	737.04	1.35	0.00	1.35	
DME/Supplies/Prosthetics			370 proced	91.92	2.84	0.00	2.84	
Glasses/Contacts			10 cases	135.60	0.11	0.11	0.00	
Dental Benefits			133 cases	104.07	1.15	1.15	0.00	
Other - Total					$97.84	$1.26	$96.58	
Total Medical Cost					$280.52	$11.86	$268.66	
Starting Net PMPM Claim Cost for Services Subj to Ded.							$264.60	
Value of $1,100 Deductible							(55.26)	
Value of $0 Out-of-Pocket Maximum after deductible							0.00	
Value of $300,000 Annual Maximum							(2.61)	
Adjusted Net PMPM for Services Subject to Deductible							$206.73	
PMPM for Services Not Subject to Deductible							$4.06	
Total Medical Cost After Deductible and Coinsurance							$210.79	75.1%
				Prescription Drugs		$91.76	$91.76	100.0%
				Mental Health Services		4.41	4.41	100.0%
				Vision		0.00	0.11	0.0%
				Hearing		0.09	0.09	100.0%

Appendix C