STATE OF WASHINGTON

Alternative Methods of Procuring Health Benefits for Home Care Workers

Office of Financial Management
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I. INTRODUCTION

This report is in response to the following budget proviso:

Third Engrossed Substitute Senate Bill 5034 Section 130(1)

The office of financial management shall prepare a report outlining alternative methods of procuring health benefits for home care workers, including individual providers and agency providers. In preparing the report, the office of financial management shall consult with the department of social and health services, representatives of individual home care providers, and agency home care providers.

Along with a summary of the current method of providing benefits, the report must include an analysis of the policy and fiscal implications of accessing health benefits through the Washington health benefits exchange. The report must also provide an analysis of a Medicaid section 1115 waiver with the federal centers for Medicare and Medicaid services that would provide additional Medicaid matching funds for individual provider home care workers who are provided with health care benefits through a collective bargaining agreement negotiated with the state under chapter 74.39A RCW, but would otherwise be eligible for Medicaid under the federal expanded eligibility provisions that take effect January 1, 2014.

The report must be submitted to the appropriate fiscal committees of the legislature by January 6, 2014.

II. BACKGROUND

Some of the state's most vulnerable people who are elderly and living with disabilities need help with preparing meals, personal care such as bathing and dressing, and housekeeping. The most vulnerable with a very low income may be eligible for Medicaid support for home care services (also known as "in-home personal care" or just "personal care"). In Washington, Medicaid personal care is provided by two types of workers:

1. Agency providers (APs), who are workers employed by private, for-profit or by not-for profit organizations that recruit, train, pay and supervise home care workers, and are responsible for the care provided by the worker they send to the home of a person in need. These agencies are licensed by the state. Many APs are represented by SEIU Healthcare 775NW or OPEIU Local 8.
2. Individual providers (IPs), who are workers hired, supervised and directed by the Medicaid consumer. IPs are under contract with the state for payment purposes and members of a statewide bargaining unit represented by SEIU Healthcare 775NW. *See* RCW 74.39A.270(2).

Approximately 36,000 IPs and 11,000 APs compose a total of 47,000 home care workers.

A. Current method of payment and provision of home care worker health benefits

Washington includes a contribution toward health care benefits for home care workers as part of the hourly rate it pays for Medicaid-funded personal care services. Along with wages and other typical benefits, the cost of providing health care benefits is part of the hourly cost of providing Medicaid-funded personal care services, and, as such, the state receives federal Medicaid funds for approximately 50 percent of the costs. The remaining 50 percent is paid by the state's General Fund. The estimated fiscal impact for fiscal year 2014 of providing health benefits to home care workers is $168 million in total, of which $84 million is from the General Fund-State.

1. Individual providers

The portion of IP hourly pay that goes to health care is determined through collective bargaining and paid on behalf of the worker to a health benefits trust (HBT or trust). Federal Taft-Hartley law requires such trusts to be governed by a board of trustees that has 50 percent of its members representing labor interests and 50 percent representing employers. The state is one of the 15 participating employers; two state employees serve as trustees representing labor. The other employers are home care agencies with union bargaining units. The HBT is managed by a board of eight trustees, four appointed by labor and four representing the employers.

Health care benefits are a mandatory subject of bargaining for IPs. They are administered by the HBT pursuant to the collective bargaining agreement between the state and SEIU 775. Solely for the purpose of collective bargaining, the Governor serves as the public employer for the IPs.

The HBT is funded by each participating employer who contributes a set amount per hour worked. The state currently contributes $2.60 per Department of Social and Health Services-paid hour worked to the HBT on behalf of all IPs. The contribution amount will increase to $2.80 per DSHS-paid hour effective July 1, 2014. The state expects to pay for approximately 46 million hours of IP services per fiscal year.

2. Agency providers

RCW74.39A.310 requires, that, among other rate adjustments, the hourly value of the health care contribution that is collectively bargained for IPs is added to the total hourly rate paid to APs for personal care services. APs are required to use that portion of their rate to provide health care for workers and are free to choose the method they use to do so. Most APs that are unionized have chosen to purchase health care through the same HBT used by IPs and employ approximately 70 percent of all AP workers. The remaining APs purchase worker health care on the open market.

As noted above, the contribution rate for health care benefits for eligible APs is provided for in RCW 74.39A.310 at the same rate as negotiated and funded in the collective bargaining agreement for IPs, which is $2.60 per DSHS-paid hour worked and increasing to $2.80 per DSHS-paid hour effective July 1, 2014. APs that participate in the HBT also contribute the same amount per hour for any care they provide on a private-pay basis or from other, non-Medicaid sources. The state expects to pay for approximately 14 million hours of Medicaid-funded AP services per fiscal year.

B. Health benefits trust enrollment and eligibility criteria

The HBT determines eligibility requirements for home care workers to qualify for health care. They are: 1) a home care worker must work at least 86 hours for at least three consecutive months; and 2) the worker cannot be covered by other health insurance. The HBT has approximately 15,000 enrollees — 11,000 IPs and 4,000 care providers who work for agencies. The estimated number of workers who are eligible and decide to purchase insurance (the take-up rate) is 34 percent for IPs and 36 percent for APs. The HBT provides health (primarily through Group Health Cooperative), vision and dental coverage, and a range of wellness incentives.

In addition:

- Enrolled home care workers pay $25 per month toward the premium cost.
- Dependents are not covered for either IPs or APs. However, APs may choose to purchase dependent-children coverage at full cost to the home care worker.

Details of the benefit plan can be found at www.myseiubenefits.org. See Table 1.

III. THE AFFORDABLE CARE ACT: CHALLENGES AND OPPORTUNITIES

The Affordable Care Act (ACA) has changed the landscape of health care by increasing the affordability and accessibility of health insurance, which provides an opportunity to rethink the way health benefits are purchased for home care workers. For example, there may be opportunities to expand coverage to more home care workers or refinance the current process at a lower cost through leveraging ACA coverage options for people with low incomes.

Washington elected to expand Medicaid coverage to individuals with family incomes up to 138 percent of the federal poverty level (FPL) based on modified adjusted gross income.[1] The federal government will pay 100 percent of the health care costs for the newly eligible adult group through 2016 (phasing down to 90 percent by 2020). Importantly, this funding is available only for the "newly eligible" population, and so individuals who qualified under previous Medicaid standards are not eligible for additional federal funds. Given that a portion of the home care workforce is likely newly eligible for Medicaid, there may be an opportunity for the HBT to provide eligible home care workers more health care access through expanded Medicaid. One important limitation of Medicaid expansion is that this coverage is not available to individuals who have fewer than five years of legal residency. There is a large percentage of home care workers who were born outside of the United States who may be affected by this restriction.

The ACA also provides premium tax credits or subsidies for citizens and legal residents with incomes between 138 percent and 400 percent FPL who purchase coverage through the health insurance exchange market. These subsidies provide an opportunity to reduce the health care costs for certain home care workers who qualify for federal subsidies on the exchange.

> **Note:** People offered insurance through their employer or from Medicaid are not eligible for premium tax credits. In addition, people are not eligible for premium tax credits if they have a legal offer of coverage through a spouse — even if the spouse's employer is not contributing toward the cost of insurance (up to 9.5 percent of income).

Although the ACA is reforming health care, particularly in the area of insurance coverage, significant reform is still in development. Further analysis about how these reforms will develop is needed. In addition, to make any decision about reforming the way we purchase health care for home care workers, there need to be reliable data. Today, serious data limitations exist as the next section will discuss.

A. Limitation of data about home care worker demographics makes it challenging to develop informed options

The fiscal implication of home care workers accessing health benefits through the exchange are influenced by health care workforce demographics. Understanding whether home care workers would benefit by getting coverage through the exchange requires knowing demographic variables such as worker age, family income, family size, citizenship status and accessibility of other insurance. Unfortunately, there is no *single* source of information that offers a complete demographic snapshot. Accordingly, several methods were used.

The first approach was to examine demographic data collected by the SEIU 775 NW from a 2012 phone survey of home care workers. The data provided estimates of family income, availability of

[1] Details of Washington's Medicaid expansion are available at: http://www.hca.wa.gov/hcr/me/Pages/index.aspx.

other insurance, eligibility information, and enrollment and benefit details for insurance offered by the HBT. However, the phone survey data have significant problems and limitations, including a small sample size. In addition, the survey was limited to English-speaking workers, and there was no validation of the information provided in the survey, such as taxable family income.[2] With these limitations, the FPL data are not valid for the necessary modeling of the potential effects of using the exchange for home care workers.

A second approach was to obtain home care worker demographic data from the state of Oregon, which recently changed its process of providing home care worker health benefits. Since Oregon has a state income tax, it was able to identify the family size and taxable family income of its home care work force. However, the Oregon demographics may not be entirely comparable to Washington's due to differences in demographics of home care workers.

A third approach was to obtain home care worker demographic information from the Automated Client Eligibility System (ACES) at the Department of Social and Health Services on household composition and size information for providers who are also clients. This analysis would represent only those individuals who both qualify for assistance and receive it. Preliminary information has been received but its potential for use for this report is extremely limited due to the lack of critical data elements. See Appendix for further discussion.

B. Preliminary options of accessing benefits under the ACA

Several considerations must be addressed before the state can take advantage of the new opportunities afforded by the ACA for home care workers. When evaluating possible options, it is important to keep in mind the following considerations:

- Leveraging resources to maximum advantage to achieve the Triple Aim: Better health and coverage, higher quality and sustainable costs;
- Sustaining current benefits and coverage levels for both APs and IPs;
- Adhering to legal requirements, including relevant health, tax and labor laws;
- Achieving financial feasibility;
- Recognizing the difference in employment situations between IPs and APs and the potential related differences of employer responsibilities under the ACA;
- Recognizing that the HBT acts as a broad insurance pool, and changes in that pool may affect pricing and viability; and
- Identifying a solution that minimizes disruption in health benefits due to churn.

[2] The surveys contacted 501 of the 40,000 home care workers represented byes the SEIU. Only 367 responded.

Considering the policy implications, the following options might provide avenues for home care worker health insurance coverage:

1. **Using Medicaid Section 1115 waiver and/or premium assistance to target Medicaid expansion dollars to sustain coverage through the HBT for workers who would otherwise be eligible for Medicaid**

The federal website Medicaid.gov[3] provides the following overview of Section 1115 Demonstrations, also known as 1115 waivers.

"Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as:

- Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible
- Providing services not typically covered by Medicaid
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs."

Typically, Medicaid Section 1115 waivers are approved for five years and can be extended for additional three-year periods. Before they can be approved, they must meet a "budget neutrality" test, which requires that the cost to the federal government under the waiver will be no more than the cost would have been without the waiver. Budget neutrality is enforced through a cap on federal matching funds over the life of the waiver. In addition, states must provide opportunity for public comment, including official tribal consultation, before a new or amended waiver can be approved. Waivers must include an approved evaluation plan to measure the results of the demonstration against a strong hypothesis.

States have often used 1115 waivers to obtain authority to use federal Medicaid funds in ways that are not otherwise allowed under federal rules. It is this authority that is being contemplated to "provide additional Medicaid matching funds for individual provider home care workers who are provided with health care benefits through a collective bargaining agreement negotiated with the state under chapter 74.39A RCW." Assessment of the financial impact of a waiver requires credible projections of the numbers of people likely to be affected as Medicaid demonstration enrollees. Potential costs to the federal and state governments during each year of the waiver must also be explained. Unfortunately, data to support reliable projections are not readily available to estimate likely Medicaid-eligible home care workers who would be included in the demonstration.

Given the variety and scope of waivers proposed and approved in recent years, the Centers for Medicaid & Medicare Services are now paying close attention to alternative Medicaid program authorities, such as state plan options and other waivers that could achieve the desired flexibility more efficiently. Whether an 1115 waiver approach or other option would allow more flexibility in applying Medicaid financing to coverage for home care workers is a separate analysis being conducted by an experienced consultant team: Manatt Health Solutions is reviewing information provided by the SEIU Healthcare NW Health Benefits Trust, SEIU Healthcare 775NW, Group

[3] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/Byes-Topics/Waivers/1115/Section-1115-Demonstrations.html

Health Cooperative, the state of Washington and other partners on health care benefits available to home care workers, including eligibility requirements (such as hours), Medicaid eligibility (such as information on income), churn issues and coverage costs.

Based on that review, Manatt will analyze the feasibility of using Medicaid premium assistance in two situations: (1) to purchase coverage through the HBT for Medicaid-eligible individuals who qualify for coverage; and (2) to purchase coverage through the HBT for Medicaid-eligible home care workers who do not currently quality for coverage through the trust. Manatt will consider the advantages and disadvantages of deploying premium assistance in these situations from the perspective of the state, the HBT and the home care workers.

Manatt has begun the analytic process. Results will take time to inform and complement this report, particularly with respect to financial issues and implications of identified options.

2. Using the HBT to provide current benefits and/or resources to directly purchase "wraparound" benefits not covered through the exchange to maintain a similar level of coverage (specifically vision and dental)

With or without a waiver as discussed in option 1 above, the HBT could continue to offer coverage. Many trust members may be newly eligible for Medicaid in 2014. The HBT would be ideally suited to counsel and navigate members to the exchange to enroll in Apple Health, which may offer improved coverage. If members qualify for exchange subsidies, the HBT could likewise provide members that option and assist them in obtaining coverage.

Alternatively, the HBT could provide resources and wraparound coverage to home care workers who would, in turn, purchase health care from the exchange. The HBT could help members who need premium and cost-sharing assistance. The HBT could also offer wraparound coverage or supplemental coverage that equates to the level of coverage now available to workers but not necessarily available through the exchange, such as adult dental services to ensure consistent level of coverage and access. It is worth noting that the ACA employer mandate that applies to some APs would preclude this approach for agency workers.[4]

> **Note:** The home care agency that does not participate in the trust would receive a corresponding rate, as required by the parity statute, to be used as they decide to offer insurance to their employees. Employees could be given the choice to purchase individual coverage on the exchange where they may qualify for Medicaid or a tax subsidy.

3. State-purchased coverage through the exchange

The state may directly purchase insurance on behalf of the home care workers. In this model, the state would facilitate enrolling the home care workers by using the exchange. The role of the HBT in this model would be reduced or eliminated since the state would assume essentially all administrative responsibilities. Obvious disadvantages to this idea include: (1) the potential loss of ability to draw federal match for health care as part of the hourly cost of Medicaid personal care; (2) loss of the HBT model discussed above, which works well and could be relied on to offer better member services and help for certain members to find options right for them either through the HBT or exchange; and (3) uncertainty about how many home care workers would be eligible for Medicaid coverage or subsidies because their family income is unknown. It is unclear what the costs or savings would be.

[4] Primarily, an employer of a staff of 50 or more is required to provide health care coverage or else incur a penalty.

In addition, the state would need to develop a solution for those workers who are not eligible for subsidies on the exchange. This would include workers who have an offer of spousal coverage or who have household incomes above 400 percent FPL. Under the collective bargaining law, health care coverage for workers not eligible for subsidies on the exchange would remain a subject of collective bargaining for the parties.

C. Other considerations

To accurately compare the current approach for purchasing health care to what might be available through the exchange, differences in benefit design and member cost sharing must be considered:

- Home care workers participating in the HBT now pay $25 per month toward their premium and receive medical, dental and vision coverage.
- Medicaid coverage also includes medical, dental and vision but does not require a monthly premium or cost sharing.
- Health insurance from the exchange includes only medical and pediatric dental, so vision and adult dental coverage must be added separately.
- Cost sharing for health plans from the exchange varies depending on the benefit level; however, federal subsidies are provided for individuals with income up to 400 percent FPL.
- Eligibility requirements for Medicaid may be excluded from these options based on immigration status, availability of coverage through a spouse or household income.
- Duplication of both the low-co-pays and co-premiums in one plan is not now part of the exchange.

Eligibility is a factor when deciding which administrative model may work best. A trust broker model allows the eligibility function to remain with the HBT. Assuming there are savings from refinancing the current process, additional investments could be made to lower eligibility requirements and expand access to coverage to home care workers who work less than 86 hours per month (the current HBT threshold).

The HBT does not offer coverage for IP dependents. It does offer dependent child coverage for APs at full cost to the worker. However, dependent coverage is available on the exchange. Whether to include dependent coverage is a collective bargaining decision that could be considered when designing a new process for home care health insurance. In addition, Apple Health for Kids covers children up to 300 percent FPL; many dependent children are covered through this program

Other policy implications of accessing health insurance through the exchange include the different circumstances for IPs and APs. Home care agencies with 50 or more full-time employees are required by the ACA to offer their employees insurance options that meet actuarial and cost-sharing requirements. If an agency does not offer adequate insurance or the agency has employees who receive subsidized health insurance from the exchange, the agency will be required to pay financial penalties. Therefore mandating all home care workers must access health benefits through the exchange would have financial implications. This issue is compounded by the statutory agency parity requirement that health benefits negotiated and funded in the collective bargaining agreement for IPs must be paid to APs at the same rate. If the IP contribution assumes coverage from the exchange, the corresponding contribution to the AP rate may not provide for sufficient private market coverage.

The impact of administrative change on home care workers and agencies should also be considered. The process has changed over time, most recently having converted from a monthly reimbursement to a cents-per-hour contribution. Every time a process is changed, disruption and uncertainty ensue for home care workers and agencies. Minimizing those administrative effects should be taken into consideration.

IV. CONCLUSION

This report identifies the potential options for revising how health insurance coverage is funded and managed for home care workers. The analysis in this report was challenged by the dearth of information on:

- home care worker family income and size;
- if and where home care workers are getting their current coverage if they are not using the SEIU trust and whether these individuals have coverage from another source or if they are opting to forgo coverage due to financial or other reasons;
- number of home care workers who have an offer of coverage through a spouse;
- comparability of provider networks; and
- number of home care workers who fall into the "five-year bar" after immigration that prevents coverage through Medicaid.

This report has identified the serious limitations of data sources. Any attempt to use the data to make decisions would be premature and would create the likelihood of misleading and inaccurate cost assumptions. More analysis, including that coming from the Manatt study, is necessary before any action is taken to change procurement methods.

APPENDIX: ANALYSIS OF AVAILABLE DATA

As discussed above, this report relied on two primary sources of data: (1) demographic information collected by SEIU 775 NW through a 2012 phone survey of home care workers; and (2) demographic data from the state of Oregon about the potential impact on individual home care workers. These two sources and a third potential source are described further as follows.

A. SEIU 775NW phone survey data

It was helpful for SEIU to reach out to its members to collect demographic information; however, the responses are insufficient for statistical interpretation. Only 501 members were contacted of a membership of 40,000; 26 percent refused to provide income information. SEIU also indicates the household income was self-reported and the survey was conducted only in English, leaving out members who do not speak English. Additionally, the categories for FPL used a cut off of 134 percent FPL and not 138 percent, the Medicaid qualifying rate. Therefore, this data are not helpful in informing a fiscal analysis of policy options.

B. Oregon state data

Oregon's data was significantly more thorough because of its state income tax and ready use of individual income information. The home care worker health care benefit system is different from Washington's: eligibility for the Oregon trust is based on 40 hours per month, less than half of Washington's requirement. In addition, the Oregon trust served only IP home care workers, not workers employed by private agencies. The Oregon data did include worker demographic information for those who work more than 80 hours, and is organized by FPL. The most significant challenge of using this data is the inability to know of the total such workers in Oregon, who would have other insurance coverage if we were to match Washington's eligibility requirements.

C. Automated Client Eligibility System (ACES) data

The Department of Social and Health Services collects household income data for the purposes of qualifying participants for various social services. ACES is a tool for determining eligibility, issuing benefits and management support, and for data sharing among agencies. For the purposes of this report, we reviewed the caregiver contracts valid in FY 2013. From a total of 56,061, we identified in ACES records 18,149 who received Basic Food assistance. There are a number of eligibility requirements for food assistance, but for the purposes of this report, eligibility is at less than 200 percent of FPL. The total of home care workers includes those who do not provide services for Medicaid clients and those who are not members of SEIU 775. In addition, the FPL is inconsistent with Medicaid expansion eligibility. Therefore, this data source cannot be used as a proxy to project costs or potential savings.

D. Additional factors

Beyond the lack of data, the cost of including services such as vision and dental are indeterminate. This is a policy discussion that would need to occur if health care plans were to be commensurate with plans now available on the exchange. Table 1, below, compares plans offered through Medicaid and the exchange to the current benefit.

TABLE 1: **Depicts comparison of current HBT benefit structure with other plans**

Silver and Gold Rates from WAHealthPathFinder.org
Region: Thurston 98502 ZIP Code (Rating Area 2)
Smoker: No
Age: 50 (10/7/1963)
Gender: Single Female with no dependents
*Based on 175% FPL ($20,108 per year)
Silver and Gold Rates from HealthPath Finder System

Quick Glance	Health Benefit Trust	Medicaid	Premera Blue Cross Preferred Silver 2000	Premera Blue Cross Preferred Gold 1500	Group Health Core Gold
Estimated Monthly Premium	$771.00	$435.30	$459.51	$497.91	$507.97
Your Estimated Cost	$25.00	$0	$192.54	$230.94	$241.00
Unsubsidized Premium Cost (Cost if at >400% FPL)	$25.00	Would not qualify; N/A	$447.48	$485.88	$495.94
Medical	included	included	included	included	included
Vision	included	included	pediatric only	pediatric only	pediatric only
Prescription Drugs	included	included	included	included	included
Dental	included	included	excluded	excluded	excluded
Premium Share	$25	$0	$0	$0	$0
Co-Pay	$15	$0	$0	$0	$0
Your Health Care Provider/Hospital	Group Health	N/A	N/A	N/A	N/A
Annual Deductible	$0	$0	$500 individual/ $1,000 family	$1,000 individual/ $2,000 family	$750 individual/ $1,500 family
Annual Out-of-Pocket Maximum	$1,000 individual/ $2,000 family	$0	$1,500 individual/ $3,000 family	$4,500 individual/ $9,000 family	$6,350 individual/ $12,700 family
Office Visit for Primary Care	$15; $0 for preventive care; 0% co-insurance	$0	$10 co-pay; 0% co-insurance	$10 co-pay; 0% co-insurance	$10 co-pay after deductible; 0% co-insurance
Office Visit for Specialist	$15 co-pay; 0% co-insurance	$0	$40 co-pay; 0% co-insurance	$30 co-pay; 0% co-insurance	$15 co-pay after deductible; 0% co-insurance

Quick Glance	Health Benefit Trust	Medicaid	Premera Blue Cross Preferred Silver 2000	Premera Blue Cross Preferred Gold 1500	Group Health Core Gold
Prescription Drug Deductible	$0 (no prescription deductible)	$0	specialty included in annual deductible	specialty included in annual deductible	included in annual deductible
Emergency Room	$200 co-pay, waived if admitted	$0	$150 co-pay before deductible; 20% co-insurance after deductible	$200 co-pay before deductible; 20% co-insurance after deductible	$100 co-pay after deductible; 10% co-insurance after deductible
Outpatient Lab/X-ray	$0 co-pay	$0	$0 co-pay; 20% co-insurance	$0 co-pay; 20% co-insurance	$0 co-pay; 10% co-insurance after deductible
Outpatient Surgery	$50 co-pay; 0% co-insurance	$0	$0 co-pay; 20% co-insurance after deductible	$0 co-pay; 20% co-insurance after deductible	$0 co-pay; 10% co-insurance after deductible
Hospitalization	$100 co-pay per day up to 5 days per admit; 0% co-insurance	$0	$0 co-pay per day; 20% co-insurance after deductible	$0 co-pay per day; 20% co-insurance after deductible	$0 co-pay per day; 10% co-insurance after deductible
Lifetime Maximum	unlimited	unlimited	unlimited	unlimited	unlimited
Health Savings Account Eligible	no	no	no	no	no
Optional Benefits					
Out-of-Country Coverage	yes; emergency and urgent care only	yes, with restrictions (see WAC 182-502-0120)	yes; covered as any other non-contracted provider	yes; covered as any other non-contracted provider	yes; emergency and urgent care only
Primary Care Physician Required	no	prior authorization required for some services (see WAC 182-531-0200)	no	no	no
Specialist Referrals Required	no	prior authorization required for some services (see WAC 182-531-0200)	no	no	yes
Chiropractic Coverage	$15 co-pay: 0% co-insurance; 10 visits per year w/o prior authorization	not covered for adults (WAC 182-501-0070)	$10 co-pay; 0% co-insurance; 10 visits per year	$10 co-pay; 0% co-insurance; 10 visits per year	$10 co-pay; 0% co-insurance; 10 visits per year

Quick Glance	Health Benefit Trust	Medicaid	Premera Blue Cross Preferred Silver 2000	Premera Blue Cross Preferred Gold 1500	Group Health Core Gold
Outpatient Mental Health Coverage	$15 co-pay; 0% co-insurance	yes	$0 co-pay; 20% co-insurance	$0 co-pay; 20% co-insurance	$10 co-pay; 0% co-insurance
Outpatient Substance Abuse Coverage	$15 co-pay; 0% co-insurance	appears to be but RCW 74.50.050 repealed because ADATSA program ended	$0 co-pay; 20% co-insurance	$0 co-pay; 20% co-insurance	$10 co-pay; 0% co-insurance
Vision Care	adult and children: eye exam 1 visit every 12 months: $15 co-pay; 0% co-insurance optical hardware: $200 per 24 months	$0 (not frames and lenses for 21+)	pediatric only	pediatric only	pediatric only
Prescription Pricing					
Value-Based Insurance Design Drugs: generic drugs that treat high blood pressure, high cholesterol, diabetes, heart failures	$4 co-pay; 0% co-insurance	N/A	N/A	N/A	N/A
Generic Prescription Drugs	$8 co-pay; 0% co-insurance	$0	$10 co-pay; 0% co-insurance	$10 co-pay; 0% co-insurance	$10 co-pay; 0% co-insurance
Brand Prescription Drugs	$25 co-pay; 0% co-insurance	$0	$45 co-pay; 0% co-insurance	$35 co-pay; 0% co-insurance	$0 co-pay; 20% co-insurance after deductible
Non-formulary Prescription Drugs	$50 co-pay; 0% co-insurance	$0	not covered	not covered	not covered
Prescription Drugs Over Coverage	N/A	N/A	N/A	N/A	N/A

Maternity Coverage					
Pre & Postnatal Office Visit	$15 co-pay; 0% co-insurance	$0	$0 co-pay; 20% co-insurance after deductible	$0 co-pay; 20% co-insurance after deductible	$0 co-pay; 0% co-insurance after deductible
Labor & Delivery Hospital Stay	$100 co-pay per day up to 5 days per admit; 0% co-insurance	$0	$0 co-pay; 20% co-insurance after deductible	$0 co-pay; 20% co-insurance after deductible	$0 co-pay; 10% co-insurance after deductible
Services Not Covered					
Bariatric Surgery	no	limited coverage (WAC 182-531-1600)	no	no	no
Cosmetic Surgery	no	no	no	no	no
Dental Care Adult	covered	covered	no	no	no
Infertility Treatment	no	no	no	no	no
Non-emergency care outside U.S.	no	no	no	no	no
Private Duty Nursing	no	covered for 17 & under, program eligibility for 18+	no	no	no
Out-of-Network Coverage					
Authorization Required	N/A	N/A	N/A	N/A	N/A
Annual Deductible	N/A	N/A	N/A	N/A	N/A
Co-insurance	N/A	N/A	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	N/A	N/A	N/A	N/A	N/A

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