

Report and Recommendations of Benefit Review Subgroup for Iowa Choice Advisory Council

Overview

The Benefits Review Subgroup discussed an appropriate benefit package that could be offered to the estimated 18,000 uninsured children in Iowa who would remain following full implementation of HF 2539. The Subgroup focused on that portion of HF 2539 which calls for the advisory council to assist in recommending the benefits to be included in “qualified health care coverage” for children less than 19 years of age, after consideration of 16 specific benefits.

The Subgroup compared the benefits currently available under Medicaid and *hawk-i*, noting differences in the two programs today. The Subgroup also reviewed the benefits currently available to an insured population (i.e. the State of Iowa [SOI] employee group). The Subgroup noted that the SOI benefit package, like most other insurance coverage available from the private sector, does not include specific benefits targeted for children. Therefore, the Subgroup focused on Medicaid and *hawk-i* for further analysis. The major differences noted between Medicaid (T19) coverage for children and *hawk-i* include:

- Early & Periodic Screening, Diagnosis & Treatment (EPSDT) is covered by T19--*hawk-i* limits coverage for well child care to age 7
- Title 19 covers certain residential treatment/custodial services —*hawk-i* does not
- Title 19 covers children to age 21, while *hawk-i* only covers children to age 19
- *hawk-i* has a \$1 million maximum lifetime benefit while Title 19 does not

The Subgroup elected to use the *hawk-i* benefit package as the starting point for defining “qualified health coverage” for children because it has been established by the members of the *hawk-i* Board based on public input. In addition, the program’s benefits expressly cover each of the 16 benefits listed in HF 2539.

The Subgroup received input on additional items to consider, such as providing early childhood care coordination and developmentally appropriate assistive technology for children with special needs (i.e. hearing aids), beyond those provided by the current *hawk-i* program. There was consideration of the addition of residential treatment/custodial care consistent with that currently provided under Title 19 and a suggestion to eliminate the \$1 million maximum lifetime benefit under *hawk-i*.

In particular, the Iowa Department of Public Health believes the inclusion of care coordination should be furthered explored. The Clinical Advisory Committee created as a part of Iowa's SCHIP program recommended that *hawk-i* include care coordination as part of the benefit package. It was not included because at that time there was relatively little experience with this service for the population outside of Medicaid and Special Needs Children. Since then, more information is available on the benefits of providing care coordination especially for the 0-5 population to ensure access to needed services, which may result in cost savings in the long term.

Recommendations

A. “Qualified health coverage” for children (as stated in HF 2539)

The Subgroup recommends that “Qualified health coverage” as provided for in HF 2539 consist of the identical medical and dental benefits included in the current *hawk-i* program.

1. Maintain Current Benefit Levels/Cost Considerations

The current monthly premium cost for children enrolled in the existing *hawk-i* program ranges from \$187 to \$194 per child (ages 1-19) and varies by the carrier participating in the program. In addition there is a flat \$408 monthly premium for children ages 0-1 year, although the Department of Human Services reports that there are few infants enrolled in the program. These premiums reflect current benefits and are subsidized with state and federal monies. If additional benefits are added, regardless of how meritorious, they will result in further costs for the program which in turn creates a higher demand for subsidies or corresponding affordability concerns.

2. Facilitate Seamless Transition with *hawk-i*

Retaining a benefit design that is consistent with the *hawk-i* program will support families as they transition through *hawk-i*, and possibly a *hawk-i* “buy in” option and into the private market if their income rises without disrupting their health coverage. Consistent benefits will also facilitate a common administrative structure for a single point of entry via DHS and enrollment for families.

3. Future Expanded Benefits

If funding is available to expand the current *hawk-i* benefit package to include: elimination of the \$1 million lifetime maximum, coverage for EPSDT, care coordination, and/or developmentally appropriate assistive technology for children with special needs, then consideration should be given to extending these additional benefits to the new plan under development.

B. Cost Sharing

The Subgroup also was asked to consider various cost saving features with the potential to reduce costs, including elimination of some benefits currently covered. To provide consistency and seamless transition, **the Subgroup does not recommend eliminating any of the benefits currently covered by the *hawk-i* program.** However, **the subgroup does support the consideration of cost sharing** as a potential method for moderating program costs for this population

The current *hawk-i* benefit design has limited use of cost-sharing practices. Currently, families whose income is less than 150 percent of the Federal Poverty Level pay no premium for enrollment in *hawk-i*. Families with income greater than this are required to pay a \$10.00 per child per month premium payment with a maximum of \$20 per family. There are no deductible or co-insurance components,

other than a \$25 charge for the inappropriate use of the emergency room that is waived for those families whose income is low enough to qualify for \$0 premium costs. While these are the type of benefit design features which have been used successfully to control utilization and costs in the private market, they have been considered to be inappropriate in the low income population which is the target of the *hawk-i* program. Introduction of these features at higher income levels could help to moderate the program costs for the expanded population.

C. Other Recommendations of Subgroup

- Develop a “dental only” option under *hawk-i* for families without access to dental coverage. The Subgroup feels that providing appropriate dental coverage should be as important as providing appropriate medical coverage.
- Make sure *hawk-i* (current and expanded) and the new program are treated as prior credible and qualifying coverage for private market access.