

FHIAP Benchmark for Group Health Insurance

FHIAP General Provisions	
Lifetime Maximum	\$1,000,000
Pre-existing Condition Waiting Period	6 Month
Medical Cost Sharing ❶	
Annual Deductible	\$1,000 individual
Member Coinsurance Level	30 percent
Stop Loss Level	\$10,000 per individual
Out-of-pocket Maximum (Includes Deductible)	\$4,000 per individual
Required Services	
Prescription Medication Cost Sharing ❶	
Member Coinsurance Level ❷	\$15 or 50 percent whichever is greater
Out-of-pocket Maximum	No out-of-pocket maximum
Other Required Services ❸	
Doctor Visits	Covered Benefit
Immunization	Covered Benefit
Routine Well Checks ❹	Covered Benefit
Women's Health Care Services	Covered Benefit
Maternity	Covered Benefit
Diagnostic X-Ray/Lab	Covered Benefit
Hospital	Covered Benefit
Outpatient Surgery	Covered Benefit
Emergency Room	Covered Benefit
Ambulance	Covered Benefit
Transplant	Covered Benefit
Mental Health/Chemical Dependency Inpatient	Covered Benefit
Mental Health/Chemical Dependency Outpatient	Covered Benefit
Skilled Nursing Care	Covered Benefit
Durable Medical Equipment	Covered Benefit
Rehabilitation ❺	Covered Benefit
Hospice	Covered Benefit
Home Health	Covered Benefit

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- ❶ The group benchmark is based on the actuarial value of the member's out-of-pocket expense for the core benefit design. The core benefit design is described by the required benefits and the general member cost sharing. The actuarial value of the member's out-of-pocket expense for all plan types (indemnity, PPO, POS and HMO) is compared to the actuarial value of the benchmark plan's medical cost-sharing and prescription medication cost-sharing. If the actuarial value of the member's out-of-pocket expense for medical and prescription benefit cost-sharing meets, or is less than, the benchmark, the benefit plan meets the benchmark and no further evaluation is necessary. If a benefit plan's member cost-sharing level for medical exceeds the benchmark, the benefit plan can still meet the benchmark if the **combined** actuarial value of the member's cost-sharing for medical and prescription benefits is less than or equal to the benchmark's **combined** actuarial value of the member's cost-sharing for medical and prescription benefits. When both in-network benefits and out-of-network benefits are provided, the measurement of benchmark compliance is made using the in-network benefit level. The benchmark is **not** the listed deductible, coinsurance level, out-of-pocket maximum, and prescription drug copays. These are an **example** of a plan with the actuarial value of the FHIAP benchmark. Other benefit designs can have the same actuarial value.
- ❷ The prescription medication benefit has a specific member cost-sharing standard. This benefit is the only required service that has a specified member cost-sharing. This has been done because most plans administer prescription medication benefits with a separate member cost-sharing. If a benefit plan's member cost-sharing level for prescription medications exceeds the benchmark, the benefit plan can still meet the benchmark if the **combined** actuarial value of the member's cost-sharing for medical and prescription benefits is less than or equal to the benchmark's **combined** actuarial value of the member's cost-sharing for medical and prescription benefits.
- ❸ Under the Other Required Services, a "Covered Benefit" means that some service is offered in this benefit category, without regard to an additional waiting period for a specific benefit, a durational limit, an internal limit, or a specific cost-sharing requirement beyond those imposed by the annual deductible, coinsurance level, maximum out-of-pocket, stop loss, and lifetime maximums. Thus, the benefit provided in these categories may have additional waiting periods (i.e., a one-year wait before transplant benefits are available); may be limited to a certain number of days of service (i.e., mental health inpatient and outpatient care limited to a specific number of days); simply limited (i.e., the transplant benefit is limited to a lifetime maximum of \$250,000) or have additional cost sharing (i.e., the ambulance benefit could have an additional \$50 per occurrence co-payment required).
- ❹ If any benefit is provided for routine well checks this benefit requirement is satisfied. Since immunizations are a separate benefit category both benefits for routine well checks and immunizations must be provided for the plan to meet the benchmark.
- ❺ Either inpatient or outpatient rehabilitation benefits will satisfy this requirement.

IMPORTANT NOTE: Although a plan may not appear to meet the benchmark, please send the benefit booklet and the *Producer Request for Benchmark Approval Form* to FHIAP. The benchmark is not the listed deductible, coinsurance level, out-of-pocket maximum, and prescription drug copays. The benchmark is an actuarial value. FHIAP can subsidize any plan that has an actuarial value that meets the benchmark, even if the features of the plan do not exactly match the benchmark example listed. With the plan information, FHIAP can determine the benefit equivalency or actuarial value to determine if the plan qualifies.