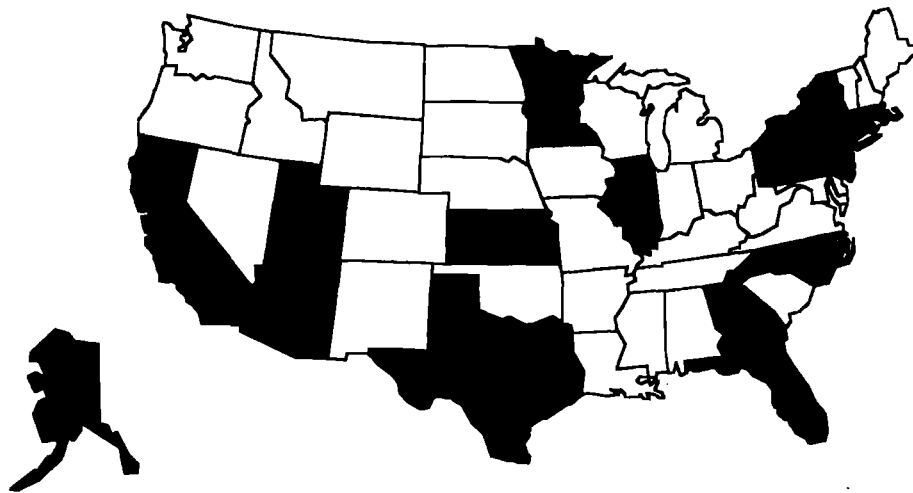


Value of Benefits Offered in Benchmark Plans for State Children's Health Insurance Program (SCHIP)

November 1997



prepared by
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for
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***Value of Benefits Offered in Benchmark Plans
for State Children's Health Insurance Program (SCHIP)***

Executive Summary

The Coalition for Fairness in Mental Illness Coverage¹ (Fairness Coalition) contracted with the Hay Group to provide analysis which would assist the Fairness Coalition in better understanding the implementation of the State Children's Health Insurance Program (SCHIP) as it applies to mental health benefits. Sixteen state plans were selected for this study. The states selected were those that Hay had information already obtained for the annual Hay Benefits Report (HBR) and expanded to include a geographic representation of all states.

The Balanced Budget Act of 1997 created SCHIP under Title XXI of the Social Security Act. This new Title enables states to initiate and expand health insurance coverage for uninsured children. Funding for the new program has been available through an enhanced match of state expenditures since October 1, 1997. To receive Federal matching funds, a state must have an approved state plan. For fiscal year 1998, the total amount allocated for the program is \$4.275 billion and a total of \$24 billion has been authorized over five years.

SCHIP allows states to expand coverage for children through one of three methods: the Medicaid program, a separate child health insurance program, or through a combination of both of these programs. The Medicaid option for states would be available for children who do not qualify for Medicaid under state rules in effect as of April 15, 1997.

The focus of this report is an examination of the benefits offered if a state were to establish or expand a separate child health insurance program or use the combination approach.

States electing to use their funds to establish or expand a separate child health insurance program will be subject to new cost-sharing and benefit rules. SCHIP establishes one national benchmark, Blue Cross/Blue Shield in the Federal Employees Health Benefits Program, that can be used in any state. Each state can also use the state employee's benefits or those of the largest Health Maintenance Organization in the state as a benchmark.

¹ National Alliance for the Mentally Ill
National Mental Health Association
American Managed Behavioral Healthcare Association
American Medical Association
American Psychiatric Association
American Psychological Association
Federation of American Health Systems
National Association of Psychiatric Health Systems

States can either install a plan that is the same as one of the benchmarks or an alternative that has the same **actuarial value** as one of the benchmarks. The alternative must provide mental health benefits that are at least equal to 75 percent of the value of the mental health benefits in the benchmark.

The analysis in the study was based on Hay's proprietary Benefits Value Comparison (BVC) model. That model has been used extensively at the Federal and state level in examining the potential cost of changes in health policy. The BVC model provides a standardized actuarial value of benchmark plans calculated in accordance with SCHIP. The values are the annual cost per child for a national insured population.

All plans evaluated in this sample offer some form of mental health benefits. Although the levels of coverage and coinsurance rates are varied, the majority of plans provide for inpatient mental health hospitalization, outpatient services and substance abuse benefits. Specific plan provisions are included in the analysis of each state.

The overall value of the FEHBP benchmark plan is \$1,460 of which \$72, or 4.9 percent, is the actuarial value of mental health benefits per year per child. The mental health benefits cover inpatient charges for up to 100 days with the enrollee paying a \$150 per day copayment at in-network facilities. Outpatient charges for mental health care are covered up to 25 visits at a 60 percent coinsurance (60 percent by the plan and 40 percent by the enrollee). Substance abuse is covered in the same manner as mental health benefits, except care for the treatment of alcoholism and drug abuse has a lifetime maximum limited to one treatment program (28-day maximum).

The total BVC for the state employee plans ranged from \$1,248 for California to \$1,740 for Utah. The mental health values ranged from \$52 for Illinois to \$115 for Texas. Mental health coverage expressed as a percentage of total coverage ranged from 3.4 percent for Utah to 7.6 percent for Texas.

The Utah plan provides for 30 inpatient days, but covers only the first 10 inpatient days at a 90 percent coinsurance and the remaining at a 50 percent coinsurance. Outpatient visits are covered at 50 percent coinsurance and limited to an annual maximum of \$1,500. The Illinois plans covers 30 inpatient mental health days (in-network only) and requires a \$100 per admission copayment, and 30 outpatient visits are covered with a \$20 enrollee copayment per visit.

The Texas plan covers 30 inpatient days at a 90 percent coinsurance for the first 15 days, and the remaining at a 70 percent coinsurance. The maximum mental health benefit limit is \$25,000, but it does not apply to serious mental illness or substance abuse.

The total BVC for the HMO plans ranged from \$986 for Minnesota to \$1,285 for Illinois. In the HMO plans, mental health values ranged from \$29 for NYLCare in Texas to \$45 for the Harvard Community Plan in Massachusetts. Mental health coverage expressed as a percentage of total coverage ranged from 2.7 percent for NYLCare to 4.4 percent for HealthPartners Select in Minnesota.

The Texas NYLCare plan covers 30 inpatient days at 50 percent coinsurance and 20 outpatient days with a \$25 copayment per visit. On the other hand the Massachusetts plan covers 60 inpatient days in full. The Minnesota plan covers inpatient mental health with at a \$200 per admission and then at 80 percent coinsurance for the next \$3,500 per year. The Minnesota value is relatively high, as a percentage of total cost, because the value of the total plan is relatively low.

The range in value for the HMOs is much narrower than for the state employee plans. One reason for this is that HMO plan design has much less variation than that of other plans. The second reason for the narrower range in HMO values is the effect of management cost controls in limiting higher cost treatment. This results in much smaller relative values being assigned to differences in maximum benefits. For example, an increase from 30 to 60 days mental health inpatient cost increases the typical non-HMO plan cost by \$10 compared to \$2 for an HMO.

The law grandfathers in certain existing comprehensive state-based plans. These plans cover a range of services with no or few copayments. The mental health value for the Florida and Pennsylvania plans is similar to that of the benchmark HMO plans. The New York Child Health Plus Plan's mental health value is much lower because it does not provide for any inpatient mental health or substance abuse services.

While the report provides a starting point for the consideration of state SCHIP proposals, there are a number of specific issues that will have to be resolved before the benchmarks can be applied at the state level. These include adjustment of benchmark values to reflect the cost of insured children in the state and selection of the specific HMO package to use as a benchmark.

Results

***Value of Benefits Offered in Benchmark Plans
for State Children's Health Insurance Program (SCHIP)***

The Coalition for Fairness in Mental Illness Coverage contracted with the Hay Group to provide analysis which would assist the Fairness Coalition in better understanding the implementation of the recently enacted State Children's Health Insurance Program (SCHIP) as it applies to mental health benefits. The timeliness of the report was critical because states could begin to implement the State Children's Health Insurance Program provisions on October 1, 1997. Accordingly the Coalition and Hay agreed to produce reports on as many states as possible in October 1997. The Coalition held a series of meetings with Hay to determine the format and content of the individual state reports and selected 16 states for the initial set of analyses.

State Children's Health Insurance Program

The Balanced Budget Act of 1997 includes an amendment to add a new title to the Social Security Act that establishes the State Children's Health Insurance Program (SCHIP). Title XXI of the Social Security Act enables states to initiate and expand health assistance to uninsured, low-income children. Funding for the new program has been available through an enhanced match of state expenditures since October 1, 1997. To receive Federal matching funds, a state must have an approved state plan. For fiscal year 1998, the total amount allocated for the program is \$4.275 billion and a total of \$24 billion has been authorized over five years.

SCHIP assistance should be provided primarily through three methods: (1) expanding eligibility for children through the State's Medicaid program; or (2) a program to obtain health insurance coverage that meets requirements relating to the amount, duration, and scope of benefits. The third method involves a combination approach. In order to be eligible for funds, states must submit to, and obtain approval from, the Secretary for a State Child Health Plan. This program is a capped entitlement for States. SCHIP calls for states to coordinate the new program with other sources of health benefits for children.

The Medicaid option for states would be available for children who do not qualify for Medicaid under state rules in effect as of April 15, 1997. The Fairness Coalition and other mental health advocacy organizations worked to ensure that states could use their existing Medicaid program to expand coverage for children. Medicaid, without arbitrary limits on mental health services, generally provides the most comprehensive mental health coverage through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

Federal law requires that EPSDT services be provided to all Medicaid-eligible recipients under age 22 to identify physical and mental problems through periodic examinations (screens) and also to furnish treatment to "correct or ameliorate defects and physical and mental illness conditions" discovered by the screenings.

EPSDT encompasses not only screening services, but provision of essential treatment for problems identified by the screen. These services must include any medically necessary service that is authorized under federal law and defined by federal regulation. Under federal rules these services must be sufficient in amount, duration and scope to reasonably achieve their purpose.

The focus of this report is an examination of the benefits offered in benchmark plans that would be used if a state were to establish or expand a separate child health insurance program or use the combination approach.

States electing to use their funds to establish or expand a separate child health insurance program will be subject to new cost-sharing and benefit rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children. Additionally, these states must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid. The law requires that any state that lowers its Medicaid eligibility standards for children below the June 1, 1997 levels be denied access to the new child health funds.

States may elect to use a combination of the Medicaid program and a separate child health insurance program to increase health coverage for children. In effect, this requires the state to follow the provisions outlined under each option.

SCHIP establishes one national benchmark, BlueCross/BlueShield in the Federal Employees Health Benefits Program (FEHBP), that can be used in any state. Each state can also use the state employee's benefits or those of the largest Health Maintenance Organization in the state as a benchmark.

Child Health Assistance

To comply with SCHIP, a state must put a qualifying plan into effect for eligible children. A qualifying plan is one that is either identical to one of several "benchmark" plans or, within certain overall constraints, is actuarially-equivalent to a benchmark plan.

Child Health Assistance (other than Medicaid), for a targeted low-income child must consist of at least benchmark coverage or benchmark-equivalent coverage. The benchmark equivalent plans must provide mental health services at an actuarial value of at least 75 percent of the actuarial value that is provided in the benchmark plan. Alternate options of providing assistance may be accomplished through existing comprehensive coverage that is provided in three identified states and written into the legislation or through coverage approved by Secretary.

Benchmark Coverage

There are three benchmark plans. The first is Standard BlueCross BlueShield preferred provider option in the Federal Employees Health Benefits Program (FEHBP) which can be used as a benchmark in any state. The second is the health benefits coverage that is generally available to state employees in the state. We assume that means any option that is offered to state employees throughout the state. The third is the largest commercial, non-Medicaid federally-qualified Health Maintenance Organization (HMO) in the state.

Hay has determined the actuarial value of the benchmark plans for each state identified in this report. These results can be found in Table 1.

Benchmark-Equivalent Coverage

As an alternative, a state may enact benchmark-equivalent coverage that meets the following standards:

- (A) The coverage includes benefits for the following categories of basic services:
 - Inpatient and outpatient hospital services
 - Physicians' surgical and medical services
 - Laboratory and x-ray services
 - Well-baby and well-child care including age-appropriate immunizations with no cost sharing, deductibles or coinsurance.
- (B) The aggregate actuarial value of the plan has to be at least equal to the value of one of the benchmark plans.
- (C) The following sets of additional services will be included if such coverage is provided under the benchmark plan and each set of services must have an actuarial value that is at least 75 percent of the actuarial value of the benchmark plan.
 - Prescription drugs
 - Mental health services
 - Vision services
 - Hearing services

The actuarial value of mental health services for each benchmark plan has been valued separately. These results can be found in Table 2. In addition, mental health benefits are shown at the 75 percent level.

Existing Comprehensive State-Based Coverage

Health benefit coverage under an existing comprehensive state-wide program is defined as a program that:

- provides a range of benefits;
- is administered by the state and receives state funds;
- is offered in New York, Florida or Pennsylvania; and
- was offered on the date of enactment of this title and, if modified, still includes a range of benefits and has an actuarial value equal to, or greater than, its value on August 5, 1997 or the value of one of the benchmark benefit packages.

Secretary approval for these plans has been grandfathered into the legislation. These existing comprehensive state-wide programs are not benchmark plans.

Secretary Approved Coverage

Any other coverage that the Secretary determines provides appropriate coverage for targeted low-income children.

Actuarial Value

The actuarial value of a health benefits plan is a relative value assigned to the plan by estimating the annual cost and utilization of each benefit provision of the plan for a set of insured individuals. When the cost and utilization is based on the actual experience of the insured individuals, the result is close to the premium for the plan. When comparing two or more health plans the same cost, utilization, and demographic information must be used for all of the plans being compared.

SCHIP requires that a member of the American Academy of Actuaries must perform the calculation using generally accepted principles and methodologies and a standardized set of utilization and price factors. Hay's Benefit Value Comparison (BVC) meets all of these requirements.

SCHIP requires that the comparison use a standardized population representative of privately insured children of the age of the children who are expected to be covered by the plan. The most appropriate cost basis would be experience for privately insured children in the state. The actuarial values included in this report are based on national average cost and utilization for children (under age 22) covered under medium to large-size employers (generally 500 or more employees) throughout the United States.

The actuary will have to analyze the cost and utilization for insured children in a state to determine the actuarial equivalence based on the experience of the insured children in that state. Use of state-specific populations should not result in significant differences in the relative actuarial value of benchmark plans. For example, if Plan A has a value that is 10 percent higher than Plan B using national average experience, Plan A should have a value approximately 10 percent greater than Plan B using state specific experience. Use of national averages in this report also permits the reader to readily compare the values of HMO and state employer plans among different states and with the national standards.

Finally, SCHIP requires that certain benefits (i.e., prescription drugs, mental health services, vision services and hearing services) be included if provided under the benchmark benefit package. SCHIP requires that these benefits have an actuarial value of at least 75 percent of the actuarial value of that category of benefits in the benchmark plan.

Health Care Management

SCHIP also specifies that differences in coverage based on method of delivery or means of cost or utilization control cannot be considered in the calculation of the actuarial value of a plan. The measure also cannot consider reductions in the actuarial value resulting from limitations on cost sharing. There are four primary types of health care management style in the United States:

1. Fee for Service (FFS)
2. Preferred Provider Organization (PPO)
3. Point-of-Service Plan (POS) Plan
4. Health Maintenance Organization (HMO)

The requirements related to management and design suggest that the benchmark coverage used for a particular plan should be drawn from benchmark plans of the same management style. In other words, a proposed HMO plan should be compared to an HMO benchmark; a proposed FFS plan should be compared to a FFS benchmark; etc.

The benchmark options available to a state generally include all four management styles. The Federal PPO is available throughout the country and many states have both a FFS and POS option. Qualifying HMOs are available in all states but Alaska.

Selection of States and Format

Information on state employee health benefit programs was obtained from the state personnel office. Information on the appropriate HMO in the state was obtained from FEHBP and the American Association of Health Plans (AAHP) as described below. The states selected were those that Hay had information already obtained for the annual Hay Benefits Report (HBR) and expanded to include a geographic representation of all states. The states included in this report are:

- Alaska
- Arizona
- California
- Connecticut
- Florida
- Georgia
- Illinois
- Kansas
- Massachusetts
- Minnesota
- New Jersey
- New York
- North Carolina
- Pennsylvania
- Texas
- Utah

State Employee Plans

Most states offer multiple plan designs to their employees. The state employee plan shown for each state is the non-HMO plan with the highest enrollment. If the most popular plan for state employees is an HMO, it is often the largest HMO that is shown in the state comparison. Other non-HMO options typically have BVC values that are similar to those of the plan with the highest enrollment.

Health Maintenance Organization

SCHIP specifies that the benchmark HMO is the largest commercial, non-Medicaid federally-qualified Health Maintenance Organization (HMO) in the state. While the specific HMO is obvious in many states in some there are several plans that might be considered to be the benchmark depending on interpretation of the law. Eventually each state that considers using an HMO benchmark will identify specifically the largest HMO plan, which meets this definition. Hay selected an HMO that was the closest fit to the SCHIP's definition based on available information.

Hay identified the largest commercial, non-Medicaid, Health Maintenance Organization in each state by using the enrollment figures listed in the American Association of Health Plans' (AAHP) National Directory of Health Plans and Utilization Review Organizations, 1997 edition.

The directory does not state if an HMO is federally qualified but AAHP has the information on qualification and willingly provided it for the purposes of this study. In ten of the 15 states with HMOs (Alaska does not have an HMO) the largest plan was federally qualified. For Connecticut, Illinois and Utah the second highest enrolled HMO was federally qualified so that plan was used. In New York and Minnesota, the enrollment of the two largest HMOs was much lower than other plans in the state so we valued the HMO with the highest enrollment even though it was not federally qualified.

HMOs offer optional coverage that can be selected by employers. As a result, the specific package used for a benchmark will have to be determined when a plan is designed in a specific state. Hay used the FEHBP benefits package for each HMO since that information was readily available.

FEHBP BlueCross BlueShield Standard PPO

Details describing the benefits package of the national benchmark FEHBP, BlueCross and BlueShield PPO are presented in a separate section of this report. The benefits used in this report are those offered in the 1998 Service Benefit Plan, Standard Option. This plan is a managed fee-for-service plan including preferred provider and point of service features. The FEHBP covers unmarried dependent children under age 22.

Grandfathered Plans

Florida, New York and Pennsylvania offered comprehensive state-based coverage before SCHIP was enacted and those child health programs were written into the law. These plans are presented within their own state report and together in a separate section of this report.

Mental Health Parity

Federal law now requires group health insurance plans to provide parity in the application of certain limits to mental health benefits. However state employee plans are not subject to the requirement.

Of the plans we evaluated, only one plan document (Texas State Employees) made any reference to the parity law. The Employees Retirement System of Texas states in its 1997 enrollment materials that it intends to comply with the mental health parity requirement on September 1, 1998. The behavioral health lifetime maximum in the materials effective September 1, 1997 is footnoted to indicate that it does not apply to serious mental illness or substance abuse.

The Federal Office of Personnel Management (OPM) has indicated that all of the 1998 FEHBP Plans have eliminated maximum dollar limits on covered mental care. They also stated that the agency had sought to bring about more improvements in mental health benefits, but because all plans were faced with premium increases to cover higher health care costs, success was limited. "As we look toward the next century, our goal is to make sure federal employees can choose among health plans that provide high quality care and service, including improved mental health coverage, at competitive prices," said OPM Acting Director Janice R. Lachance. She added, "We will continue to work hard to achieve that goal."

Half of the state employee plans evaluated had dollar limits that apply to mental health benefits. These were Alaska, Connecticut, Florida, New Jersey, New York, North Carolina, Texas (see above), and Utah. The only HMO plan (using the FEHBP design) that we evaluated that had dollar limits to mental health benefits was Minnesota's HealthPartners Select. The Florida Healthy Kids Program also has a lifetime dollar maximum benefit.

Benefits Value Calculation

The proprietary Hay ***Benefit Value Calculation (BVC)*** software evaluates plan design information to compute the standardized cost of employee benefit programs. The BVC determines the value of a benefit based upon plan provisions and excludes the influence of variables such as funding methods, actuarial and economic assumptions, negotiated discounts, and employee demographics. Differences in these factors can affect the employer's cost of providing the benefit, but have no effect on the benefit amount received by the employee. The method uses a standard set of assumptions to remove their effects. The value includes the cost of administration of the program.

Hay developed the HCBVC model for the Congressional Research Service (CRS) to estimate the cost effects of alternative national health care reform proposals and other health care policy issues. Besides our internal validation of the model against our own data base of employer health care plans, CRS has also subjected the model to a thorough review and has acknowledged its validity.

In its simplest terms, the model reads the design parameters (approximately 130) of a health care plan and the computes the total cost of benefits that would be paid by the plan during a typical expense year. The expense data are synthesized from actual claims experience in twelve categories of care including in- and out- patient hospitalization, surgery, imaging, prescription drugs, and mental health.

Design parameters required for each plan include deductibles, coinsurance rates or copayments, maximum out-of-pocket limits, and the interactions among these parameters; for example, whether a separate hospital deductible counts toward meeting the maximum out-of-pocket limit. Other inputs include the number of covered inpatient hospital days, number of covered outpatient mental health visits, prescription drug copayment, and inpatient and outpatient mental health care copayments.

The model is particularly well suited to developing assessments of the relative values of health care plans. It can also be configured to run including and excluding certain benefits (in this case mental health benefits) so that the cost of the mental health package can be valued separately from the remainder of the plan.

The current versions of the BVC are the Health Care Benefits Value Comparison (HCBVC) version 7.6 for non-HMO plans and Managed Care Benefit Value Comparison (MCBVC) version 2.6 for HMO plans. Hay coded the benefit provisions of each plan in HCBVC 7.6 and MCBVC 2.6. Values of the plans were determined for plan years beginning October 1, 1997.

Dental and vision benefits can be bundled in the health plan or offered as separate options. Since the treatment varied, the BVCs excluded dental and vision benefits for consistency among the benchmark plans. Dental care is not one of the required SCHIP coverages. Inclusion of that package in any of the measures would inflate the overall premium and reduce mental health coverage as a percentage of the total premium.

Results

Results are presented by state. Each state report includes relevant state specific information for benchmark plans within the state and the value of the 1998 FEHBP BlueCross BlueShield Plan. For each state identified, Hay prepared a summary that includes :

- A table identifying the plans evaluated for that state.
- A table of each benchmark plan's annual actuarial value of coverage per child, broken down to demonstrate the value of the mental health portion.
- A table summarizing general plan provisions for each benchmark plan.
- A table summarizing mental health benefits for each benchmark plan.
- Descriptions of the mental health benefits for each plan.

A summary of the results of our report are presented below. Table 1 provides a summary of the total benefit value calculation of each plan. Table 2 provides a summary of both the benefit value calculation of the mental health portion of each plan and a calculation of the mental health portion reduced to 75 percent. Table 3 presents a summary of both the mental health portion as a percentage of the total value of each plan and for 75 percent of the mental health portion.

Table 1
Total Annual Value of Benefits Per Child

	Non-HMO	HMO
FEHB BCBS Standard	\$1,460	
Alaska	\$1,548	N/A
Arizona	\$1,594	\$1,111
California	\$1,248	\$1,145
Connecticut	\$1,479	\$1,141
Florida	\$1,277	\$1,201
Georgia	\$1,640	\$1,163
Illinois	\$1,431	\$1,285
Kansas	\$1,499	\$1,165
Massachusetts	\$1,495	\$1,166
Minnesota	\$1,556	\$ 986
New Jersey	\$1,469	\$1,035
New York	\$1,550	\$1,272
North Carolina	\$1,729	\$1,103
Pennsylvania	\$1,513	\$1,037
Texas	\$1,517	\$1,108
Utah	\$1,740	\$1,129
FL (SCHIP)		\$1,201
NY (SCHIP)		\$1,216
PA (SCHIP)		\$1,256

Table 2
Annual Value of Mental Health Benefits Per Child

	Mental Health Benefits		75% of Mental Health Benefits	
	Non-HMO	HMO	Non-HMO	HMO
FEHB BCBS Standard	\$ 72		\$54	
Alaska	\$112	N/A	\$84	N/A
Arizona	\$ 82	\$43	\$62	\$32
California	\$ 76	\$44	\$57	\$33
Connecticut	\$ 83	\$40	\$62	\$30
Florida	\$ 76	\$43	\$57	\$32
Georgia	\$ 97	\$44	\$73	\$33
Illinois	\$ 52	\$42	\$39	\$32
Kansas	\$ 94	\$43	\$71	\$32
Massachusetts	\$106	\$45	\$80	\$34
Minnesota	\$ 88	\$43	\$66	\$32
New Jersey	\$ 77	\$40	\$58	\$30
New York	\$ 92	\$43	\$69	\$32
North Carolina	\$110	\$41	\$83	\$31
Pennsylvania	\$ 86	\$41	\$65	\$31
Texas	\$115	\$29	\$86	\$22
Utah	\$ 60	\$43	\$45	\$32
FL (SCHIP)		\$37		\$28
NY (SCHIP)		\$11		\$ 8
PA (SCHIP)		\$42		\$32

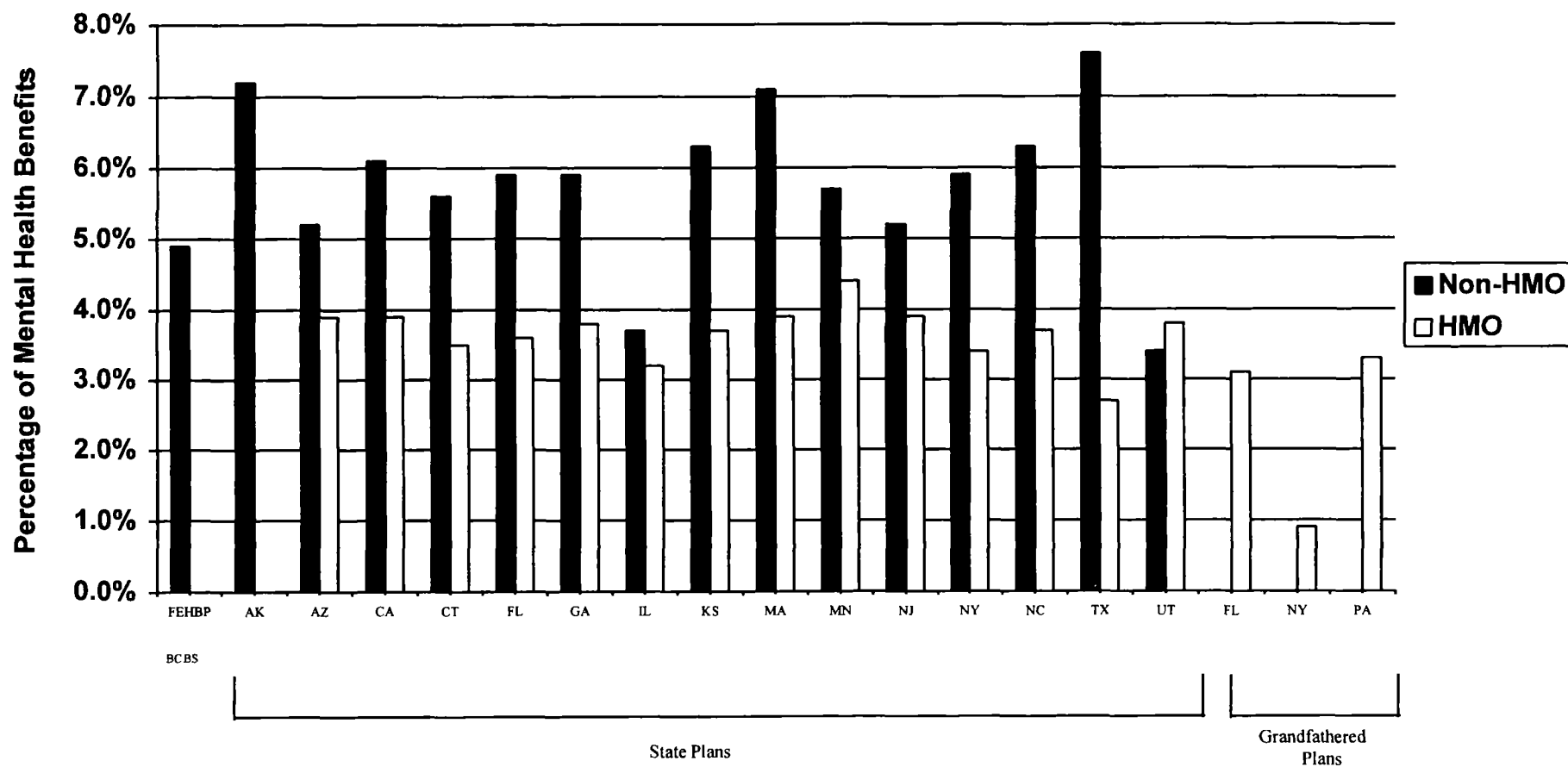
Note : The 75 percent value is shown since that is the minimum value of mental health services that must be provided if the plan is used as the benchmark.

Table 3
Mental Health Value as a Percentage of Total Values

	Mental Health Benefits		75% of Mental Health Benefits	
	Non-HMO	HMO	Non-HMO	HMO
FEHB BCBS Standard	4.9%		3.7%	
Alaska	7.2%	N/A	5.4%	N/A
Arizona	5.2%	3.9%	3.9%	2.9%
California	6.1%	3.9%	4.6%	2.9%
Connecticut	5.6%	3.5%	4.2%	2.6%
Florida	5.9%	3.6%	4.5%	2.7%
Georgia	5.9%	3.8%	4.5%	2.8%
Illinois	3.7%	3.2%	2.7%	2.5%
Kansas	6.3%	3.7%	4.7%	2.7%
Massachusetts	7.1%	3.9%	5.3%	2.9%
Minnesota	5.7%	4.4%	4.3%	3.2%
New Jersey	5.2%	3.9%	3.9%	2.9%
New York	5.9%	3.4%	4.5%	2.5%
North Carolina	6.3%	3.7%	4.8%	2.8%
Pennsylvania	5.7%	4.0%	4.3%	3.0%
Texas	7.6%	2.7%	5.7%	2.0%
Utah	3.4%	3.8%	2.6%	2.8%
FL (SCHIP)		3.1%		2.3%
NY (SCHIP)		0.9%		0.7%
PA (SCHIP)		3.3%		2.5%

Note : The 75 percent value is shown since that is the minimum value of mental health services that must be provided if the plan is used as the benchmark.

Mental Health as a Percentage of Total Benefits



The overall value of the FEHBP benchmark plan is \$1,460 of which \$72, or 4.9 percent, is for mental health benefits cost per year per child. The mental health benefits cover inpatient charges for up to 100 days with the enrollee paying a \$150 per day copayment at in-network facilities. Outpatient charges for mental health care are covered up to 25 visits at a 60 percent coinsurance (60 percent by the plan and 40 percent by the enrollee.) Substance abuse is covered in the same manner as mental health benefits, except care for the treatment of alcoholism and drug abuse has a lifetime maximum limited to one treatment program (28-day maximum).

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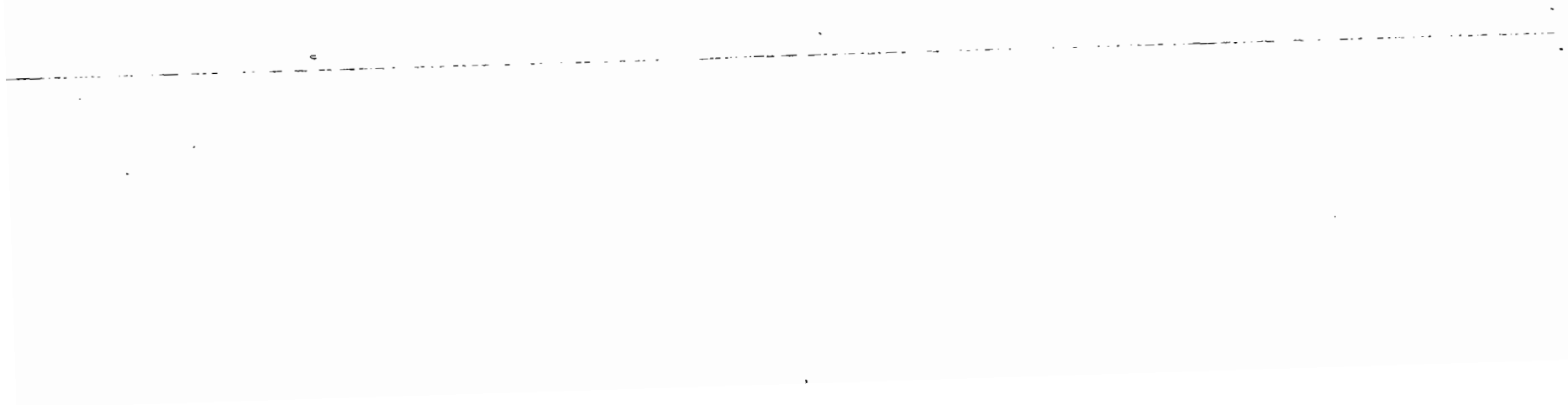
The total BVC for the HMO plans ranged from \$986 for Minnesota to \$1,285 for Illinois. In the HMO plans, mental health values ranged from \$29 for NYLCare in Texas to \$45 for the Harvard Community Plan in Massachusetts. Mental health coverage expressed as a percentage of total coverage ranged from 2.7 percent for NYLCare to 4.4 percent for HealthPartners Select in Minnesota.

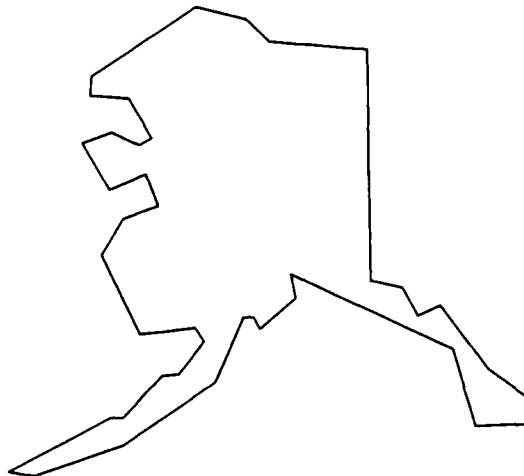
The Texas NYLCare plan covers 30 inpatient days at 50 percent coinsurance and 20 outpatient days with a \$25 copayment per visit. On the other hand the Massachusetts plan covers 60 inpatient days in full. The Minnesota plan covers inpatient mental health with at a \$200 per admission and then at 80 percent coinsurance for the next \$3,500 per year. The Minnesota value is relatively high, as a percentage of total cost, because the value of the total plan is relatively low.

The range in value for the HMOs is much narrower than for the state employee plans. One reason for this is that HMO plan design has much less variation than that of other plans. The second reason for the narrower range in HMO values is the effect of management cost controls in limiting higher cost treatment. This results in much smaller relative values being assigned to differences in maximum benefits. For example, an increase from 30 to 60 days mental health inpatient cost increases the typical non-HMO plan cost by \$10 compared to \$2 for an HMO.

The law grandfathers in certain existing comprehensive state-based plans. Among these plans, the total benefit values are similar. These plans cover a range of services with no or few copayments. The mental health value is similar between the Florida and Pennsylvania plans. The New York Child Health Plus Plan's mental health value is much lower because it does not provide for any inpatient mental health or substance abuse services. Substance Abuse services are not covered at all in Pennsylvania's Child Health Insurance Plan. Florida's Healthy Kids Plan only covers substance abuse services for pregnant adolescents.

Alaska



ALASKA (AK)***I. Plans Evaluated***

AK State Employee Plan		Federal Employees Health Benefit Plan
Plan Name	Aetna Life Insurance Co.	BC/BS PPO Plan (Standard Option)
Type of Plan	FFS	PPO
Year	1997	1998

II. Annual Actuarial Value of Coverage per Child

	Aetna Life Insurance Co.	FEHBP BC/BS PPO Plan
Mental Health BVC Portion	\$ 112	\$ 72
Other Health BVC Portion	\$1,436	\$1,388
Total BVC	\$1,548	\$1,460
Mental Health portion as a percent of Total	7.2%	4.9%

III. Summary of General Plan Provisions

	Aetna Life Insurance Co.	FEHBP BC/BS PPO Plan
Plan Deductible	\$ 250 per person \$500 family max	\$200 per person
In-Patient days	365	365
In-Patient Coinsurance	80/20 percent	<i>Network:</i> 100 percent <i>Non Net.:</i> 100 percent after \$250/ adm.
Out-Patient Coinsurance	80/20 percent	<i>Network:</i> 95/5 percent <i>Non Net.:</i> 75/25 percent
Out of Pocket Maximum	\$1,000	<i>Network:</i> \$2,000 <i>Non Net.:</i> \$3,750
Lifetime Maximum	\$1,000,000 (with \$5,000 restored annually)	N/A

IV. Summary of Mental Health Benefits

	Aetna Life Insurance Co.	FEHBP BC/BS PPO Plan
In-Patient days	365	100 days
In-Patient Coinsurance	80/20 percent	<i>Network:</i> \$150/day <i>Non Net.:</i> \$250/day
Separate MH In-Patient deductible?	No, MH applies to General Plan deductible	No, MH applies to General Plan deductible
Out-Patient Visits Limit	N/A	25 visits
Out-Patient Professional Care Coinsurance	80/20 percent	60/40 percent
Out-Patient Facility Care Coinsurance	80/20 percent	<i>Network:</i> \$25 copay <i>Non Net.:</i> \$100 Member \$150 Non-member
MH Benefit Maximum	\$50,000 Lifetime	Lifetime max. of one inpatient S/A treatment program (28 days)
Alcoholism & S/A covered same as MH?	yes	no, see description for details

V. Description of Mental Health Benefits

A. State Employees of Alaska Plan

Source: 1997 State Employee Group Insurance Information Booklet (pp. 35-36);

The State plan is offered through Aetna Life Insurance Co.

Description of Mental Health Benefits

The medical plan pays for treatment of chemical dependency and mental disorders. Inpatient room and board and other necessary services and supplies are covered. Also covered are physician's charges for inpatient and outpatient services. The Plan requires certification from the health carrier for all inpatient stays, outpatient chemical dependency and mental disorder treatment.

Mental Disorders

Treatment of a mental disorder received through plan referral is paid at normal plan benefits following the deductible. Treatment received without a plan referral is paid at 50 percent. There is a \$1,500 annual maximum that applies to outpatient treatment received without a plan referral. Any benefits received with a plan referral will apply to this maximum.*

A mental disorder is a disease commonly understood to be a mental disorder, whether or not it has a physiological or organic basis, and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist or psychologist. A mental or nervous disorder includes, but is not limited to:

- Schizophrenia
- Bipolar disorder
(manic/depressive)
- Pervasive Mental Development
Disorder (Autism)
- Panic disorder
- Major Depressive disorder
- Psychotic depression
- Obsessive compulsive disorder

Chemical Dependency

Treatment of chemical dependency is paid at normal plan benefits following the deductible. If treatment is received without a plan referral, the first \$400 of inpatient treatment expenses and the first \$200 of outpatient treatment expenses will not be covered.

Benefits for chemical dependency treatment received without a plan referral are limited to \$8,300 per person every two consecutive calendar years and to \$16,600 per person. Any benefits received with a plan referral will apply to this maximum.*

* *There is a \$50,000 lifetime benefit maximum that applies to all benefits for mental disorders and chemical dependency treatment. However, if this amount is exhausted completely for treatment of mental disorders, the above annual and lifetime maximums would be available for treatment of chemical dependency.*

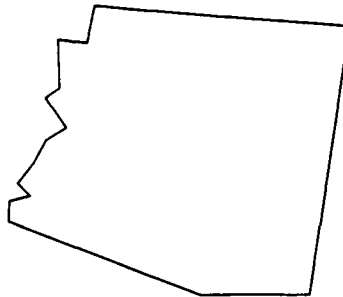
B. Largest Enrolled HMO in Alaska

There is no Health Maintenance Organization based in the State of Alaska listed in the 1997 AAHP National Directory of Health Plans and Utilization Review Organizations. The 1997 benefits package plan description based on the contract with Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law does not provide an HMO in the State of Alaska.

Arizona



ARIZONA (AZ)



I. Plans Evaluated

AZ State Employee Plan		Largest Enrolled HMO	Federal Employees Health Benefit Plan
Plan Name	Indemnity Plus/ FHNL, IG	Intergroup Prepaid Health Services of America	BC/BS PPO Plan (Standard Option)
Type of Plan	PPO	HMO	PPO
Year	1998	1997	1998

II. Annual Actuarial Value of Coverage per Child

	Indemnity Plus/ FHNL, IG	Intergroup Prepaid Health Services	FEHBP BC/BS PPO Plan
Mental Health BVC Portion	\$ 82	\$ 43	\$ 72
Other Health BVC Portion	\$1,512	\$1,068	\$1,388
Total BVC	\$1,594	\$1,111	\$1,460
Mental Health portion as a percent of Total	5.2%	3.9%	4.9%

III. Summary of General Plan Provisions

	Indemnity Plus/ FHNL, IG	Intergroup Prepaid Health Services	FEHBP BC/BS PPO Plan
Plan Deductible	\$150 /Individual \$300 /Family Maximum	N/A	\$200 / calendar year
In-Patient days	365	365	365
In-Patient Coinsurance	<i>Network:</i> 90/10 percent <i>Non Net.:</i> 80/20 percent	no copay	<i>Network:</i> 100 percent <i>Non Net.:</i> 100 percent after \$250/adm.
Out-Patient Coinsurance	<i>Network:</i> 90/10 percent <i>Non Net.:</i> 80/20 percent	\$10 copay	<i>Network:</i> 95/5 percent <i>Non Net.:</i> 75/25 percent
Out of Pocket Maximum	<i>Network:</i> \$450 <i>Non Net.:</i> \$750/Indiv. \$1,500/Family	\$5,500 for Self, \$13,200 for Family	<i>Network:</i> \$2,000 <i>Non Net.:</i> \$3,750
Lifetime Maximum	\$1,000,000	N/A	N/A

IV. Summary of Mental Health Benefits

	Indemnity Plus/ FHNL, IG	Intergroup Prepaid Health Services	FEHBP BC/BS PPO Plan
In-Patient days	30 days	30 days	100 days
In-Patient Coinsurance	<i>Network:</i> 90/10 percent <i>Non Net.:</i> 80/20 percent	no copay	<i>Network:</i> \$150/day <i>Non Net.:</i> \$250/day
Separate MH In-Patient deductible?	N/A	N/A	No, MH applies to General Plan deductible
Out-Patient Visits Limit	20 visits	20 visits	25 visits
Out-Patient Professional Care Coinsurance	<i>Network:</i> 90/10 percent <i>Non Net.:</i> 80/20 percent	\$15 copay for individual \$7.50 for group therapy	60/40 percent
Out-Patient Facility Care Coinsurance	N/A	N/A	<i>Network:</i> \$25 copay <i>Non Net.:</i> \$100/day
MH Benefit Maximum	N/A	N/A	one inpatient S/A treatment program
Alcoholism & S/A covered same as MH?	yes	no, see description for details	no, see description for details

V. Description of Mental Health Benefits**A. State Employees of Arizona**

Source: Benefacts - Guide to Benefits for Arizona State Employees (1996/97 Plan Year) and Active Employee 10/1/97-9/30/98 Open Enrollment Employee Benefits

Five carriers offer Plans to Arizona State Employees for the 1996/1997 Plan Year. Depending on the county of residence, an employee may select from:

- Fee-for-Service Plan:
 - CompPreferred Indemnity
 - Intergroup MSA Supersaver
- Preferred Provider Organization:
 - Indemnity Plus
 - (underwritten by Foundation Health
 - National Life Insurance Co. (FHNL)
 - and administered by Intergroup)
- Five HMOs:
 - BC/BS of Arizona BlueSelect
 - CIGNA HealthCare
 - Health Partners Direct Access
 - Intergroup HMO
 - PacificCare, formerly FHP

The Indemnity Plus plan was valued.

Description of Mental Health Benefits**Mental Disorders/Substance Abuse****Inpatient Services**

A maximum of 30 days of inpatient treatment per enrollee is allowed for any and all treatment of mental disorders and any related complications during each plan year in which the enrollee has coverage with that group.

PPO Provider Coinsurance: 90/10 percent split

Indemnity Coinsurance: (after the deductible) 80/20 percent split

Outpatient Services

A maximum of 20 visits per enrollee is allowed for outpatient psychotherapy and/all psychological services per plan year.

PPO Provider Coinsurance: 90/10 percent split

Indemnity Coinsurance: (after the deductible) 80/20 percent split

Not Covered

Psychiatric and medical services which are the direct result of any eating disorders such as bulimia, anorexia nervosa, or any physical manifestation of a mental disorder, are eligible for payment only under the Mental Disorders provision.

No benefits will be paid under this Benefit Plan for expenses associated with:

- Marital, family or other counseling services;
- Services related to the diagnosis and treatment of the following Mental Disorders: disturbance of conduct, disturbance of emotions, specific delays in development, mental retardation, and autism.

Precertification is required for all Mental Disorder services, or Treatment programs.

B. Intergroup Prepaid Health Services of America (1997)

Source: The 1997 benefits package plan description based on the contract with Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law to provide a comprehensive medical plan to FEHB members. (pages 19-20)

Description of Mental Health Benefits**Mental Conditions/Substance Abuse Benefits**

Care must be received from or arranged by Plan doctors.

Mental Conditions**Covered Benefits**

To the extent shown below, the Plan provides for the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient Care

- Up to 20 outpatient visits for individual therapy to Plan doctors, consultants or other psychiatric personnel each calendar year; Participant pays a \$15 copay for each individual therapy session; a \$7.50 copay for each group therapy session. After 20 visits, enrollee pays all charges.

Inpatient Care

- Up to 30 days of hospitalization each calendar year; this may include partial hospitalization. If partial hospitalization is provided, the benefit will be exchanged as two partial hospitalization days equal to one inpatient day; no copayment for the first 30 days. Enrollee pays all charges thereafter.

Not Covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment.
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.

Substance AbuseCovered Benefits

This plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition, and to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient Care

All necessary outpatient visits to Plan providers for treatment; Enrollee pays no copayments.

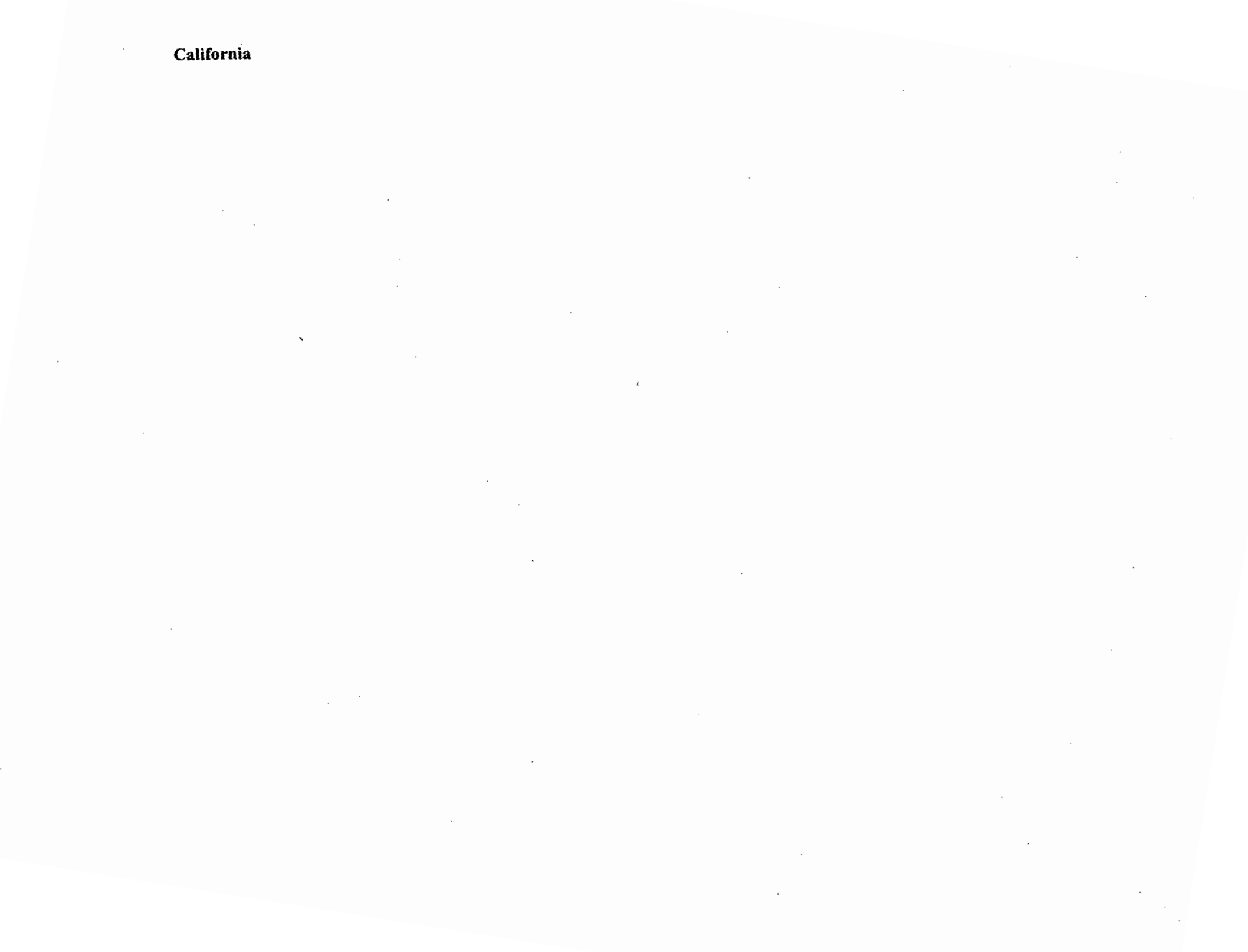
Inpatient Care

Lifetime maximum of two substance abuse rehabilitation (intermediate care) programs in an Alcohol Detoxification or Rehabilitation Center approved by the Plan; Enrollee pays no copayment during the benefit period. Enrollee pays all charges thereafter.

Not Covered

- Treatment that is not authorized by a Plan doctor.
- All charges if the participant does not complete the treatment program.

California



CALIFORNIA (CA)



I. Plans Evaluated

	CA State Employee Plan	Largest Enrolled HMO	Federal Employees Health Benefit Plan	State Child Health Insurance Plan
Plan Name	PERSCare	Kaiser Foundation Health Plan, Inc. No. California Region	BC/BS PPO Plan (Standard Option)	California Children's Health Plan (CCHP)
Type of Plan	PPO	HMO	PPO	
Year	1998	1997	1998	1998

II. Annual Actuarial Value of Coverage per Child

	PERSCare	Kaiser Foundation Health Plan	FEHBP BC/BS PPO Plan	California Children's Health Plan
Mental Health BVC Portion	\$ 76	\$ 44	\$ 72	not enough data to value the plan
Other Health BVC Portion	\$1,172	\$1,101	\$1,388	
Total BVC	\$1,248	\$1,145	\$1,460	
Mental Health portion as a percent of Total	6.1%	3.9%	4.9%	

III. Summary of General Plan Provisions

	PERSCare	Kaiser Foundation Health Plan	FEHBP BC/BS PPO Plan	California Children's Health Plan
Plan Deductible	\$250 / Ind. \$500 / Family	N/A	\$200 / calendar year	
In-Patient days	365	365	365	
In-Patient Coinsurance	<i>Network:</i> 90/10 percent <i>Non Net.:</i> 60/40 percent	no copay	<i>Network:</i> 100 percent <i>Non Net.:</i> 100 percent after \$250/adm.	
Out-Patient Coinsurance	<i>Network:</i> 90/10 percent <i>Non Net.:</i> 60/40 percent	\$5 copay	<i>Network:</i> 95/5 percent <i>Non Net.:</i> 75/25 percent	
Out of Pocket Maximum	<i>Network:</i> \$2,000 Ind., \$4,000 Family <i>Non-Net.:</i> None	\$1,500 Self \$3,000 Family	<i>Network:</i> \$2,000 <i>Non Net.:</i> \$3,750	

IV. Summary of Mental Health Benefits

	PERSCare	Kaiser Foundation Health Plan	FEHBP BC/BS PPO Plan	California Children's Health Plan
In-Patient days	30 days	45 days	100 days	
In-Patient Coinsurance	<i>Network:</i> 90/10 percent <i>Non Net.:</i> 60/40 percent	no copay	<i>Network:</i> \$150/day <i>Non Net.:</i> \$250/day	
Separate MH In-Patient deductible?	No, MH applies to General Plan deductible	N/A	No, MH applies to General Plan deductible	
Out-Patient Visits Limit	30 visits	40 visits	25 visits	
Out-Patient Professional Care Coinsurance	<i>Network:</i> 90/10 percent <i>Non Net.:</i> 60/40 percent	\$10 copay \$5 copay for group therapy	60/40 percent	
Out-Patient Facility Care Coinsurance	N/A	N/A	<i>Network:</i> \$25 copay <i>Non Net.:</i> \$100/day	
MH Benefit Maximum	N/A	N/A	one inpatient S/A treatment program	
Alcoholism & S/A covered same as MH?	no, see description for details	no, see description for details	no, see description for details	

V. *Description of Mental Health Benefits*

A. State of California

Source: California Public Employee's Retirement System (CalPERS) Open Enrollment materials (1998) for the contract year beginning January 1, 1998.

Seventeen Medical Plans are offered to California State employees. Depending on the county of residence, an employee may select from:

- | | |
|---|---|
| <ul style="list-style-type: none"> • Two PPO Plans:
PERSCare
PERS Choice • Four Association PPO/FFS Plans
CAHP Health Benefits Trust
CCPOA Managed Care Plan
CPFA Plan
PORAC • Some Out-of State Plans (HMO)
Intergroup of Arizona | <ul style="list-style-type: none"> • Eleven HMOs:
Aetna U.S. Health care
Blue Shield Access+ HMO
CIGNA HealthCare
HealthNet / Foundation
HP of the Redwoods
Kaiser Plans
Lifeguard
Maxicare
National HMO
OMNI Health care
PacifiCare/FHP |
|---|---|

The "Health Plan Decision Guide" explains that several health plans have experienced mergers and are no longer available as separate plans in the CalPERS program. Kaiser North and Kaiser South have consolidated their operations, creating one plan. Foundation and HealthNet have announced plans to merge. PacifiCare has acquired FHP. These HMOs constitute the top three plans with the highest enrollment among State employees. The plan with the fourth highest enrollment among State employees is PERSCare. Since this plan offers a delivery system other than HMO, PERSCare was evaluated.

Source: PERSCare Preferred Provider Organization Evidence of Coverage the following description from the General Benefits Information (page 17) pertains to Mental Health and Substance Abuse Services of all plans.

Description of Mental Health Benefits

Benefits/Administrative Changes for the 1998 Contract Year

There is no lifetime maximum for mental health services. The Plan now pays ninety percent (90%) of the Allowable Amount for outpatient mental health care if services are received from a Preferred Provider. The Plan pays sixty percent (60%) of the Allowable Amount if services are received from a non-Preferred Provider.

Mental Health Benefits**Inpatient Care**

The Plan pays 90 percent for PPO and out-of-area inpatient care and 60 percent for non-PPO inpatient care (for up to 30 days per calendar year). These charges are subject to the deductible and do not apply toward the maximum calendar year copayment responsibility.

Precertification from Healthmarc must be obtained five (5) business days prior to admission, or within twenty-four (24) hours or by the end of the first business day following an emergency admission. Failure to obtain the required precertification within the specified time frame may result in increased copayment responsibility and/or denial of benefits.

Benefits are provided for hospital and physician services medically necessary to stabilize an acute psychiatric condition up to thirty (30) days per calendar year. Treatment for chronic psychiatric or psychological conditions is not covered.

Inpatient benefits may be utilized to cover day or evening psychiatric hospital programs when precertified in advance by Healthmarc at the rate of two (2) day or evening treatments to equal one (1) full inpatient day treatment. The outpatient calendar year maximum benefit will not exceed the equivalent of thirty (30) inpatient days per calendar year.

Outpatient Care

The Plan pays 90 percent for PPO and out-of-area outpatient care and 60 percent for non-PPO (for up to 15 days per calendar year) outpatient care. These charges are subject to the deductible and do not apply toward the maximum calendar year copayment responsibility. For benefits to be payable, the provider must be a currently licensed physician or mental health provider.

The Plan covers:

- Individual and group sessions
- Physician/psychiatrist visits for mental health drug management
- Physician/psychiatrist outpatient consultations
(any combination up to 30 visits per calendar year)

Any treatment plan in excess of seven (7) visits per calendar year must be precertified by Healthmarc. Failure to obtain the required precertification within the specified time frame may result in increased copayment responsibility and/or denial of benefits.

The intent of this benefit is to provide medically necessary treatment to stabilize an acute chemical dependency condition up to thirty (30) visits per calendar year. Mental health treatment is limited to evaluation, crisis intervention, and treatment for conditions which are subject to significant improvement through short-term therapy. Treatment for chronic psychiatric or psychological conditions is not covered. Visits for psychiatric care, biofeedback, and psychological testing will be accrued against the maximum benefit of thirty (30) visits per calendar year.

Chemical Dependency

The lifetime maximum payment for any combination of inpatient and outpatient chemical dependency services is twelve thousand dollars (\$12,000).

Inpatient Care

The Plan pays 90 percent for PPO and out-of-area inpatient care and 60 percent for non-PPO inpatient care (for up to 15 days per calendar year). These charges are subject to the deductible and do not apply toward the maximum calendar year copayment responsibility.

Precertification from Healthmarc must be obtained five (5) business days prior to admission, or within twenty-four (24) hours or by the end of the first business day following an emergency admission. Failure to obtain the required precertification within the specified time frame may result in increased copayment responsibility and/or denial of benefits.

Benefits are provided for hospital and physician services medically necessary for short-term (3 to 5 days) medical management of detoxification or withdrawal symptoms, up to fifteen (15) days per calendar year. Inpatient charges in connection with chemical dependency rehabilitation services and programs are not a covered benefit.

Inpatient benefits may be utilized to cover day or evening chemical dependency treatment programs when precertified in advance by Healthmarc, at the rate of two (2) day or evening treatments to equal to one (1) full inpatient day treatment. The outpatient calendar year maximum benefit will not exceed the equivalent of fifteen (15) inpatient days per calendar year.

Outpatient Care

The Plan pays 90 percent for PPO and out-of-area outpatient care and 60 percent for non-PPO (for up to 15 days per calendar year) outpatient care. These charges are subject to the deductible and do not apply toward the maximum calendar year copayment responsibility. For benefits to be payable, the provider must be a currently licensed physician or mental health provider.

The Plan covers:

- Individual and group sessions
- Physician/psychiatrist visits for mental health drug management
- Physician/psychiatrist outpatient consultations
(any combination up to 30 visits per calendar year)

Any treatment plan in excess of seven (7) visits per calendar year must be precertified by Healthmarc. Failure to obtain the required precertification within the specified time frame may result in increased copayment responsibility and/or denial of benefits.

The intent of this benefit is to provide medically necessary treatment to stabilize an acute chemical dependency condition, up to thirty (30) visits per calendar year.

Benefit Limitations, Exceptions, And Exclusions

General Exclusions pertaining to Mental health benefits.

Benefits of this Plan are not provided for, or in connection with, the following:

1. Marriage and family counseling: Counseling for the sole purpose of resolving conflicts between a subscriber and his or her spouse or children.
2. Psychiatric and psychological care
 - A. Treatment of the following conditions:
 1. personality disorders;
 2. sexual deviations and disorders;
 3. abuse of drugs;
 4. conduct disorders;
 5. mental retardation and developmental delays;
 6. conditions of abnormal behavior which are not directly attributed to a mental disorder which is the focus of attention or treatment;

- 7. attention deficit disorders.
 - B. Telephone consultations.
 - C. Psychological testing or testing for intelligence or learning disabilities unless medically necessary to assess brain function suspected to be impaired due to trauma or organic dysfunction.
 - D. Inpatient treatment for eating disorders.
 - E. Services on court order or as a condition of parole or probation unless services are determined to be medically necessary and appropriate for the condition being treated and otherwise covered by the plan.
3. Rehabilitation or rehabilitative care.
- Inpatient charges in connection with rehabilitation services and programs for mental health and chemical dependency treatment, and eating disorders.

B. Kaiser Foundation Health Plan, Inc. Northern California Region (1997)

Source: The 1997 benefits package plan description based on the contract with Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law to provide a comprehensive medical plan to FEHB members. (page 15)

Description of Mental Health Benefits**Mental Conditions/Substance Abuse Benefits**

Care must be received from or arranged by Plan doctors.

Mental Conditions**Covered Benefits**

To the extent shown below, the Plan provides for the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing; Enrollee pays \$5 per visit
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services -- less one day for each two sessions for partial hospitalization during the calendar year)
- Partial hospitalization for up to 90 sessions per calendar year (less two sessions for each day of inpatient care received during the calendar year)

Outpatient Care

Up to 20 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; if a member has exhausted the 20 visit limitation, up to 20 additional days in the same calendar year will be provided when prescribed by a Plan Mental Health Provider; Enrollee pays a \$10 copay for each covered visit, \$5 copay for group therapy and all charges thereafter.

Unless an appointment is canceled at least 24 hours in advance, members must pay \$20 for a missed individual therapy appointment and \$10 for a missed group therapy appointment.

Inpatient Care

Up to 45 days of hospitalization each calendar year; Enrollee pays nothing for the first 45 days- all charges thereafter.

Not Covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment.
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.

Substance AbuseCovered Benefits

This plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition. If psychiatric services are necessary, they are provided in conjunction with the mental conditions benefit shown above. In addition the Plan provides:

Inpatient Care

Short-term recovery services, including counseling and support, under the Plan's substance abuse treatment program. Enrollee pays nothing.

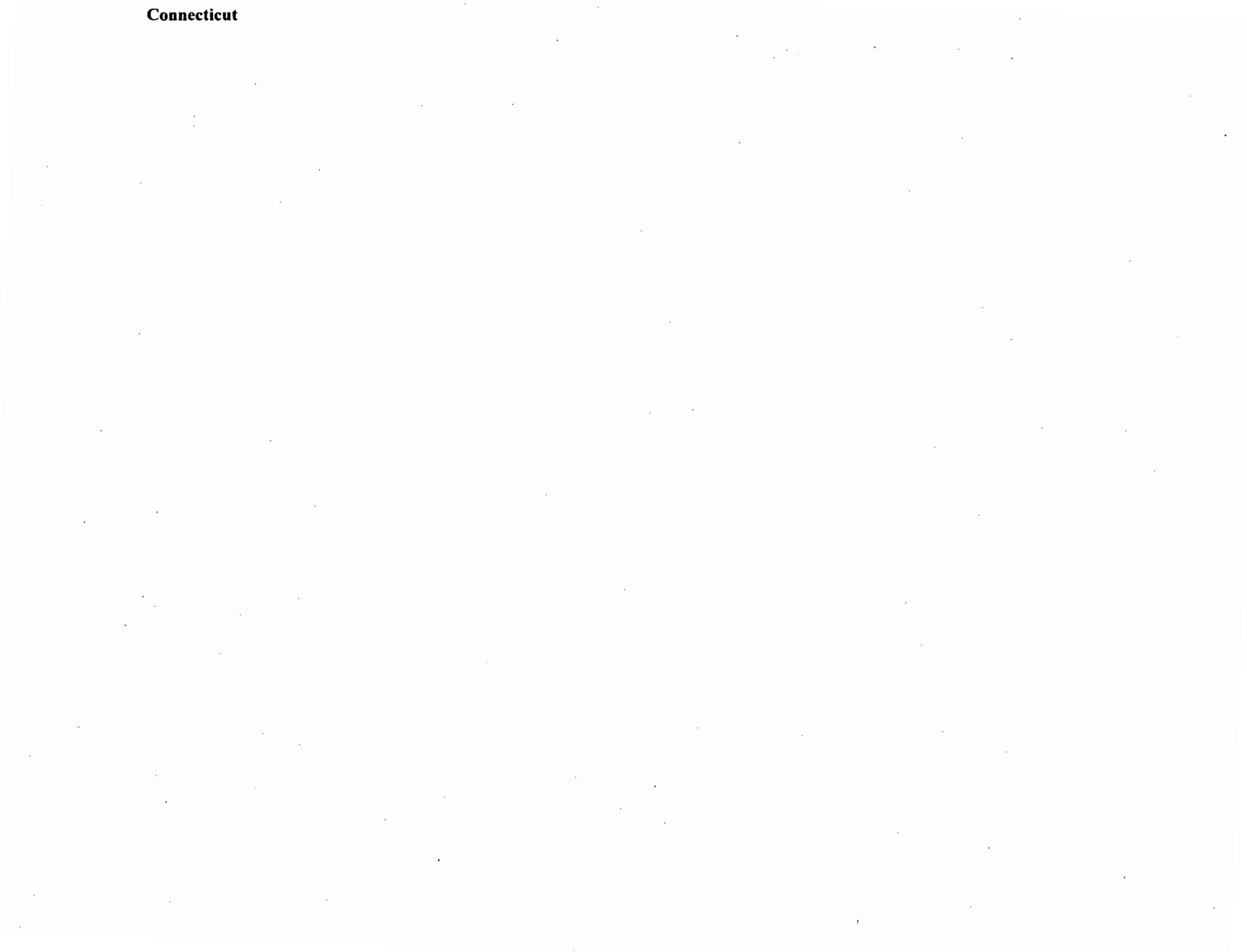
Outpatient Care

Treatment and counseling, including the services to determine the need for special facilities; Enrollee pays a \$5 copay for each visit. Determination of the need for services of a specialized facility and referral to such a facility in appropriate cases covered.

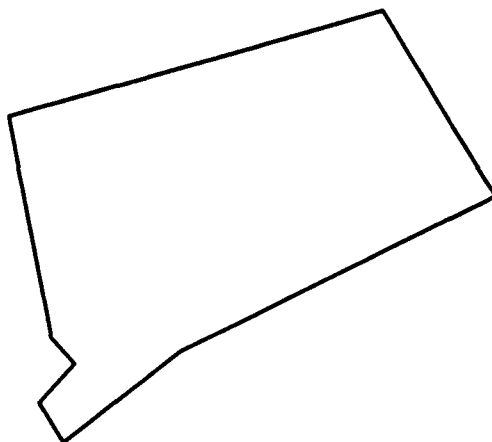
Not Covered

- Treatment that is not authorized by a Plan doctor.
- Care in a specialized alcoholism, drug abuse or drug addiction treatment center except that methadone treatment for a pregnant member is provided at no charge at licensed treatment centers throughout the pregnancy and for two months after delivery.

Connecticut



CONNECTICUT (CT)



I. Plans Evaluated

CT State Employee Plan		Largest Enrolled HMO	Federal Employees Health Benefit Plan
Plan Name	BC/BS State Preferred	ConnectiCare	BC/BS PPO Plan (Standard Option)
Type of Plan	PPO	HMO	PPO
Year	1997	1997	1998

II. Annual Actuarial Value of Coverage per Child

	BC/BS State Preferred	ConnectiCare	FEHBP BC/BS PPO Plan
Mental Health BVC Portion	\$ 83	\$ 40	\$ 72
Other Health BVC Portion	\$1,396	\$1,101	\$1,388
Total BVC	\$1,479	\$1,141	\$1,460
Mental Health portion as a percent of Total	5.6%	3.5%	4.9%

III. Summary of General Plan Provisions

	BC/BS State Preferred	ConnectiCare	FEHBP BC/BS PPO Plan
Plan Deductible	<i>Network:</i> None <i>Non Net.:</i> \$500/ind., \$1,500 family	N/A	\$200 / calendar year
In-Patient days	365	365	365
In-Patient Coinsurance	<i>Network:</i> 100 percent <i>Non Net.:</i> 80/20 percent	no copay	<i>Network:</i> 100 percent <i>Non Net.:</i> 100 percent after \$250/adm.
Out-Patient Coinsurance	<i>Network:</i> \$5 copay <i>Non Net.:</i> 80/20 percent	no copay	<i>Network:</i> 95/5 percent <i>Non Net.:</i> 75/25 percent
Out of Pocket Maximum	N/A	N/A	<i>Network:</i> \$2,000 <i>Non Net.:</i> \$3,750

IV. Summary of Mental Health Benefits

	CT State Employee Plan	ConnectiCare	FEHBP BC/BS PPO Plan
In-Patient days	60	365	100 days
In-Patient Coinsurance	<i>Network:</i> 100 percent <i>Non Net.:</i> 80/20 percent	no copay	<i>Network:</i> \$150/day <i>Non Net.:</i> \$250/day
Separate MH In-Patient deductible?	No, MH applies to General Plan deductible	N/A	No, MH applies to General Plan deductible
Out-Patient Visits Limit	40 visits	20 visits	25 visits
Out-Patient Professional Care Coinsurance	<i>Network & Non Net.:</i> 50/50 percent	\$29 or \$45 copay Group Therapy at \$20 or \$12 copay	60/40 percent
Out-Patient Facility Care Coinsurance	N/A	N/A	<i>Network:</i> \$25 copay <i>Non Net.:</i> \$100/day
MH Benefit Maximum	\$2,000 per member per year	N/A	one inpatient S/A treatment program
Alcoholism & S/A covered same as MH?	no, see description for details	no, see description for details	no, see description for details

V. Description of Mental Health Benefits**A. State of Connecticut**

Source: State of Connecticut Employees Health and Dental Plan, Health Care Planner: Comparison of Options. (1997)

Five Plans are offered to Connecticut State Employees. Depending on the county of residence, an employee may select from:

- PPO Plan:
 - BC/BS State Preferred (PPO)
 - Blue Care POS
- HMOs:
 - Blue Care POE
 - Kaiser Permanente
 - M.D. Health Plan

Only the BC/BS plans and M.D. Health Plan offer statewide coverage. The BC/BS of Connecticut plan was valued. BC/BS enrollees participate in a comprehensive managed health care program which highlights utilization review of hospitalizations and second-opinion surgical reviews.

Description of Mental Health Benefits**Mental Health****Inpatient**

Network: Covered in full up to 60 days.
Non Network: Up to 60 days, 80/20 percent.

Outpatient

Network and non-network benefits are the same. The plan pays 50 percent per visit up to a combined 40 visit maximum with outpatient substance abuse per member per contract year. The maximum benefit is \$2,000 per contract year. Enrollee payments do not accrue toward coinsurance limit. (Care is accessed by calling the VBH Referral Line.)

Substance Abuse Services**Inpatient**

Network: Treatment of alcohol dependency is covered up to 45 days per contract year. Treatment of chemical dependency is covered up to 60 days per contract year. Care is accessed by calling the VBH Referral Line.)

Non-network: Alcohol/drug treatment is covered up to 45 days per calendar year.

Outpatient

Network and non-network benefits are the same. The plan pays 50 percent per visit up to a combined 40 visit maximum with outpatient mental health per member per contract year. The maximum benefit is \$2,000 per contract year. Enrollee payments do not accrue toward coinsurance limit. (Care is accessed by calling the VBH Referral Line.)

B. ConnectiCare (1997)

Source: The 1997 benefits package plan description based on the contract with Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law to provide a comprehensive medical plan to FEHB members. (page 14.)

Description of Mental Health Benefits**Mental Conditions/Substance Abuse Benefits**

Care must be received from or arranged by Plan doctors.

Mental Conditions**Covered Benefits**

To the extent shown below, the Plan provides for the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient Care

Up to 20 outpatient visits to a participating psychiatrist, psychologist, clinical nurse specialist or masters prepared social worker. Enrollee pays the following copayments:

If Provided by:	Psychiatrist/Psychologist	Social Worker/ Clinical Nurse Specialist
Most Services:	\$45 copay	\$29 copay
Short Visits	\$25 copay	\$17 copay
Group Therapy	\$20 copay	\$12 copay

Inpatient Care

Up to 60 days of hospitalization each calendar year upon referral by a participating provider; Enrollee pays no copayment for the first 60 days - all charges thereafter. Each day of partial hospitalization will count as one half day of inpatient care.

Not Covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment.
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.

Substance AbuseCovered Benefits

This plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition, and to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient Care

Up to 20 outpatient visits to Plan providers for treatment each calendar year; Enrollee pays the same copayment for each covered visit as for outpatient care for mental conditions - all charges thereafter.

The substance abuse benefit may be combined with the outpatient mental conditions benefit shown above, provided such treatment is necessary and is approved by the Plan, to permit an additional 20 outpatient visits per calendar year with the applicable mental conditions benefit copayments for a total of 40 outpatient visits.

Inpatient Care

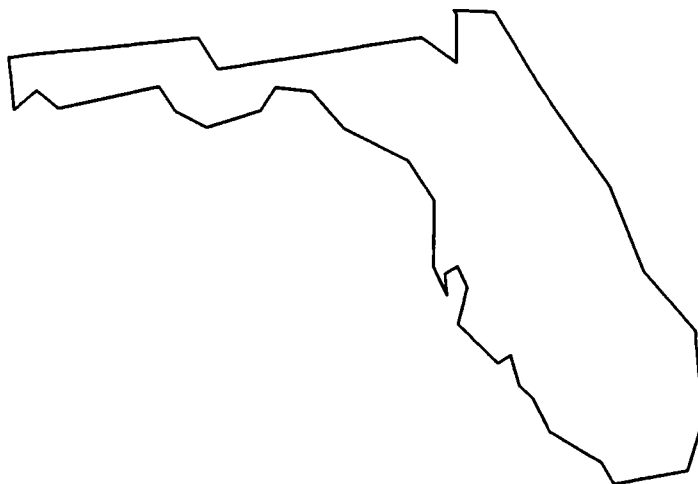
Up to 45 days per calendar year in a substance abuse treatment (intermediate care) program in an alcohol detoxification or treatment center approved by the Plan; you pay nothing during the benefit period -- all charges thereafter. Enrollee pays all charges if the treatment program is not completed.

Each day of partial hospitalization will count as one half day of inpatient care.

Not Covered

Treatment that is not authorized by a Plan doctor.

Florida

FLORIDA (FL)***I. Plans Evaluated***

	FL State Employee Plan	Largest Enrolled HMO	Federal Employees Health Benefit Plan	State Child Health Insurance Plan
Plan Name	State of Florida Group Health Self Insured Plan	Humana Medical Plan	BC/BS PPO Plan (Standard Option)	Florida Healthy Kids
Type of Plan	PPO	HMO	PPO	HMO
Year	1997	1997	1997	1998

II. Annual Actuarial Value of Coverage per Child

	Florida Group Health	Humana Medical Plan	FEHBP BC/BS PPO Plan	Florida Healthy Kids
Mental Health BVC Portion	\$ 76	\$ 43	\$ 72	\$ 37
Other Health BVC Portion	\$1,201	\$1,158	\$1,388	\$1,164
Total BVC	\$1,277	\$1,201	\$1,460	\$1,201
Mental Health portion as a percent of Total	5.9%	3.6%	4.9%	3.1%

III. Summary of General Plan Provisions

	Florida Group Health	Humana Medical Plan	FEHBP BC/BS PPO Plan	Florida Healthy Kids
Plan Deductible	<i>Network:</i> \$150/\$300 <i>Non Net.:</i> 300/\$600	N/A	\$200	N/A
In-Patient days	365	365	365	365
In-Patient Coinsurance	<i>Network:</i> 90/10 percent after \$150/adm. <i>Non Net.:</i> 80/20 percent after \$300/adm.	no copay	<i>Network:</i> 100 percent <i>Non Net.:</i> 100 percent after \$250/adm.	no copay
Out-Patient Coinsurance	<i>Network:</i> 90/10 percent <i>Non Net.:</i> 70/30 percent	\$5 copay	<i>Network:</i> 95/5 percent <i>Non Net.:</i> 75/25 percent	\$3 copay
Out of Pocket Maximum	\$2,500 for Self, \$5,000 for Family	\$3,000 for Self, \$8,400 for Family	<i>Network:</i> \$2,000 <i>Non Net.:</i> \$3,750	N/A
Lifetime Aggregate Maximum	\$1,000,000	N/A	N/A	N/A

IV. Summary of Mental Health Benefits

	Florida Group Health	Humana Medical Plan	FEHBP BC/BS PPO Plan	Florida Healthy Kids
In-Patient days	31 days	30 days	100 days	15 days
In-Patient Coinsurance	<i>Network:</i> 90/10 percent after \$150/adm. <i>Non Net.:</i> 80/20 percent after \$300/adm.	no copay	<i>Network:</i> \$150/day <i>Non Net.:</i> \$250/day	no copay
Separate MH In-Patient deductible?	No, MH applies to General Plan deductible	N/A	No, MH applies to General Plan deductible	N/A
Out-Patient Visits Limit	\$2,000 per year	40 visits	25 visits	up to 20 visits
Out-Patient Professional Care Coinsurance	<i>Network:</i> \$10 plus 90/10 percent <i>Non Net.:</i> \$20 plus 70/30 percent	\$5 copay	60/40 percent	\$5 copay
Out-Patient Facility Care Coinsurance	N/A	N/A	<i>Network:</i> \$25 copay <i>NonNet.:</i> \$100/day	N/A
MH Benefit Maximum	\$2,000 per year for one or more conditions	Substance Abuse: 44 visits lifetime	one inpatient S/A treatment program	Lifetime max. \$20,000
Alcoholism & S/A covered same as MH?	yes	no, see description for details	no, see description for details	S/A covered only for pregnant adolescents

V. Description of Mental Health Benefits***A. State Employees of Florida***

Source: Benefits Handbook for Navigating Your Benefits Options and the State of Florida Group Health Self Insurance Plan.

Eligible State Employees are offered two group health insurance options.

- State Self-Insured Plan (PPO)
- Health Maintenance Organization (HMO)

HMOs may not be available in all areas of the state. If an HMO is not available in the employee's county of residence, the only state sponsored health insurance option is the State Self-Insured Plan. The State Self-Insured Plan was valued.

Description of Mental Health Benefits

Inpatient Facility: Alcohol/Drug or Mental health - 31 days per calendar year for one or more conditions. Inpatient/Outpatient physical services: \$2,000 per calendar year for one or more conditions.

Mental Health Benefits

"Mental or Nervous Disorder" means any and all disorders set forth in the diagnostic categories of the most recent published edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of underlying cause, or effect, of the disorder. Examples include, but are not limited to, attention-deficit, hyperactivity, anorexia nervosa, bulimia, bipolar affective disorder, autism, mental retardation, Tourette's disorder, schizophrenia, anxiety and depression.

Inpatient (Facility Charge)

PPO: The enrollee pays \$150 per admission and 10 percent of Network allowed amount or actual fee, whichever is less; 31 day maximum per calendar year.

Non-PPO: The enrollee pays \$300 per admission and 20 percent of allowance plus room and board charges above \$190 per day; 31 day maximum per calendar year.

Outpatient

PPO: The enrollee pays \$10 and 10 percent of Network allowed amount plus anything above \$2,000 per year.

Non-PPO: The enrollee pays \$20 and 30 percent of non-Network allowance plus anything above \$2,000 per year.

Alcohol/Drug TreatmentInpatient (Facility Charge)

PPO: The enrollee pays \$150 per admission plus 10 percent of Network allowed amount or actual fee, whichever is less; 31 day maximum per calendar year.

Non-PPO: The enrollee pays \$300 per admission plus 20 percent of allowance plus room and board charges above \$190 per day; 31 day maximum per calendar year.

Outpatient

“Alcohol and Drug Abuse Outpatient Program” means a structured rehabilitation program accredited by the Joint Commission on the Accreditation of Hospitals or the American Osteopathic Association and approved by the Department of Health and Rehabilitative Services (HRS) for the outpatient treatment of persons suffering from alcoholism or drug abuse. Such treatment shall only be covered if provided by a licensed facility on an organized formal and regularly scheduled basis.

PPO: The Enrollee pays \$10 plus 10 percent of Network allowed amount plus anything above \$2,000 per year.

Non-PPO: The Enrollee pays \$20 plus 30 percent of non-Network allowance plus anything above \$2,000 per year.

Covered Hospital and Other Facility Services**B.7. Covered Specialty Institution or Residential Facility Services; Non-PPO:**

The Plan pays eighty percent (80 percent) of the Allowance for covered inpatient rehabilitative services related to alcoholism or drug addiction provided by a non-PPO specialty institution or residential facility, subject to the following:

- (a) coverage shall include an insured employee and requires that the employee’s treatment in such an institution be requested by the employing agency and approved by the Department of Management Services;

- (b) payment shall not be made for more than thirty-one (31) inpatient days of treatment during any calendar year;
- (c) payment for room and board shall be as provided under Subsection B.1.(a): Non-PPO Hospital Inpatient Room and Board Services;
- (d) payment for services other than room and board shall be as provided under Subsection B.2.: Other Covered Non-PPO Inpatient Services;
- (e) payment for inpatient services will not be made in the same calendar year that payment for outpatient services is made pursuant to Subsection B.9.: Covered Outpatient Alcohol and Drug Abuse Facility Services;
- (f) treatment shall be provided by, or under the supervision of, or prescribed by, a licensed physician psychologist if services are provided in a program accredited by the Joint Commission on the Accreditation of Hospitals or approved by the state.

B.8. Covered Inpatient Services; PPO:

The following inpatient services received by an insured when confined to a network hospital or specialty institution shall be paid at ninety percent (90) of the Allowed Amount under the network schedule:

- (a) room and board - limited to semi-private room accommodations unless private room accommodations are recommended by the Servicing Agent due to medical necessity and determined to be so by the Administrator;
- (b) intensive care or progressive care unit;
- (c) other covered inpatient or progressive care unit;
- (d) payment for inpatient services provided by a specialty institution for treatment of alcoholism or drug addiction will not be made in the same calendar year that payment for outpatient services is made pursuant to Subsection B.9.: Covered Outpatient Alcohol and Drug Abuse Facility Services; Treatment shall be provided by, or under the supervision of, or prescribed by, a licensed physician or licensed psychologist if services are provided in a program accredited by the Joint Commission on the Accreditation of Hospitals or approved by the state.

B.9. Covered Outpatient Alcohol and Drug Abuse Facility Services:

- (a) The Plan shall pay seventy percent (70) of the Allowed Amount for the outpatient treatment of an insured under the approved alcohol and drug abuse program but not to exceed an actual payment of two-thousand dollars (\$2,000) during a calendar year.
- (b) No payment will be made under paragraph 9.(a) above during any calendar year the insured is confined to a hospital, residential facility or specialty institution for alcoholism or drug addiction unless such confinement is for the necessary detoxification of the insured prior to the beginning the outpatient treatment program. Payment for such detoxification shall be in accordance with Subsections B.1. and 2., or Subsection B.7., or Subsection B.8., whichever is appropriate; however, payment for detoxification shall not be made for more than six (6) days during a calendar year and shall be in addition to the Allowed Amount under paragraph 9.(a).
- (c) Treatment shall be provided by, or under the supervision of, or prescribed by, a licensed physician or licensed psychologist if services are provided in a program accredited by the Joint Commission on the Accreditation of Hospitals or approved by the state.

B. Humana Health Plan, Inc. (1997)

Source: The 1997 benefits package plan description based on the contract with Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law to provide a comprehensive medical plan to FEHB members. (page 15)

Description of Mental Health Benefits**Mental Conditions/Substance Abuse Benefits**

Care must be received from or arranged by Plan doctors.

Mental Conditions**Covered Benefits**

To the extent shown below, the Plan provides for the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient Care

Up to 40 visits to Plan doctors, consultants or other psychiatric personnel each calendar year; Enrollee pays a \$5 copay for each covered visit, \$5 copay for group therapy.

Inpatient Care

Up to 30 days of hospitalization each calendar year; Enrollee pays nothing for the first 30 days- all charges thereafter.

Not Covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment.
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.

Substance AbuseCovered Benefits

This plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition. Services for the psychiatric aspects are provided in conjunction with the mental conditions benefit shown above.

Outpatient visits to Plan mental health providers for follow-up care and counseling are covered, as well as inpatient services necessary for diagnosis and treatment. The Mental Conditions Benefits per inpatient day limitations and copays apply. In addition the Plan provides:

Outpatient Care

Plan provides 44 visits per lifetime for substance abuse. Enrollee pays all charges over \$35 per visit.

Not Covered

- Treatment that is not authorized by a Plan doctor.

C. Healthy Kids Replication Program (1997)

Source: Healthy Kids Replication Program Design and Enrollee Benefit Schedule

Description of Mental Health Benefits**Mental Conditions/Substance Abuse Benefits**

All services must be approved by the plan or upon approved referral. There is a lifetime maximum coverage of \$20,000 for both inpatient and outpatient mental health and substance abuse treatment.

Mental Health**Inpatient Coverage**

The Plan covers in full up to 15 days per contract year. There is no charge to the enrollee.

Outpatient Coverage

The Plan covers up to 20 days per contract year for outpatient short term evaluation and crisis intervention for psychological or psychiatric diagnosis. Counseling and placement assistance for drug and alcohol abuse are also covered. Enrollee pays a \$5 copay.

Substance Abuse and Addiction**Inpatient Coverage**

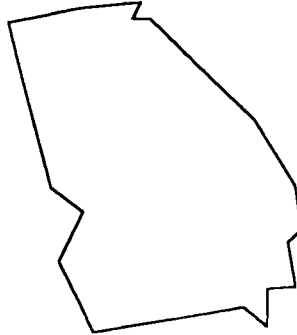
The Plan covers only pregnant adolescents for up to 7 days for detox only. There is no charge to the enrollee.

Outpatient Coverage

The Plan benefit is limited to pregnant adolescents.

Georgia

GEORGIA (GA)



I. Plans Evaluated

GA State Employee Plan		Largest Enrolled HMO	Federal Employees Health Benefit Plan
Plan Name	State Health Benefit Plan (Standard Option)	Kaiser Foundation Health Plan of GA, Inc.	BC/BS PPO Plan (Standard Option)
Type of Plan	FFS	HMO	PPO
Year	1995	1997	1998

II. Annual Actuarial Value of Coverage per Child

	GA State Employee Plan	Kaiser Foundation Health Plan of GA	FEHBP BC/BS PPO Plan
Mental Health BVC Portion	\$ 97	\$ 44	\$ 72
Other Health BVC Portion	\$1,543	\$1,119	\$1,388
Total BVC	\$1,640	\$1,163	\$1,460
Mental Health portion as a percent of Total	5.9%	3.8%	4.9%

III. Summary of General Plan Provisions

	State Health Benefit Plan	Kaiser Foundation Health Plan of GA	FEHBP BC/BS PPO Plan
Plan Deductible	\$250 individual \$750 family	N/A	\$200 / calendar year
In-Patient Days	365	365	365
In-Patient Coinsurance	90/10 percent after \$100/adm	no copay	<i>Network:</i> 100 percent <i>Non Net.:</i> 100 percent after \$250/adm.
Out-Patient Coinsurance	80/20 percent	\$5 copay	<i>Network:</i> 95/5 percent <i>Non Net.:</i> 75/25 percent
Out of Pocket Maximum	\$1,300 for Self, \$3,300 for Family	\$2,000 for Self, \$5,000 for Family	<i>Network:</i> \$2,000 <i>Non Net.:</i> \$3,750
Lifetime Benefit Maximum	\$1,000,000	N/A	N/A

IV. Summary of Mental Health Benefits

	GA State Employee Plan	Kaiser Foundation Health Plan of GA	FEHBP BC/BS PPO Plan
In-Patient days	60 days inpatient	30 days inpatient	100 days
In-Patient Coinsurance	<i>Network:</i> 90/10 percent after \$100/adm <i>Non Net.:</i> 60/40 percent after \$100/adm	no copay	<i>Network:</i> \$150/day <i>Non Net.:</i> \$250/day
Separate MH In-Patient deductible?	No, MH applies to General Plan deductible	N/A	No, MH applies to General Plan deductible
Out-Patient Visits Limit	<i>Network:</i> 50 visits <i>Non Net.:</i> 25 visits	20 visits	25 visits
Out-Patient Professional Care Coinsurance	<i>Network:</i> 80/20 percent <i>Non Net.:</i> 50/50 percent	visits 1-5: no copay visits 6-20: \$15 copay	60/40 percent
Out-Patient Facility Care Coinsurance	N/A	N/A	<i>Network:</i> \$25 copay <i>Non Net.:</i> \$100/day
MH Benefit Maximum	\$2,500/year MH OOP & lifetime limit of three inpatient S/A treatments	N/A	one inpatient S/A treatment program
Alcoholism & S/A covered same as MH?	yes	no, see description for details	no, see description for details

V. Description of Mental Health Benefits

A. State Employees of Georgia

Source: The Georgia State Merit System of Personnel Administration's "State Health Benefit Plan, November 1995" with "State Health Benefit Plan UPDATER, June 1996" and "State Health Benefit Plan UPDATER, Spring/Summer 1997".

The State Merit System offers a State Health Benefit Plan. The three different coverage options offered are the Standard Option, the High Option and the HMO Option. All options offer statewide coverage. The Standard Option was valued.

Description of Mental Health Benefits

Behavioral Benefits

Effective August 1, 1995, a system of managed care was installed to ensure efficient delivery of a wider spectrum of care and treatment for mental health conditions and substance abuse ("behavioral care"). The Behavioral Health Services (BHS) features a statewide network of preferred providers, 24-hour access to assessment and referral services, and an improved level of benefits for all enrollees who request and accept network provided referral from the BHS administrator.

The Plan will pay benefits for the treatment and care of mental-health conditions and substance abuse by both physicians and specific other behavioral-health-care specialists--after the enrollee satisfies the appropriate deductible(s).

The BHS program is administered by Green Spring of Georgia, a subsidiary of Green Spring Health Services Inc., a national health-care firm. BHS features a state-wide network of pre-screened mental-health and substance-abuse providers, who have contracted with Green Spring to serve HBP members at guaranteed rates.

BHS can be contacted by calling a toll-free, 24-hour-a-day telephone number. A Green Spring staff member, will verify the enrollee's Health Plan membership. A Green Spring care manager, will assess the enrollee's situation, authorize initial treatment, and assist the enrollee in choosing a provider who participates in the BHS network. All Green Spring staff members are bound by strict confidentiality procedures governing the integrity of members; personal records, and will treat any information as privileged.

The enrollee may choose to accept the BHS referral and be treated by a network provider--but that is not mandatory. The enrollee may choose instead to disregard the BHS referral and be treated by a provider of his or her choice.

The difference is this: BHS offers two separate levels of benefits. If the enrollee accepts the referral, a higher level of Plan benefits is available under the BHS program. If the enrollee does not accept the referral, a lower level of benefits are provided.

Another difference is the range of providers available through the network. Coverage for non-network providers is limited to two categories: qualified psychiatrists and Ph.D. psychologists. The network includes a variety of other behavioral-care specialists, each of whom must undergo a rigorous credentialing process. The minimum requirement is a master's degree, plus the equivalent of four additional years of clinical education and training. These providers include licensed professional counselors (LPCs), licensed clinical social workers (LCSWs), and marriage-and-family therapists (MFTs).

Also available through BHS network referral (but not otherwise) are two intermediate-care services--partial hospitalization/day treatment and an intensive out-patient program--plus a special out-patient service called brief-visit therapy that's designed for situational use.

If the enrollee is displeased with the kind(s) or the quality of the care received through the BHS program, the enrollee has the right to appeal the BHS decisions.

Note: The enrollee should call BHS whenever mental-health or substance-abuse care or treatment is needed -- *even if State Health Benefit Plan is the secondary coverage.*

Summary of BHS Benefits

Here are highlights of the behavioral benefits BHS will pay...

SERVICE	<i><u>For network treatment with a BHS referral...</u></i>	<i><u>For treatment without a BHS referral...</u></i>
<i>In-patient mental health</i>	90% of eligible charges, after deductible. Limit 60 days per year.	60% ¹ of average network rate if necessity is BHS-certified. Days reduce the 60-day limit. Limit 60 days per year.
<i>In-patient substance abuse</i>	90%, as above. Days reduce the 60-day limit. Lifetime maximum is 3 episodes.	60% ¹ of average network rate if necessity is BHS-certified. Days reduce the 60-day limit. Lifetime limit: 3 episodes.
<i>In-patient professional charges</i>	80% of network rate. Limit 1 visit per pre-certified day available, any network provider.	50% of network rate. Limit 1 visit per day, psychiatrist or Ph.D. psychologist only. Limit 25 visits per year.
<i>Intermediate: day treatment/ partial hospital</i>	90% of eligible charges, after deductible. Limit 30 visits/days ² per year	No benefit.
<i>Intermediate: intensive out- patient program</i>	90% of eligible charges, after deductible. Limit 30 visits/days ² per year	No benefit.
<i>Out-patient brief-visit therapy</i>	100%, no deductible. Limit 3 visits per year ³ .	No benefit.
<i>Out-patient counseling/ psychotherapy</i>	80% of network rate. Limit 50 visits/year ³ , any network provider.	50% of network rate. Limit 25 visits/year ³ , psychiatrist or Ph.D. psychologist only.

BHS has a separate maximum out-of-pocket limit for referred network care: \$2,500 per patient per calendar year in eligible expenses. Non-certified and excess hospital days don't count toward the stop-loss limit; neither do expenses incurred without a BHS referral.

Both Plan deductibles--general and hospital--apply to behavioral care.

¹ No benefit is payable for non-certified days.

² Combined limit for partial hospitalization, day treatment, and the 25 intensive out-patient care.

³ The 50-visit limit includes both the three brief visits and the 25 counseling sessions.

B. Kaiser Foundation Health Plan of Georgia, Inc. (1997)

Source: The 1997 benefits package plan description based on the contract with Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law to provide a comprehensive medical plan to FEHB members. (page 14)

Description of Mental Health Benefits

Care must be received from or arranged by Plan doctors.

Mental Conditions**Covered Benefits**

To the extent shown below, the Plan provides for the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation;
- Psychological testing;
- Psychiatric treatment (including individual and group therapy); and
- Hospitalization (including inpatient professional services).

Outpatient Care

Up to 20 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; Enrollee pays no copayment for visits 1-5, and a \$15 copay for visits six through twenty. Enrollee pays all charges thereafter.

Inpatient Care

Up to 30 days of hospitalization each calendar year; Enrollee pays no copayment for the first 30 days - all charges thereafter.

Not Covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment.
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.

Substance Abuse

Covered Benefits

This plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition, and to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient Care

Up to 30 outpatient visits to Plan doctors, consultants or other substance abuse specialists each calendar year for the treatment of alcohol or drug abuse when prescribed by a Plan doctor and provided at a designated facility, and necessary aftercare visits when provided at a designated facility, and prescribed by a Plan doctor. A visit may consist of an individual therapy visit or up to a day visit to a specialized facility; the Plan doctor will determine the appropriate type of visit. Enrollee pays no copayment for the first 30 days - all charges thereafter.

Inpatient Care

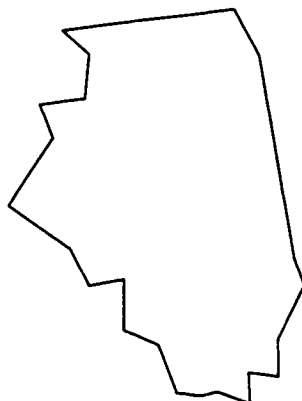
Inpatient treatment for the psychiatric aspects of substance abuse is limited to the inpatient mental conditions benefit listed above.

Not Covered

- Treatment that is not authorized by a Plan doctor.
- Inpatient treatment in a specialized treatment facility.

Illinois

ILLINOIS (IL)



I. Plans Evaluated

IL State Employee Plan		Second Largest Enrolled HMO	Federal Employees Health Benefit Plan
Plan Name	Quality Health Care Plan	Humana Health Plan, Inc. Chicago	BC/BS PPO Plan (Standard Option)
Type of Plan	POS	HMO	PPO
Year	1998	1997	1998

II. Annual Actuarial Value of Coverage per Child

	Quality Health Care Plan	Humana Health Plan, Inc. Chicago	FEHBP BC/BS PPO Plan
Mental Health BVC Portion	\$ 52	\$ 42	\$ 72
Other Health BVC Portion	\$1,379	\$1,243	\$1,388
Total BVC	\$1,431	\$1,285	\$1,460
Mental Health portion as a percent of Total	3.7%	3.2%	4.9%

III. Summary of General Plan Provisions

	Quality Health Care Plan	Humana Health Plan, Inc. Chicago	FEHBP BC/BS PPO Plan
Plan Deductible	<i>Network:</i> N/A <i>Non Net.:</i> \$300/\$600	N/A	\$200 / calendar year
In-Patient days	365	365	365
In-Patient Coinsurance	<i>Network:</i> \$100/adm. <i>Non Net.:</i> \$100 copay and 80/20 percent	no copay	<i>Network:</i> 100 percent <i>Non Net.:</i> 100 percent after \$250/adm.
Out-Patient Coinsurance	<i>Network:</i> \$10 copay <i>Non Net.:</i> 80/20 percent	no copay	<i>Network:</i> 95/5 percent <i>Non Net.:</i> 75/25 percent
Out of Pocket Maximum	<i>Non Net.:</i> 2,500 for Self, \$6,000 for Family	N/A	<i>Network:</i> \$2,000 <i>Non Net.:</i> \$3,750

IV. Summary of Mental Health Benefits

	Quality Health Care Plan	Humana Health Plan, Inc. Chicago	FEHBP BC/BS PPO Plan
In-Patient days	<i>Network:</i> 30 days <i>Non Net.:</i> no benefit	30 days	100 days
In-Patient Coinsurance	<i>Network:</i> \$100/adm. <i>Non Net.:</i> no benefit	no copay	<i>Network:</i> \$150/day <i>Non Net.:</i> \$250/day
Separate MH In-Patient deductible?	N/A	N/A	No, MH applies to General Plan deductible
Out-Patient Visits Limit	<i>Network:</i> 30 visits <i>Non Net.:</i> no benefit	20 visits	25 visits
Out-Patient Professional Care Coinsurance	<i>Network:</i> \$20 copay <i>Non Net.:</i> no benefit	no copay	60/40 percent
Out-Patient Facility Care Coinsurance	N/A	N/A	<i>Network:</i> \$25 <i>Non Net.:</i> \$100 /day
MH Benefit Maximum	N/A	N/A	one inpatient S/A treatment program
Alcoholism & S/A covered same as MH?	no, see description for details	yes	no, see description for details

V. Description of Mental Health Benefits**A. State Employees of Illinois**

Source: Department of Central Management Services, State of Illinois Benefits Choice Options (1998) (p. 26)

State Employees are offered:

- Point of Service (POS) Plan
- Indemnity Plan
 - Quality Care Health Plan
(with PPO hospital only)
- Health Maintenance Organizations:
 - American HMO
 - Group Health Plan
 - Health Alliance
 - Health Direct
 - Humana Premier HMO
 - John Deere HC/Heritage
 - Maxicare
 - NYLCare
 - PersonalCare
 - Principal Health Care
 - United Health Care Select

The Point of Service (POS) Plan was valued. Descriptions are provided for both the Point of Service Plan and the Quality Care Health Plan (PPO).

Description of Mental Health Benefits**Point of Service Plan**

Mental Health and Substance Abuse benefits are covered In-Network Only.

Inpatient Care

Psychiatric Admission is covered at 100% after a \$100 (per admission) copay for up to 30 days per year.

Alcohol and Substance Abuse is covered at 100% after a \$100 (per admission) copay for up to 10 days of rehabilitation per year.

Outpatient Psychiatric and Substance Abuse

Up to 30 outpatient visits each calendar year; Enrollee pays a \$20 copay.

Quality Care Health Plan (PPO)**Mental Health / Substance Abuse Treatment Coverage**

To obtain the highest benefit possible (the in-network/enhanced benefit), mental health and substance abuse services must be pre-authorized by the Member Assistance Program (MAP). The enrollee must obtain pre-authorization from MAP. Failure to obtain pre-authorization may result in a reduction or loss of benefit reimbursement.

	<u>In-Network (Enhanced Benefit)</u>	<u>Out-of-Network (Standard Benefit)</u>
Outpatient	100% coverage after \$20 copayment per visit	50% coverage up to \$35 per visit* 50 visit maximum per contract year
Inpatient	\$50 copayment per day, up to a maximum of \$275 per admission 100% coverage of additional facility charges and 100% coverage of physician charges, after the \$15 per day copayment**	\$50 copayment per day, up to a maximum of \$250 per admission. 60% coverage of additional facility charges and 50% coverage of physician charges up to \$35.00 per day. 50 visit maximum per contract year.
Alternative Treatment (i.e. intensive outpatient, partial hospitalization)	\$25 copayment per day, up to a maximum of \$125 per admission 100% coverage of additional facility charges and 100% coverage of physician charges after the \$15 per day copayment**	\$25 copayment per day, up to a maximum of \$125 per admission. 60% coverage of additional facility charges, and 50% coverage of physician charges up to a maximum of \$35.00 per day. 50 visit maximum per contract year.

* Outpatient services delivered by an out-of-network provider, must be provided by a licensed clinical social worker (LCSW), licensed psychologist (Ph.D.), or a licensed psychiatrist (MD).

** Out-of-network physicians charges are covered at 50% up to \$35 per day. 50 visit maximum per contract year.

If the enrollee does not live within 25 miles of an in-network facility for inpatient or an alternative level of treatment, the following benefits apply:

Inpatient

- \$50 copay per day, up to a maximum of \$250 per admission.
- 80% coverage of additional facility charges. Physician charges are reimbursed at the appropriate in-network or out-of-network benefit level.
- Member's maximum out-of-pocket expense of \$1,500 per contract year.

Alternative

- \$25 copay per day, up to a maximum of \$125 per admission. 80% coverage of additional facility charges. Physician charges are reimbursed at the appropriate in-network or out-of-network benefit level.
- Member's maximum out-of-pocket expense of \$1,500 per contract year.

Outpatient

- Same as outpatient benefits listed in the above chart.

B. Humana Health Plan Inc., Chicago (1997)

Source: The 1997 benefits package plan description based on the contract with Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law to provide a comprehensive medical plan to FEHB members. (page 16)

The Health Care Service Corporation BC/BS of IL has the highest enrollment in the state. However only the plan offered to FEHBP is not federally qualified. Therefore, we chose to value the second highest enrolled plan, Humana Health Care Plans.

Description of Mental Health Benefits

Care must be received from or arranged by Plan doctors.

Mental Conditions**Covered Benefits**

To the extent shown below, the Plan provides for the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation;
- Psychological testing;
- Psychiatric treatment (including individual and group therapy); and
- Hospitalization (including inpatient professional services).

Outpatient Care

Up to 20 outpatient visits for individual therapy to Plan doctors, consultants or other psychiatric personnel each calendar year; Enrollee pays no copayment - all charges thereafter.

Inpatient Care

Up to 30 days of hospitalization each calendar year; Enrollee pays no copayment for the first 30 days - all charges thereafter.

Not Covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment.
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.

Substance AbuseCovered Benefits

This plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition, and to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient Care

Up to 20 outpatient visits to Plan providers for treatment each calendar year; Enrollee pays no copayment for each covered visit.

The substance abuse benefit may be combined with the Mental Conditions Benefit shown above, provided such treatment is necessary and is approved by the Plan, to permit an additional 20 outpatient visits per calendar year.

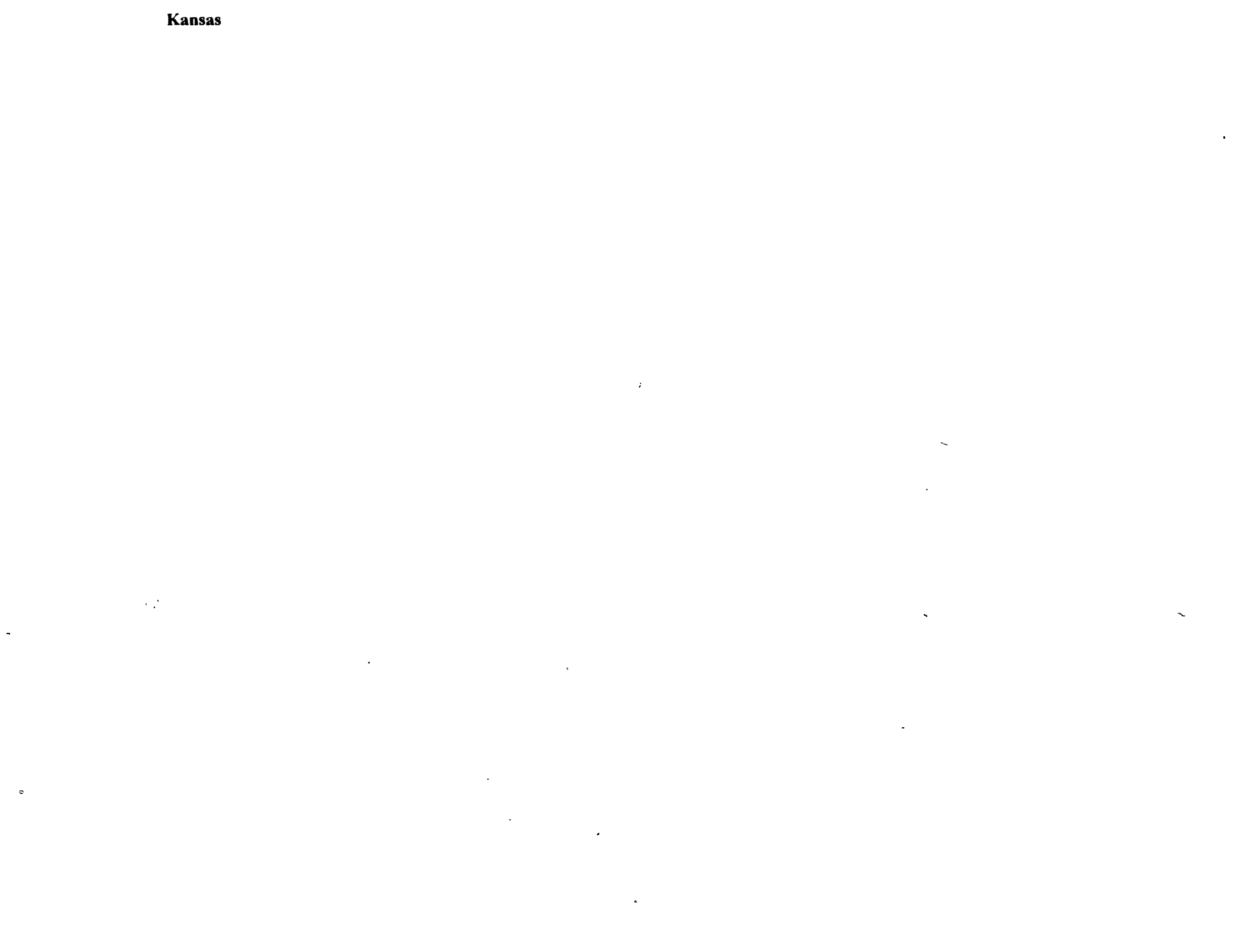
Inpatient Care

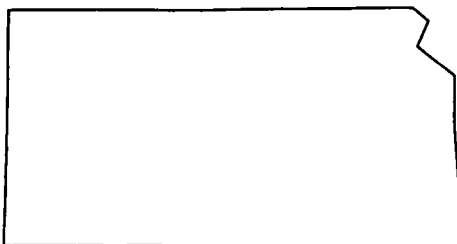
Up to 30 days each calendar year in a substance abuse rehabilitation (intermediate care) program in an alcohol detoxification or rehabilitation center approved by the Plan; no copayment during the benefits period - all charges thereafter.

Not Covered

- Treatment that is not authorized by a Plan doctor.

Kansas



KANSAS (KS)**I. Plans Evaluated**

KS State Employee Plan		Largest Enrolled HMO	Federal Employees Health Benefit Plan
Plan Name	BC/BS Blue Select	Kaiser Foundation Health Plan of Kansas City, Inc.	BC/BS PPO Plan (Standard Option)
Type of Plan	POS	HMO	PPO
Year	1998	1997	1998

II. Annual Actuarial Value of Coverage per Child

	KS State Employee Plan	Kaiser Foundation Health Plan of KC	FEHBP BC/BS PPO Plan
Mental Health BVC Portion	\$ 94	\$ 43	\$ 72
Other Health BVC Portion	\$1,405	\$1,122	\$1,388
Total BVC	\$1,499	\$1,165	\$1,460
Mental Health portion as a percent of Total	6.3%	3.7%	4.9%

III. Summary of General Plan Provisions

	KS State Employee Plan	Kaiser Foundation Health Plan of KC	FEHBP BC/BS PPO Plan
Plan Deductible	Primary Care: None Self Ref.: \$200/person \$400/family	N/A	\$200 / calendar year
In-Patient days	365	365	365
In-Patient Coinsurance	\$50 per day to a maximum of 5 days/person or 10 days/family	no copay	<i>Network:</i> 100 percent <i>Non Net.:</i> 100 percent after \$250/dam.
Out-Patient Coinsurance	Primary: 80/20 percent Self Ref: 70/30 percent	\$5 copay	<i>Network:</i> 95/5 percent <i>Non Net.:</i> 75/25 percent
Out of Pocket Maximum	Primary: \$500/\$1,000 Self Ref: \$1,000/\$2,000	\$1000 for Self, \$3,000 for Family	<i>Network:</i> \$2,000 <i>Non Net.:</i> \$3,750

IV. Summary of Mental Health Benefits

	KS State Employee Plan	Kaiser Foundation Health Plan of KC	FEHBP BC/BS PPO Plan
In-Patient days	Primary Care: 60 days Self Ref.: 30 days	30 days inpatient or 60 sessions of day/night care	100 days
In-Patient Coinsurance	\$50 per day to a maximum of 5 days/person or 10 days/family	no copay	<i>Network:</i> \$150/day <i>Non Net.:</i> \$250/day
Separate MH In-Patient deductible?	No, MH applies to General Plan deductible	N/A	No, MH applies to General Plan deductible
Out-Patient Visits Limit	Primary Care: up to 25 visits per plan year	20 visits or 40 visits for group therapy	25 visits
Out-Patient Professional Care Coinsurance	visits 1-3: no copay visits 4-25: \$25 copay	first visit: no copay visits 2-5: \$5 copay visits 6-20: \$25 copay and \$10 for group therapy	60/40 percent
Out-Patient Facility Care Coinsurance	N/A	N/A	<i>Network:</i> \$25 copay <i>Non Net.:</i> \$100/day
MH Benefit Maximum	N/A	N/A	one inpatient S/A treatment program
Alcoholism & S/A covered same as MH?	yes	no, see description for details	no, see description for details

V. *Description of Mental Health Benefits*

A. State Employees of Kansas

Source: State of Kansas Benefits Information and Options for Active Employees (1998)

Ten Medical Plans are offered to Kansas State Employees for the 1998 Plan year. Depending on the county of residence, an employee may select from:

- | | |
|-------------------------------------|-------------------------------------|
| • Two Point of Service (POS) Plans: | • Health Maintenance Organizations: |
| Blue Select | CIGNA HealthCare |
| Principle Maximum Choice | HealthNet HMO |
| • Fee-for-Service Plan: | Kaiser Permanente |
| Blue Cross Traditional | Preferred Plus of Kansas (PPK) |
| • Preferred Provider Organization: | Premier Blue |
| Principal PPO Program | Principal Health Care-Gold 10 |

The BC/BS Blue Select Plan has the highest enrollment among state employees and offers statewide coverage. Although only the BC/BS Blue Select plan was valued, the following description from the General Benefits Information (page 17) pertains to Mental Health and Substance Abuse Services of all plans.

Description of Mental Health Benefits

Mental Health and Substance Abuse Services

Inpatient

Coverage is provided for up to sixty (60) days per plan year, when medically necessary, for the evaluation and treatment of Mental Illness and for rehabilitation when required for diagnosis and treatment of abuse or addiction to alcohol or drugs upon authorization by the HEALTHPLAN or its designee. Inpatient services will be covered only if provided by a facility designated by the HEALTHPLAN.*

The benefits may be exchangeable with partial hospitalization sessions if medically necessary and appropriate, of not less than three(3) hours and not more than twelve (12) hours in any twenty four (24) hour period, based upon the following exchange formula: If the charge for one partial hospitalization session does not exceed fifty (50) percent of the allowable charges for one inpatient day of the average semi-private rate at the Participating Hospital where the session is conducted, the benefit exchange shall be two (2) partial hospitalization sessions equal to one day of inpatient care. If the charge for one partial hospitalization session does exceed fifty (50) percent of the allowable charges for one inpatient day of the average semi-private rate at the Participating Hospital where the session is conducted, the benefit exchange will be one partial hospitalization session equal to one day of inpatient care.

* Inpatient benefits for the Self-Referral portion of Blue Select or the Non-PPO portion of The Principal PPO will be limited to 30 days per plan year.

Outpatient

HMOs	up to 25 visits per plan year; (group therapy sessions count as 1/2 visit) visits 1-3 covered at 100%; visits 4-25 have a \$25 copayment per visit
BC/BS Traditional	up to 25 visits per plan year; visits 1-3 covered at 100%; visits 4-25 have a \$25 copayment per visit (Copayments will not count toward the annual coinsurance maximum)
BC/BS Select	<u>Primary Care</u> : up to 25 visits per plan year; visits 1-3 covered at 100%; visits 4-25 have a \$25 copayment per visit
Principal PPO	<u>PPO</u> : up to 25 visits per plan year; visits 1-3 covered at 100%; visits 4-25 have a \$25 copayment per visit

B. Kaiser Foundation Health Plan of Kansas City, Inc. (1997)

Source: The 1997 benefits package plan description based on the contract with Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law to provide a comprehensive medical plan to FEHB members. (page 16)

Description of Mental Health Benefits

Care must be received from or arranged by Plan doctors.

Mental Conditions**Covered Benefits**

To the extent shown below, the Plan provides for the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation;
- Psychological testing; Enrollee pays \$20 copay for each hour of required diagnostic testing;
- Psychiatric treatment (including individual and group therapy); and
- Hospitalization (including inpatient professional services).

Outpatient Care

- Up to 20 outpatient visits for individual therapy to Plan doctors, consultants or other psychiatric personnel each calendar year; Enrollee pays no copayment for the first visit, a \$5 copay per visit for visits two through five and a \$25 copay per visit for visits six through twenty - all charges thereafter.
- Up to 40 outpatient visits for group therapy to Plan doctors consultants or other psychiatric personnel each calendar year; Enrollee pays no copayment for the first visit, a \$10 copay for each remaining covered visit - all charges thereafter.
- Each two group therapy visit counts as one individual therapy visit and vice versa.
- Unless an appointment is canceled at least 24 hours in advance, a \$20 fee is assessed for a broken individual therapy appointment and a \$10 fee for a broken group therapy appointment.

Inpatient Care

Up to 30 days of hospitalization each calendar year reduced by one day for every two sessions of day or night care; no copayment for the first 30 days - all charges thereafter. Up to 60 sessions of day or night care per calendar year reduced by two sessions for every one day of inpatient hospitalization; Enrollee pays no copayment for the first 60 sessions - all charges thereafter.

Not Covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment.
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.

Substance AbuseCovered Benefits

This plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition, and to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient Care

All necessary outpatient visits to Plan providers for treatment; Enrollee pays no copayment for the first visit, a \$20 copay for each subsequent covered visit - all charges thereafter.

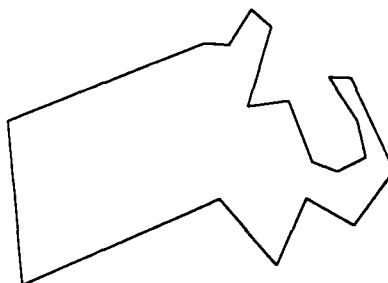
Inpatient Care

Up to 30 days of rehabilitative care each calendar year; no copayment for the first 30 days - all charges thereafter. Rehabilitative care is not covered, unless in the judgment of the Plan doctor, the patient has undergone and been unresponsive to outpatient treatment.

Not Covered

- Treatment that is not authorized by a Plan doctor.
- Treatment for alcoholism, drug abuse and drug addiction on court order or as a condition of parole or probation, unless a Plan doctor or his or her designee determines such treatment to be necessary and appropriate.

MASSACHUSETTS (MA)



I. Plans Evaluated

MA State Employee Plan		Largest Enrolled HMO	Federal Employees Health Benefit Plan
Plan Name	GIC Indemnity Plan	Harvard Community Health Plan	BC/BS PPO Plan (Standard Option)
Type of Plan	PPO	HMO	PPO
Year	1998	1997	1998

II. Annual Actuarial Value of Coverage per Child

	GIC Indemnity Plan	Harvard Community HP	FEHBP BC/BS PPO Plan
Mental Health BVC Portion	\$ 106	\$ 45	\$ 72
Other Health BVC Portion	\$1,389	\$1,121	\$1,388
Total BVC	\$1,495	\$1,166	\$1,460
Mental Health portion as a percent of Total	7.1%	3.9%	4.9%

III. Summary of General Plan Provisions

	GIC Indemnity Plan	Harvard Community HP	FEHBP BC/BS PPO Plan
Plan Deductible	<i>Network:</i> \$75/\$150 <i>Non Net.:</i> \$100/\$200	N/A	\$200 / calendar year
In-Patient days	365	365	365
In-Patient Coinsurance	<i>Network:</i> \$150/adm., no copay for 120 days, then 96/4 percent <i>Non Net.:</i> \$250/adm., then 80/20 percent	no copay	<i>Network:</i> 100 percent <i>Non Net.:</i> 100 percent after \$250/adm.
Out-Patient Coinsurance	<i>Network:</i> \$5 copay <i>Non Net.:</i> \$5 copay then 80/20 percent	\$5 copay	<i>Network:</i> 95/5 percent <i>Non Net.:</i> 75/25 percent
Out of Pocket Maximum	<i>Network:</i> \$750 <i>Non Net.:</i> \$3,000	\$4,500 for Self, \$12,000 for Family	<i>Network:</i> \$2,000 <i>Non Net.:</i> \$3,750

IV. Summary of Mental Health Benefits

	GIC Indemnity Plan	Harvard Community HP	FEHBP BC/BS PPO Plan
In-Patient days	<i>Network:</i> 365 days <i>Non Net.:</i> 60 days	60 days	100 days
In-Patient Coinsurance	<i>Network:</i> no copay <i>Non Net.:</i> \$150 separate ded., then 80/20 percent	no copay	<i>Network:</i> \$150/day <i>Non Net.:</i> \$250/day
Separate MH In-Patient deductible?	<i>Network:</i> N/A <i>Non Net.:</i> \$200 annual ded; plus \$150/adm.	N/A	No, MH applies to General Plan deductible
Out-Patient Visits Limit	<i>Network:</i> 365 <i>Non Net.:</i> 15 visits	20 visits or 40 visits for group therapy	25 visits
Out-Patient Professional Care Coinsurance	<i>Network:</i> visits 1-4: no copay visits 5-25: \$20 or \$10 group Visits 26 and over: \$40 or \$20 group <i>Non Net.:</i> 50/50 percent	visits 1-8: \$5 copay visits 9-20: \$35 copay \$15 for group therapy	60/40 percent
Out-Patient Facility Care Coinsurance	N/A	N/A	<i>Network:</i> \$25 copay <i>Non Net.:</i> \$100/day
MH Benefit Maximum	Max two inpatient S/A admissions w/in 5 years	N/A	one inpatient S/A treatment program
Alcoholism & S/A covered same as MH?	no, see description for details	no, see description for details	no, see description for details

V. Description of Mental Health Benefits***A. State Employees of the Commonwealth of Massachusetts***

*Source: Group Insurance Commission Commonwealth of Massachusetts, 1997-1998
Benefit Decision Guide: A Guide to Benefits for Employees*

Eleven health plans are offered to Massachusetts State Employees for the 1998 Plan year. Depending on the county of residence, an employee may select from:

- | | |
|-------------------------------------|-------------------------------------|
| • Fee-for-Service Plan: | • Health Maintenance Organizations: |
| GIC Indemnity Plan | Community Health Plan |
| • Preferred Provider Organizations: | Fallon Community Health Plan |
| GIC Indemnity Plan Plus | Harvard Pilgrim Health Care |
| Commonwealth PPO * | Health New England |
| | Healthsource CMHC |
| | Kaiser Permanente |
| | Neighbor Health Plan |
| | Tufts Health Plan |

Commonwealth PPO Plan is closed to new enrollment effective July 1, 1997. The GIC Indemnity Plan Plus has the highest enrollment among state employees and offers statewide coverage. Although only The GIC Indemnity Plan Plus was valued, the following description from the Benefits Decision Guide (pages 6-8) pertains to Mental Health and Substance Abuse Services of all plans.

Description of Mental Health Benefits

OPTIONS Mental Health and Employee Assistance Program (EAP) manages mental health benefits for enrollees in the GIC Indemnity Plan

Mental health, substance and Employee Assistance Program (EAP) benefits for members of the GIC Indemnity Plan and Commonwealth PPO are provided by OPTIONS Mental Health. The plan includes a network of carefully selected mental health and substance abuse providers.

Care must be determined by OPTIONS to be medically necessary in order for the enrollee to receive benefits.

OPTIONS also provides an Employee Assistance Program (EAP) that offers confidential assistance with problems of daily living. The program offers a lecture series and wellness seminars, such as stress reduction, and support to management and staff when a violent or traumatic event has occurred. The staff of case managers will work with the enrollee and his/her provider to make sure the enrollee receives the most appropriate care.

Benefits	Coverage	
	Network	Out-of-Network
Annual Deductible (Separate from the medical deductible and out-of-pocket maximum)	None	\$200 per person
Inpatient Care Per admission deductible Mental Health General hospital Psychiatric hospital Substance abuse ¹ General hospital or Substance abuse facility	None 100% 100% 100%	\$150 80% 80% up to 60 days per year 80% up to 30 days per year
Intermediate Care (Including, but not limited to, 24-hour intermediate care facilities, e.g., residential, group homes, halfway houses, therapeutic foster care, day/partial hospitals, structure outpatient treatment programs)	100%	80%
Outpatient Care – includes Employee Assistance Program	Visits 1-4: No copayment Visits 5-25: \$20 per visit, \$10 per group visit Visits 26 and over: \$40 per visit, \$20 per group visit	50% per visit up to 15 visits ²
In-Home Mental Health Care	100%	
Provider Eligibility	MD, PhD, EdD, PsyD, MSW, LICSW, MSN, MA, RNMSCS	

¹ Maximum of two inpatient admissions per five-year period (in- and out-of-network combined), commencing with the first admission, and subject to case management.

² After 15 calendar year visits to an out-of-network provider, enrollee cannot then receive benefits for outpatient visits to a network provider in same year.

Health Maintenance Organizations offered to State Employees

For all Health Maintenance Organizations listed in the summary, inpatient hospital room, board and special services are covered at 100 percent. The summary does not make a distinction for a differences for inpatient mental health care.

Community Health PlanOutpatient Mental Health Care

Maximum 30 visits per year/\$10 per visit

Outpatient Drug & Alcohol Abuse Treatment

Maximum 30 visits per year/\$10 per visit

Fallon Community Health PlanOutpatient Mental Health Care

Maximum 20 visits per year/\$10 per visit

Outpatient Drug & Alcohol Abuse Treatment

Unlimited visits with approved provider/\$10 per visit

Harvard Pilgrim Health CareOutpatient Mental Health Care

Greater of 20 visits or \$500 per year

Visits 1-8: \$10 per visit

Visits 9-20: \$10 per group or \$25 per individual visit

Outpatient Drug & Alcohol Abuse Treatment

Greater of 20 visits or \$500 per year

Visits 1-8: \$10 per visit

Visits 9-20: \$10 per group or \$25 per individual visit

Detoxification: \$10 per visit

Health New EnglandOutpatient Mental Health Care

Maximum 20 visits per year

\$10 per visit

Outpatient Drug & Alcohol Abuse Treatment

Maximum 20 visits per year

\$10 per visit

Healthsource CMHCOutpatient Mental Health Care

Maximum \$500 per visit

\$10 per visit

Outpatient Drug & Alcohol Abuse Treatment

Maximum \$500 per visit

\$10 per visit

Kaiser PermanenteOutpatient Mental Health Care

Maximum 30 visits per year

\$10 per visit

Outpatient Drug & Alcohol Abuse Treatment

Maximum 30 visits per year

\$10 per visit

Neighborhood Health PlanOutpatient Mental Health Care

Greater of 20 visits per year or \$500

\$10 per visit

Outpatient Drug & Alcohol Abuse Treatment

Greater of 20 visits per year or \$500

\$10 per visit

Tufts Health PlanOutpatient Mental Health Care

Maximum 30 visits per year

Visits 1-8: \$10 per visit

Visits 9-20: 50% coverage

Outpatient Drug & Alcohol Abuse Treatment

Detoxification: \$10 per visit (unlimited visits)

Rehabilitation: \$10 per visit

Maximum: \$500 per year

B. Harvard Community Health Plan, Inc. (1997)

(Harvard Community Health Plan, Harvard Community Health Plan of New England and Pilgrim Health Care have merged; the plan is now called Harvard Pilgrim Health Care.)

Source: The 1997 benefits package plan description based on the contract with Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law to provide a comprehensive medical plan to FEHB members. (page 16)

Description of Mental Health Benefits

Care must be received from or arranged by Plan doctors.

Mental Conditions**Covered Benefits**

To the extent shown below, the Plan provides for the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation;
- Psychological testing;
- Psychiatric treatment (including individual and group therapy); and
- Hospitalization (including inpatient professional services).

Outpatient Care

Up to 20 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; Enrollee pays a \$5 copayment for individual or group therapy sessions 1-8, a \$35 per visit copay for individual therapy sessions 9-20, or a \$15 per visit copay for group therapy sessions 9-20 and all charges thereafter.

- If treatment is needed for both a psychiatric and a substance abuse disorder the enrollee pays a \$5 per visit copay for the first 16 visits with the remaining 4 visits up to the 20th visit maximum subject to the copay levels described above.
- Outpatient visits for medication monitoring and evaluation are not subject to the 20 visit maximum; Enrollee pays a \$5 copay per visit.
- If a member has a severe psychiatric or substance abuse disorder, such as determined by the Plan, certain recommended treatments, including individual case management and intensive outpatient care will be provided. With no visit or dollar limit, enrollee pays a \$5 per visit copay.

Inpatient Care

Up to 60 days of hospitalization each calendar year; no copayment for the first 60 days - all charges thereafter. These 60 days of inpatient hospitalization can be exchanged on a two- for-one basis for up to 120 days of day treatment.

Not Covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment.
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.

Substance AbuseCovered Benefits

This plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition, and to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient Care

Outpatient services for the psychiatric aspects of substance abuse are provided in conjunction with the mental condition benefits shown above, including follow-up care and counseling. The outpatient mental conditions visit limitations and copays apply to any covered substance abuse care.

Inpatient Care

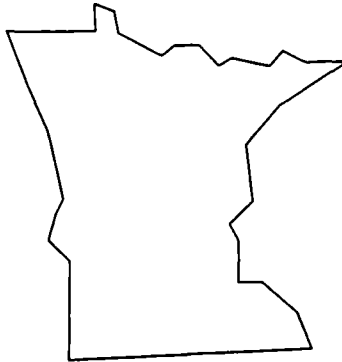
Up to 30 days per calendar year in a substance abuse treatment facility; no copayment for the first 30 days - all charges thereafter. These 30 days of inpatient hospitalization can be exchanged on a two-for-one basis up to 60 days of day treatment.

Not Covered

- Treatment that is not authorized by a Plan doctor.

Minnesota

MINNESOTA (MN)



I. Plans Evaluated

MN State Employee Plan		Largest Enrolled HMO	Federal Employees Health Benefit Plan
Plan Name	State Health Plan	HealthPartners Select (formerly Group Health) (Low Option)	BC/BS PPO Plan (Standard Option)
Type of Plan	PPO	HMO	PPO
Year	1997	1997	1998

II. Annual Actuarial Value of Coverage per Child

	State Health Plan	HealthPartners Select	FEHBP BC/BS PPO Plan
Mental Health BVC Portion	\$ 88	\$ 43	\$ 72
Other Health BVC Portion	\$1,468	\$ 943	\$1,388
Total BVC	\$1,556	\$ 986	\$1,460
Mental Health portion as a percent of Total	5.7%	4.4%	4.9%

III. Summary of General Plan Provisions

State Health Plan		HealthPartners Select	FEHBP BC/BS PPO Plan
Plan Deductible	<i>Primary Net.: None</i> <i>Plus Net.: \$350/person</i> <i>\$700/family</i>	N/A	\$200 / calendar year
In-Patient days	365	365	365
In-Patient Coinsurance	<i>Primary Net.: no copay</i> <i>Plus Net.: 70/30 percent</i>	no copay	<i>Network: 100 percent</i> <i>Non Net.: 100 percent</i> <i>after \$250/adm.</i>
Out-Patient Coinsurance	<i>Primary Net.: no copay</i> <i>Plus Net.: 70/30 percent</i>	\$10 copay	<i>Network: 95/5 percent</i> <i>Non Net.: 75/25 percent</i>
Out of Pocket Maximum	<i>Primary Net.: None</i> <i>Plus Net.: \$350/\$700</i>	\$3,200 for Self, \$5,000 for Family	<i>Network: \$2,000</i> <i>Non Net.: \$3,750</i>

IV. Summary of Mental Health Benefits

State Health Plan		HealthPartners Select	FEHBP BC/BS PPO Plan
In-Patient days	365	365	100 days
In-Patient Coinsurance	<i>Primary Net.: no copay</i> <i>Plus Net.: no benefits</i>	\$200 per admission plus 80/20 percent of the next \$3,500 per year	<i>Network: \$150</i> <i>Non Net.: \$250 Member</i> <i>\$400 Non-member</i>
Separate MH In-Patient deductible?	N/A	N/A	No, MH applies to General Plan deductible
Out-Patient Visits	365	365	25 visits
Out-Patient Professional Care Coinsurance	<i>Primary Net.: no copay</i> <i>Plus Net.: no benefits</i>	\$10 copay	60/40 percent
Out-Patient Facility Care Coinsurance	N/A	N/A	<i>Network: \$25 copay</i> <i>Non Net.: \$100/day</i>
MH Benefit Maximum	N/A	\$3,500 per calendar year	one inpatient S/A treatment program
Alcoholism & S/A covered same as MH?	yes	yes	no, see description for details

V. Description of Mental Health Benefits**A. State Employees of Minnesota**

Source: State of Minnesota "Your Employee Benefits 1996-1997"

Six Medical Plans are offered to Minnesota State Employees. Depending on the county of residence, an employee may select from:

- Preferred Provider Organization:
State Health Plan
- Health Maintenance Organizations:
HealthPartners Health Plan
HealthPartners Classic Plan
Medica Premier
Medica Primary
State Health Plan Select

The State Health Plan was valued.

Description of Mental Health Benefits**Mental Health and Substance Abuse Services**

No mental health nor substance abuse services benefits are covered out-of-network.

Inpatient

Mental health hospital inpatient care is covered at 100 percent.

Chemical dependency inpatient care is covered at 100 percent.

Outpatient

Mental health outpatient care services are covered at 100 percent.

Chemical dependency outpatient care services are covered at 100 percent.

B. HealthPartners Select (1997)

Source: The 1997 benefits package plan description based on the contract with Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law to provide a comprehensive medical plan to FEHB members. (page 14)

HealthPartners Select is the highest enrolled HMO in Minnesota. Neither this plan, nor the second highest enrolled plan in Minnesota are federally qualified plans. The Third highest enrolled plan had a much lower enrollment level. Therefore the HealthPartners Select was valued.

Description of Mental Health Benefits

Care must be received from or arranged by Plan doctors.

Mental Conditions**Covered Benefits**

To the extent shown below, the Plan provides for the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation;
- Psychological testing;
- Psychiatric treatment (including individual and group therapy); and
- Hospitalization (including inpatient professional services).

Outpatient Care

All necessary care from Plan doctors, consultants or other psychiatric personnel each calendar year; Enrollee pays \$10 copayment per office visit.

Inpatient Care

All necessary hospitalization and inpatient psychiatric medical care each calendar year; Enrollee pays the first \$200 per admission plus 20 percent of the next \$3,500 of charges per calendar year.

Not Covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment.

- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.

Substance Abuse

Covered Benefits

This plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition, and to the extent shown below, the services necessary for diagnosis and treatment. Voluntary detoxification services are covered only when followed by a Plan-prescribed course of chemical dependency treatment.

Outpatient Care

All necessary outpatient visits to Plan providers or referral providers for substance abuse evaluation and treatment; Enrollee pays no copayment. Aftercare is not covered.

Inpatient Care

Treatment in a substance abuse rehabilitation (intermediate care) program in an alcohol detoxification or rehabilitation center approved by the Plan. Enrollee pays the first \$200 per admission plus 20 percent of the next \$3,500 of charges per calendar year.

Not Covered

- Treatment that is not authorized by a Plan doctor.

New Jersey

1890

1891

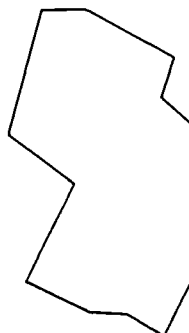
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NEW JERSEY (NJ)***I. Plans Evaluated***

NJ State Employee Plan		Largest Enrolled HMO	Federal Employees Health Benefit Plan
Plan Name	New Jersey Plus	US Healthcare of New Jersey (Standard Option)	BC/BS PPO Plan (Standard Option)
Type of Plan	POS	HMO	PPO
Year	1996	1997	1998

II. Annual Actuarial Value of Coverage per Child

	New Jersey Plus	US Healthcare of New Jersey	FEHBP BC/BS PPO Plan
Mental Health BVC Portion	\$ 77	\$ 40	\$ 72
Other Health BVC Portion	\$1,392	\$ 995	\$1,388
Total BVC	\$1,469	\$1,035	\$1,460
Mental Health portion as a percent of Total	5.2%	3.9%	4.9%

III. Summary of General Plan Provisions

New Jersey Plus		US Healthcare of New Jersey	FEHBP BC/BS PPO Plan
Plan Deductible	<i>Network:</i> None <i>Non Net.:</i> \$100/person \$200/family AND \$200/admission	N/A	\$200 / calendar year
In-Patient days	365	365	365
In-Patient Coinsurance	<i>Network:</i> no copay <i>Non Net.:</i> 70/30 percent plus \$200/admission	no copay	<i>Network:</i> 100 percent <i>Non Net.:</i> 100 percent after \$250/adm.
Out-Patient Coinsurance	<i>Network:</i> \$5 copay <i>Non Net.:</i> 70/30 percent	\$10 copay	<i>Network:</i> 95/5 percent <i>Non Net.:</i> 75/25 percent
Out of Pocket Maximum	<i>Network:</i> \$400 Self, \$1,000 Family <i>Non Net.:</i> \$2,000/\$5,000	\$1,500 for Self, \$3,000 for Family	<i>Network:</i> \$2,000 <i>Non Net.:</i> \$3,750
Maximum Benefit	<i>Network:</i> None <i>Non Net.:</i> \$1,000, 000	N/A	N/A

IV. Summary of Mental Health Benefits

New Jersey Plus		US Healthcare of New Jersey	FEHBP BC/BS PPO Plan
In-Patient days	<i>Network:</i> 25 days + <i>Non Net.:</i> 50 days	35 days	100 days
In-Patient Coinsurance	<i>Network:</i> no copay <i>Non Net.:</i> 50/50 percent plus \$200 / admission	no copay	<i>Network:</i> \$150/day <i>Non Net.:</i> \$250/day
Separate MH In-Patient deductible?	No, MH applies to General Plan deductible	N/A	No, MH applies to General Plan deductible
Out-Patient Visits	365	40 visits	25 visits
Out-Patient Professional Care Coinsurance	<i>Network:</i> \$5 copay <i>Non Net.:</i> 70/30 percent	\$25 copay	60/40 percent
Out-Patient Facility Care Coinsurance	N/A	N/A	<i>Network:</i> \$25 copay <i>Non Net.:</i> \$100/day
MH Benefit Maximum	\$15,000 annual \$50,000 lifetime	N/A	one inpatient S/A treatment program
Alcoholism & S/A covered same as MH?	no, see description for details	yes	no, see description for details

V. Description of Mental Health Benefits**A. State Employees of New Jersey**

Source: New Jersey Benefits, State Health Program, Information Handbook for Active and Retired Members. (1996) (Most current document)

The Program offers three types of coverage:

- The Traditional Plan (FFS):
administered by BCBSNJ
- Point of Service Plan (POS):
New Jersey Plus
administered by BCBSNJ
- HMOs
Cigna/CoMED
Aetna US Healthcare
HIP of NJ
Medigroup HMO Network
Oxford Health Plans
Prucare of NJ
Sanus Health Plans

The Traditional Plan and the POS Plan are self insured. The New Jersey Plus plan was valued.

Description of Mental Health Benefits**Mental Health****Inpatient**

In-Network: Up to 25 days per calendar year are covered in full; Balance covered at 90/10 percent up to annual maximum of \$15,000 (\$50,000 lifetime maximum) per individual.

Out-of-Network: Up to 50 days per calendar year are covered at 50/50 percent after deductible; \$15,000 annual maximum (\$50,000 lifetime maximum) subject to \$200 deductible per confinement per individual.

Outpatient

In-Network: 90/10 percent up to annual maximum of \$15,000 (\$50,000 lifetime maximum) per individual.

Out-of-Network: 70/30 percent after deductible; \$15,000 annual maximum (\$50,000 lifetime maximum) subject to \$200 deductible per confinement per individual.

Alcohol or Substance Abuse

Inpatient

In-Network: 100 percent; Covered on the same basis as any other illness

Out-of-Network: 70/30 percent after deductible subject to \$200 deductible per confinement per individual.

Outpatient

In-Network: 100 percent after \$5 per visit copayment; Covered on the same basis as any other illness;

Out-of-Network: 70/30 percent after deductible; Covered on the same basis as any other medical or psychological condition.

B. U.S. Health care of New Jersey (1997)

Source: The 1997 benefits package plan description based on the contract with Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law to provide a comprehensive medical plan to FEHB members. (page 14)

Description of Mental Health Benefits

Care must be received from or arranged by Plan doctors.

Mental Conditions**Covered Benefits**

To the extent shown below, the Plan provides for the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation;
- Psychological testing;
- Psychiatric treatment (including individual and group therapy); and
- Hospitalization (including inpatient professional services).

Outpatient Care

Up to 40 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; Enrollee pays a \$25 copay per covered visit - all charges thereafter.

Inpatient Care

Up to 35 days of hospitalization each calendar year; Enrollee pays no copayment for the first 35 days - all charges thereafter. Inpatient days may be exchanged for outpatient days at a rate of four outpatient visits or two partial treatment days for each inpatient day when approved by the Plan.

Not Covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment.
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.

Substance AbuseCovered Benefits

This plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition. Services for the psychiatric aspects such as outpatient rehabilitation or residential rehabilitation services are provided in conjunction with the mental condition benefits shown above. The mental condition benefits visit/day limitations and copayment apply to any covered services for the necessary for psychiatric aspects of substance abuse.

Not Covered

- Treatment that is not authorized by a Plan doctor.

New York

NEW YORK (NY)



I. Plans Evaluated

	NY State Employee Plan	Largest Enrolled HMO	Federal Employees Health Benefit	State Child Health Insurance Plan
Plan Name	The Empire Plan	HIP Health Insurance Plan	BC/BS PPO Plan (Standard Option)	Child Health Plus
Type of Plan	PPO	HMO	PPO	HMO
Year	1997	1997	1998	1998

II. Annual Actuarial Value of Coverage per Child

	The Empire Plan	HIP Health Insurance Plan	FEHBP BC/BS PPO Plan	Child Health Plus
Mental Health BVC Portion	\$ 92	\$ 43	\$ 72	\$ 11
Other Health BVC Portion	\$1,458	\$1,229	\$1,388	\$1,205
Total BVC	\$1,550	\$1,272	\$1,460	\$1,216
Mental Health portion as a percent of Total	5.9%	3.4%	4.9%	0.9%

III. Summary of General Plan Provisions

	The Empire Plan	HIP Health Insurance Plan	FEHBP BC/BS PPO Plan	Child Health Plus
Plan Deductible	<i>Network:</i> none <i>Non Net.:</i> \$161	N/A	\$200 / calendar year	N/A
In-Patient days	365	365	365	365
In-Patient Coinsurance	<i>Network:</i> no copay <i>Non Net.:</i> 80/20 percent	no copay	<i>Network:</i> 100 percent <i>Non Net.:</i> 100 percent after \$250/adm.	no copay
Out-Patient Coinsurance	<i>Network:</i> \$5-\$8 copays <i>Non Net.:</i> 80/20 percent	no copay	<i>Network:</i> 95/5 percent <i>Non Net.:</i> 75/25 percent	\$2 copay
Out of Pocket Maximum	\$776 per covered employee	N/A	<i>Network:</i> \$2,000 <i>Non Net.:</i> \$3,750	N/A

IV. Summary of Mental Health Benefits

	The Empire Plan	HIP Health Insurance Plan	FEHBP BC/BS PPO Plan	Child Health Plus
In-Patient days	365	45 days	100 days	no benefit
In-Patient Coinsurance	<i>Network:</i> no copay <i>Non Net.:</i> 50/50 percent after deductible	no copay	<i>Network:</i> \$150/day <i>Non Net.:</i> \$250/day	no benefit
Separate MH In-Patient deductible?	<i>Network:</i> N/A <i>Non Net.:</i> \$500 outpatient \$2,000 inpatient	N/A	No, MH applies to General Plan deductible	N/A
Out-Patient Visits Limit	365	40 visits	25 visits	20 visits
Out-Patient Professional Care Coinsurance	<i>Network:</i> \$15 copay <i>Non Net.:</i> 50/50 percent after outpatient ded.	\$10 copay \$5 copay for group therapy	60/40 percent	no copay
Out-Patient Facility Care Coinsurance	N/A	N/A	<i>Network:</i> \$25 copay <i>Non Net.:</i> \$100/day	N/A
MH Benefit Maximum	<i>Non Net.:</i> \$50,000 annual and \$100,000 lifetime maximum	N/A	one inpatient S/A treatment program	N/A
Alcoholism & S/A covered same as MH?	no, see description for details	no, see description for details	no, see description for details	no, see description for details

V. Description of Mental Health Benefits**A. State Employees of New York**

Source: New York State Health Insurance Program (NYSHIP) Health Insurance Choices November 1996.

New York State Employees are offered the choice of:

- Point of Service Plan:
The Empire Plan
- HMOs:
 - Blue Choice
 - Capital District Physicians' HP
 - CHP
 - Community Blue
 - Elderplan, Inc.
 - HealthCare Plan
 - Healthsource HMO of NY
 - HIP
 - HMO Blue
 - HMO-CNY
 - Independent Health
 - Kaiser Permanente
 - MVP Health Plan
 - MetraHealth Care Plan of UNY
 - NYLCare of NY
 - PHP/Prepaid Health Plan
 - Preferred Care
 - U.S. Healthcare
 - Vytra Healthcare
 - WellCare of NY

The Empire Plan is available to all NYSHIP enrollees, regardless of where they live. The Empire Plan is a comprehensive health insurance program that has four main parts:

1. Health Call - for hospital and medical benefits management, administered by Intracorp. HealthCall provides precertification for hospital admissions and MRI, discharge planning, voluntary medical case management and the high risk pregnancy program.
2. Blue Cross - for inpatient and outpatient hospital coverage and related benefits such as skilled nursing facility and hospice care.
3. MetraHealth - for medical expense benefits such as office visits, surgery and the Managed Physical Medicine Program. MetraHealth Service Corp. is the administrator for Metropolitan Life Insurance Company.
4. Value Behavioral Health (VBH) - for mental health and substance abuse benefits, including alcoholism.

Benefits are established by the State of New York through negotiations with employee unions and administratively for non-represented groups. Group-specific benefit information for the largest union group, Civil Servant Employee Association (CSEA) Plan was valued.

Description of Mental Health Benefits

The Empire Plan's Mental Health and Substance Abuse Program offers two levels of benefits. If the enrollee calls Value Behavioral Health (VBH) before the enrollee receives services and follows VBH's recommendations, the enrollee will receive the highest level of benefits. VBH's Clinical Referral Line is available 24 hours a day, every day of the year.

In an emergency, VBH will either arrange for an appropriate provider to call the enrollee back (usually within 30 minutes) or direct the enrollee to an appropriate facility for treatment. In a life-threatening situation, the enrollee should go to the emergency room. Then, someone must call VBH within 48 hours.

Program requirements apply even if Medicare or another health insurance plan is primary. All benefits apply only to treatment determined medically necessary by VBH.

If the enrollee does not coordinate treatment with VBH or follow their recommendations, limited Non-Network Benefits are available for medically necessary care.

Mental Health Services

Network: Mental Health Services are unlimited when medically necessary. Inpatient care is covered in full with no deductible. Mental Health Crisis Intervention is covered up to three visits per crisis. Outpatient Care requires the enrollee to pay a \$15 copayment. There are no annual or lifetime benefit maximums for in network benefits.

Non-Network: Benefits are available for medically necessary care up to 30 days/year. The enrollee pays a \$2,000 deductible for inpatient care or a \$500 deductible for outpatient care per enrollee, per spouse/domestic partner, per all covered children combined. The plan then pays 50 percent of the network allowance. There are limits on inpatient and outpatient benefits and \$50,000 annual and \$100,000 lifetime maximums if care is not arranged through VBH.

Alcohol/Drug Abuse Services

Network: Inpatient rehabilitation is covered in full. Outpatient rehabilitation is unlimited when medically necessary. Three Substance Abuse stays per lifetime (more may be approved case by case). Outpatient Care requires the enrollee to pay a \$5 copayment.

Non-Network: 30 visits per year or one Substance Abuse stay per year, three stays per lifetime. After the enrollee meets the deductible, the Plan pays up to 50 percent of the network allowance. Enrollee pays deductible and remaining balance.

Ambulance Service

Ambulance service to a hospital where the enrollee will be receiving mental health or substance abuse treatment is covered when medically necessary.

B. HIP Health Insurance Plan (1997)

Source: The 1997 benefits package plan description based on the contract with Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law to provide a comprehensive medical plan to FEHB members. (page 16)

HIP Health Insurance Plan is the highest enrolled HMO in New York. Neither this plan, nor the second highest enrolled plan in New York are federally qualified plans. The third highest enrolled plan had a much lower enrollment level. Therefore, the HIP Health Insurance Plan was valued.

Description of Mental Health Benefits**Mental Conditions/Substance Abuse Benefits**

Care must be received from or arranged by Plan doctors.

Mental Conditions**Covered Benefits**

To the extent shown below, the Plan provides for the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient Care

All necessary visits to Plan mental facilities; Enrollee pays no copayment.

Inpatient Care

Up to 30 days of hospitalization each calendar year; Enrollee pays nothing for the first 30 days- all charges thereafter.

Not Covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment.
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.

Substance AbuseCovered Benefits

This plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition and to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient Care

All necessary visits to Plan providers for treatment each calendar year; Enrollee pays no copayment.

Inpatient Care

Up to 30 days per calendar year in a substance abuse rehabilitation (intermediate care) program in an alcohol or drug rehabilitation center approved by the Plan. Enrollee pays no copayment during the benefit period - all charges thereafter.

Not Covered

- Treatment that is not authorized by a Plan doctor.

C. Child Health Plus (1997)

Source: The Child Health Plus Benefits Package

Outpatient Visits

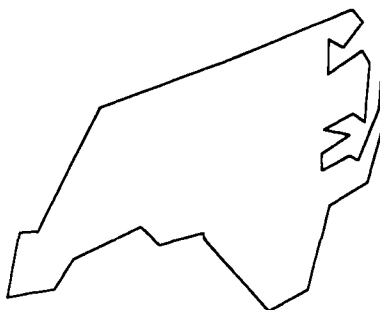
The Plan provides at least 60 outpatient visits per year for mental health and for the diagnosis and treatment of alcoholism and substance abuse. A minimum of 20 of the 60 visits may be used for family therapy visits related to alcohol abuse. A maximum of 20 of the 60 visits may be for mental health.

Not Covered

Inpatient Mental Health and Substance or Alcohol Abuse Services are not covered.

North Carolina

NORTH CAROLINA (NC)



I. Plans Evaluated

NC State Employee Plan		Largest Enrolled HMO	Federal Employees Health Benefit Plan
Plan Name	State of NC Comprehensive Major Medical Plan	Kaiser Foundation Health Plan of NC, Inc.	BC/BS PPO Plan (Standard Option)
Type of Plan	FFS	HMO	PPO
Year	1996	1997	1998

II. Annual Actuarial Value of Coverage per Child

	NC State Employee Plan	Kaiser Foundation Health Plan of NC	FEHBP BC/BS PPO Plan
Mental Health BVC Portion	\$ 110	\$ 41	\$ 72
Other Health BVC Portion	\$1,619	\$1,062	\$1,388
Total BVC	\$1,729	\$1,103	\$1,460
Mental Health portion as a percent of Total	6.3%	3.7%	4.9%

III. Summary of General Plan Provisions

	NC State Employee Plan	Kaiser Foundation Health Plan of NC	FEHBP BC/BS PPO Plan
Plan Deductible	\$250/year limit \$750 for family	N/A	\$200 / calendar year
In-Patient days	365	365	365
In-Patient Coinsurance	\$75/adm. plus 80/20 percent	no copay	<i>Network:</i> 100 percent <i>Non Net.:</i> 100 percent after \$250/adm.
Out-Patient Coinsurance	\$10 copay	\$10 copay	<i>Network:</i> 95/5 percent <i>Non Net.:</i> 75/25 percent
Out of Pocket Maximum	\$1,000	\$3,300 for Self, \$8,500 for Family	<i>Network:</i> \$2,000 <i>Non Net.:</i> \$3,750
Lifetime Maximum	\$2,000,000	N/A	N/A

IV. Summary of Mental Health Benefits

	NC State Employee Plan	Kaiser Foundation Health Plan of NC	FEHBP BC/BS PPO Plan
In-Patient days	365 (w/ case mgr. approval)	30 days inpatient or 60 sessions of day/night care	100 days
In-Patient Coinsurance	<i>Network:</i> 80/20 percent <i>NonNet.:</i> 60/40 percent	no copay	<i>Network:</i> \$150/day <i>Non Net.:</i> \$250/day
Separate MH In-Patient deductible?	N/A	N/A	No, MH applies to General Plan deductible
Out-Patient Visits Limit	365	20 visits or 40 visits for group therapy	25 visits
Out-Patient Professional Care Coinsurance	80/20 percent (visits in excess of 26 are covered only w/ case manager approval)	\$10 copay and \$5 copay for group therapy	60/40 percent
Out-Patient Facility Care Coinsurance	N/A	N/A	<i>Network:</i> \$25 copay <i>Non Net.:</i> \$100/day
MH Benefit Maximum	\$25,000 lifetime Chemical Dependency	N/A	one inpatient S/A treatment program
Alcoholism & S/A covered same as MH?	no, see description for details	no, see description for details	no, see description for details

V. Description of Mental Health Benefits**A. North Carolina State Employees**

Source: State North Carolina Health Care Options "It's Your Choice" (1996) and State North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan "Your Health Benefits" (1996).

State Employees in North Carolina have many health care options. Depending on the county of residence, an employee may select from:

- Fee-for-Service Plan:
State of NC Comprehensive
Major Medical Plan
- Preferred Provider Organizations:
BCBS of NC Personal Care
Healthsource NC, Inc.
MaxiCare NC, Inc.
- Health Maintenance Organizations:
CIGNA HealthCare of NC
Doctor's Health Plan
Kaiser Foundation HP of NC
Optimum Choice of The
Carolinas, Inc.
Partners NHP of NC, Inc.
PHP, Inc.
PruCare HMO.
QualChoice of NC, Inc.
WellPath Select, Inc.

The State of NC Comprehensive Major Medical Plan was valued. It offers statewide coverage and is self-funded.

Description of Mental Health Benefits**Mental Health Services*****Inpatient Services***

All inpatient, partial hospitalization, residential treatment and intensive outpatient services covered only if approved by a case manager. Enrollee is responsible for obtaining certification from the Mental Health Case Manager, 24 hours a day, 365 days a year *prior* to receiving the mental health services listed below:

- inpatient mental health care (if the enrollee is admitted to a hospital for mental health treatment, the enrollee must be confined to a mental health bed and be treated by an eligible mental health provider)
- urgent admissions
- 23-hour observation bed stays
- partial hospitalization treatment
- psychiatric residential treatment care (limited to children 17 and under)
- care in an intensive outpatient program
- more than 26 outpatient visits per Plan year

- psychological testing (except during the first 26 visits, or when included in the hospital's or program's daily charge)
- hypnotherapy
- sodium amytal interviews
- electroconvulsive treatment
- stress, relaxation and occupational therapies (except when included in the hospital's or program's daily charge)
- psychosurgery

Failure to obtain prior approval of covered mental health services will result in the enrollee being responsible for the entire cost of care.

The enrollee must use a preferred (contracting) provider for mental health services or pay an additional 20 percent copayment up to \$5,000.

Enrollee may receive services from the following eligible mental health providers only:

- psychiatric (M.D. or D.O.)
- licensed or certified doctor of psychology (Ph.D., Psy.D. or Ed.D.)
- certified clinical social worker (CCSW)
- psychiatric clinical nurse specialist, with master's degree (RNCS)
- North Carolina certified fee-based practicing pastoral counselor (until June 30, 1999)
- licensed professional counselor

The following individuals must work under the direct supervision and be salaried employees of a psychiatrist or a licensed or certified doctor of psychology:

- registered nurse certified in psychiatry or mental health nursing (RNC)
- licensed psychological associate (LPA)
- social worker who practices in area mental health centers (This social worker will no longer be an eligible provider as of January 1, 1997, unless he or she becomes a CCSW prior to that date.)

Emergencies

If enrollee must go to a hospital for an emergency admission (immediately life-threatening situation), someone (either the enrollee, a family member, the hospital or the doctor) must contact the Mental Health Case Manager, promptly. The number is available 24 hours a day, seven days a week.

Outpatient Services

Outpatient visits are unlimited, but visits in excess of 26 in a fiscal year (July 1 - June 30) are covered only if approved by a case manager.

The enrollee is responsible for keeping track of the number of outpatient mental health visits received each Plan year (July 1 through June 30). This is best done by checking with the mental health caregiver.

Chemical Dependency

The Plan provides benefits for inpatient and outpatient chemical dependency and substance abuse treatment as follows:

- \$200 per day
- \$8,000 per Plan year (July 1 through June 30)
- \$25,00 lifetime maximum

Up to 5 days of treatment for medical detoxification are allowed and are not subject to the chemical dependency limitations noted above. Inpatient chemical dependency and substance abuse treatment do not require certification from the Mental Health Case Manager; however, inpatient services do require admission and length-of-stay certification.

Dual Diagnoses

If your doctor makes dual diagnoses, which include mental health and chemical dependency/substance abuse, inpatient treatment should be precertified as follows:

- When mental health is the primary diagnosis and chemical dependency is the secondary diagnosis, precertification must be obtained by contacting the Mental Health Case Manager.
- When chemical dependency is the primary diagnosis and mental health is the secondary diagnosis, precertification must be obtained by calling the Claims Processing Contractor.

B. Kaiser Foundation Health Plan of North Carolina, Inc. (1997)

Source: The 1997 benefits package plan description based on the contract with Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law to provide a comprehensive medical plan to FEHB members. (page 16)

Description of Mental Health Benefits

Care must be received from or arranged by Plan doctors.

Mental Conditions**Covered Benefits**

To the extent shown below, the Plan provides for the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation;
- Psychological testing (each visit counts as one outpatient individual therapy visit, and the individual therapy \$10 copay noted below applies);
- Psychiatric treatment (including individual and group therapy); and
- Hospitalization (including inpatient professional services).

Outpatient Care

Up to 20 outpatient visits for individual therapy or up to 40 group therapy visits to Plan doctors, consultants or other psychiatric personnel each calendar year; Each two group visits count as one individual visit and vice versa; Enrollee pays \$10 per covered individual visit, and a \$5 per covered group visit - all charges thereafter.

Inpatient Care

Up to 30 days of hospitalization each calendar year; Enrollee pays no copayment for the first 30 days - all charges thereafter. Up to 60 sessions of day or night care per calendar year reduced by two days for each day of inpatient hospitalization and vice versa; Enrollee pays no copayment for the first 60 days - all charges thereafter.

Not Covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment.
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.

Substance AbuseCovered Benefits

This plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition, and to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient Care

Up to 20 outpatient visits for individual therapy or up to 40 group therapy visits to Plan doctors, consultants or other substance abuse specialists each calendar year; Each two group visits count as one individual visit and vice versa; Enrollee pays \$10 per covered individual visit, and a \$5 per covered group visit - all charges thereafter.

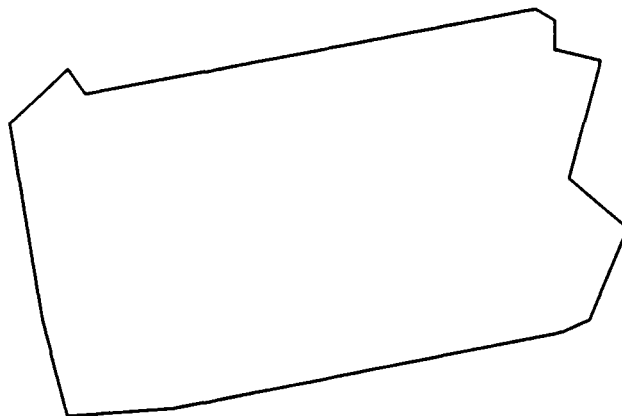
Inpatient Care

Up to 30 days of inpatient care or up to 60 sessions of care in an intensive outpatient treatment program (including day and night care) for specialized treatment per calendar year; Each inpatient day reduces the number of intensive outpatient treatment sessions by two and vice versa. Enrollee must pay all daily charges over \$100 for inpatient residential care and all daily charges over \$50 for care in an intensive outpatient treatment program.

Not Covered

Treatment that is not authorized by a Plan doctor.

Pennsylvania

PENNSYLVANIA (PA)**I. Plans Evaluated**

	PA State Employee Plan	Largest Enrolled HMO	Federal Employees Health Benefit Plan	State Child Health Insurance Plan
Plan Name	PEBTF POS Option	US Healthcare of Pennsylvania (Standard Option)	BC/BS PPO Plan (Standard Option)	PA Child Health Insurance Plan (CHIP)
Type of Plan	POS	HMO	PPO	HMO
Year	1998	1997	1998	1998

II. Annual Actuarial Value of Coverage per Child

	PEBTF POS Option	US Healthcare of PA	FEHBP BC/BS Plan	PA CHIP
Mental Health BVC Portion	\$ 86	\$ 41	\$ 72	\$ 42
Other Health BVC Portion	\$1,427	\$1,009	\$1,388	\$1,214
Total BVC	\$1,513	\$1,037	\$1,460	\$1,256
Mental Health portion as a percent of Total	5.7%	4.0%	4.9%	3.3%

III. Summary of General Plan Provisions

	PEBTF POS Option	US Healthcare	FEHBP BC/BS PPO Plan	PA CHIP
Plan Deductible	<i>Non Net.:</i> \$200/year ind., \$600/year family	N/A	\$200/year	N/A
In-Patient days	365	365	365	90 days
In-Patient Coinsurance	<i>Network:</i> 100 percent <i>Non Net.:</i> 80/20 percent	no copay	<i>Network:</i> 100 percent <i>Non Net.:</i> 100 percent after \$250/adm.	no copay
Out-Patient Coinsurance	<i>Network:</i> \$5 copay <i>Non Net.:</i> 80/20 percent	\$10 copay	<i>Network:</i> 95/5 percent <i>Non Net.:</i> 75/25 percent	no copay
Out of Pocket Maximum	\$1,700 self \$3,600 family	\$1,500 self \$3,000 family	<i>Network:</i> \$2,000 <i>Non Net.:</i> \$3,750	N/A
Lifetime Aggregate Maximum	<i>Non Net.:</i> \$500,000	\$1,000,000	N/A	N/A

IV. Summary of Mental Health Benefits

	PEBTF POS Option	US Healthcare	FEHBP BC/BS PPO Plan	PA CHIP
In-Patient days	60 days	35 days	100 days	90 days
In-Patient Coinsurance	<i>Network:</i> 100 percent <i>Non Net.:</i> 80/20 percent	no copay	<i>Network:</i> \$150/day <i>Non Net.:</i> \$250/day	no co-pay
Separate MH In-Patient deductible?	No, MH applies to General Plan deductible	N/A	No, MH applies to General Plan deductible	no co-pay
Out-Patient Visits Limit	30 visits	20 visits	25 visits	50 visits
Out-Patient Professional Care Coinsurance	<i>Network:</i> \$25 co-pay <i>Non Net.:</i> 50/50 percent to a maximum of \$35	\$25 co-pay	60/40 percent	no copay
Out-Patient Facility Care Coinsurance	N/A	N/A	<i>Network:</i> \$25 copay <i>Non Net.:</i> \$100/day	N/A
MH Benefit Maximum	Lifetime max: 4 detoxification 120 outpatient visits 90 residential days	N/A	one inpatient S/A treatment program	N/A
Alcoholism & S/A covered same as MH?	no, see description for details	no, see description for details	no, see description for details	substance abuse services are not covered

V. Description of Mental Health Benefits***A. Pennsylvania State Employees***

Source: The Pennsylvania Employees Benefit Trust Fund (PEBTF) Summary Plan Description (July 1994) obtained as current plan in September 1997.

Eligible State Employees may choose one of three medical options. Depending on the county of residence, an employee may select from:

- Basic Option
BlueCross BlueShield
- Point-of-Service Option
- HMOs
(Plans vary depending on service area of residence)

Although only the Point-of-Service Option was valued, the following Mental Health and Substance Abuse Services pertain to all plans.

Point-of-Service Option**Mental Health Care**

Inpatient mental health care, including emergency crisis intervention to assess the need for hospitalization, is covered for up to 60 days per year. In-network, coverage is 100%. Out-of-network, the enrollee pays 20% after the deductible.

Outpatient care or partial hospitalization is limited to 30 visits per year. In-network, the enrollee's cost is \$25 per visit. Out-of-network, the plan pays 50% after the deductible to a maximum of \$35 per visit.

Substance Abuse Treatment

All substance abuse treatment is covered *in-network* only.

Alcohol and Drug Detoxification

The plan covers detoxification as either an inpatient or outpatient, whichever is determined to be medically appropriate by the PCP or POS specialist. Coverage for detoxification is limited to seven days per year, with a lifetime maximum of four admissions.

Rehabilitation Treatment and Counseling

Non-hospital residential treatment is covered up to 30 days per year at a participating substance abuse treatment facility when the enrollee is referred by a PCP or POS network provider. Coverage is limited to 90 days lifetime.

Outpatient care at a treatment facility is covered up to 60 visits per year and a maximum of 120 visits lifetime. When medically necessary, up to 30 outpatient visits may be exchanged on a two-for-one basis to secure up to 15 additional inpatient days of care at a residential treatment facility.

Basic Option*Mental Illness*

A hospital stay for mental illness is covered in full for up to 60 days in any 12 consecutive months. Any inpatient stays for alcoholism or drug abuse treatment are applied toward this 60-day limit.

Inpatient Rehabilitative Treatment for Substance Abuse

The plan covers charges made by a participating substance abuse treatment facility. Benefits are paid (subject to precertification) for up to 30 days of inpatient care in a plan year -- up to a lifetime maximum of 90 days. Three days of inpatient care reduces the 365-day limit on hospital stays by one day.

The following expenses are covered:

- room and board
- general nursing services
- diagnostic tests
- supplies and equipment
- counseling for enrollee and eligible dependents

Inpatient rehabilitative services received from a non-participating facility are not covered under major medical.

Outpatient Rehabilitative Treatment for Substance Abuse

Up to 30 visits for treatment facility at a outpatient rehabilitative treatment at a participating substance abuse treatment facility are covered in a plan year. There is a lifetime maximum of 120 visits. The enrollee can exchange two outpatient visits for one day of inpatient care -- up to a maximum of 15 additional days of inpatient care in a year.

Services for non-participating facilities are not covered under major medical.

Outpatient rehabilitative services include:

- general nursing care
- diagnostic and psychological testing
- prescribed drugs
- family counseling

Health Maintenance Organization (HMO) Option

Mental Health Care

Inpatient mental health care, including emergency crisis intervention to assess the need for hospitalization, is covered in full for up to 60 days per year.

Outpatient care or partial hospitalization is limited to 30 visits per year. The enrollee pays \$25 per visit.

Substance Abuse

Alcohol and Drug Detoxification: The plan covers detoxification as either inpatient or outpatient, whichever is determined to be medically appropriate by the HMO. Coverage for detoxification is limited to seven days per year with a maximum of four admissions per lifetime.

Rehabilitative Treatment and Counseling

Non-Hospital residential treatment is covered up to 30 days per year at a participating substance abuse treatment facility. Coverage is limited to 90 days lifetime.

Outpatient care at a treatment facility is covered up to 60 visits per year and a maximum of 120 visits lifetime. When medically necessary, up to 30 outpatient days may be exchanged on a two-for-one basis to secure up to 15 additional inpatient days of care at a residential treatment facility.

B. US Healthcare of Pennsylvania (1997)

Source: The 1997 benefits package plan description based on the contract with Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law to provide a comprehensive medical plan to FEHB members. (page 16)

Description of Mental Health Benefits**Mental Conditions/Substance Abuse Benefits**

Care must be received from or arranged by Plan doctors.

Mental Conditions**Covered Benefits**

To the extent shown below, the Plan provides for the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient Care

Up to 20 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; Enrollee pays a \$25 copay for each covered visit, and all charges thereafter.

Inpatient Care

Up to 35 days of hospitalization each calendar year; Enrollee pays nothing for the first 35 days- all charges thereafter. Inpatient days may be exchanged for outpatient days at a rate of four outpatient visits or two partial treatment days for each inpatient day when approved by the Plan.

Not Covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment.
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.

Substance AbuseCovered Benefits

This plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition and, to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient Care

30 outpatient visits and an additional 30 outpatient visits which can be exchanged for up to 15 inpatient days to Plan doctors, participating consultants or other substance abuse providers each calendar year; Enrollee pays a \$15 copay for each covered visit, up to a maximum of \$240.

Inpatient Care

Up to 35 days of inpatient care at a substance abuse facility or hospital each calendar year; Enrollee pays nothing for the first 35 days- all charges thereafter. Inpatient days may be exchanged for outpatient treatment at a rate of two day treatments for each inpatient day.

Not Covered

- Treatment that is not authorized by a Plan doctor.

C. Children's Health Insurance Program (CHIP)

Source: Children's Health Insurance Program (CHIP) Fact Sheet and Covered Services Summary Plan by Caring Program/Blue CHIP HMO.

The Children's Health Insurance Program was signed into law in December of 1992. The Commonwealth currently contracts with five health care entities (known as Grantees) to administer the program.

Description of Mental Health Benefits**Mental Health**

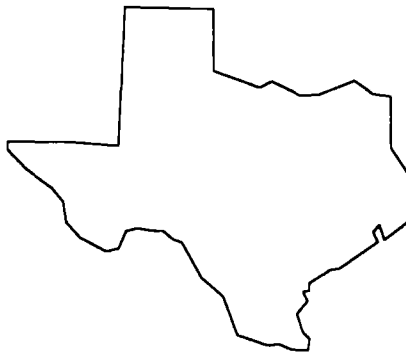
Mental health benefits include:

- Inpatient services as required per Act 113; The Plan covers 90 inpatient days per calendar year in conjunction with State Medical Assistance Spend Down. Partial hospitalizations and emergency psychiatric care are covered;
- The Plan covers 50 outpatient visits.
- Comprehensive enrollee case management designed to insure coordination, monitoring, and access to any medically necessary service or resource to provide support, training and assistance designed to enable CHIP enrollees to function in family, school and community.
- Individual, group or family therapy which is office or community (family, home, school, day care, etc.) based; appropriate and medically necessary intervention in the home, school or other community setting with an emphasis on family involvement.
- Prescription medication with a \$5 copay.

Substance Abuse Benefits

Substance Abuse is not a covered service.

Texas

TEXAS (TX)***I. Plans Evaluated***

TX State Employee Plan		Largest Enrolled HMO	Federal Employees Health Benefit Plan
Plan Name	BCBSTX Health Select (In-Area Benefits)	NYLCare Health Plans of the Gulf Coast, Inc. (formerly Sanus Health Plan)	BC/BS PPO Plan (Standard Option)
Type of Plan	POS	HMO	PPO
Year	1998	1997	1997

II. Annual Actuarial Value of Coverage per Child

	TX State Employee Plan	NYLCare	FEHBP BC/BS PPO Plan
Mental Health BVC Portion	\$ 115	\$ 29	\$ 72
Other Health BVC Portion	\$1,402	\$1,079	\$1,388
Total BVC	\$1,517	\$1,108	\$1,460
Mental Health portion as a percent of Total	7.6%	2.7%	4.9%

III. Summary of General Plan Provisions

TX State Employee Plan		NYLCare	FEHBP BC/BS PPO Plan
Plan Deductible	Network: None Non Net.: \$200/person \$600/family	N/A	\$200 / calendar year
In-Patient days	365	365	365
In-Patient Coinsurance	Network: 90/10 percent Non Net.: 70/30 percent	no copay	Network: 100 percent Non Net.: 100 percent after \$250/adm.
Out-Patient Coinsurance	Network: \$15 copay Non Net.: 70/30 percent	\$5 copay	Network: 95/5 percent Non Net.: 75/25 percent
Out of Pocket Maximum	Network: \$500/person Non Net.: \$1,500/person	\$650 Self \$1,500 Family	Network: \$2,000 Non Net.: \$3,750
Lifetime Aggregate Maximum	Network: None Non Net.: \$1,000,000	N/A	N/A

IV. Summary of Mental Health Benefits

TX State Employee Plan		NYLCare	FEHBP BC/BS PPO Plan
In-Patient days	Inpatient: 30 days Intermediate Care: 60	Inpatient: 30 days Daycare: 60 days	100 days
In-Patient Coinsurance	Days 1 - 15 Network: 90/10 percent Non Net.: 70/30 percent Days 16 - 30 Network: 70/30 percent Non Net.: 50/50 percent	50/50 percent	Network: \$150/day Non Net. \$250/day
Separate MH In-Patient deductible?	No, MH applies to General Plan deductible	N/A	No, MH applies to General Plan deductible
Out-Patient Visits Limit	30 visits	20 visits	25 visits
Out-Patient Professional Care Coinsurance	Network: 90/10 percent Non Net.: 70/30 percent	\$25 copay	60/40 percent
Out-Patient Facility Care Coinsurance	N/A	N/A	Network: \$25 copay Non Net.: \$100/day
MH Benefit Maximum	\$25,000 *	N/A	one inpatient S/A treatment program
Alcoholism & S/A covered same as MH?	no, see description for details	no, see description for details	no, see description for details

* Behavioral Health lifetime maximum does not apply to serious mental illness or substance abuse

V. Description of Mental Health Benefits**A. State Employees of Texas**

Source: The Road to Benefits (9/1995) and The Road to Benefits: Benefits Booklet Supplement (9/1997) and Health Select of Texas Information Booklet

Several medical plans are offered to Texas State Employees for the 1998 Plan year. Depending on the county of residence, an employee may select from:

- Two Point of Service (POS) Plans:
 - Health Select (In-Area)
 - Health Select (Out-of-Area)
- Fee-for-Service Plan:
 - Blue Cross Traditional
- Five HMOs:
 - PCA
 - Prudential
 - NileCare
 - United Health
 - Humana

The Health Select Plan has the highest enrollment among non-HMO plans and offers the most extensive coverage of the state.

Description of Mental Health Benefits**Mental Health and Substance Abuse Services*****Notice of Election of Exemption under the HIPAA (paraphrased)***

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes certain requirements on group health plans. Among these requirements, is parity in the application of certain limits to mental health benefits. The parity requirement will become effective for the Texas Employees Uniform Group Insurance Program on September 1, 1998.

Referrals for behavioral health services

There are separate guidelines for network treatment of behavioral health (which includes mental health, serious mental illness, substance abuse, and speech disorders). The BCBSTX Behavioral Health Department can work with the enrollee directly to obtain a referral. The BCBSTX Behavioral Health Department will refer the enrollee to a network counselor, psychologist, psychiatrist, or treatment center, and will send the enrollee a referral stating the approved time span and approved number of visits.

The enrollee's out-of-pocket costs may vary, depending on the choice of providers and diagnosis. If the enrollee has a referral to a network provider, and the diagnosis is *not* a serious mental illness (as defined by Texas law), the enrollee's out-of-pocket costs will be 10% per visit subject to the outpatient visit limit.

If the enrollee has a referral to a network provider, and the diagnosis is a serious mental illness (as defined by Texas law), the enrollee will pay a \$15 copayment for each visit.

As with other covered services, the enrollee may receive care from a non-network provider, but benefits will be paid at non-network levels with a maximum allowed of \$60 per outpatient visit. (The \$60 maximum does not apply to services for treatment of serious mental illness.)

Network benefits for behavioral health are available by calling BCBSTX Behavioral Health Department. Either the enrollee or a family member may call.

If the enrollee does not obtain referrals for treatment of behavioral health services through the Behavioral Health Department, benefits will be paid at non-network levels.

Precertification of behavioral health services

When using the network, the network provider is responsible for precertification of behavioral health services.

If the enrollee does not use the network the enrollee is responsible for precertification of behavioral health services, including:

- Hospital admissions;
- Intermediate care facilities;
- Residential treatment centers;
- Crisis stabilization units;
- Psychiatric day treatment facilities.

If the enrollee does not obtain precertification for these services, the enrollee may be responsible for the full cost of the services.

Behavioral Health

(does not include serious mental illness or substance abuse treatment, which are covered like any other illness or injury)

	In Network	Non-Network
Outpatient visits Maximum 30 visits per calendar year	90/10 percent coinsurance (even after out-of-pocket coinsurance maximum is met)	70/30 percent coinsurance; maximum \$60 per visit (even after out-of-pocket coinsurance maximum is met)
*Inpatient treatment Maximum 30 days per calendar year	First 15 days, 90/10 percent coinsurance; Next 15 days, 70/30 percent coinsurance	First 15 days, 70/30 percent coinsurance; Next 15 days, 50/50 percent coinsurance
**Intermediate care facility Maximum 60 days per calendar year	First 30 days, 90/10 percent coinsurance Next 30 days, 70/30 percent coinsurance	First 30 days, 70/30 percent coinsurance; Next 30 days, 50/50 percent coinsurance
Behavioral Health lifetime maximum (does not apply to serious mental illness or substance abuse)	\$25,000 combined network/non-network maximum	

* Precertification required.

** Precertification required. This includes residential treatment centers for children and adolescents, crisis stabilization units, and psychiatric day treatment facilities. Each day of a hospital stay reduces by two the number of days available for psychiatric intermediate care facilities services. Each two days of intermediate care facilities services reduces by one the number of days available for hospital inpatient stays.

Services that are never covered at 100%

After the enrollee meets the out-of-pocket coinsurance maximums as described above, HealthSelect pays 100% for most covered services and supplies. However, there are two exceptions:

- Charges for private duty nursing; and
- Charges for outpatient behavioral health visits.

The enrollee's share of the cost of these services *do* count toward the out-of-pocket coinsurance maximums (\$500 for network and \$1,500 for non-network benefits). But once the enrollee reaches those coinsurance maximums, the enrollee must continue to pay a portion of the cost of these two services, as shown in the benefits summary.

B. NYLCare Health Plans of the Gulf Coast, Inc.
(formerly Sanus Health Plan)

Source: The 1997 benefits package plan description based on the contract with Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law to provide a comprehensive medical plan to FEHB members. (page 16)

Description of Mental Health Benefits

Care must be received from or arranged by Plan doctors.

Mental Conditions

Covered Benefits

To the extent shown below, the Plan provides for the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation;
- Psychological testing;
- Psychiatric treatment (including individual and group therapy); and
- Hospitalization (including inpatient professional services).

Outpatient Care

Up to 20 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; Enrollee pays a \$25 copay for each visit - and all charges thereafter.

Inpatient Care

Up to 30 days of hospitalization or up to 60 days of daycare each calendar year; Enrollee pays 50 percent of the actual charges for the first 30 days - all charges thereafter.

Not Covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment.
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.

Substance Abuse*Covered Benefits*

This plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition, and to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient Care

All necessary outpatient visits to Plan providers for treatment; Enrollee pays a \$5 copayment for each covered visit.

Inpatient Care

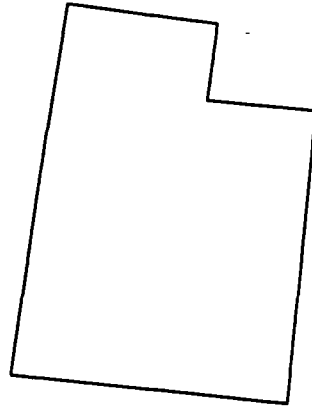
All necessary care. Enrollee pays no copayment.

Not Covered

Treatment that is not authorized by a Plan doctor.

Acute Inpatient Detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate.

UTAH (UT)***I. Plans Evaluated***

UT State Employee Plan		Largest Enrolled HMO	Federal Employees Health Benefit Plan
Plan Name	Traditional Care	FHP of Utah	BC/BS PPO Plan (Standard Option)
Type of Plan	FFS	HMO	PPO
Year	1998	1997	1998

II. Annual Actuarial Value of Coverage per Child

	Traditional Care	FHP of Utah	FEHBP BC/BS PPO Plan
Mental Health BVC Portion	\$ 60	\$ 43	\$ 72
Other Health BVC Portion	\$1,680	\$1,100	\$1,388
Total BVC	\$1,740	\$1,129	\$1,460
Mental Health portion as a percent of Total	3.4%	3.8%	4.9%

III. Summary of General Plan Provisions

	Traditional Care	FHP of Utah	FEHBP BC/BS PPO Plan
Plan Deductible	N/A	N/A	\$200 / calendar year
In-Patient days	365	365	365
In-Patient Coinsurance	90/10 percent of PESB*	no copay	Network: 100 percent Non Net.: 100 percent after \$250/adm.
Out-Patient Coinsurance	\$10 copay	\$5 copay	Network: 95/5 percent Non Net.: 75/25 percent
Out of Pocket Maximum	N/A	\$1000 for Self, \$3,000 for Family	Network: \$2,000 Non Net.: \$3,750

* PESB = Public Employees Schedule of Benefits

IV. Summary of Mental Health Benefits

	Traditional Care	FHP of Utah	FEHBP BC/BS PPO Plan
In-Patient days	30 days	30 days inpatient or 60 sessions of day/night care	100 days
In-Patient Coinsurance	first 10 days: 90/10 percent of PESB days 11- 30: 50/50 percent of PESB	no copay	Network: \$150/day Non Net.: \$250/day
Separate MH In-Patient deductible?	No, MH applies to General Plan deductible	N/A	No, MH applies to General Plan deductible
Out-Patient Visits Limit	Yearly max of \$1,500	up to 20 visits or 40 visits for group therapy	up to 25 visits
Out-Patient Professional Care Coinsurance	50/50 percent of PESB with a yearly max of \$1,500	first visit: no copay visits 2-5: \$5 copay visits 6-20: \$25 copay and \$10 for group therapy	60/40 percent
Out-Patient Facility Care Coinsurance	N/A	N/A	Network: \$25 copay Non Net.: \$100/day
MH Benefit Maximum	\$1,500/year outpatient; 60 inpatient days in a 3 year period	N/A	one inpatient S/A treatment program
Alcoholism & S/A covered same as MH?	yes	no, see description for details	no, see description for details

V. Description of Mental Health Benefits**A. State Employees of Utah**

Source: State of Utah Public Employees Health Program (PEHP) (1994-1995)

Three Plans are offered to Utah State Employees:

- Traditional Care (FFS)
- Preferred Care (PPO)
- Preferred Care Plus - only for members outside the preferred counties;

State employees are also offered participation in the Federal Employees Health Program.

The Traditional Care (FFS) Plan has the highest enrollment among state employees and offers statewide coverage. Although only the Traditional Care (FFS) Plan was valued, the following description from the PEHP materials (pages 34-37) pertains to Mental Health and Substance Abuse Services of all plans.

Description of Mental Health Benefits**Mental Health: For all Plans**

An enrollee may receive outpatient treatment at a psychiatric day treatment facility.

Plan maximums, pre-authorization rules, limitations (For all plans)

Plan maximums, pre-authorization rules, limitations, and exclusions apply to Traditional Care, Preferred Care, and Preferred Care Plus.

For those enrolled in Preferred Care, eligible inpatient services provided by a non-preferred provider are payable, after the copayment, at 75 percent of the Preferred Care fee for the first ten days. Those enrolled in Preferred Care Plus are responsible for any balance due above the Preferred Care rate. Those enrolled in Traditional Care are responsible for any balance above the Public Employees Schedule of Benefits (PESB) unless services are rendered by a Preferred Provider.

Facility And Hospital Services (For all plans.)

The enrollee's copayment can be reduced by 50 percent or more if the service, condition, or procedure is identified as being a Designated Service Plan (DSP) service and is rendered by a DSP provider at a DSP facility.

Institutional charges from hospitals, inpatient treatment centers, and outpatient facilities must be pre-authorized to receive full contract benefits

When approved, facility charges are payable at 90 percent of the PESB for the first 10 days and 50 percent for the next 20 days for a maximum of 30 days per plan year. Charges for the full hospital stay will be prorated to determine a per diem rate for adjudication of daily benefits. Traditional care is payable at 90 percent of the PESB for the first 10 days and 50 percent thereafter, for a maximum of 30 days per plan year.

Limitations

- There is a 30-day maximum benefit for facility and hospital services in a plan year.
- There is a 60-day maximum benefit for facility and hospital services for mental health care in a 36-month period beginning with the first day of treatment
- Inpatient treatment for mental health and/or substance abuse which is not pre-authorized will not be payable
- Attention Deficit Disorder (ADD), eating disorders, and pain clinics are considered under this benefit
- When an inpatient stay spans an old and new plan year, benefits will be based on the old plan year provisions. However, actual days used will apply to applicable plan years.

Inpatient Doctor Visits

For Traditional Care, benefits for inpatient doctor visits are payable at 70 percent of the PESB. Hospital visits by Preferred Care physicians have a \$10 copayment.

Limitations

- There is a 30-day maximum benefit for doctor's inpatient services in a plan year. Services must be concurrent with covered hospitalization.
- There is a 60-day maximum benefit for doctor's inpatient services in a 36-month period beginning with the first day of service.

Outpatient Doctor Visits

Outpatient treatment by a licensed professional psychologist, licensed clinical social worker, licensed psychiatric nurse specialist, or medical doctor is eligible for payment. Benefits are payable at 50 percent of the PESB or the Preferred Care fee.

Limitations

- Maximum benefits payable for outpatient mental health treatment are limited to \$1,500 in a plan year.
- Attention Deficit Disorder (ADD) is considered under this benefit.
- Eating disorders are considered under this benefit.
- Eligible psychological testing is considered under this benefit.
- Eligible neuropsychological evaluations and testing are considered under this benefit.
- Medical management to monitor use of psychotropic drugs is considered under this benefit.
- Chronic pain disorders or syndrome requiring repetitive analgesic injections or on-going management will be payable under outpatient mental health benefits.
- Laboratory services or medical visits to monitor certain medications, such as Clozaril for schizophrenia, will be considered under this benefit.
- Light therapy may be reviewed for outpatient mental health benefits with written pre-authorization.

Exclusions

- Charges for marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, conduct disorders, learning disabilities, and situational disturbances such as everyday stress and strain, financial, marital, and environmental.
- Charges for mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.
- Inpatient charges for behavior modification, enuresis, or encopresis.
- Hospital charges while on leave of absence from hospital.
- Office calls in conjunction with repetitive therapeutic injections.
- Inpatient facility admissions that are not pre-authorized.
- Charges in conjunction with wilderness programs.
- Psychological evaluations for legal purposes such as custodial rights, etc.

Substance Abuse: For all Plans

There are many excellent outpatient programs available.

Plan maximums, pre-authorization rules, limitations (For all plans.)

Plan maximums, pre-authorization rules, limitations, and exclusions apply to traditional care, preferred care, and preferred care plus.

For those enrolled in Preferred Care, eligible inpatient services provided by a non-preferred provider are payable, after the copayment, at 75 percent of the Preferred Care fee for the first ten days. Those enrolled in Preferred Care Plus, are responsible for any balance due above the Preferred Care rate. Those enrolled in Traditional Care are responsible for any balance above the PESB unless services are rendered by a Preferred Provider.

Facility And Hospital Services (For all plans.)

The enrollee's copayment can be reduced by 50 percent or more if the service, condition, or procedure is identified as being a DSP service and is rendered by a DSP provider at a DSP facility.

Institutional charges from hospitals, inpatient treatment centers, and outpatient facilities must be pre-authorized to receive full contract benefits. When approved, facility charges are payable at 90 percent for the first 10 days and 50 percent for the next 20 days for a maximum of 30 days per plan year. Charges for the full hospital stay will be prorated to determine a per diem rate for adjudication of daily benefits. Traditional care is payable at 90 percent PESB for the first 10 days and 50 percent PESB thereafter, for a maximum of 30 days per plan year.

Limitations

- Benefits for facility and hospital services are limited to 30 days in a 36 month period beginning with the first day of treatment. The 30 day limit is considered to be part of the 30 day limit for mental health treatment in a plan year.
- When an inpatient stay spans an old and new plan year, benefits will be based on the old plan year provisions.

Inpatient Doctor Visits

For Traditional Care, benefits for inpatient doctor visits are payable at 70% PESB. Hospital visits by Preferred Care Physicians have a \$10 copayment.

Limitations

- There is a 30 day maximum benefit for doctor's inpatient services in a 36 month period beginning with the first day of service. Services must be concurrent with covered hospitalization.

Outpatient Doctor Visits

Outpatient treatment by a licensed professional psychologist, licensed clinical social worker, licensed psychiatric nurse specialist, or medical doctor is eligible for payment. Benefits are payable at 50 percent of the PESB or the Preferred Care fee.

Limitations

Benefits for outpatient doctor visits are included in the \$1,500 maximum in a plan year for all services provided for mental health and substance abuse.

Exclusions

- Tobacco abuse (refer to the Healthy Utah program)
- Inpatient facility admissions that are not pre-authorized
- Charges in conjunction with wilderness programs

B. FHP of Utah (1997)

Source: The 1997 benefits package plan description based on the contract with Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law to provide a comprehensive medical plan to FEHB members. (page 14)

Description of Mental Health Benefits

Care must be received from or arranged by Plan doctors.

Mental Conditions**Covered Benefits**

To the extent shown below, the Plan provides for the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation;
- Psychological testing;
- Psychiatric treatment (including individual and group therapy); and
- Hospitalization (including inpatient professional services).

Outpatient Care

Up to 30 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; Enrollee pays a \$5 copay for each covered visit -- all charges thereafter.

Inpatient Care

Up to 30 days of hospitalization each calendar year; Enrollee pays nothing for the first 30 days -- all charges thereafter.

Not Covered

- Care for psychiatric conditions which in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition

Substance Abuse*Covered Benefits*

This plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition, and to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient Care

Up to 20 outpatient visits per calendar year to Plan providers for treatment; Enrollee pays a \$5 copay for each covered visit -- all charges thereafter.

These substance abuse benefits may be combined with the outpatient mental conditions benefits shown above, provided such treatment is necessary as a mental conditions service and is approved by the Plan, to permit an additional 30 outpatient visits per calendar year with the applicable mental conditions copayments.

Inpatient Care

Lifetime maximum of two 30-day substance abuse rehabilitation (intermediate care) programs in an alcohol detoxification or rehabilitation center approved by the Plan; Enrollee pays nothing during the benefit period -- all charges thereafter.

Not Covered

- Treatment that is not authorized by a Plan doctor.

Federal Employees Health Benefits Program BlueCross BlueShield PPO

Source: The 1998 benefits package plan description based on the contract with Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law to provide a comprehensive medical plan to FEHB members. Benefits selected are offered in the Standard Option. (pages 23- 24)

Description of Mental Health Benefits**Mental Conditions Inpatient Care****Precertification**

The medical necessity of an admission to a hospital or other covered facility must be precertified to receive full Plan benefits. Emergency admissions must be reported within two business days following admission even if the patient has been discharged. Otherwise, payable benefits will be reduced by \$500.

Hospital Care

Covered charges up to 100 days per calendar year;

PPO benefit: After the enrollee pays a \$150 per day copayment, the Plan pays the remainder of the Preferred rate up to 100 days;

Non-PPO benefit: After the enrollee pays a \$250 per day copayment in Member hospitals or a \$400 per day copayment in Non-member hospitals, the Plan pays the remainder of the rate up to 100 days;

After the enrollee pays the per day copayments, the Plan pays the remainder of the Preferred rate (for PPO/Preferred Hospitals), Member Rate (for Member Hospitals) or Non-Member rate in excess of the sum of the enrollee's copayments. In Preferred and Member Hospitals, in some instances, when the Preferred or Member rate or the Billed charge is less than the sum of the enrollee's copayments, the enrollee will be responsible only for the lowest amount. In Non-member hospitals, in some instances, the Average charge may be less than the sum of the enrollee's copayments.

Covered services include room and board and other hospital services.

Inpatient Visits

After the enrollee pays a \$200 calendar year deductible, the Plan pays up to 60 percent of the Allowable charge for inpatient mental conditions and substance abuse professional care rendered by Participating and Non-Participating providers.

Mental Conditions Outpatient Care

The Plan pays all covered outpatient care (including related services and supplies, such as psychological testing) for the treatment of a mental condition, including substance abuse, as follows:

Facility Care

PPO benefit: After satisfaction of the \$200 calendar year deductible, the enrollee pays a \$25 copay per day at PPO/Preferred facilities for outpatient facility care. The Plan pays in full the remainder of the rate.

Non-PPO benefit: After satisfaction of the \$200 calendar year deductible, the enrollee pays a \$100 copay per day at Member facilities or a \$150 copay per day at Non-member facilities, for outpatient facility care. The Plan pays in full the remainder of the rate.

These copayments are applied per facility day, not per service. After meeting the deductibles, the enrollee is responsible for the lesser of the stated copayment or the Billed charge(s). If Preferred or Member facilities are available, and utilized, the enrollee is responsible for the lesser of the stated copayments, the Billed charge(s), or the Preferred Member rate at the time your claim is processed.

Professional Care

The Plan provides coverage for outpatient mental conditions and substance abuse professional care rendered by Participating and Non-Participating providers.

After satisfaction of the \$200 calendar year deductible, the Plan pays 60 percent of the Allowable charge for outpatient care for mental conditions/substance abuse.

Therapy

Outpatient visits are available up to 25 visits per person per year for:

- Individual or group therapy, up to two hours per day, including collateral visits with members of the patient's immediate family, provided by a physician, qualified clinical psychologist, psychiatric nurse or clinical social worker.
- Day-night hospital services (sometimes called partial hospitalization)
- Pharmacotherapy

The number of visits for which the enrollee will be reimbursed will be reduced if these services are used to meet part or all of the calendar year deductible.

Substance Abuse*Inpatient Care*

The Plan provides benefits for the treatment of alcoholism and drug abuse at the levels indicated on the previous page for hospital care and inpatient visits for mental conditions care. Treatment is also payable in a freestanding alcoholism facility approved by the Local Plan.

Lifetime Maximum

Inpatient care for the treatment of alcoholism and drug abuse is limited to one treatment program (28-day maximum) per lifetime.

Inpatient Care

The Plan provides benefits for outpatient facility and professional care for the treatment of substance abuse at the benefit levels indicated above. Outpatient visits accrue towards the visit limits described above.

Not Covered

The following items are not covered under this Plan:

- Marital, family, educational or other counseling or training services;
- Services rendered or billed by a school or halfway house or a member of its staff;
- Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present;
or
- Services and supplies that are not medically necessary.

Grandfathered Plans

Grandfathered plans are those that were in existence on March 23, 1989, and have not been materially modified since that date.

Grandfathered plans are exempt from the requirements of the ACA, including the requirement to provide minimum essential coverage.

Grandfathered plans are also exempt from the requirement to provide community rating.

Grandfathered plans are also exempt from the requirement to provide guaranteed renewal.

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I. Plans Evaluated

SCHIP Plans	Florida	New York	Pennsylvania
Plan Name	Florida Healthy Kids	New York Child Health Plus	PA Child Health Insurance Plan (CHIP)
Type of Plan	HMO	HMO	HMO
Year	1997	1998	1998

II. Annual Actuarial Value of Coverage per Child

	Florida Healthy Kids	New York Child Health Plus	Pennsylvania CHIP
Mental Health BVC Portion	\$ 37	\$ 11	\$ 42
Other Health BVC Portion	\$1,164	\$1,205	\$1,214
Total BVC	\$1,201	\$1,216	\$1,256
Mental Health portion as a percent of Total	3.1%	0.9%	3.3%

III. Summary of General Plan Provisions

	Florida Healthy Kids	New York Child Health Plus	Pennsylvania CHIP
Plan Deductible	N/A	N/A	N/A
In-Patient days	365	365	90 days
In-Patient Coinsurance	no copay	no copay	no copay
Out-Patient Coinsurance	\$3 copay	\$2 copay	no copay
Out of Pocket Maximum	N/A	N/A	N/A

IV. Summary of Mental Health Benefits

	Florida Healthy Kids	New York Child Health Plus	Pennsylvania CHIP
In-Patient days	15 days	no benefit	90 days
In-Patient Coinsurance	no copay	no benefit	no co-pay
Separate MH In-Patient deductible?	N/A	N/A	no co-pay
Out-Patient Visits Limit	up to 20 visits	20 visits	50 visits
Out-Patient Professional Care Coinsurance	\$5 copay	no copay	no copay
Out-Patient Facility Care Coinsurance	N/A	N/A	N/A
MH Benefit Maximum	Lifetime max. \$20,000	N/A	N/A
Alcoholism & S/A covered same as MH?	S/A covered only for pregnant adolescents	no, see description for details	substance abuse services are not covered

V. Description of Mental Health Benefits**C. Florida's Healthy Kids Replication Program (1997)**

Source: Healthy Kids Replication Program Design and Enrollee Benefit Schedule

Description of Mental Health Benefits**Mental Conditions/Substance Abuse Benefits**

All services must be approved the plan or upon approved referral. There is a lifetime maximum coverage of \$20,000 for both inpatient and outpatient mental health and substance abuse treatment.

Mental Health**Inpatient Coverage**

The Plan covers in full up to 15 days per contract year. Enrollee pays no copayment.

Outpatient Coverage

The Plan covers up to 20 days per contract year for outpatient short term evaluation and crisis intervention for psychological or psychiatric diagnosis. Counseling and placement assistance for drug and alcohol abuse are also covered. Enrollee pays a \$5 copay.

Substance Abuse and Addiction**Inpatient Coverage**

The Plan covers only pregnant adolescents for up to 7 days for detox only. Enrollee pays no copayment.

Outpatient Coverage

The Plan benefit is limited to pregnant adolescents.

B. New York's Child Health Plus (1997)

Source: The Child Health Plus Benefits Package

Description of Mental Health Benefits

Outpatient Visits

The Plan provides at least 60 outpatient visits per year for mental health and for the diagnosis and treatment of alcoholism and substance abuse. A minimum of 20 of the 60 visits may be used for family therapy visits related to alcohol abuse. A maximum of 20 of the 60 visits may be for mental health.

Not Covered

Inpatient Mental Health and Substance or Alcohol Abuse Services are not covered.

C. Pennsylvania's Children's Health Insurance Program (CHIP)

Source: Children's Health Insurance Program (CHIP) Fact Sheet and Covered Services Summary Plan by Caring Program/Blue CHIP HMO.

The Children's Health Insurance Program was signed into law in December of 1992. Commonwealth currently contracts with five health care entities (known as Grantees) to administer the program.

Description of Mental Health Benefits**Mental Health**

Mental health benefits include:

- Inpatient services as required per Act 113; The Plan covers 90 inpatient days per calendar year in conjunction with State Medical Assistance Spend Down. Partial hospitalizations and emergency psychiatric care are covered;
- The Plan covers 50 outpatient visits.
- Comprehensive enrollee case management designed to insure coordination, monitoring, and access to any medically necessary service or resource to provide support, training and assistance designed to enable CHIP enrollees to function in family, school and community.
- Individual, group or family therapy which is office or community (family, home, school, day care, etc.) based; appropriate and medically necessary intervention in the home, school or other community setting with an emphasis on family involvement.
- Prescription medication with a \$5 copay.

Substance Abuse Benefits

Substance Abuse is not a covered service.

Glossary

Glossary of Abbreviations & TermsAbbreviations:

AAHP	American Association of Health Plans (formerly GHAA)
adm.	admission (as in deductible per admission)
AK	Alaska
AZ	Arizona
BC/BS	BlueCross and BlueShield
BVC	Benefit Value Comparison as determined by HCBVC 7.6 or MCBVC 2.6
CA	California
CT	Connecticut
ded.	deductible (usually annual on a calendar year basis, but also fiscal or plan year)
EPSDT	Early and Periodic Screening, Diagnosis and Treatment services
FEHBP	Federal Employee Health Benefit Program
HBR	Hay Benefits Report (formerly HHBR) published annually
HMO	Health Maintenance Organization
FFS	Fee for Service Plan
FL	Florida
GA	Georgia
IL	Illinois
KS	Kansas
MA	Massachusetts
MH	Mental Health
MN	Minnesota
Net.	Network or In-Network services or benefits
Non Net.	Non Network or Out-of-Network services or benefits
NC	North Carolina
NJ	New Jersey
NY	New York
OOP	Out-of-Pocket expenses
PA	Pennsylvania
POS	Point-of-Service Plan
PPO	Preferred Provider Organization (Option)
S/A	Substance Abuse
Self Ref.	Self Referral
TX	Texas
UT	Utah

Terms:

Early and Periodic Screening, Diagnosis and Treatment (EPSDT): Services that are required to be provided to all Medicaid eligible recipients under the age of 22 to identify physical and mental problems through periodic examinations (screens) and also to furnish treatment to “correct or ameliorate defects and physical and mental illness and conditions” discovered by the screens.

Fee for Service (FFS): A method of paying health care providers for individual medical services rendered, as opposed to paying them salaries or capitated payments.

Federally Qualified HMO: An HMO that has satisfied certain federal qualifications pertaining to organization structure, provider contracts, health service delivery information, utilization review and quality assurance, grievance procedures financial status and marketing information as specified in Title XIII of the Public Health Service Act. See **Health Maintenance Organization**.

Hay Benefits Report (HBR): a comprehensive report on the benefits offered by over 1,000 large employers that has been published annually for over 25 years.

HCBVC 7.6: Health Care **Benefit Value Comparison** Model version 7.6 (1996) Hay’s proprietary actuarial model used to calculate a relative benefit value for non-HMO health care plans.

Health Maintenance Organization (HMO): A type of **managed-care** plan that acts as both insurer and provider of a comprehensive set of health care services to an enrolled population. Benefits are typically financed through capitation with limited copayments, and services are furnished through a system of affiliated providers. Services can be provided through four basic model types: a Group-Model HMO, Independent Practice Association HMO, Managed Care, Network Model HMO, Staff-Model HMO.

Managed Care: Any system of health service payment or delivery arrangements where the health plan attempts to control or coordinate use of health services by its enrolled members in order to contain health expenditures, improve quality or both. Arrangements often involve a defined delivery system of providers with some form of contractual arrangement with the plan.

MCBVC 2.6: Managed Care **Benefit Value Comparison** Model version 2.6 (1996) Hay’s proprietary actuarial model used to calculate a relative benefit value for **managed care (HMO)** health care plans.

Point-of-Service Plan (POS) Plan: A **managed care** plan that combines features of both prepaid and fee-for-service insurance. Health plan enrollees decide whether to use network or non-network providers at the time care is needed and must accept the management for the entire treatment of the illness. Enrollees are usually offered a financial incentive to use providers on the preferred list.

Preferred Provider Organization (PPO): A **managed-care** plan that contracts with networks of panels of providers to furnish services and be paid on a negotiated fee schedule. Enrollees are offered a financial incentive to use providers on the preferred list, but may use non-network providers as well.

Self Referral: The selection of care directed by the enrollee and not a Primary Care Physician.