Actuarial Report
Child Health Plan Plus
October 1997

Background

This actuarial report was developed at the request of the Colorado Department of Health Care Policy and Financing by *Leif Associates, Inc.*, an independent actuarial consulting firm. The purpose of the report is to supplement the State of Colorado's application for Federal funds under Title XXI of the Social Security Act for the Child Health Plan Plus.

Title XXI, Section 2103, specifies that the scope of health insurance coverage under this program must consist of either benchmark coverage, benchmark-equivalent coverage, existing comprehensive state-based coverage, or Secretary-approved coverage. Certain actuarial values must be set forth in an actuarial opinion in an actuarial report to accompany the State's application. Those actuarial values include the following:

- The actuarial value of the coverage provided by the benchmark benefit packages;
- The actuarial value of the coverage offered under the State child health plan;
- The actuarial value of the coverage of any categories of additional services under benchmark benefit packages; and,
- The actuarial value of any categories of additional services under coverage offered by the State child health plan.

This actuarial report includes the actuarial values listed above, along with supporting documentation and other information.

Benchmark Benefit Packages

The benchmark benefit packages identified in Title XXI, Section 2103, are as follows:

- **FEHBP-equivalent children's health insurance coverage**. This is described as the standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5, United States Code.

  The Blue Cross/Blue Shield preferred provider option service benefit plan is composed of an in-network benefit and an out-of-network benefit package. As stated in FEHBP documentation, the non-PPO benefits are the standard benefits of the plan. PPO benefits apply only when the covered person uses a PPO provider. Therefore, the non-PPO benefits of the FEHBP plan were used in this study to determine the actuarial value of FEHBP coverage.

- **State employee coverage**. This is described as a health benefits coverage plan that is offered and generally available to State employees in the State involved.

  The State of Colorado currently offers five HMO and three self-funded health benefit plans for its employees to choose from. The plan that currently has the largest enrollment is known as the Exclusive Path. This plan covers approximately 15,000 State employees and their dependents, out of a total of approximately 28,000 State employees that are covered under the State's employee health benefit plans. The Exclusive Path uses a large network of health care providers, and coverage is provided only when care is secured from those

providers. It has the typical plan design features of an HMO plan. For purposes of this study, the Exclusive Path was chosen as the benchmark state employee benefit coverage.

- **Coverage offered through an HMO.** This is described as the health insurance coverage plan that:

  (A) is offered by a health maintenance organization (as defined in section 2791 (b)(3) of the Public Health Service Act), and

  (B) has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

  In order to determine the HMO benchmark coverage for Colorado, an informal survey of the largest HMOs in the state was conducted by the Colorado Department of Health Care Policy and Financing. Based on this informal survey, it was determined that the HMO plan that has the largest insured commercial, non-Medicaid enrollment of covered lives in Colorado is the Kaiser Foundation Health Plan of Colorado Plan 710, with pharmacy, durable medical equipment, and optical riders. This plan was used as the benchmark HMO coverage for purposes of this study.

A plan design grid, which shows the details of the benefits of these three benchmark plans, is attached to this report and labeled as Exhibit I.

Child Health Plan Plus Benefit Packages

The benefit structure for the Child Health Plan Plus will vary depending on whether HMO plans are available. The fee-for-service program will be available in areas where no HMO coverage is available.

The proposed HMO Child Health Plan Plus includes two separate benchmark-equivalent benefit packages. One is for children in families between 100% and 150% of the Federal poverty level. The other is for children in families between 150% and 185% of the Federal poverty level. The plans each provide coverage for the same health care services. The only difference between the two plans is the level of cost sharing. Copayments, when required, will be higher for participants with family incomes between 150% and 185% of the Federal poverty level than for participants with family incomes between 100% and 150% of the Federal poverty level.

A plan design grid, which shows the details of all three Child Health Plan Plus benefit packages, is attached to this report and labeled as Exhibit II. The coverage includes benefits for items and services within each of the categories of basic services described in Section 2103.

Methodology for Determining Actuarial Equivalency

In order to determine the actuarial equivalency of the proposed Child Health Plan Plus benefit packages to the benchmark plans, the following methodology was used.

- **Identification of a standardized set of utilization and price factors**.

  The standardized set of utilization and price factors used to determine the actuarial equivalency of the Child Health Plan Plus to the benchmark plans is set forth in Exhibit III of this report. These standardized utilization and price factors have the following characteristics:

1. The factors were based on a compilation of data from a number of unpublished sources;
2. The factors were adjusted to reflect weighted statewide Colorado health care utilization and costs, rather than those for a specific geographic location within Colorado;
3. The factors represent the unique health care utilization and cost patterns for children, rather than adults or the combination of children and adults;
4. The factors were developed for children at various ages and weighted using the standardized population of children described below to arrive at combined average factors for children under nineteen years of age;
5. The factors were projected to mid-year 1998, using typical utilization and cost trends;
6. The factors were based on typical insured coverage utilization and costs in a traditional fee-for-service environment with limited utilization management;
7. The development of the factors involved considerable actuarial judgement.

- **Identification of a standardized population.**

  The standardized population used to determine the actuarial equivalency of the Child Health Plan Plus to the benchmark plans is set forth in Exhibit IV of this report. This standardized population is the projected 1997 Colorado population by single age for children ages 0 through 18, as determined by the U.S. Bureau of the Census, Population Projections Branch. This standardized population is believed to be representative of the distribution of privately insured children of the age of children who are expected to be covered under the State child health plan.

- **Calculation of the actuarial value of the benchmark plans and the categories of additional services included in the benchmark plans**.

  Based on the standardized set of utilization and cost factors and the standardized population described above, the aggregate actuarial value and the actuarial value of categories of additional services provided by the three benchmark benefit plans was determined. The actuarial values, stated in terms of average monthly claim costs, are set forth below.

	FEHBP Coverage	*State Employee Coverage*	*HMO Coverage*
Aggregate Actuarial Value	$ 74.35	$ 81.81	$ 82.71
Additional Services Actuarial Value			
Prescription Drugs	$ 4.21	$ 4.53	$ 6.11
Mental Health Services	$ 6.39	$ 6.50	$ 6.54
Vision Services	$ -0-	$ 0.70	$ 0.92
Hearing Services	$ -0-	$ 0.29	$ 0.19

In calculating the actuarial values stated above, the same actuarial principles and standardized factors were used in comparing the value of different coverage and categories of services, without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used.

- **Calculation of the actuarial value of the Colorado plans and the categories of additional services included in the Colorado plans**.

Based on the standardized set of utilization and cost factors and the standardized population described above, the aggregate actuarial value and the actuarial value of categories of additional services provided by the proposed Colorado plans was determined. The actuarial values, stated in terms of average monthly claim costs, are set forth below.

	Fee-For-Service Plan	*HMO Plans*	
		Between 100% and 150% FPL	*Between 150% and 185% FPL*
Aggregate Actuarial Value	$ 87.91	$ 98.43	$ 96.69
Additional Services Actuarial Value			
Prescription Drugs	$ 6.67	$ 6.86	$ 6.22
Mental Health Services	$ 6.63	$ 6.63	$ 6.60
Vision Services	$ 1.04	$ 1.04	$ 1.00
Hearing Services	$ .65	$ 0.65	$ 0.65

In calculating the actuarial values stated above, the same actuarial principles and standardized factors were used in comparing the value of different coverage and categories of services, without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used.

The cost sharing reflected in the benefit structure for participants below 150% of Federal poverty level meets the requirements stated in Section 2103 (e) (3). The copayments for participants between 150% and 185% of Federal poverty level are minimal, and when combined with the proposed premium payments for the program, are not expected to result in cost sharing that exceeds 5% of family income. Therefore, it is expected that the actuarial values shown above will not be increased because of cost sharing limitations which might otherwise result in an increase in the actuarial value of the plans.

It is important to recognize that the actuarial values developed from the standardized utilization and cost factors in this report do not represent the actual expected costs of the Child Health Plan Plus. The program is expected to include significant utilization management and negotiated provider reimbursements through the implementation of HMO contracts. It is also expected that the age distribution of children enrolled in the plan will not mirror that of privately insured children, as reflected in the Colorado population projections. Assumptions regarding the cost impact of managed care approaches and the actual expected enrollment distribution are not included in this report.

- **Determination of actuarial equivalence of the Colorado plans to the benchmark plans.**

The proposed Child Health Plan Plus benefit packages have an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages. The actuarial value of these benefit packages exceeds the

actuarial value of all three benchmark benefit packages.

With respect to each of the categories of additional services described in Section 2103, the proposed Child Health Plan Plus benefit packages have an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in the benchmark packages. The actuarial value of these additional services exceeds the actuarial value of the corresponding additional service in each of the three benefit plans. A summary table is shown below.

	Benchmark Plans			*Colorado Plans*		
	FEHBP Coverage	*State Employee Coverage*	*HMO Coverage*	*Fee-For-Service Plans*	*HMO 100% to 150% FPL*	*HMO 150% to 185% FPL*
Aggregate Actuarial Value	$ 74.35	$ 81.81	$ 82.71	$ 87.91	$ 98.43	$ 96.69
Additional Services Actuarial Value						
Prescription Drugs	$ 4.21	$ 4.53	$ 6.11	$ 6.67	$ 6.86	$ 6.22
Mental Health Services	$ 6.39	$ 6.50	$ 6.54	$ 6.63	$ 6.63	$ 6.60
Vision Services	$ -0-	$ 0.70	$ 0.92	$ 1.04	$ 1.04	$ 1.00
Hearing Services	$ -0-	$ 0.29	$ 0.19	$ 0.65	$ 0.65	$ .65

Report Preparation

Elizabeth J. Leif, Consulting Actuary and President of Leif Associates, Inc., a private actuarial consulting firm, prepared this actuarial report. Ms. Leif is a Fellow of the Society of Actuaries, a Fellow of the Conference of Consulting Actuaries, and a member of the American Academy of Actuaries.

Actuarial Opinion

I, Elizabeth J. Leif, a member of the American Academy of Actuaries, have performed the actuarial calculations described in this report and prepared the report and supporting documentation. It is my opinion that:

- The report has been prepared using generally accepted actuarial principles and methodologies;
- The report has been prepared in accordance with the principles and standards of the Actuarial Standards Board for such reports;
- A standardized set of utilization and price factors has been used;
- A standardized population that is representative of privately insured children of the age of children who are expected to be covered under the Child Health Plan Plus has been used;
- The same principles and factors have been applied in comparing the value of different coverage (or categories of services);
- Differences in coverage based on the method of delivery or means of cost control or utilization used have not been

taken into account;

- The ability of the State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the Child Health Plan Plus that results from the limitations on cost sharing under such coverage has been taken into account.

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Exhibit 1 - Child Health Plan Plus
Benchmark Benefit Packages

Benefit Category	1997 FEHBP - Standard BCBS PPO Plan		1997 Colorado State Employee Coverage - Exclusive Path	HMO Plan - Kaiser Permanente Plan 710
	PPO	Non-PPO[1]		
ANNUAL DEDUCTIBLE Individual Family	$200 per person[2] $400 per family		None	None
COINSURANCE	95%	75%	100%	100%
OUT-OF-POCKET MAXIMUM Individual Family	$2,000 $2,000	$3,750 $3,750	None	None
HOSPITAL AND EMERGENCY ROOM TRANSPORT	After $200 calendar year deductible, plan pays 75% of the allowable charge		Up to a $500 maximum benefit for ground ambulance; up to a $4,000 maximum benefit for air ambulance	No charge
INPATIENT	$250 deductible per admission;[3]		$150 copay per admission	Paid in full

	100% coinsurance after per admission deductible	70% coinsurance after per admission deductible		
INPATIENT PHYSICIAN CARE	95% coinsurance after the $200 calendar year deductible	75% coinsurance after the $200 calendar year deductible	Paid in full	Paid in full
OUTPATIENT FACILITY CARE	After $200 calendar year deductible, plan pays in full, subject to $25 (PPO) or $100 (Member facility) copayment per facility per day	After $200 calendar year deductible, plan pays in full, subject to $150 copayment per facility per day	$75 copay per emergency room visit; $25 copay per physician emergency room visit	$10 copay each visit; $50 copay for emergency services received inside the service area from non-plan providers
OUTPATIENT SURGERY	Plan pays in full, subject to $25 (PPO) or $100 (Member facility) copayment	Plan pays in full, subject to $150 copayment	$10 copay per visit	$10 copay per visit
ACCIDENTAL INJURY	Plan pays 100% of covered charges within 72 hours after accidental injury for hospital outpatient care		Paid same as illness	Paid same as illness
MEDICAL OFFICE OR HOME VISIT	$10 copayment for each outpatient office visit charge	75% coinsurance after the $200 calendar year deductible	$10 copay per visit	$10 copay per visit
LABORATORY & X-RAY SERVICES	Covered at outpatient facility care rates for X-ray, laboratory, pathological services, and machine diagnostic tests		Paid in full	Paid in full
ALLERGY TESTS, TEST MATERIALS, AND TREATMENT MATERIALS	After the $200 calendar year deductible, plan pays 95% (PPO) or 75% (PAR or non-participating physician)		$10 copay per visit	$10 copay per visit
PREVENTIVE CARE	Paid at outpatient facility care rates for cervical cancer screening, mammogram for breast cancer screening, fecal occult blood test for colorectal cancer screening, PSA for prostate cancer screening, tetanus-diphtheria booster, and immunization for influenza and pneumonia		$5 copay for certain services;[4] no payment required for routine mammograms according to age-specific guidelines or prostate screening	Immunizations medically indicated and consistent with accepted medical practice are provided without charge

WELL CHILD CARE	For children up to age 22, plan pays 100% of the allowable charge for all healthy newborn inpatient physician visits, and routine physical exams, lab tests, immunizations, and related office visits as recommended by the American Academy of Pediatrics		$5 copay for certain services	$10 copay per visit
MATERNITY CARE Prenatal Delivery & inpatient well baby care	Plan pays in full Pays in full for unlimited days with no per admission deductible (PPO hospital) or after $250 per admission deductible (Member hospital)	After the $200 calendar year deductible, plan pays 75% After the $250 per admission deductible, plan pays 70%	$10 copay per office visit $150 copay per admission	$10 copay per office visit No charge
INFERTILITY DIAGNOSIS AND TREATMENT	95% coinsurance after the $200 calendar year deductible	75% coinsurance after the $200 calendar year deductible	$10 copay per office visit; covered up to $2,500 per calendar year[5]	Medical services are provided with $10 copay per visit. Artificial insemination is covered, except for donor semen, donor eggs, and services related to procurement and storage. All other services related to conception by artificial means, prescription drugs related to such services are not covered.[6] Infertility drugs covered with a 50% charge

ABORTION	Benefits will not be paid for procedures, services, drugs, and supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of rape or incest		Covered only if there is a medical condition that threatens the mother's life if the pregnancy continues, a lethal medical condition in the unborn child that would cause the death of the unborn child during pregnancy or at birth, or a psychiatric condition that may seriously threaten the mother's life if the pregnancy continues to term	
ALL OTHER MENTAL HEALTH				
Inpatient care	After a $150 (PPO) or $250 (Member hospital) copayment, plan pays the remainder up to 100 days	After a $400 per day copayment, plan pays the remainder of the cost up to 100 days	$150 copayment, then 100% up to 45 days per calendar year	1 - 20 days, no charge; 21 - 45 days, 50%
Inpatient physician visits	After the $200 calendar year deductible, plan pays 60% of the allowable charge			No charge
Outpatient facility care	After the $200 calendar year deductible, plan pays in full, subject to $25 (PPO) or $100 (Member facility) copayment	After the $200 calendar year deductible, plan pays in full, subject to $150 copayment		
Professional care	After the $200 calendar year deductible, plan pays 60% of the allowable charge; limited to 25 visits per person per calendar year		$10 copayment per visit, then 100%	1 - 10 visits, $10 each visit; 11 or more visits, $25 each visit

ALCOHOL & SUBSTANCE ABUSE	Inpatient: one treatment program (28-day maximum) per person per lifetime; covered at the same levels as hospital care and inpatient visits for mental conditions; outpatient also subject to the same levels as mental conditions	Same as mental health	Inpatient detoxification: same as other hospitalization. Inpatient rehab: only evaluation and referral are covered. Outpatient: 50% covered up to $650 per 12 month period
ORGAN TRANSPLANTS	After the $200 calendar year deductible, plan pays 95% (PPO) or 75% (PAR or non-participating) • Allogeneic bone marrow[7] • Autologous bone marrow and autologous peripheral stem cell support[8] • Allogeneic bone marrow and allogeneic peripheral stem cell support for multiple myeloma and autologous bone marrow and autologous peripheral stem cell support[9] • Single or double lung transplants for end-stage pulmonary diseases[10] • Cornea • Kidney • Heart • Liver • Heart-lung • Pancreas	100% of covered expenses, including organ procurement and acquisition.[11] Kidney and cornea require a $10 copay per office visit and a $150 per admission hospital copay • Heart • Heart-lung • Kidney-pancreas • Pancreas • Liver • Bone marrow (allogeneic and autologous)[12] • Peripheral blood stem cell • Kidney • Cornea Travel expenses for transportation, lodging and meal expenses at 100% up to a total maximum of $10,000 for a child transplant recipient[13]	Covered transplants are: • Kidney • Heart • Heart-lung • Liver • Lung • Cornea • Kidney/pancreas • Bone marrow transplants associated with high dose chemotherapy for germ cell tumors and neuro-blastoma in children are covered. • Bone marrow transplants associated with high dose chemotherapy for other solid tissue tumors are not covered
DURABLE MEDICAL EQUIPMENT	After $200 calendar year deductible, plan pays 75% for rental or purchase of durable medical equipment, wheelchairs, hospital beds, crutches, orthopedic braces, prosthetic appliances, and one bra per person per calendar year for use with an external breast prosthesis	Covered at 100%, no annual maximum; includes artificial arms, legs, or eyes, leg braces, arm and back braces, maxillofacial prosthesis, cervical collars, surgical implants, oxygen and equipment needed to administer it, and insulin pumps and related supplies	Covered with 20% copayment, including oxygen and orthotic and prosthetic devices
PHYSICAL AND OCCUPATIONAL THERAPY	After $200 calendar year deductible, plan pays 75% up to 50 visits for physical therapy and 25 visits for occupational and speech therapy per person per calendar year	$10 copay per visit for independent therapists; no payment required for hospital outpatient therapy	$10 copay per visit, up to 2 months per condition, or up to 30 visits per condition if not received within 2 months

HOME HEALTH CARE	After the $200 calendar year deductible, plan pays 75% for home nursing care for up to 2 hours per day up to 25 visits per calendar year		Paid at 100%, up to 60 visits per year	No charge
HOSPICE CARE Home Hospital Bereavement Support	Plan pays in full for member with life expectancy of six months or less for physician visits, nursing care, medical social services, physical therapy, services of home health aides, durable medical equipment rental, prescription drugs, and medical supplies Up to 5 consecutive days if receiving home hospice care; must be separated by at least 21 days and is paid in full with no (PPO) or $250 (Non-member hospital) per admission deductible Not covered		Paid at 100%, $8,100 benefit payment limit during a 3-month period. Paid at no less than $91 per day Paid at 100%, after $150 per admission copayment, up to 30 days Up to $1,053 per family per calendar year	No charge No charge No charge
OUTPATIENT PRESCRIPTION DRUGS	$50 per person annual deductible, then 80% coinsurance; $100 family annual deductible; $12 per prescription copay for mail service prescription drug program[14]	$50 per person annual deductible, then 60% coinsurance; $100 family annual deductible	$10 generic, $15 brand name plus cost difference between brand and generic if generic is available and not prescribed "dispense as written." $10 per brand name if no generic equivalent exists	$5 copay per prescription for up to a 60-day supply.
CONTRACEPTIVE DEVICES AND DRUGS	• IUDs, Norplant, Depo-Provera, and oral contraceptives obtained from a physician are covered at 95% or 75% after $200 deductible • IUDs, Norplant, Depo-Provera, and oral contraceptives dispensed by a retail pharmacy are covered as prescription drugs • Oral contraceptives are also covered under the mail service prescription drug program		The plan covers oral contraceptives, birth control shots, and certain contraceptive devices and their insertion. Does not cover Norplant device and related expenses	Oral contraceptives are covered. Norplant is covered at a charge of $200, with no refund if the drug is removed. Contraceptive devices are provided at reasonable charges

SKILLED NURSING FACILITY CARE	When Medicare Part A is primary, plan provides secondary benefits for Medicare Part A copayment incurred in full during the 1st through 30th day	Not covered	No charge up to 100 days per calendar year
VISION SERVICES	After $200 deductible, plan pays 75% for one set of eyeglasses or contact lenses required as a result of a single instance of intra-ocular surgery or injury	Routine eye exams covered at 100% after a $5 office copayment, once every 24 months. No allowance for lenses/ frames. One set of prescription eyeglasses or contact lenses are covered when needed to replace human lenses absent at birth or lost through intra-ocular surgery or eye injury or for treatment for keratoconus	$10 copay per visit for eye exams for glasses; each 24 months, one pair of lenses, frames up to $65, contact lenses up to $100
HEARING SERVICES		Hearing exams paid at 100%, after a $5 copayment. Up to $500 hearing aid allowance once every 3 years	Hearing exams covered with $10 copay per visit
DENTISTRY	Oral and maxillofacial surgery, limited to listed procedures.[15] Plan pays 75% after $200 calendar year deductible for services, supplies, or appliances for accidental injury to sound natural teeth; scheduled amount for other dental care	Covered only if treated in a hospital or other facility on either an inpatient or outpatient basis for certain conditions.[16] Benefits based on surgery benefits	Coverage is not provided for dental care and x-rays, dental services following accidental injury to teeth, dental appliances, orthodontia, and dental services associated with medical treatment. Coverage is provided for medically necessary services for the treatment of cleft lip or palate for newborn members, unless the member is covered for these services under a dental insurance policy
LIFETIME MAXIMUM	Only for smoking cessation and substance abuse	None	None
SMOKING CESSATION TREATMENT PROGRAM	$100 per person per lifetime for one program	Not covered	Covered with a reasonable charge

EXCLUSIONS	• If no charge would be made if individual had no health insurance coverage • Furnished without charge • While in active military service • Sustained as result of act of war or during combat • Furnished by immediate relatives or household members • Furnished by provider barred from FEHBP program • Furnished by a non-covered facility, except that medically necessary prescription drugs are covered • For or related to sex transformation, sexual dysfunction, or sexual inadequacy • Not specifically listed as covered • Experimental or investigational, except for the clinical trials benefit • Not provided in accordance with accepted professional medical standards in the U.S. • Any portion of fee that has been waived • Charges the enrollee or plan has no legal obligation to pay • In the case of inpatient care, medical services which are not medically necessary • Standby physicians • Biofeedback and other forms of self-care or self-help training, including cardiac rehab • Orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for dentures • Custodial care • Services and supplies furnished or billed by an extended care facility, nursing home, or other non-covered facility, except as specifically described • Eyeglasses, contact lenses, routine eye exams or vision testing for the prescribing or fitting of eyeglasses or contact lenses • Eye exercises, visual training, or orthoptics, except for non-surgical treatment of amblyopia and strabismus • Hearing aids or examinations for the prescribing or fitting of hearing aids • Treatment of obesity, weight reduction, or dietary control, except for gastric bypass surgery or gastric stapling procedures • Personal comfort items such as	• Biofeedback • Custodial care • Maintenance care • Any care that is not preauthorized • Hypnosis or hypnotherapy treatment • Any treatment that is not medically necessary • Treatments considered experimental and/ or investigational and/or unproven • Treatment of nicotine or caffeine addiction • Services and related expenses for weight loss program • Nutritional supplements • Acupuncture • Genetic counseling • Norplant device and related expenses • Rehabilitation for learning disorders, stuttering, short- and long-term memory therapy, or behavior modification • Cognitive therapy services. • Personal comfort and convenience items • Cosmetic surgery • Sex-change operations • Sterilization reversal • Radial keratotomy • Attention deficit disorder • Biofeedback • Chiropractic services • Hair loss • Private duty nursing	• Workers Comp or employer responsibility • Custodial or intermediate level care • Cosmetic services • Dental services and X-rays including services following accidental injury to teeth or surgery on the jaw • Physical exams for employment or insurance • Experimental or investigational services • Services not generally and customarily available • Sex transformations • Routine foot care not medically necessary • Chiropractic services • Services for members confined in criminal justice institutions • Refractive eye surgery • Long-term rehabilitation • Pulmonary rehabilitation • Food products for enteral feedings • Directed blood donations • Reversal of voluntary, surgically induced infertility

	beauty and barber services, radio, television, or telephone • Services or supplies for cosmetic purposes • Routine services, except for those preventive services specifically identified • Routine foot care • Recreational or educational therapy • Assisted Reproductive Technology procedures, such as artificial insemination, in vitro fertilization, embryo transfer, and GIFT • Services rendered by non-covered providers such as chiropractors, except in medically under-served areas • Procedures, services, drugs, and supplies related to abortions, except when the life of the mother would be endangered or result of rape or incest • Inpatient private duty nursing • Radial keratotomy • Reversal of surgical sterilization • Marital, family, educational, or other counseling or training services	• Skilled nursing facilities • Workers' Comp	

[1]The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

[2]Calendar year deductible applies to all covered services and supplies except for certain inpatient hospital benefits, facility benefits - outpatient surgery, additional benefits, prescription drug benefits, and dental benefits.

[3]Must be precertified; benefits will be reduced by $500 if emergency admission is not precertified within two business days following the day of admission;

[4]Immunizations as recommended by American Academies of Pediatrics and Family Physicians, routine gynecological exams twice each year, age-specific routine physical examinations, and routine vision examinations.

[5]Covers artificial insemination in vivo. Does not cover any cost associated with donor sperm or any other service, supply, or drug used with or for an artificially induced pregnancy, such as "test tube" fertilization, drug-induced ovulation, or other artificial means of conception.

[6]Does not cover in vitro fertilization, ovum transplants, gamete intrafallopian transfer, and zygote intrafallopian transfer.

[7]For acute lymphocytic or nonlymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, chronic myelogenous leukemia, infantile malignant osteopetrosis, severe combined immunodeficiency, Wiskott-Aldrich syndrome, mucopolysaccharidosis, mucolipidosis, severe or very severe aplastic anemia, advanced forms of myelodysplastic syndromes, and thalassemia major.

[8]For acute lymphocytic or nonlymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors, and multiple myeloma.

[9]For breast cancer and epithelial ovarian cancer, only when performed as part of a clinical trial that meets the requirements and is conducted at a cancer research facility.

[10]Pulmonary fibrosis, primary pulmonary hypertension, and emphysema; double lung transplant for end-stage cystic fibrosis.

[11]Does not cover solid organ transplant in patients with an existing or recent malignancy, excluding hepatomas less than 5 cm in diameter, or patients with carcinoma.

[12]Does not cover bone marrow transplantation (allogeneic and autologous) for melanomas, colon cancers, AIDS, certain brain tumors, testicular cancer, sarcomas, lung cancer, ovarian cancer, and peripheral neuroepithelioma. Does not cover autologous bone marrow transplant and peripheral blood stem cell transplant for chronic myelogenous leukemia, multiple myeloma, or brain metastases.

[13]Covers expenses incurred by both the child transplant recipient and up to two adults accompanying the transplant recipient.

[14]Drugs obtained through the mail service prescription drug program are not subject to any deductible.

[15]Excision of tumors and cysts, surgery needed to correct accidental injuries, excision of exostoses of jaws and hard palate, external incision and drainage of cellulitis, incision and surgical treatment of accessory sinuses, salivary glands or ducts, reduction of dislocations and excision of temporomandibular joints, and removal of impacted teeth.

[16]Excision of exostoses of the jaw, surgical correction of accidental injuries, incision and drainage of cellulitis, incision of accessory sinuses, salivary glands, or ducts, tumors of the jaw, accident-related dental expenses, orthognathic surgery when required because of a malocclusion of the jaw, and TMJ-related services up to $1,000 per calendar year.

Exhibit II - Child Health Plan Plus
Colorado Benefit Plans

Benefit Category	Fee-For-Service Plan	HMO Plan Families < 150% FPL	HMO Plan Families > 150% FPL
ANNUAL DEDUCTIBLE Individual Family	None	None	None
COINSURANCE	100%	100%	100%
OUT-OF-POCKET MAXIMUM Individual Family	None	None	None

HOSPITAL EMERGENCY ROOM AND EMERGENCY TRANSPORT (COMBINED)	$15 copay emergency room; emergency transport not covered	$15 copay, waived if admitted	$15 copay, waived if admitted
INPATIENT	Paid in full	Paid in full	Paid in full
INPATIENT PHYSICIAN CARE	Paid in full	Paid in full	Paid in full
OUTPATIENT FACILITY CARE	Paid in full	Paid in full	Paid in full
OUTPATIENT SURGERY	Paid in full	Paid in full	Paid in full
ACCIDENTAL INJURY	Paid same as illness	Paid same as illness	Paid same as illness
MEDICAL OFFICE OR HOME VISIT	$2 copay per visit	$2 copay per visit	$5 copay per visit
LABORATORY & X-RAY SERVICES	Paid in full	Paid in full	Paid in full
ALLERGY TESTS, TEST MATERIALS, AND TREATMENT MATERIALS	$2 copay per visit	$2 copay per visit	$5 copay per visit
PREVENTIVE CARE	Paid in full	Paid in full	Paid in full
WELL CHILD CARE	Paid in full	Paid in full	Paid in full
MATERNITY CARE Prenatal Delivery & inpatient well baby care	 Paid in full Paid in full	 Paid in full Paid in full	 Paid in full Paid in full
INFERTILITY DIAGNOSIS AND TREATMENT	$2 copay per visit	$2 copay per visit	$5 copay per visit
ABORTION	Covered only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest	Covered only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest	Covered only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest

ALL OTHER MENTAL HEALTH Inpatient care Outpatient care	 Paid in full up to 45 days per calendar year $2 copay, 20 visit limit	 Paid in full up to 45 days per calendar year $2 copay, 20 visit limit	 Paid in full up to 45 days per calendar year $5 copay, 20 visit limit
ALCOHOL & SUBSTANCE ABUSE	Diagnosis, medical treatment and referral services, as defined by Guidelines for Adolescent Preventive Services; alcohol and substance abuse treatment is not covered	Diagnosis, medical treatment and referral services, as defined by Guidelines for Adolescent Preventive Services; alcohol and substance abuse treatment is not covered	Diagnosis, medical treatment and referral services, as defined by Guidelines for Adolescent Preventive Services; alcohol and substance abuse treatment is not covered
ORGAN TRANSPLANTS	Not covered	Covered transplants are: • Liver • Heart • Heart/lung • Cornea • Kidney • Bone marrow for aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer, and Wiscott Aldrich syndrome • Peripheral stem cell support for same conditions	Covered transplants are: • Liver • Heart • Heart/lung • Cornea • Kidney • Bone marrow for aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer, and Wiscott Aldrich syndrome • Peripheral stem cell support for same conditions
DURABLE MEDICAL EQUIPMENT	Paid in full up to $2,000 per year	Paid in full up to $2,000 per year	Paid in full up to $2,000 per year
PHYSICAL AND OCCUPATIONAL THERAPY	$2 copay, up to 30 visits per year	$2 copay, up to 30 visits per year	$5 copay, up to 30 visits per year
HOME HEALTH CARE	No charge	No charge	No charge
HOSPICE CARE	Not covered	Paid in full	Paid in full

OUTPATIENT PRESCRIPTION DRUGS	$2 copay per prescription	$1 copay per prescription	$3 generic, $5 brand name copay per prescription
CONTRACEPTIVE DEVICES AND DRUGS	Covered	Covered	Covered
SKILLED NURSING FACILITY CARE	Not covered	Paid in full	Paid in full
VISION SERVICES	$2 copay per visit, $50 annual benefit for eyeglasses	$2 copay per visit, $50 annual benefit for eyeglasses	$5 copay per visit, $50 annual benefit for eyeglasses
HEARING SERVICES	Paid in full, up to $800 per year	Paid in full, up to $800 per year	Paid in full, up to $800 per year
DENTISTRY	Not covered	$2 copay for preventive services	$5 copay for preventive services
LIFETIME MAXIMUM	None	None	None
EXCLUSIONS	• Experimental procedures • Custodial care • Personal comfort items • TMJ treatment • Treatment for obesity • Acupuncture • Biofeedback • In vitro fertilization • Gamete or zygote intrafallopian transfer • Artificial insemination • Reversal of voluntary sterilization • Transsexual surgery • Treatment of sexual disorders • Cosmetic surgery • Radial keratotomy • Biofeedback • Chiropractic services • Private duty nursing • Workers' Comp	• Experimental procedures • Custodial care • Personal comfort items • TMJ treatment • Treatment for obesity • Acupuncture • Biofeedback • In vitro fertilization • Gamete or zygote intrafallopian transfer • Artificial insemination • Reversal of voluntary sterilization • Transsexual surgery • Treatment of sexual disorders • Cosmetic surgery • Radial keratotomy • Biofeedback • Chiropractic services • Private duty nursing • Workers' Comp • Physical exams for employment or insurance • Routine foot care not medically necessary • Services for members confined in criminal justice institutions • Any treatment not medically necessary	• Experimental procedures • Custodial care • Personal comfort items • TMJ treatment • Treatment for obesity • Acupuncture • Biofeedback • In vitro fertilization • Gamete or zygote intrafallopian transfer • Artificial insemination • Reversal of voluntary sterilization • Transsexual surgery • Treatment of sexual disorders • Cosmetic surgery • Radial keratotomy • Biofeedback • Chiropractic services • Private duty nursing • Workers' Comp • Physical exams for employment or insurance • Routine foot care not medically necessary • Services for members confined in criminal justice institutions • Any treatment not medically necessary

	• Physical exams for employment or insurance • Routine foot care not medically necessary • Services for members confined in criminal justice institutions • Any treatment not medically necessary • Dental care • Hospice care • Transplants • Emergency transport • Skilled nursing facility • Autism		

Exhibit III - Child Health Plan Plus
Standardized Utilization and Cost Factors

	Standardized Utilization				Standardized Cost			
	0 - 1	2 - 6	7 - 18	Combined	0 - 1	2 - 6	7 - 18	Combined
Categories of Basic Services								
Inpatient Hospital								
Medical/Surgical	0.6480	0.0795	0.0835	0.1384	$ 2,618.59	$ 1,962.05	$ 2,125.73	$ 2,131.97
Maternity	0.0000	0.0000	0.0012	0.0007	$ 1,661.22	$ 1,661.22	$ 1,661.22	$ 1,661.22
Outpatient Hospital								
Emergency Room	0.1705	0.1840	0.1915	0.1875	$ 285.08	$ 285.08	$ 285.08	$ 285.08
Surgery	0.0409	0.0428	0.0279	0.0331	$ 2,346.81	$ 2,346.81	$ 2,346.81	$ 2,346.81
Other	0.0000	0.3891	0.1089	0.1711	$ 176.73	$ 176.73	$ 176.73	$ 176.73
Physician								
Inpatient Surgery	0.0459	0.0094	0.0136	0.0157	$ 1,229.10	$ 1,662.66	$ 1,735.79	$ 1,666.62
Outpatient Surgery	0.1501	0.1328	0.1831	0.1668	$ 390.91	$ 373.60	$ 235.15	$ 286.57
Office Visits and Misc.	5.8634	3.1907	1.8037	2.5662	$ 59.74	$ 58.26	$ 61.28	$ 60.34
Hospital Visits	0.5235	0.0595	0.1578	0.1685	$ 179.78	$ 153.18	$ 141.88	$ 148.57
Emergency Room Visits	0.1744	0.1620	0.1486	0.1547	$ 125.65	$ 115.90	$ 101.22	$ 107.45
Maternity Care	0.0000	0.0000	0.0004	0.0003	$ 2,919.51	$ 2,919.51	$ 2,919.51	$ 2,919.51
Other	0.1329	0.0177	0.0154	0.0276	$ 165.73	$ 163.84	$ 167.56	$ 166.41
Laboratory and X-Ray Services								
Radiology/Pathology Facility Services	0.1323	0.0813	0.0951	0.0952	$ 376.90	$ 376.90	$ 376.90	$ 376.90

Radiology/Pathology Physician Services	1.7186	1.2825	1.1491	1.2401	$ 33.26	$ 37.34	$ 40.27	$ 38.81
Well Child Services								
Immunizations	2.9311	1.0148	0.2033	0.6843	$ 32.55	$ 32.55	$ 32.55	$ 32.55
Well Baby Exams	3.2099	0.0000	0.0000	0.3178	$ 68.55	$ 6.46	$ 68.55	$ 52.41
Well Child Exams	0.0000	0.1021	0.1500	0.1227	$ -	$ 99.58	$ 149.34	$ 121.62
Categories of Additional Services								
Prescription Drugs	4.1778	2.8195	1.6975	2.2347	$ 24.33	$ 31.00	$ 42.66	$ 37.81
Mental Health Services								
Inpatient	0.0000	0.0035	0.0730	0.0477	$ 1,339.47	$ 1,339.47	$ 1,339.47	$ 1,339.47
Outpatient	0.0000	0.0644	0.2070	0.1494	$ 128.50	$ 128.50	$ 128.50	$ 128.50
Vision Services								
Vision Exams	0.0248	0.0754	0.1766	0.1353	$ 74.35	$ 74.35	$ 74.35	$ 74.35
Glasses/Contacts	0.0000	0.0285	0.0699	0.0522	$ 213.37	$ 213.37	$ 213.37	$ 213.37
Hearing Services								
Hearing Exams	0.0018	0.1003	0.0322	0.0469	$ 57.59	$ 57.59	$ 57.59	$ 57.59
Hearing Aids	0.0000	0.0070	0.0070	0.0063	$ 1,000.00	$ 1,000.00	$ 1,000.00	$ 1,000.00
Other Categories of Services								
Substance Abuse Inpatient	0.0000	0.0000	0.0206	0.0132	$ 980.60	$ 980.48	$ 980.48	$ 980.49
Substance Abuse Outpatient	0.0000	0.0000	0.0064	0.0041	$ 113.40	$ 113.40	$ 113.40	$ 113.40
Skilled Nursing Facility	0.0000	0.0000	0.0011	0.0007	$ 406.31	$ 406.31	$ 406.31	$ 406.31
Chiropractor	0.0187	0.0383	0.1380	0.1002	$ 64.38	$ 64.38	$ 64.38	$ 64.38
Physical Therapy	0.0454	0.0757	0.0774	0.0738	$ 68.16	$ 68.16	$ 68.16	$ 68.16
Home Health	0.0175	0.0331	0.0092	0.0162	$ 278.50	$ 278.50	$ 278.50	$ 278.50
Ambulance	0.0212	0.0064	0.0074	0.0085	$ 393.48	$ 393.48	$ 393.48	$ 393.48
Durable Medical Equipment	0.0405	0.0221	0.0221	0.0239	$ 328.93	$ 328.93	$ 328.93	$ 328.93
Audiology Exams	0.0000	0.0018	0.0018	0.0017	$ 91.93	$ 93.43	$ 115.67	$ 107.54
Dental Care	0.0000	3.0010	3.0010	2.7039	$ 72.74	$ 72.74	$ 72.74	$ 72.74

Exhibit IV - Child Health Plan Plus
Standardized Population

Age	*Projected 1997 Colorado Population*

0	53,107
1	52,777
2	54,040
3	54,375
4	55,875
5	57,106
6	57,295
7	57,769
8	54,393
9	57,578
10	58,257
11	57,685
12	57,100
13	56,528
14	57,943
15	58,539
16	57,654
17	58,276
18	53,920
Total	1,070,217

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