Lucile Packard Foundation *for* Children's Health

Issue Brief

May 2013

Private Coverage Under California's Affordable Care Act: Benefit and Cost-Sharing Requirements Affecting Children and Adolescents with Special Health Care Needs

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Executive Summary

Plans providing insurance in the California Health Benefit Exchange and in individual and small group markets will use Kaiser Permanente's HMO Plan for Small Businesses as their essential health benefits benchmark plan. This benchmark plan offers a broad set of benefits that should meet the needs of most children and adolescents, including those with special health care needs. The breadth of preventive care coverage, as required by the Affordable Care Act (ACA) and expanded under the Kaiser plan, is more generous than what is currently available in most plans sold to individuals or small businesses. In addition, the continuum of mental health and substance abuse treatment and the range of rehabilitive and habilitive services provide an expansive set of essential health benefits.

This benchmark plan offers a broad set of benefits that should meet the needs of most children and adolescents, including those with special health care needs.

Visit limits are seldom applied to essential health benefits. However, Kaiser's benchmark plan relies on authorization criteria to determine the amount, duration, and scope of specific services. Like Kaiser, qualified health plans sold through the health benefit exchange will adopt prior authorization and medical necessity criteria which, in effect, function as benefit limits. Given the breadth of covered services in the benchmark plan, utilization management strategies are likely to be stringent to constrain health benefit costs.

Importantly, California has elected to adopt Kaiser's benefits without substitution, except for prescription drugs. This state policy will ensure a level of uniformity in coverage among health plans sold inside and outside of California's Health Benefit Exchange beginning in 2014.

Despite the broad range of covered benefits, there are still some services important for the care of children and adolescents with special health care needs that are not covered under the benchmark plan. These include family therapy, inpatient chemical dependency treatment beyond detoxification, long-term intensive outpatient care and long-term residential treatment for mental health disorders and chemical dependency. Long-term home health care and hearing aids and cochlear implants also are expressly omitted.

The California Health Benefit Exchange has developed standard plan designs that all participating carriers will offer. Benefits are the same in all of the standard plan designs. However, cost-sharing obligations differ significantly by the type of plan selected – platinum, gold, silver, bronze, and catastrophic – and also by household income. With respect to deductible requirements, platinum and gold plans have none, but families in the non-subsidized silver plan will face a $4,000 deductible for certain medical services and a $500 deductible for brand-name drugs. Much higher deductibles will apply in the bronze and catastrophic plans – $10,000 and $12,800, respectively. Co-payment and co-insurance rates also will differ by plan type, with platinum plans offering the lowest rates and bronze plans the highest. The out-of-pocket maximum limit for families will be $8,000 in the platinum plan and $12,800 in each of the other types of plans. Still another affordability concern is the separate cost-sharing requirements and out-of-pocket maximum for pediatric dental services.

Cost-sharing obligations differ significantly by the type of plan selected – platinum, gold, silver, bronze, and catastrophic – and also by household income.

For families and individuals with incomes between 100% and 400% of the federal poverty level (FPL), premium credits and cost-sharing subsidies represent a significant protection against high medical costs. Despite these important protections afforded by the ACA, out-of-pocket costs for those with incomes above 200% FPL are still significant in the subsidized silver plan. Families with incomes between 200% and 250% FPL will have to meet a $3,000 deductible, which applies to hospital and emergency room services, and a $500 deductible for brand-name drugs. In addition, they will have significant co-payment and co-insurance requirements for non-preventive services, including $40 per primary care visit and 20% for inpatient hospital care.

As uninsured families with children who have special health care needs consider their private coverage options under California's Affordable Care Act, they should first determine if their child is exempt from enrollment in private benchmark coverage and is eligible instead for Medi-Cal benefits, which for children include all of the essential health benefits – to the extent that they are deemed medically necessary – without premium or cost-sharing requirements. Categories of income-eligible exempt individuals include, but are not limited to, those who qualify under the state's definition of medically frail. This includes those with serious emotional disturbances, serious and complex medical conditions, and individuals with physical or mental disabilities that significantly impair their ability to perform activities of daily living. It also includes pregnant women and children in foster care or receiving foster care or adoption assistance.[1, 2]

Important Questions Remain

With so many new policies being adopted under California's Affordable Care Act, it will be important for policymakers, researchers, and advocacy organizations to monitor several issues important to children and adolescents with special health care needs. What is the state's definition of medically frail individuals and how are income-eligible families being informed of this during eligibility determination? Are families who select lower

cost plans (i.e., silver, bronze, and catastrophic) receiving sufficient information about their out-of-pocket cost liabilities if they are not eligible for subsidies? To what extent are cost-sharing requirements in these plans exposing families and their providers to medical debt and serving as a barrier to receipt of needed medical care? Are state-mandated benefits for children being covered as required? Are pediatric medical and mental health specialists and hospitals participating as in-network providers in qualified health plans? If not, will families whose children and adolescents have chronic conditions need to go out of network to receive care and be obligated to meet higher co-payment or co-insurance requirements? Finally, how will coordination of benefits and care work for families whose children are eligible for California Children's Services or for California's public mental health services?

California officials made a very good choice in selecting the Kaiser small group plan as the state's essential health benefits benchmark plan because of its expansive benefit coverage relative to most small group plans. As directed by HHS, the state is offering a variety of products with the same set of benefits but very different cost-sharing requirements. To the extent that families can purchase platinum or gold plans, they will have much greater protection from high out-of-pocket costs than those who purchase silver, bronze, or catastrophic plans.

Introduction

This policy brief examines the extent to which California's essential health benefits benchmark plan – Kaiser's Small Group HMO Plan – meets the needs of children and adolescents, including those with special health care needs. It also examines the cost-sharing requirements that will be used by health insurance plans sold in California's Health Benefit Exchange, including the subsidized silver plan, and discusses implications for families and policymakers.

A total of 70 services were analyzed under the 10 essential health benefit (EHB) categories required by the Department of Health and Human Services (HHS) to implement the Affordable Care Act (ACA) (Table 1). These services were selected based on recommendations from the American Academy of Pediatrics and the Children's Dental Project and from past benefit research conducted by the authors.[3]

To the extent that families can purchase platinum or gold plans, they will have much greater protection from high out-of-pocket costs than those who purchase silver, bronze, or catastrophic plans.

Information for this brief was obtained from several sources. Benefit information was based on Kaiser's "Evidence of Coverage" document[4] and an interview with a senior Kaiser Permanente official. Cost-sharing information was based on the "Covered California" Standard Benefit Plan Designs Summary of Benefits and Coverage.[5] Additional documents were analyzed, including Senate Bill 951[6] and Assembly Bill 1453,[7] California's Health Benefit Exchange's Qualified Health Plan Solicitation to Health Issuers,[8, 9] California's mandated benefits, and reports on health reform implementation in California.[10, 11]

There are a few important limitations. The benefit and cost-sharing policies are for preferred or in-network providers only. The cost-sharing information reported on is for co-

pay plans only. The prescription drug benchmark formulary was not analyzed because qualified plans are able to submit substitutions to their benchmark formulary. Information on subsidized dental coverage was not available when this report was prepared. Final premium information also was not available.

The policy brief is organized into three sections: 1) background on California's essential health benefits benchmark plan and cost-sharing requirements; 2) the strengths and limits of benchmark benefits and cost-sharing requirements within all five levels of coverage [platinum, gold, silver (including subsidized coverage for those between 100% and 250% FPL), bronze, and catastrophic] and potential issues of concern; and 3) a comparison of private benchmark coverage and Medi-Cal benefits, including its Early and Periodic Screening, Diagnosis, and Treatment Program (called Child Health Development Program or CHDP in California). Detailed tables on benefits, cost sharing, and state mandates are included.

Background on California's Selection of a Benchmark Plan and Definition of Essential Health Benefits

California's Senate Bill 951 and Assembly Bill 1453, signed into law by Governor Brown on September 30, 2012, designated Kaiser's Small Group HMO 30 Plan as its essential health benefits benchmark plan required under the ACA.

Starting January 1, 2014, all individual health insurance policies and small group plans inside and outside of California's Health Benefit Exchange must offer the health benefits covered by Kaiser's benchmark plan. California prohibits insurers from making benefit substitutions, except for prescription drugs,[12] and also prohibits insurers from imposing treatment limits that exceed those in Kaiser's benchmark plan.

Plans exempt from these federal and state benefit requirements are grandfathered plans (health plans in existence on March 23, 2010, when the ACA became law), large employer plans (>50 employees), and self-insured plans of any size. California's benchmark plan will apply for 2014 and 2015. Starting in 2016, HHS will direct states about future essential health benefits options.

The EHBs specified under the ACA include 1) ambulatory patient services, 2) emergency services, 3) hospitalization, 4) maternity and newborn care, 5) mental health and substance abuse services, including behavioral health treatment, 6) prescription drugs, 7) rehabilitation and habilitative services, 8) laboratory services, 9) preventive and wellness services and chronic disease management, and 10) pediatric services, including oral and vision care.

HHS provided states with minimal guidance on the amount, duration, and scope of services to be covered under each of these 10 required benefits. The exception has been with respect to mental health and substance abuse services,[13] prescription drugs,[14] habilitative services,[15] preventive care,[16] and pediatric oral and vision services,[17] as described in the footnotes.

In addition, Secretary Sebelius required that EHBs should be equal to the scope of benefits provided in a typical employer plan, which has subsequently been referred to as a small group

plan. EHBs, according to the HHS Secretary, also should reflect a balance between the 10 benefit categories, take into account the needs of diverse segments of the population, including children, and ensure discrimination protections.[18]

In addition to HHS' requirements, California's Senate Bill 951 and Assembly Bill 1453 clarified the state's EHB requirements for habilitative and pediatric oral and vision care as follows.

- *Habilitative* benchmark benefits are covered under the same terms and conditions applied to rehabilitative services. They are defined as "medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Examples of health care services that are not habilitative services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training."
- *Pediatric oral care* benchmark benefits are covered as the benefits under California's Healthy Families Program in 2011-12, including medically necessary orthodontic care.
- *Pediatric vision care* benchmark benefits are covered as the benefits under the BlueCross BlueShield Fed Blue Vision Federal Employees Vision Program (FedVIP).

California's qualified health plans will include several mandated benefits affecting children and adolescents that were enacted prior to 2011. These mandates, described in Table 4, include medically necessary benefits for pediatric asthma and diabetes, contraceptives, HIV and HPV testing and treatment, reconstructive surgery for congenital defects or developmental abnormalities, phenylketonuria testing and treatment, mental health parity, and behavioral health treatment for pervasive developmental disorder and autism.

Despite the fact that qualified plans in California's exchange must cover essentially the same set of benefits specified in the Kaiser benchmark plan, qualified health plans can offer a range of insurance products at different actuarial or "metal" levels, and the amount of cost sharing required will differ in these plans. Platinum plans will require the least cost sharing, and catastrophic plans, as their name implies, will require the most. Importantly, individuals and families with household incomes between 100% and 400% of the federal poverty level (FPL), ($19,530 up to $78,120 for a family of three) will be eligible for assistance with their monthly premiums in the form of a tax credit. For individuals and families with incomes between 100% and 250% of the FPL ($19,530 up to $48,825 for a family of three), additional cost-sharing assistance will be available in the form of lower deductibles, co-payments, and co-insurance.

Habilitative benchmark benefits are covered under the same terms and conditions applied to rehabilitative services.

The tax credit assistance is available only to families purchasing insurance through the exchange and is based on the cost of the silver plan. Should a family elect to purchase either richer coverage (platinum or gold) or leaner coverage (bronze or catastrophic), the amount of the tax credit can be applied to the premium costs of those plans.

Although final premium prices were not available when this report was prepared, the upper limit of cost-sharing amounts has been established by the state for qualified health plans that will be sold to individuals, families, and small businesses in 2014. The actuarial value for each plan, as shown in Table 2, ranges from a high of 88% in the platinum plan (the percentage of health costs that a health plan will pay for an average person) to a low of 60.4% in the catastrophic plan. That means, on average, that in a platinum plan, enrollees will be paying about 12% of the costs, and in a catastrophic plan, about 40%.

The use and amount of deductibles vary by actuarial level or plan type. (In this report, we report on family, not individual, deductibles.) Platinum and gold plans have no overall deductible or medical or dental deductible. The silver plan, however, has a $4,000 deductible that applies to certain medical services and a $500 deductible for brand-name drugs. The bronze plan has an overall deductible of $10,000 that applies to all covered services, except for preventive care, prenatal care, and the first three ambulatory care visits. The catastrophic plan has an overall deductible of $12,800 that applies to all services, except for preventive care services and the first three non-preventive care visits. To protect against high out-of-pocket costs, all of the plans set a maximum limit after which the plan will fully pay for covered services at no additional cost to the member. In the platinum plan the out-of-pocket limit on expenses for a family is $8,000, and in all of the other plans, the out-of-pocket maximum is $12,800.

In a platinum plan, enrollees will be paying about 12% of the costs, and in a catastrophic plan, about 40%.

Strengths and Limits of Benchmark Plan Benefit and Cost-Sharing Requirements in Platinum, Gold, Silver, Bronze, and Catastrophic Plans

1. Ambulatory Services

Primary care visits, specialist visits, other practitioner visits, and urgent care are covered in the Kaiser benchmark plan without visit limits, as shown in Table 1. The cost-sharing requirements for these services differ by plan type, as shown in Table 2.

In general, co-payment rates for primary care visits and other practitioner visits are set at the same amount, and specialist visit co-payment rates are up to two times higher than the primary care co-payment rates. In both the bronze and catastrophic plans, the deductible applies after the first three non-preventive office or urgent care visits (including mental health and substance abuse visits).

Potential Issues of Concern:

- Although ambulatory benefits are available without limits, qualified plans can impose authorization requirements for specialists and other practitioners (which include physical, occupational, and speech

therapists) that may need to be examined. (Note: Kaiser's referral and authorization policies do not have to be adopted by qualified health plans.) For example, authorization requirements may limit access to therapy services by requiring significant improvement within a short period of time or by excluding conditions not caused by an illness or injury.

- The requirement for meeting the deductible in bronze and catastrophic plans may be a significant deterrent to families seeking ambulatory services.

2. Preventive and Wellness Services and Chronic Disease Management

The Kaiser benchmark plan covers all of the preventive services listed in Table 1, including preventive care, screening, immunizations, health education counseling and programs, developmental screening, alcohol and other substance abuse screening, family planning counseling, and STD preventive counseling. No cost sharing is allowed for these services, according to the ACA.

Potential Issues of Concern:

- Qualified health plans may not provide new enrollees with an explanation of the full scope of preventive services required by the ACA and covered in the Kaiser benchmark plan. It is not enough to list preventive benefits as "well child preventive exams" or "routine physical maintenance exams."

3. Emergency Services

Emergency room services and medical transportation are covered in the Kaiser benchmark plan without limits, except for the requirement that an individual using the service must have an "emergency medical condition."[19] Importantly, cost sharing for emergency room services in all of the plans will be waived if the patient is admitted. Otherwise, families will need to meet sizeable deductibles in the silver, bronze, and catastrophic plans.

Co-payments are substantially higher for emergency room services than for ambulatory services, ranging from $150 in the platinum plan to $300 in the bronze plan.

Potential Issues of Concern:

- The deductible requirements in silver, bronze, and catastrophic plans may present a significant financial burden for families whose children require emergency room care and are not hospitalized.

4. Hospitalization

Inpatient and outpatient hospital services are covered without limits in Kaiser's benchmark plan. The cost-sharing policies for these hospital services vary sharply by plan type. The most generous plan – the platinum plan – requires a $250 daily co-pay for up to five inpatient hospital days or a maximum of $1,250. Outpatient surgery facility and physician fees in the platinum plan have a $250 co-payment, as well. In the gold plan, co-payment rates for inpatient hospital care jump to $600 per day for up to five days or to a maximum of $3,000, and for outpatient hospital surgical care the cost-sharing fee is $600. In the silver plan, a co-insurance rate of 20% is used for inpatient hospital care, and the same co-insurance rate applies to outpatient hospital surgery services. The cost-sharing obligations for both inpatient hospital care and outpatient hospital surgery services continue to increase in the bronze plan to 30%. In both the silver and bronze plans,

deductibles apply to inpatient care, and to outpatient hospital surgical care in the silver plan. Finally, in the catastrophic plan, there is no cost sharing after the high overall deductible is met.

Potential Issues of Concern:

- Parents in all plans and especially in silver, bronze, and catastrophic plans may not be fully aware of their significant out-of-pocket liabilities for hospital care.
- Hospitals may incur bad debt/uncompensated care as a result of families' inability to meet high deductible expenses and other co-payment or co-insurance requirements.

5. Maternity and Newborn Care

The Kaiser benchmark plan covers prenatal and preconception services and inpatient delivery services without visit restrictions. Consistent with ACA requirements, no cost sharing is allowed for prenatal and preconception services. Hospital cost-sharing policies apply to inpatient delivery and physician and surgeon services: in the platinum plan, $250/day up to 5 days; in the gold plan, $600/day up to 5 days; in the silver plan, 20% and the deductible applies; and in the catastrophic plan, the $12,800 deductible applies.

Potential Issues of Concern:

- Parents may not be fully aware of the hospital delivery cost-sharing obligations, including deductible requirements and co-payments or co-insurance, particularly since they have coverage for prenatal care without cost sharing.

6. Laboratory Services

There are no restrictions on laboratory services in the Kaiser benchmark plan. Cost sharing varies by type of service, with lab tests having the lowest out-of-pocket fees and imaging services having the highest in platinum, gold, and silver plans. None of these three types of plans applies the deductible to lab services. In contrast, the bronze plan requires a 30% co-insurance rate for each type of lab service (lab tests, x-rays, and imaging), and the $10,000 deductible must be met. In the catastrophic plan there is no cost sharing after the high overall deductible ($12,800) is met.

Potential Issues of Concern:

- Qualified health plans may not make clear in their plan brochures what lab tests are part of preventive care services and thus without cost sharing.
- Since lab services are so commonly used by children and especially by adolescents, the deductible requirements in the bronze and catastrophic service may represent a significant financial burden of which the prescribing provider is likely to be unaware, and may in some cases impede individuals from obtaining needed lab services.

7. Prescription Drugs

Kaiser's benchmark plan covers prescription drugs – generic, brand-name, and specialty drugs – according to its formulary guidelines. As discussed earlier, qualified plans are allowed to use their own prescription drug formulary as long as coverage for prescription drugs complies with California's mandated benefits. In all plans, the co-payment/co-insurance difference between generic and specialty drugs is significant, and deductible requirements apply

in silver, gold, and bronze plans. The most generous plan, the platinum plan, has a drug co-pay that increases from $5 per generic drug to 10% for specialty drugs. The gold plan drug cost-sharing amount ranges from $20 to 20%. A similar cost-sharing requirement applies in the silver plan after a $500 family drug deductible is met. The bronze plan drug cost-sharing amount increases from $25 to 30%, and the overall deductible applies. Catastrophic plan enrollees must meet their $12,800 deductible before the plan reimburses for any drugs.

Potential Issues of Concern:

- Further examination may be needed of qualified health plan formularies as they pertain to children and adolescents. If certain drugs are not on plan formularies, families will be responsible for full payment.
- Qualified health plans may not make clear in their plan brochures that contraceptives are covered without cost sharing.
- The high deductible requirements in bronze and catastrophic plans may lead families and older adolescents and young adults to forgo obtaining prescription medications, even generic drugs.

8. Mental Health and Substance Abuse Services, including Behavioral Health Treatment

Kaiser's benchmark plan offers a continuum of mental health and chemical dependency services, including psychological testing, individual and group outpatient therapy, pharmacotherapy, inpatient psychiatric treatment, inpatient detoxification services, intensive outpatient care, and residential programs, for children and adults with disorders, including serious emotional disorders and serious mental illness. In addition, as a result of California's mandated benefits (Table 4), applied behavior analysis and evidence-based behavior intervention programs are covered for individuals with pervasive developmental disorder and autism. The Kaiser benchmark plan, however, excludes family therapy and inpatient hospital treatment for chemical dependency beyond detoxification. Coverage of intensive outpatient care and residential treatment is only covered for short-term treatment, which will be defined by insurers' authorization criteria. The same cost-sharing policies described above under hospitalization apply to mental health and substance user disorder services.

Potential Issues of Concern:

- Although mental health and substance use disorder benefits are covered in the benchmark plan without limits, qualified plans' authorization requirements may need to be carefully reviewed to ensure that certain conditions are not excluded – for example, children whose primary diagnosis is a chronic medical condition or a behavior disorder or an eating disorder.
- Families may not be aware of the availability of the state's Department of Mental Health services for those children and adolescents who meet their eligibility criteria and require longer term intensive outpatient care and residential treatment.

9. Rehabilitative and Habilitative Services and Devices

The Kaiser benchmark plan covers a broad set of rehabilitative and habilitative services and

devices, including physical, occupational, and speech therapy; home health care; skilled nursing facility care; durable medical equipment; medical supplies; and hospice care. Audiology tests, hearing aids, and cochlear implants, however, are not covered. Home health care is covered on a part-time or intermittent basis for up to 100 visits per year, and skilled nursing facility care is capped at 100 days per benefit period (see Table 2 for explanation). Insurers will apply their own authorization criteria for enrollees to access rehabilitative and habilitative services (addressing, for example, authorized access based on functional status, activity of daily living goals, or level of improvement). In each of the platinum, gold, and silver plans, the cost-sharing amount for rehabilitative, habilitative, and home health services is the same as for ambulatory services, and no deductible applies. In contrast, deductibles apply for rehabilitative and habilitative services and devices in bronze and catastrophic plans. Co-insurance rates are applied to DME and medical supplies, ranging from 10% to 30%, depending on the plan type. Again, in the bronze and catastrophic plans, the deductible applies. Cost-sharing policies for skilled nursing facility services are the same as for hospital care, and no cost sharing is allowed for hospice care.

Potential Issues of Concern:

- Qualified plans' authorization requirements for rehabilitative and habilitative services may require careful review to ensure that they address children's needs.

- Families may not be aware of the availability of the state's California's Children's Services (CCS) Program for those children and adolescents who meet their eligibility requirements and require longer term rehabilitative or habilitative services and certain DME, such as hearing aids or cochlear implants.

10. Pediatric Services, Including Dental and Vision Care

Kaiser's benchmark plan does not cover dental and vision care, so the state, under the ACA, was required to obtain supplemental coverage for these pediatric benefits. The state designated Healthy Families Program benefits as their pediatric dental benchmark. This plan (which is in the process of transferring its enrollees to Medi-Cal) offers a broad set of dental services, including preventive, diagnostic, and restorative care, including fillings, oral surgery, root canals, and crowns and bridges. Orthodontia services for medically handicapping malocclusion are available only for children under 18 through the CCS program.

With respect to vision care, the state designated BlueCross BlueShield Federal Employee Program "Blue Vision" as its pediatric vision benchmark. This plan covers diagnostic eye exams, one pair of lenses per year, and contact lenses in lieu of eyeglasses. Cost sharing for pediatric dental and vision care is based on four different types of benefit plan designs: a high and low option PPO and a high and low option HMO. Cost sharing for these plans is separate from the cost sharing applied to other EHBs. The high option HMO and PPO dental plans have about the same actuarial value – 86%/87%, and the low option HMO and PPO dental plans have a 72% actuarial value. The HMO plans have no deductible, and the PPO plans have a relatively low deductible ($50/$60), which is not applied to preventive and diagnostic

services. All of the plans have the same out-of-pocket limit on expenses – $1,000 – and none of the plans has any co-payment for preventive exams, prophylaxis, fluoride treatment, radiographs, and sealants.

Potential Issues of Concern:

- Families may not be aware of the requirement that different and additional cost sharing applies for dental and vision care, including deductible requirements and out-of-pocket protections.
- Families may not be aware of CCS eligibility criteria for orthodontia and the state mandated coverage of anesthesia for certain children requiring dental surgery or procedures (Table 4).

Comparison of Private Benchmark Coverage and Medi-Cal and EPSDT Coverage

Although benefit coverage for children and adolescents under the Kaiser essential health benefits benchmark plan is quite generous, the coverage available under Medi-Cal and its Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program (referred to as the Child Health and Disability Prevention Program or CHDP in California) is more expansive and carries no cost-sharing obligations, as shown in Table 5.

Under the EPSDT benefit, eligible children under age 21 have coverage for medically necessary services allowed under the federal Medicaid program to correct or ameliorate any physical or mental illness or other condition discovered as part of preventive care. Services such as family therapy, private duty nursing, hearing aids, cochlear implants, extended home health care, and longer term mental health and substance abuse treatment are covered if they are determined to be medically necessary and authorized by the state.

However, Medi-Cal requires that these services be offered only by certain qualified providers. For example, family therapy and special day programs are available from the county mental health department, and additional therapy services are available from designated California Children's Services providers.

Understanding the benefit and cost-sharing distinctions between private benchmark coverage and Medi-Cal and EPSDT is important for families whose children qualify as exempt from mandatory enrollment in benchmark coverage. As discussed earlier, these include individuals who are medically frail, as defined by the state, including those with serious emotional disturbances, serious and complex medical conditions, and those with physical or mental disabilities.

- The National Alliance to Advance Adolescent Health, a non-profit organization, provides education, research, policy analysis, and technical assistance to achieve improvements in the way that adolescent health care is structured and delivered in the United States. For more information, visit www.thenationalalliance.org.

Footnotes

[1] Musumeci M. *Medicaid Eligibility and Enrollment for People with Disabilities Under the Affordable Care Act.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, December 2012.

[2] Youdelman M. *Ensuring Accessibility for Individuals with Disabilities in the ACA's Marketplaces.* Washington, DC: National Health Law Program, May 2013.

[3] McManus P. *A Comparative Review of Essential Health Benefits Pertinent to Children in Large Federal, State, and Small Group Health Insurance Plans: Implications for Selecting State Benchmark Plans.* Washington, DC: American Academy of Pediatrics. July 2012.

[4] *Kaiser Permanente for Small Business, Evidence of Coverage for Small Group Plan, January 1, 2012 - December 31, 2012.* Oakland, CA: Kaiser Foundation Health Plans, Inc. Northern California Region.

[5] *Covered California Standard Benefit Plan Designs, Summary of Benefits and Coverage. March 15, 2013.* Available at www.healthexchange.ca.gov. Accessed on April 1 and May 10, 2013.

[6] Senate Bill 951 introduced by Senator Hernandez on January 5, 2012 and amended on March 26 and April 16, 2012. Available at www.leginfo.ca.gov. Accessed on April 1, 2013.

[7] Assembly Bill 1453 introduced by Assembly Member Monning on January 5, 2012 and amended on March 29 and April 17, 2012. Available at www.leginfo.ca.gov. Accessed on April 2, 2013.

[8] Covered California, California Health Benefit Exchange. *2012-2013 Initial Qualified Health Plan Solicitation to Health Issuers.* Sacramento, CA: California Health Benefit Exchange, Final Release, November 16, 2012 and amended on December 28, 2012.

[9] Covered California, California Health Benefit Exchange. *Qualified Health Plan Contract for 2014*. Sacramento, CA: California Health Benefit Exchange, May 6, 2013.

[10] Bernstein W, Boozang P, Campbell P, Dutton M, Lam A, Manatt Health Solutions. *Implementing National Health Reform in California: Changes to Public and Private Insurance.* Oakland, CA: California Healthcare Foundation, June 2010.

[11] *Issue Brief: Interaction between California State Benefit Mandates and the Affordable Care Act's "Essential Health Benefits."* Oakland, CA: California Health Benefits Review Program, March 2012.

[12] Insurers may substitute their prescription drug formulary as long as coverage for prescription drugs complies with California mandated benefits.

[13] HHS' Final Rule on Standards Related to Essential Health Benefits confirms that plans in both the individual and small group markets are required to comply with the parity standards set forth in Section 146.136, implementing the requirements under the Mental Health Parity and Addiction Equity Act. In *Federal Register*, February 25, 2013.

[14] HHS' Final Rule on Standards Related to Essential Health benefits states that a plan must cover (1) one drug in every USP category and class, or (2) the same number of drugs in each category and class as the EHB-benchmark plan. In *Federal Register*, February 25, 2013.

[15] JJS' Final Rule on Standards Related to Essential Health Benefits states that a plan must (1) provide parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services, or (2) decide which habilitative services to cover and report on that coverage to HHS. In *Federal Register*, February 25, 2013.

[16] A detailed list of covered preventive services for children and women, including pregnant women is available at www.healthcare.gov. Accessed on April 1, 2013. The ACA requires coverage of preventive care and screenings for children and women provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. It also requires preventive health services with a rating of 'A' or 'B' in the current recommendations of the U.S. Preventive Services Task Force, and immunizations recommended from the CDC's Advisory Committee on Immunization Practices.

[17] States have the option of supplementing dental and vision benchmark coverage included in the FEDVIP dental plan with the largest enrollment or available under the state's separate CHIP program. In *Federal Register*, February 25, 2013.

[18] *Essential Health Benefits Bulletin*. HHS' Center for Consumer Information and Insurance Oversight. December 16, 2011.

[19] Kaiser defines an emergency medical condition as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; serious dysfunction of any bodily organ or part. A medical health condition is an Emergency Medical Condition when it meets the requirements of the [statement] above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true: the person is an immediate danger to himself or herself or to others; the person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder."

ABOUT THE FOUNDATION: The Lucile Packard Foundation for Children's Health works in alignment with Lucile Packard Children's Hospital and the child health programs of Stanford University. The mission of the Foundation is to elevate the priority of children's health, and to increase the quality and accessibility of children's health care through leadership and direct investment. The Foundation is a public charity, founded in 1997.

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Table 1. Coverage of Benefits in California's Exchange Standard Plans

BENEFITS	COVERAGE
1. AMBULATORY SERVICES	
- Primary Care Visit	Y
- Specialist Visit	Y
- Other Practitioner Visit[1]	Y
- Urgent Care	Y
2. PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT	
- Preventive Care/Screening/Immunization	Y
- Health Education Counseling and Programs	Y
- Developmental Screening	Y
- Alcohol/Substance Abuse Screening	Y
- Family Planning Counseling	Y
- STD Preventive Counseling	Y
3. EMERGENCY SERVICES	
- Emergency Room Services	Y
- Medical Transportation	Y
4. HOSPITALIZATION	
- Inpatient Hospital Room Services	Y
- Inpatient Physician/Surgeon Services	Y
- Outpatient Surgery Facility Fee	Y
- Outpatient Surgery Physician/Surgeon Services	Y
5. MATERNITY AND NEWBORN CARE	
- Prenatal and Preconception Visits	Y[2]
- Inpatient Delivery Services	Y
- Inpatient Physician/Surgeon Services	Y
6. LABORATORY SERVICES	
- Laboratory Tests	Y
- X-rays and Diagnostic Imaging	Y
- Imaging (CT/PET Scans/MRIs)	Y
7. PRESCRIPTION DRUGS	
- Generic Drugs	Y
- Preferred Brand-Name Drugs	Y
- Non-Preferred Brand-Name Drugs	Y
- Specialty Drugs	Y
8. MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT	
Outpatient Care – Mental Health	
- Psychological Testing	Y[3]

BENEFITS	COVERAGE
- Individual and Group Outpatient Therapy	Y
- Family Therapy	N
- Pharmacotherapy	Y
- Applied Behavioral Analysis	Y[4]
- Intensive Outpatient Psychiatric Treatment	L[5]
Inpatient Care – Mental Health	
- Inpatient Psychiatric Hospitalization	Y
- Crisis Residential Services	L[6]
Outpatient Care – Chemical Dependency	
- Individual/Group Chemical Dependency Therapy	Y
- Family Therapy	N
- Outpatient Medical Treatment for Withdrawal Symptoms	Y
- Intensive Outpatient Treatment	Y
- Methadone Maintenance	L[7]
Inpatient Care – Chemical Dependency	
- Inpatient Hospital Care	L[8]
- Residential Recovery Services	Y
9. REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES	
- Physical Therapy	Y
- Occupational Therapy	Y
- Speech Therapy	Y
- Habilitative Services	Y[9]
- Home Health Care	L[10]
- Private Duty Nursing	N
- Skilled Nursing Facility Care	L[11]
- Hospice Services	Y
- Durable Medical Equipment	Y[12]
- Medical Supplies	Y[12]
- Hearing Exams	Y
- Audiology Tests	N
- Hearing Aids	N
- Cochlear Implants	N
10. PEDIATRIC SERVICES, INCLUDING DENTAL AND VISION CARE	
Dental Care[13]	
- Periodic Dental Examinations	Y
- Prophylaxis	Y
- Fluoride Treatment	Y
- Radiographs (two bitewing, panoramic)	Y

BENEFITS	COVERAGE
- Sealants (permanent molar)	Y
- Two Surface Primary Tooth Composite Filling	Y
- One Surface Primary Tooth Composite Filling	Y
- Anterior Incisor Fracture Repair	Y
- Primary Tooth Stainless Steel Crown	Y
- Primary Tooth Extraction	Y
- Bilateral Fixed Space Maintainer	NS
- Orthodontics	L[14]
Vision Care[15]	
- Eye Exams	Y
- Glasses	L[16]
- Contact lenses	L[16]

Code: Y=Yes N=Not covered L=Limited NS=Not specified

Footnotes

[1] Other practitioner visits include physical, occupational, and speech therapy visits.
[2] Prenatal care includes regularly scheduled preventive prenatal care exams and the first follow-up preconception consultation and exam.
[3] Psychological testing is covered when necessary to evaluate a mental disorder.
[4] Behavioral health treatment for pervasive developmental disorder and autism is a California-mandated benefit and includes professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore the functioning of an individual with pervasive developmental disorder or autism.
[5] Intensive outpatient hospital care and multidisciplinary treatment in an outpatient psychiatric treatment program are covered on a short-term basis. No visit limits are applied.
[6] Crisis residential services are covered for short-term treatment in a licensed psychiatric treatment facility with 24-hour-a-day monitoring for stabilization of an acute psychiatric crisis. No visit limits are applied.
[7] Methadone maintenance is covered only for pregnant women during pregnancy and 2 months after delivery at an approved licensed treatment center.
[8] Inpatient hospital care for chemical dependency is limited to detoxification only.
[9] Habilitative services are covered under the same terms and conditions that apply to rehabilitative services. These services are defined as “medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual’s environment.”
[10] Home health care is covered up to 2 hours/visit by a nurse, medical social worker, or physical, occupational, or speech therapist, and up to 4 hours/visit by a home health aide, up to 3 visits per day (counting all home health visits) and up to 100 visits/year (counting all home health visits).
[11] Skilled nursing facility care is covered up to 100 days per benefit period. A benefit period begins on the date admitted to hospital or skilled nursing facility at a skilled level of care. A benefit period ends on the date one has not been an inpatient in a hospital or skilled nursing facility receiving a skilled level of care for 60 consecutive days. A new benefit period can begin only after an existing benefit period ends. A prior 3-day stay in an acute care hospital is not required.
[12] Durable medical services and supplies are covered according to the plan’s formulary.
[13] Pediatric dental coverage is offered through stand-alone plans.
[14] Orthodontia is available only for children 18 and under through California Children’s Services Program when the condition meets program criteria for medically handicapping malocclusion.
[15] Pediatric vision coverage is offered through stand-alone plans.
[16] Lenses are limited to one per year and frames are limited to one every year. Contact lenses are covered only in lieu of glasses.

Table 2. Cost-Sharing Requirements in California's Exchange Standard Plans[1]

BENEFITS	MEMBER COST SHARING BY TYPE OF PLAN				
	Platinum	Gold	Silver	Bronze	Catastrophic
Actuarial Value	88.0%	78.0%	68.3%	60.4%	60.4%
Overall (Family) Deductible[2]	$0	$0	NA	$10,000	$12,800
Other (Family) Deductibles					
- Medical[3]	$0	$0	$4,000	NA	NA
- Brand-Name Drugs[4]	$0	$0	$500	NA	NA
Out-of-Pocket Limit on Expenses (Family)	$8,000	$12,800	$12,800	$12,800	$12,800
1. AMBULATORY SERVICES					
- Primary Care Visit	$20	$30	$45	$60Ⓓ[2,5]	$0Ⓓ[2,5]
- Specialist Visit	$40	$50	$65	$70Ⓓ[2]	$0Ⓓ[2]
- Other Practitioner Visit	$20	$30	$45	$60Ⓓ[2]	$0Ⓓ[2]
- Urgent Care	$40	$60	$90	$120Ⓓ[2,5]	$0Ⓓ[2,5]
2. PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT					
- Preventive Care/Screening Immunization	None	None	None	None	None
- Health Education Preventive Counseling	None	None	None	None	None
- Developmental Screening	None	None	None	None	None
- Alcohol/Substance Abuse Screening	None	None	None	None	None
- Family Planning Counseling	None	None	None	None	None
- STD Preventive Counseling	None	None	None	None	None
3. EMERGENCY SERVICES					
- Emergency Room Services[6]	$150	$250	$250Ⓓ[3]	$300Ⓓ[2]	$0Ⓓ[2]
- Medical Transportation	$150	$250	$250Ⓓ[3]	$300Ⓓ[2]	$0Ⓓ[2]
4. HOSPITALIZATION					
- Inpatient Hospital Room Services	$250/day up to 5 days	$600/day up to 5 days	20%Ⓓ[3]	30%Ⓓ[2]	$0Ⓓ[2]
- Inpatient Physician/Surgeon Services					
- Outpatient Surgery Facility Fee	$250	$600	20%Ⓓ[3]	30%Ⓓ[2]	$0Ⓓ[2]
- Outpatient Surgery Physician/Surgeon Services			20%		

BENEFITS	MEMBER COST SHARING BY TYPE OF PLAN				
	Platinum	Gold	Silver	Bronze	Catastrophic
5. MATERNITY AND NEWBORN CARE					
- Prenatal Care and Preconception Visits	None	None	None	None	None
- Inpatient Delivery Services - Inpatient Physician/Surgeon Services	$250/day up to 5 days	$600/day up to 5 days	20%Ⓓ[3]	30%Ⓓ[2]	$0Ⓓ[2]
6. LABORATORY SERVICES					
- Lab Tests	$20	$30	$45	30%Ⓓ[2]	$0Ⓓ[2]
- X-Rays and Diagnostic Imaging	$40	$50	$65	30%Ⓓ[2]	$0Ⓓ[2]
- Imaging (CT/PET Scans/MRI)	$150	$250	$250	30%Ⓓ[2]	$0Ⓓ[2]
7. PRESCRIPTION DRUGS					
- Generic Drugs	$5	$20	$25	$25Ⓓ[2]	$0Ⓓ[2]
- Preferred Brand-Name Drugs	$15	$50	$50Ⓓ[4]	$50Ⓓ[2]	$0Ⓓ[2]
- Non-Preferred Brand-Name Drugs	$25	$70	$70Ⓓ[4]	$75Ⓓ[2]	$0Ⓓ[2]
- Specialty Drugs	10%	20%	20%Ⓓ[4]	30%Ⓓ[2]	$0Ⓓ[2]
8. MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCL. BEHAVIORAL HEALTH TREATMENT					
- Psychological Testing	NS	NS	NS	NS	NS
- Mental Health/Behavioral Health Outpatient Services	$20	$30	$45	$60Ⓓ[2]	$0Ⓓ[2]
- Mental/Behavioral Health Inpatient Services	$250/day up to 5 days	$600/day up to 5 days	20%Ⓓ[3]	30%Ⓓ[2]	$0Ⓓ[2]
- Substance Use Disorder Outpatient Services	$20	$30	$45	$60Ⓓ[2]	$0Ⓓ[2]
- Substance Use Disorder Inpatient Services	$250/day up to 5 days	$600/day up to 5 days	20%Ⓓ[3]	30%Ⓓ[2]	$0Ⓓ[2]
9. REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES					
- Rehabilitative Services	$20	$30	$45	30%Ⓓ[2]	$0Ⓓ[2]
- Habilitative Services	$20	$30	$45	30%Ⓓ[2]	$0Ⓓ[2]
- Home Health Care	$20	$30	$45	30%Ⓓ[2]	$0Ⓓ[2]
- Durable Medical Equipment/Medical Supplies	10%	20%	20%	30%Ⓓ[2]	$0Ⓓ[2]
- Skilled Nursing Facility Care	$150/day up to 5 days	$300/day up to 5 days	20%Ⓓ[3]	30%Ⓓ[2]	$0Ⓓ[2]
- Hospice Care	None	None	None	None	None

BENEFITS	MEMBER COST SHARING BY TYPE OF PLAN			
	PPO High Option	PPO Low Option	HMO High Option	HMO Low Option
10. PEDIATRIC SERVICES, INCLUDING DENTAL AND VISION CARE				
Dental Care				
Actuarial Value	86%	72%	87%	72%
Deductible[7]	$50[7]	$60	$0	$0
Out-of-Pocket Limit on Expenses[9]	$1,000	$1,000	$1,000	$1,000
- Periodic Dental Exams	None	None	None	None
- Prophylaxis	None	None	None	None
- Fluoride Treatment	None	None	None	None
- Radiographs (2 bitewing panoramic)	None	None	None	None
- Sealants (Permanent Molar)	None	None	None	None
- Office Visits	NS	NS	None	$20
- Two Surface Primary Tooth Composite Filling	20%	50%	$40[10]	$95[10]
- One Surface Primary Tooth Composite Filling	20%	50%	$40[10]	$95[10]
- Anterior Incisor Fracture Repair	20%	50%	$40[10]	$95[10]
- Primary Tooth Stainless Steel Crown	50%	50%	$365[11]	$365[11]
- Bilateral Fixed Space Maintainer	NS	NS	NS	NS
- Orthodontics[12]	50%	50%	$1,000	$1,000
Vision Care				
Actuarial Value	NS	NS	NS	NS
Deductible	NS	NS	NS	NS
Out-of-Pocket Limit on Expenses	NS	NS	NS	NS
- Eye Exams	None	None	None	None
- Glasses	NS	NS	NS	NS

Code: NA=Not applicable NS=Not specified Ⓓ=Deductible applies

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Footnotes

[1] This table compares co-pay plans, not co-insurance or HSA plans. Not included in this table is information on small business health option programs (SHOP). Information on co-insurance and HSA plans for individuals and for SHOP plans can be found at www.healthexchange.ca.gov.

[2] The services for which the overall deductible applies is marked in the table byⒹ[2].

[3] The services for which only the medical deductible applies is marked in the table byⒹ[3].

[4] The services for which only the drug deductible applies is marked in the table by Ⓓ[4].

[5] The deductible applies after the first 3 non-preventive visits.

[6] Emergency fees are waived if admitted to the hospital.

[7] Deductibles accrue on a per-child basis and no child is responsible for more than $1,000 in out-of-pocket costs.

[8] The dental deductible does not apply to diagnostic and preventive services, including exams, cleanings, x-rays, and sealants.

[9] If 2 or more children are enrolled in a single pediatric plan, the out-of-pocket maximum is doubled, but for any single child it cannot exceed $1,000.

[10] This co-pay amount represents the plan's average co-pay charged for these basic restorative services and cannot exceed the stated amount.

[11] This co-pay amount represents the plan's average co-pay charged for these major services and cannot exceed the stated amount.

[12] Orthodontia is available only for children 18 and under through California Children's Services Program when the condition meets program criteria for medically handicapping malocclusion.

Table 3. Cost Sharing in the Subsidized Silver Co-Pay Exchange Standard Plans by Poverty Level[1]

BENEFITS	100% FPL - 150% FPL ($19,530 - $29,295)[1]	150% FPL - 200% FPL ($29,295 - $39,060)[1]	200% FPL - 250% FPL ($39,060 - $48,825)[1]
Actuarial Value	94.9%	87.7%	73.3%
Overall (Family) Deductible[2]	$0	NA	NA
Other (Family) Deductible			
- Medical[3]	$0	$1,000	$3,000
- Brand-Name Drugs[4]	$0	$100	$500
Out-of-Pocket Limit on Expenses (Family)	$4,500	$4,500	$10,400
1. AMBULATORY SERVICES			
- Primary Care Visit	$3	$15	$40
- Specialist Visit	$5	$20	$50
- Other Practitioner Visit	$3	$15	$40
- Urgent Care	$6	$30	$80
2. PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT			
- Preventive Care/Screening Immunization	None	None	None
- Health Education Preventive Counseling	None	None	None
- Developmental Screening	None	None	None
- Family Planning Counseling	None	None	None
- Alcohol/Substance Abuse Screening	None	None	None
3. EMERGENCY SERVICES			
- Emergency Room Services[5]	$25	$75Ⓓ[3]	$250Ⓓ[3]
- Medical Transportation	$25	$75Ⓓ[3]	$250Ⓓ[3]
4. HOSPITALIZATION			
- Inpatient Hospital Room Services	10%	15%Ⓓ[3]	20%Ⓓ[3]
- Inpatient Physician/Surgeon Services	10%	15%Ⓓ[3]	20%Ⓓ[3]
- Outpatient Surgery Facility Fee	10%	15%Ⓓ[3]	20%Ⓓ[3]
- Outpatient Surgery Physician/Surgeon Services	10%	15%	20%
5. MATERNITY AND NEWBORN CARE			
- Prenatal and Preconception Visits	None	None	None
- Inpatient Delivery Services	10%	15%Ⓓ[3]	20%Ⓓ[3]
- Inpatient Physician/Surgeon Services	10%	15%Ⓓ[3]	20%Ⓓ[3]

BENEFITS	100% FPL - 150% FPL ($19,530 - $29,295)[1]	150% FPL - 200% FPL ($29,295 - $39,060)[1]	200% FPL - 250% FPL ($39,060 - $48,825)[1]
6. LABORATORY SERVICES			
- Lab Tests	$3	$15	$40
- X-Rays and Diagnostic Imaging	$5	$20	$50
- Imaging (CT/PET Scans/MRISs)	$50	$100	$250
7. PRESCRIPTION DRUGS			
- Generic Drugs	$3	$5	$20
- Preferred Brand-Name Drugs	$5	$15Ⓓ[4]	$30Ⓓ[4]
- Non-Preferred Brand-Name Drugs	$10	$25Ⓓ[4]	$50Ⓓ[4]
- Specialty Drugs	10%	15%Ⓓ[4]	20%Ⓓ[4]
8. MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT			
- Mental Health/Behavioral Health Outpatient Services	$3	$15	$40
- Mental/Behavioral Inpatient Services	10%	15%Ⓓ[3]	20%Ⓓ[3]
- Substance Use Disorder Outpatient Services	$3	$15	$40
- Substance Use Disorder Inpatient Services	10%	15%Ⓓ[3]	20%Ⓓ[3]
9. REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES			
- Rehabilitation Services	$3	$15	$40
- Habilitation Services	$3	$15	$40
- Home Health Care	$3	$15	$40
- Durable Medical Equipment/Medical Supplies	10%	15%	20%
- Skilled Nursing Facility Care	10%	15%Ⓓ[3]	20%Ⓓ[3]
- Hospice Care	None	None	None
10. PEDIATRIC SERVICES, INCLUDING DENTAL AND VISION CARE[6]			

Code: NA=Not applicable NS=Not specified Ⓓ=Deductible applies

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Footnotes

[1] The federal poverty level (FPL) information reported in this table is for a family of three.
[2] The services for which the overall deductible applies is marked in the table byⒹ[2].
[3] The services for which only the medical deductible applies is marked in the table byⒹ[3].
[4] The services for which only the drug deductible applies is marked in the able by Ⓓ[4].
[5] Emergency fees are waived if admitted to the hospital.
[6] Dental and vision cost-sharing subsidy information was not available to authors.

Table 4. Summary of California's Mandated Benefits Pertaining to Children and Adolescents

Preventive Services for Children

- Coverage of Preventive Health Services, consistent with the ACA, includes US Preventive Services Task Force (USPSTF) services that have a rating of 'A' or 'B,' immunizations recommended by the Advisory Committee on Immunization Practices (ACIP), evidence-informed preventive care and screenings in guidelines supported by the Health Resources and Services Administration (HRSA), and additional preventive care and screenings for women in guidelines supported by HRSA. (Section 1367.002)
- Coverage of Pediatric Asthma-Related Management and Treatment includes medically necessary inhaler spacers; nebulizers, including face masks and tubing; peak flow meters; and education for pediatric asthma. (Section 1367.06)

Prescription Drug Coverage for Contraceptives

- Coverage of FDA-Approved Prescription Contraceptive Methods.(Section 1367.25)

HIV Testing

- Coverage of Human Immunodeficiency Virus (HIV) Testing, regardless of whether the testing is related to a primary diagnosis. (Section 1367.46)

Diabetes Management and Treatment

- Coverage of Equipment and Supplies for the Management and Treatment of Diabetes, includes blood glucose monitors and blood glucose testing strips, blood glucose monitors designed to assist the visually impaired, insulin pumps and all related necessary supplies, ketone urine testing strips, lancets and lance puncture devices, pen delivery systems for the administration of insulin, podiatric devices to prevent or treat diabetes-related complications, insulin syringes, visual aids to assist the visually impaired with proper dosing of insulin. Also coverage includes insulin, prescription medications for the treatment of diabetes, glucagon, and self-management training, education, and medical nutrition therapy. (Section 1367.51)

Reconstructive Surgery

- Coverage for Reconstructive Surgery includes surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate, in order to improve function and create a normal appearance, to the extent possible. (Section 1367.63)

Cervical Cancer Screening

- Coverage for Cervical Cancer Screening Test include Pap test, HPV test, and the option of any other FDA-approved cervical cancer screening test. (Section 1367.66)

Anesthesia for Dental Procedures

- Coverage for General Anesthesia and Associated Facility Charges for Dental Procedures in a hospital or surgery center setting when the patient requires dental procedures that ordinarily would not require general anesthesia in a hospital or surgery center. These enrollees must be either under the age of 7, be developmentally disabled regardless of age, or have a compromised health condition for whom general anesthesia is medically necessary regardless of age. (Section 1367.71)

Cancer Clinical Trials

- Coverage for Routine Patient Care Costs Related to Clinical Trial (Phases I-IV) if the enrollee's treating physician, who is providing covered health care services to the enrollee recommends participation in the clinical trial after determining that participation has a meaningful potential to benefit the enrollee. (Section 1370.6)

Phenylketonuria Testing and Treatment

- Coverage for Hospital, Medical, or Surgical Expenses for Testing and Treatment of Phenylketonuria (PKU) includes formulas and special food products that are part of a diet prescribed by a licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the plan, provided that the diet is medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. (Section 1374.56)

Mental Health Parity

- Coverage for Diagnosis and Medically Necessary Treatment of Severe Mental Illnesses of a Person of Any Age and of Serious Emotional Disturbances of a Child Under the Same Terms and Conditions Applied to Other Medical Conditions. These benefits include outpatient services, inpatient hospital services, partial hospital services, prescription drugs (if the plan includes it). The terms and conditions include, but are not limited to maximum lifetime benefits, co-payments, and individual and family deductibles. Severe mental illnesses include schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa. A child suffering from "serious emotional disturbances of a child" is defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code. (Section 1374.72)

Behavioral Health Treatment for Pervasive Developmental Disability and Autism

- Coverage for Behavioral Health Treatment for Pervasive Developmental Disorder or Autism includes professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore the functioning of an individual with pervasive developmental disorder or autism that meets all of the following criteria: A) the treatment is prescribed by a licensed physician and surgeon or is developed by a licensed psychologist; B) the treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by either a qualified autism service provider, qualified autism service professional supervised and employed by the qualified autism service provider, or qualified autism service paraprofessional supervised and employed by a qualified autism service provider; C) the treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism provider. The treatment plan shall be reviewed no less than once every 6 months by the qualified autism provider and modified whenever appropriate and shall i) describe the patient's behavioral health impairments to be treated, ii) design an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported, iii) provide intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism, and iv) discontinue intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate. The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. (Section 1374.73)

Table 5. Comparison of Private Benchmark Plan and Medi-Cal and EPSDT for Children Under 21

BENEFITS	BENCHMARK COVERAGE	MEDI-CAL & EPSDT
1. AMBULATORY SERVICES		
- Primary Care Visit	Y	Y
- Specialist Visit	Y	Y
- Other Practitioner Visit[1]	Y	Y
- Urgent Care	Y	Y
2. PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT		
- Preventive Care/Screening/Immunization	Y	Y
- Health Education Counseling	Y	Y
- Developmental Screening	Y	Y
- Alcohol/Substance Abuse Screening	Y	Y
- Family Planning Counseling	Y	Y
- STD Preventive Counseling	Y	Y
3. EMERGENCY SERVICES		
- Emergency Room Services	Y	Y
- Medical Transportation	Y	Y
4. HOSPITALIZATION		
Inpatient Care		
- Hospital Room	Y	Y
- Physician/Surgeon Services	Y	Y
Outpatient Care		
- Outpatient Facility Services	Y	Y
- Physician/Surgeon Services	Y	Y
5. MATERNITY AND NEWBORN CARE		
- Prenatal and Preconception Visits	Y[2]	Y
- Inpatient Delivery Services	Y	Y
- Inpatient Physician/Surgeon Services	Y	Y
6. LABORATORY SERVICES		
- Laboratory Tests	Y	Y
- X-rays and Diagnostic Imaging	Y	Y
- Imaging (CT/PET Scans/MRIs)	Y	Y
7. PRESCRIPTION DRUGS		
- Generic Drugs	Y	Y
- Preferred Brand-Name Drugs	Y	Y
- Non-Preferred Brand-Name Drugs	Y	Y
- Specialty Drugs	Y	Y
8. MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT		
Outpatient Care – Mental Health		

BENEFITS	BENCHMARK COVERAGE	MEDI-CAL & EPSDT
- Psychological Testing	Y[3]	Y
- Individual and Group Outpatient Therapy	Y	Y
- Family Therapy	N	L[4]
- Pharmacotherapy	Y	Y
- Applied Behavioral Analysis	Y[5]	N
- Intensive Outpatient Psychiatric Treatment	L[6]	L[4]
Inpatient Care – Mental Health		
- Inpatient Psychiatric Hospitalization	Y	Y
- Crisis Residential Services	L[7]	L[4]
Outpatient Care – Chemical Dependency		
- Individual/Group Chemical Dependency Therapy	Y	Y
- Family Therapy	N	L[4]
- Outpatient Medical Treatment for Withdrawal Symptoms	Y	Y
- Intensive Outpatient Treatment	Y	L[4]
- Methadone Maintenance	L[8]	L[4]
Inpatient Care – Chemical Dependency		
- Inpatient Hospital Care	L[9]	Y
- Residential Recovery Services	Y	L[4]
9. REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES		
- Physical Therapy	Y	Y
- Occupational Therapy	Y	Y
- Speech Therapy	Y	Y
- Habilitative Services	Y[10]	Y
- Home Health Care	L[11]	Y
- Private Duty Nursing	N	Y
- Skilled Nursing Facility Care	L[12]	Y
- Hospice Services	Y	Y
- Durable Medical Equipment	Y[13]	Y
- Medical Supplies	Y[13]	Y
- Hearing Exams	Y	Y
- Audiology Tests	N	Y
- Hearing Aids	N	L[14]
- Cochlear Implants	N	L[14]
10. PEDIATRIC SERVICES, INCLUDING DENTAL AND VISION CARE		
Dental Care[15]		
- Periodic Dental Examinations	Y	Y
- Prophylaxis	Y	Y
- Fluoride Treatment	Y	Y
- Radiographs (two bitewing, panoramic)	Y	Y
- Sealants (permanent molar)	Y	Y

BENEFITS	BENCHMARK COVERAGE	MEDI-CAL & EPSDT
Restorative		
- Two Surface Primary Tooth Composite Filling	Y	Y
- One Surface Primary Tooth Composite Filling	Y	Y
- Anterior Incisor Fracture Repair	Y	Y
- Primary Tooth Stainless Steel Crown	Y	Y
- Primary Tooth Extraction	Y	Y
- Bilateral Fixed Space Maintainer	NS	Y
- Orthodontics	L[16]	L[16]
Vision Care[17]		
- Eye Exams	Y	L[18]
- Glasses	L[19]	Y
- Contact lenses	L[19]	Y

Code: Y=Yes N=Not covered L=Limited NS=Not specified

Footnotes

[1] Other practitioner visits include physical, occupational, and speech therapy visits.
[2] Prenatal care includes regularly scheduled preventive prenatal care exams and the first follow-up preconception consultation and exam.
[3] Psychological testing is covered when necessary to evaluate a mental disorder.
[4] Family therapy is covered for children and adolescents with serious emotional disturbances who are eligible for California Department of Mental Health services.
[5] Behavioral health treatment for pervasive developmental disorder and autism is a California-mandated benefit and includes professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore the functioning of an individual with pervasive developmental disorder or autism.
[6] Intensive outpatient hospital care and multidisciplinary treatment in an outpatient psychiatric treatment program are covered on a short-term basis. No visit limits are applied.
[7] Crisis residential services are covered for short-term treatment in a licensed psychiatric treatment facility with 24-hour-a-day monitoring for stabilization of an acute psychiatric crisis. No visit limits are applied.
[8] Methadone maintenance is covered only for pregnant women during pregnancy and 2 months after delivery at an approved licensed treatment center.
[9] Inpatient hospital care for chemical dependency is limited to detoxification only.
[10] Habilitative services are covered under the same terms and conditions that apply to rehabilitative services. These services are defined as "medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment."
[11] Home health care is covered up to 2 hours/visit by a nurse, medical social worker, or physical, occupational, or speech therapist, and up to 4 hours/visit by a home health aide, up to 3 visits per day (counting all home health visits) and up to 100 visits/year (counting all home health visits).
[12] Skilled nursing facility care is covered up to 100 days per benefit period. A benefit period begins on the date admitted to hospital or skilled nursing facility at a skilled level of care. A benefit period ends on the date one has not been an inpatient in a hospital or skilled nursing facility receiving a skilled level of care for 60 consecutive days. A new benefit period can begin only after an existing benefit period ends. A prior 3-day stay in an acute care hospital is not required.
[13] Durable medical services and supplies are covered according to the plan's formulary.
[14] Hearing aids and cochlear implants are covered for those who are eligible for California Children's Services Program.
[15] Pediatric dental coverage is offered through stand-alone plans.
[16] Orthodontia is available only for children 18 and under through California Children's Services Program when the condition meets program criteria for medically handicapping malocclusion.
[17] Pediatric vision coverage is offered through stand-alone plans.
[18] Routine eye exams with refraction are limited to one service in a 24-month period.
[19] Lenses are limited to one per year and frames are limited to one every year in the high option plan and every other year in the standard or low option plan. Contact lenses are covered only in lieu of glasses