

Maternal and Child Health Plan Benefit Model: Evidence-Informed Coverage

Plan Implementation Guidance Document

This document provides a description of the Maternal and Child Health Plan Benefit Model and guidance for its implementation. It also includes an actuarial analysis illustrating the financial impact of the Maternal and Child Health Plan Benefit Model on both HMO and PPO plan designs. Employers can use this information to estimate the cost implications of adopting the recommended benefits in their own covered population.

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Introduction

The Maternal and Child Health Plan Benefit Model (Plan Benefit Model) proposes a set of evidence-informed, comprehensive, standardized, integrated, and sustainable employer-sponsored health benefits for children and adolescents (ages 0 to 21 years), as well as preconception, pregnant, and postpartum women.

The model includes recommendations on *minimum* health, pharmacy, vision, and dental benefits; cost-sharing arrangements; and other information pertinent to plan design and administration. The Plan Benefit Model is not meant to be a gold-standard; rather, it is the National Business Group on Health's (Business Group's) baseline recommendation on which benefits *all* large employers should cover in *all* of their health plans.

The Plan Benefit Model was designed to:

1. Encourage evidence-informed benefit design.
2. Emphasize prevention and early detection.
3. Improve standardization.
4. Reduce employee cost barriers to essential care services.
5. Balance employee affordability and employer sustainability.

Plan Benefit Model Design

The Business Group used a multi-step process to identify, structure, and estimate the financial impact of the health benefits recommended in the Plan Benefit Model.

Development

The Business Group established the Maternal and Family Health Benefits Advisory Board (Benefits Advisory Board) to develop and vet the Plan Benefit Model, and to provide guidance on the overall project. The Benefits Advisory Board consisted of 14 Business Group member medical directors, benefit managers, and health promotion program staff; healthcare consultants; and delegates from the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), and the National Association of Pediatric Nurse Practitioners (NAPNAP). The Benefits Advisory Board met between February 2006 and May 2007 to design and revise the Plan Benefit Model.

Content and Data Sources

The benefits recommended in the Plan Benefit Model were adapted from clinical guidelines and recommendations developed by 28 professional organizations, healthcare groups, and Federal health agencies (refer to Figure 2A). In order to promote consistency and standardization, well-child care benefits were modeled on the American Academy of Pediatrics' *Bright Futures Guidelines* (2007, 3rd edition), which functions as the standard of preventive care in pediatric practices across the country.

When clinical guidelines and recommendations were not available, industry standard definitions and benefit coverage limits were applied. The Federal Employees Health Benefit Plan (FEHBP) was used

as the industry standard default. FEHBP is the largest group medical plan in the United States and is reviewed annually for adequacy.

In situations where clinical guidelines or recommendations conflicted, the Benefits Advisory Board reviewed the original documents and developed their own “expert opinion” statement.

Figure 2A: Organizations Cited in the Plan Benefit Model
Advisory Committee on Immunization Practices (ACIP)
Agency for Healthcare Research and Quality (AHRQ)
American Academy of Family Physicians (AAFP)
American Academy of Ophthalmology (AAO)
American Academy of Pediatric Dentistry (AAPD)
American Academy of Pediatrics (AAP)
American Association for Pediatric Ophthalmology and Strabismus (AAPOS)
American Association of Certified Orthoptists (AACO)
American College of Obstetricians and Gynecologists (ACOG)
American Dental Association (ADA)
American Dietetic Association (ADA)
American Medical Association (AMA)
American Psychological Association (APA)
American Speech-Language-Hearing Association (ASHA)
Bright Futures Guidelines
California Healthcare Foundation (CHCF)
Center for Medicare and Medicaid Services (CMHS)
Centers for Disease Control and Prevention (CDC)
Eye Med
Federal Employee Health Benefit Plan (FEHBP)
Hospice Foundation of America (HFA)
Kaiser Family Foundation (KFF)
National Academy of Neuropsychology (NAN)
National Hospice and Palliative Care Organization
U.S. Armed Services Health Care Services (TriCare)
U.S. Breastfeeding Committee (USBC)
U.S. Department of Health and Human Services, Bureau of Health Professionals (HRSA-BHP)
U.S. Preventive Services Task Force (USPSTF)

Review

The Plan Benefit Model was reviewed by the Benefits Advisory Board. In addition, an ad-hoc committee of 20 individuals and organizations reviewed the model and submitted comments and corrections. These external reviewers provided additional expertise and guidance. Reviewers included primary care providers; academic researchers; maternal and child health policy experts; patient and family advocates; and ancillary service providers, including dentists, dieticians, vision providers, and others. A full list of external reviewers is provided in the acknowledgements section on page A-iii.

Evidence-Informed Coverage

The Plan Benefit Model was informed by medical evidence. Some recommended interventions (e.g., STI screening) are evidence-based. Other recommended interventions do not meet the stringent criteria for being evidence-based, but nonetheless represent the best available information for health improvement. These interventions are based on what is called “recommended guidance.”

Generally, the term “evidence-based” refers to medical interventions (e.g., tests, procedures, medications) that have been evaluated and determined to be effective. This means the intervention has a measurable impact on health outcomes: it prevents disease, reduces mortality, or improves a person’s functionality.

Evidence-based interventions have a strong base of research to support their efficacy, safety, and cost-effectiveness.

An intervention is considered “**evidence-based**” when^{1, 2}:

- Peer-reviewed, documented evidence shows that the intervention is medically effective in reducing morbidity or mortality;
- Reported medical benefits of the intervention outweigh its risks;
- The estimated cost of the intervention is reasonable when compared to its expected benefit; and
- The recommended action is practical and feasible.

Recommended guidance is based on the best available information about a condition, disease, or health service, but lacks the scientific research support in order to be considered evidence-based. Expert opinion, expert panel judgments, and consensus opinion are all forms of recommended guidance.

Evidence-based benefit design is an approach for developing health benefits. Evidence-based plans promote health care with demonstrated effectiveness by providing more generous coverage for services supported by strong evidence, and less generous coverage for services that are unproven or evidence indicates may be ineffective or unsafe.³ The Business Group and many individual employers believe that this approach promotes quality and standardization, and helps reduce costs by eliminating waste.³

Evidence-based benefit design is a useful approach for many areas of clinical care. However, it is not feasible in *all* areas. For many interventions commonly performed in the course of child and adolescent care, there are few, if any, properly constructed studies that link the intervention with intended health outcomes. The absence of evidence does not demonstrate a lack of usefulness, however; it mostly reflects a lack of documented study.⁴ Many organizations and institutions are working to fill these existing gaps in information.⁴

Until scientific research can be conducted, employers must find other ways to evaluate the usefulness and appropriateness of child health interventions. Recommended guidance (e.g., an expert opinion from a leading professional organization) is one important source of information in the benefit design process.

Evidence-based recommendations in pediatrics are limited due to⁵:

- *Unique ethical issues regarding the withholding of treatment from vulnerable populations.* It would be unthinkable for a clinician to withhold a long-standing treatment from a child in order to test its utility; yet, that is what a true randomized controlled trial (RCT) would require.
- *Lower levels of research investment.* Children’s health problems (compared to adult issues) are less likely to be studied, and, when studied, the research is not as well funded.
- *Challenges of research in children.* Children are more difficult to study than adults. For example, because children’s bodies change rapidly through the natural process of growth and development, the effect of a given intervention (e.g., counseling to promote weight loss in obese children) can be difficult to measure.
- *Demographic challenges.* Children aged 1 to 5 years in the United States are the most diverse in terms of race and ethnicity of any age cohort.
- *Social determinants of health* (e.g., poverty, education, social support) impact children to a far greater extent than adults.

The Plan Benefit Model is based primarily on recommended guidance. For the purpose of transparency, each proposed benefit carries an “evidence rating.”

Evidence Rating	Level
Evidence-Based Research	1
Recommended Guidance <ul style="list-style-type: none">• Expert Opinion• Expert Panel• Expert Consensus	2
Federally Vetted	3
Industry Standard	4

Plan Benefit Model Guidance

Covered Population

The Plan Benefit Model is designed to address the minimum health care needs of a target population:

1. Preconception, pregnant, and postpartum women.
2. Children (0 to 12 years of age) and adolescents (13 to 21 years of age), including those with special health care needs.

The Plan Benefit Model does not include recommendations on benefits for adult men (with the exception of vasectomy) or for adult women outside of the scope of maternity care.

The adolescent age limit (21 years) is consistent with commonly accepted definitions for differentiating between adolescence and adulthood.^{4,6} Plan provisions for preconception, pregnant, and postpartum women apply to adolescents who require reproductive health services.

Benefit coverage for labor and delivery, which includes services for newborns, can be applied to the mother and/or retrospectively to the newborn child once an application for the child’s health coverage has been completed. It is recommended that the application for enrolling the newborn child be completed and submitted to the employer’s health plan within 30 days of birth.

Referenced Health Plans

The Plan Benefit Model was designed to support two common managed care plan designs: **preferred provider organizations (PPOs)** and **health maintenance organizations (HMOs)**. These two plan designs were chosen because they are extremely common. As such, utilization and claims data could be used for actuarial modeling purposes. The Plan Benefit model can be applied to other plan designs, such as consumer-directed health plans (CDHPs); however, restructuring would be required.

Covered Services

Covered services described in the Plan Benefit Model are designed to support a range of healthcare services along a prevention—illness—chronic disease continuum. The covered services are organized into five descriptive categories:

- **Preventive Services** are designed to detect the existence of, or risk for, diseases, conditions, and problems. These services include comprehensive health assessments; age-appropriate screening, counseling, preventive medication, and preventive treatment; parent and child education; and anticipatory guidance. The recommended preventive services address the physical, mental, vision, and oral health care needs of the target population.
- **Physician/Practitioner Services** support the delivery of care by individual health professionals who may or may not be affiliated with a group practice or hospital.
- **Emergency Care, Hospitalization, and Other Facility-Based Care** address acute health care needs. These services may be necessary to treat illness, address injury, or support pregnancy.
- **Therapeutic Services / Ancillary Services** include an array of specialty services that may be performed in a practitioner's office, the beneficiary's home, or in a healthcare facility.
- **Laboratory, Diagnostic, Assessment, and Testing Services** are used to determine the presence, severity, or cause of an illness, or for diagnosing a specific illness, injury, or disability.

Plan Benefit Model Key Concepts

Cost-Sharing

Employee/employer cost-sharing is an employer strategy designed to lessen the financial liability of a health plan. While employee cost-sharing is an effective cost-containment strategy, many experts believe that employers have maximized the financial benefit of cost-sharing.⁷ High cost-sharing, specifically high premiums, can price some families out of the market. Similarly, high deductibles and copayment/coinsurance requirements may force families to delay or forgo care.

Research has shown that as the cost of healthcare increases for beneficiaries, utilization of unnecessary *and* essential care decreases. When beneficiaries forgo preventive care or delay seeking care for an acute problem, there is a real risk that the problem will become exacerbated over time. In the end, the beneficiary is likely to require more intensive and expensive care than would have been required had he or she sought care when symptoms first emerged.

The Plan Benefit Model supports access to essential care services by removing beneficiary cost barriers wherever possible. The Plan Benefit Model aims to balance employee affordability and employer sustainability.

Growth in healthcare premiums has consistently outpaced both inflation and growth in workers' earnings for the past 20 years.⁸ Between 2004 and 2008, the cost of buying coverage for an employee (i.e., the employee's share of the premium) increased 31% (\$211) for single coverage and 39% (\$956) for family coverage.^{9,10} Family out-of-pocket costs for medical care are also on the rise. In 2004, 18% of families with employer-sponsored health coverage spent 10% or more of their annual income on medical expenses (premiums and copayment/coinsurance), compared to 16% in 2001. This represents a 12.5% increase over 8 years.¹¹

Typical cost-sharing methods include: premiums, deductibles, copayment or coinsurance, annual out-of-pocket maximums, and/or lifetime maximums. The Plan Benefit Model includes the following cost-sharing recommendations. These cost-sharing provisions were included in the actuarial analysis, with the exception of recommended premium and out-of-pocket amounts.

- **Preventive Services.** The Plan Benefit Model recommends zero cost-sharing for preventive services to avoid real or perceived financial barriers, and to increase utilization.
- **Premium.** If employers require employees to contribute toward the cost of health benefits, the Plan Benefit Model recommends an amount between 15% and 25% of the total plan cost.¹² In 2008, the average cost of coverage was approximately \$4,704 for individual coverage and \$13,476 for family coverage (these figures include employer *and* employee premium costs).¹³ Twenty percent (20%) cost-sharing was applied to these numbers in order to calculate the following recommended premiums:
 - Individual (1): \$941
 - Individual plus one dependent (2): \$1,891
 - Family (3+): \$2,695

If a higher premium amount is required, the Plan Benefit Model recommends lowering the maximum out-of-pocket limit by a similar percentage. The Plan Benefit Model also recommends using scaled premiums that are consistent with an employer's salary banding methodology.

- **Deductible.** The Plan Benefit Model recommends *against* using deductibles because they can be cost barriers to essential services. If a deductible must be used, one amount should be collectively applied to all covered services described in the Plan Benefit Model.
- **Out-of-Pocket (OOP) Maximum.** OOP maximums protect beneficiaries from mounting cost-sharing requirements (premium costs and copayment/coinsurance). If an employer includes a cost-sharing provision, the Plan Benefit Model recommends the following annual total OOP schedule*:
 - Individual (1): \$2,370 total (\$1,500 maximum copayment/coinsurance, plus \$870 premium).
 - Individual plus one dependent (2): \$5,420 total (\$3,000 maximum copayment/coinsurance, plus \$1,740 premium).
 - Family (3+): \$5,420 total (\$3,000 maximum copayment/coinsurance, plus \$2,420 premium).

*Note that these recommended OOP maximums *include* dental and vision out-of-pocket expenses; they *do not* include out-of-pocket pharmaceutical costs.

- **Copayment.** The Plan Benefit Model recommends a copayment schedule for the HMO model. Copayments are a disincentive to the overuse of certain healthcare services; they also scale out-of-pocket spending with service use (i.e., beneficiaries who use more healthcare services are required to pay more in out-of-pocket costs than those who use fewer services). This schedule excludes preventive care, and is scaled to correspond with the cost and utilization frequency of the service category. Plan participants are protected from excessive copayment costs through the OOP maximum noted above.

- **Coinsurance.** The Plan Benefit Model recommends a coinsurance schedule for the PPO model. Coinsurance is a disincentive to the overuse of certain healthcare services; it also scales out-of-pocket spending with service use. This schedule excludes preventive services, and is scaled to correspond with the cost and utilization frequency of the service category. Plan participants are protected from excessive coinsurance costs through the OOP maximum noted above.
- **Annual / lifetime caps** are excluded from the Plan Benefit Model for reasons of equity.

The Plan Benefit Model's OOP maximum includes premium costs, which is atypical in the marketplace today. Premium costs were included in the OOP maximum so that employees will be able to assess their maximum financial liability for health coverage under an employer-sponsored group medical plan.

Communication

Employer-sponsored health plans subject to the Employee Retirement Income Security Act (ERISA) of 1974 are required to provide plan participants with specific information about the benefits to which they are entitled, including covered benefits, plan rules, financial information, and documents about plan operation and management. The Plan Benefit Model attempts to support the regulatory provisions contained in 29 CFR - CHAPTER XXV - PART 2520 regarding the publication of health plan provisions in a summary plan description (SPD). Employers are encouraged to develop their own plan administration rules regarding the following items, which are not referenced in the Plan Benefit Model:

For additional information on effectively communicating benefit changes to beneficiaries, please refer to Part 5.

- COBRA eligibility and administration procedures.
- Claims administration procedures.
- Eligibility requirements.
- Provider network administration rules.
- Details regarding plan sponsorship, governance, and termination provisions.

Plan Structure

- The Plan Benefit Model recommends that **group care** be reimbursed as a covered service. Group care allows for multiple plan participants to be seen at the same time by an individual provider or healthcare team. Group care is a cost-effective means of care that can improve quality and timeliness in specific situations. Group care is most relevant for education-based services such as nutrition counseling or anticipatory guidance. Employers are encouraged to develop administrative procedures and set reimbursement levels with their plan administrator(s).
- The Plan Benefit Model also recommends that care delivered by a “healthcare team” be reimbursed as a covered service. A **healthcare team** is a group of healthcare professionals who work together to recommend diagnoses or treatments. Currently, claims for services delivered by two or more providers on the same day for the same diagnosis are frequently denied. The

denial of such claims inhibits efficient referrals (e.g., the immediate referral from a primary care provider to a mental health specialist) and coordinated care.

- A **network**, for the purpose of a PPO or an HMO, is typically a geographic area designated by the employer or the health plan. Providers and provider services are classified as being “in-network” or “out-of-network.” The Plan Benefit Model provisions recommended here only cover in-network providers and provider services. Employers should apply their own out-of-network provisions, as appropriate.
- **Plan coordination.** The Plan Benefit Model strongly encourages employers to coordinate the delivery of care when using multiple plan administrators (e.g., vision, dental, behavioral health). Beneficiaries are often confused by multiple plan administration rules and cost-sharing requirements, and employers sometimes duplicate payment for like services (e.g., EAP and mental health treatment services).
- **Flex benefits.** The Plan Benefit Model recommends that employers “flex” benefits for children and women with complex case management needs. All children with special health care needs and all women with high-risk pregnancies should qualify for case management. A definition of case management is provided in the next section. Employers should work with their health plan administrators to determine the exact nature of flex benefits. Some examples include:
 - Extending a single benefit for multiple providers (e.g., home health visits).
 - Providing additional benefits for high-risk populations (e.g., increasing preventive dental care visits from the recommended two visits per year to three visits per year for certain children).
 - Reducing or eliminating copayment or coinsurance amounts on essential services or products.

Key Definitions that Govern Plan Provisions

Most employer-sponsored health plans use a set of definitions to explain and govern plan provisions, and mediate appeals from plan participants and providers when claims are denied. The key definitions that guide the Plan Benefit Model are listed below. Each definition was created or adapted to meet the specific health care needs of children, adolescents, and pregnant women.

Medical Necessity

Medically necessary care is:

- Prescribed by a physician or other qualified healthcare provider.^A
- Required to prevent, diagnose, or treat an illness, injury, or disease or its symptoms; help maintain, improve, or restore the individual’s health or functional capacity; prevent deterioration of the individual’s condition; or remedy developmental delays or disabilities.
- Generally agreed to be of clinical value.
- Clinically consistent with the patient’s diagnosis and/or symptoms.
- Appropriate in terms of type, scope, frequency, duration, intensity, and delivered in a setting that is appropriate to the needs of the patient.^{B,C}

^A The fact that services are provided, prescribed, or approved by a physician or other qualified healthcare provider does not in and of itself mean that the service is medically necessary.

^B Care should not be primarily for the convenience of the patient, physician, or another healthcare provider (e.g., elective cesarean delivery).

^C Care should be rendered in the least intensive setting appropriate for the delivery of the service, procedure, or equipment.

Children With Special Health Care Needs

Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually required by children of the same age.¹⁴ Children who are victims of abuse or trauma and children in foster care also qualify as “children with special needs” due to their demonstrated risk for physical, emotional, and behavioral problems.³

Case Management

Case Management refers to the arrangement, coordination, and monitoring of healthcare services to meet the needs of a particular patient and his/her family. Case management is conducted by a case manager or other qualified healthcare provider who—in collaboration with the patient and the patient’s healthcare team—develops, monitors, and revises a plan that outlines the patient’s immediate and ongoing health care needs. Case management may also include the coordination or delivery of the following services:

- Arrangement for community services.
- Arrangement for physician ordered services.
- Benefit administration.
- Benefit education/optimization and provider/facility selection.
- Collaboration with care providers within or outside of the healthcare team (e.g., social services, school counselors).
- Crisis intervention.
- Family consultation.
- Patient education.
- Patient advocacy.

The Plan Benefit Model recommends that all children with special health care needs and all women with high-risk pregnancies have access to case management services.

Experimental Treatment Modalities

A drug, device, or procedure will be considered “experimental” if any of the following criteria apply:

- There is insufficient outcome data to substantiate the treatment’s safety.
- No reliable evidence demonstrates that the treatment is effective in clinical diagnosis, evaluation, or management of the patient’s illness, injury, disease, or its symptoms, or; evaluation of reliable evidence indicates that additional research is necessary before the treatment can be classified as equally or more effective than conventional therapies.
- The treatment is not of proven benefit or not generally recognized by the medical community as effective or appropriate for the patient’s specific diagnosis.
- The treatment has not been granted required FDA approval for marketing.^A
- The treatment is only provided or performed in special settings for research purposes.

^A This criterion does not exclude ‘off label’ use.

Plan Integration

Employers are strongly encouraged to systematically coordinate their health plan design and administration activities with other benefit and human resource programs. The Business Group believes this type of integrated approach will lead to decreased healthcare costs. Examples of integration opportunities include:

- Team with workforce scheduling staff to develop alternatives for pregnant and postpartum women and parents of children with special healthcare needs (e.g., compressed workweeks, telecommuting, flex-time, alternative start and end times, and partial workloads).
- Collaborate with disability plan administrators regarding return-to-work strategies for postpartum women.
- Coordinate plan benefit administration activities with employee assistance program (EAP) managers regarding the availability and use of mental health prevention and treatment benefits.
- Include information on the value of preventive services in work/life manager and employee training sessions.
- Include well-child care and prenatal care resources in health promotion materials.
- Incorporate maternal and child health needs into existing worksite-based health promotion programs and policies (e.g., healthy cafeteria, on-site immunizations, campus-wide smoking ban).

Actuarial Analysis

Purpose

Benefit managers charged with administering employer-sponsored health benefits are often forced to make difficult resource allocation decisions. Typically, an employer's benefits budget determines the selection and continuation of health benefits. However, increasing healthcare costs and stagnating quality have led many employers to shift their focus from budget-based allocation decisions to value-based purchasing strategies. **Value-based purchasing** brings together information on the quality of healthcare, including health outcomes and health status, with data on the dollar outlays going towards health.¹⁵ It aligns financial incentives for beneficiaries *and* providers to encourage the use of high-value care while discouraging the use of low-value or unproven services.¹⁶ Employers have also begun to evaluate the medical evidence for benefits, as described in the previous section.

Concepts of evidence and value have helped balance health benefit decisions in recent years. However, the cost impact of benefit modification remains a critical factor in employers' resource allocation decisions. To help employers understand the cost of adopting the Plan Benefit Model recommendations, the Business Group sponsored an actuarial meta-analysis of the model. This analysis estimated the cost impact of the model's recommendations on typical large-employer health

Because preventive services can prevent or reduce the need for treatment they provide a **cost-offset. Employers who invest their healthcare dollars in screening, counseling, and preventive medications may be able to avoid spending healthcare dollars on treatment. In some cases, where the cost of screening is *less* than the cost of treatment, employers may be able to save healthcare dollars by investing in preventive services. For more information on cost-offsets, refer to page 77.**

plans (PPO and HMO plan types). The analysis provides cost-impact assessments of the following:

- The Plan Benefit Model (in whole);
- Each service category (e.g., preventive services); and
- Each recommended line-item benefit (e.g., immunizations).

The meta-analysis was conducted by PricewaterhouseCoopers, LLP (PwC) in conjunction with the Business Group.

Process

In order to estimate the cost impact of the Plan Benefit Model, PwC:

1. Identified International Classification of Diseases Version 9 (ICD-9) diagnoses codes supported by the Plan Benefit Model.^A
2. Used these codes and the Plan Benefit Model recommendations to construct a benchmark model, called the PricewaterhouseCoopers' PPO/HMO Benchmark Model (PPO/HMO Benchmark Model) (Figure 2B).
3. Priced the ICD-9 codes and developed utilization and cost estimates for the PPO/HMO Benchmark Model using PwC proprietary health insurance cost models, Medstat data, and data from other private and public-sector sources (e.g., peer-reviewed journal articles, meta-analyses).
4. Used key attributes of the PPO/HMO Benchmark Model to illustrate the employer and employee costs of a standard PPO and HMO. These plan costs were then applied to the Plan Benefit Model in order to calculate the estimated cost increase or decrease of applying the Plan Benefit Model recommendations to a typical large-employer health plan.

The HMO/PPO Benchmark Model is an actuarial model that PwC created in order to develop cost-impact estimates for the Maternal and Child Health Plan Benefit Model (Plan Benefit Model).

PPO/HMO Benchmark Model

The PPO/HMO Benchmark Model (Figure 2B) provides estimates of the average cost of typical large-employer health plan (PPO and HMO plan types). The costs are modeled for 2007 and represent typical utilization rates and service costs for large-employer health plans covering a commercial population of active employees and dependents.^B The estimates are based on dollar amounts paid to healthcare providers who deliver medical, mental health, dental, and vision services covered under typical employer-sponsored health plans; they do not include administrative costs charged by the health plan administrator.

The PPO/HMO Benchmark Model was based on the following sources:

- PwC proprietary health insurance cost models;
- Large-employer claims experience from the Medstat database of 3 million members for services incurred in 2004; and
- Published healthcare cost reports.

Figure 2B: PricewaterhouseCoopers' HMO/PPO Benchmark Model

	Average Allowed Costs	Amount Paid by Employees	Amount Paid by Employers
HMO plan costs			
Average per member per month (PMPM)	\$322.07	\$29.98	\$292.10
Average per employee per year (PEPY)	\$8,116	\$755	\$7,361
PPO plan costs			
Average per member per month (PMPM)	\$390.31	\$86.52	\$303.79
Average per employee per year (PEPY)	\$9,836	\$2,180	\$7,656

PPO/HMO Benchmark Model Terminology

The following items describe terminology used in the PPO/HMO Benchmark Model:

- **Average Allowed Charges PMPM** represents billed charges (less provider discounts) and is equivalent to the total plan costs paid by the employer and the employees.
- **Amount Paid by Employees.** The estimated cost of services paid by employees depends on the cost-sharing provisions of their health plan. In order to facilitate comparisons to a known plan design, the following cost-sharing provisions were used in the PPO/HMO Benchmark Model:
 - **PPO Medical Cost-Sharing.** PPO cost-sharing for medical services includes a \$250 deductible, 20% coinsurance, and a \$2,500 out-of-pocket (OOP) maximum. The deductible and OOP maximum are on a per member basis. The family deductible is \$500, and the family OOP maximum is \$5,000. Note that this plan design does not have a fixed dollar copayment for office visits, which is fairly common in today's marketplace. However, many employers are shifting toward coinsurance as the predominant method of cost-sharing.
 - **HMO Medical Cost-Sharing.** HMO cost-sharing for medical services includes \$10 copayment for primary care office visits, \$25 copayment for specialist office visits, \$100 copayment for emergency department visits and inpatient hospital admissions, \$50 copayment for outpatient surgery, and 20% coinsurance for durable medical equipment (DME).
 - **Prescription Drugs.** For both PPO and HMO plans, cost-sharing includes \$10 copayment for retail generic drugs and \$25 copayment for retail brand prescriptions. Required copayment for mail-order prescriptions with a 90-day supply are \$20 for generic prescriptions and \$50 for brand prescriptions. Prescription drugs are not subject to an OOP maximum in the PPO/HMO Benchmark Model.
 - **Dental.** For both PPO and HMO plans, cost-sharing includes a \$50 deductible. There is no coinsurance for preventive services, 20% coinsurance for restorative services, and 50% coinsurance for orthodontic services. The maximum annual dental benefit paid by the employer is \$2,500 per member, with a \$5,000 family maximum.

- **Vision.** For both PPO and HMO plans, vision exams require a \$25 copayment and the maximum annual benefit for eye-wear is \$200 per member.
- **Benefits Paid by Employer.** The amount paid by the employer is the difference between the *total allowed amount* and *the amount paid by employees*.

Maternal and Child Health Plan Benefit Model Actuarial Analysis

The Plan Benefit Model actuarial analysis begins on page 18. The data are organized into a PPO cost estimate (Figure 2E) and a HMO cost estimate (Figure 2F). The analysis documents provide estimates of the incremental cost to an employer of adopting each line-item benefit recommended in the Plan Benefit Model. The cost increases are expressed on a per member per month (PMPM) basis and as a percent increase to the PPO/HMO Benchmark Model described in Figure 2B.

Estimated Cost Impact of the Plan Benefit Model

If an employer *did not offer any* of the recommended benefits and choose to adopt the Plan Benefit Model in full, the recommended PPO plan would cost \$390.31 PMPM or \$9,836 per member per year (PMPY) and the HMO plan would cost \$322.07 PMPM or \$8,116 PMPY (refer to Figures 2E and 2F).

If an employer’s current health plans were identical to the PPO/HMO Benchmark Model and the employer were to adopt all of the Plan Benefit Model recommendations, the employer’s health plan costs would increase 10% and 6.2%, respectively (refer to column H in Figures 2E and 2F for line-item benefit cost estimates, and Figures 2C and 2D for high-level summaries). However, because most large employers provide coverage for at least some of the benefits recommended in the Plan Benefit Model (e.g., prenatal care), the total cost increase is likely to be less than noted. Analysis of the variance between an employer’s current health plans, the PPO/HMO Benchmark Model, and the Plan Benefit Model is required for an exact cost-impact assessment.

Figure 2C: Estimated Impact of Plan Benefit Model Recommendations on a Typical Large-Employer HMO Plan Design

	Employer Impact of Plan Benefit Model (PMPM)	Total Employer-Adjusted Cost of Plan Benefit Model (PMPM)	Percent Employer Change from Current Cost Estimate (% of total)*
Impact Benefit Additions and Modifications	\$13.34	4.6%	6.2%
Impact From Cost-Shifting to Employer/From Employee	\$4.44	1.6%	N/A
Total	\$17.78	6.2%	6.2%

Figure 2D: Estimated Impact of Plan Benefit Model Recommendations on a Typical Large-Employer PPO Plan Design

	Employer Impact of Plan Benefit Model (PMPM)	Total Employer-Adjusted Cost of Plan Benefit Model (PMPM)	Percent Employer Change from Current Cost Estimate (% of total)*
Impact Benefit Additions and Modifications	\$20.81	6.9%	9.9%
Impact From Cost-Shifting to Employer/From Employee	\$9.50	3.1%	N/A
Total	\$30.31	10.0%	10.0%

How to Use the Actuarial Analysis Information

Employers can use the actuarial cost estimates listed in Figures 2C-2F to estimate the cost implications of adopting the recommended benefits for their covered population.

It is important to note that the financial data presented in the actuarial analysis documents *cannot* be used to predict the *exact* cost of implementing Plan Benefit Model recommendations for any particular employer. The cost increase estimates were based on the degree to which the HMO/PPO Benchmark Model benefits were *lower* than the benefits recommended in the Plan Benefit Model. If a given employer’s current health benefits costs are lower *or* higher than those listed in the HMO/PPO Benchmark Model, or if the employer’s current health plan costs do not match the HMO/PPO Benchmark Model costs, then the actuarial analysis cost estimates will not be exact. Therefore, it is important that employers compare their current health benefits to those recommended in the Plan Benefit Model and analyze the variance. A side-by-side comparison tool is provided in Part 3 for this purpose.

Explanation of Terms Used in the Actuarial Analysis Documents

Current Cost Estimate (PMPM)

- **Total costs (PMPM)**, similar to the **Allowed Charges**, represent 100% of the estimated costs that will be paid by the employer and employee. Total costs are expressed on a per member per month (PMPM) basis.
- **Paid by Members (PMPM)** represents the estimated amount or percent of the total costs that are paid by employees and dependents. These costs typically reflect the specific cost-sharing amounts that are included in each covered benefit or service. Employees and dependents are collectively referred to as “members” and costs are expressed on a per member per month (PMPM) basis.
- **Paid by Employer (PMPM)** represents the estimated amount or percent of the total costs that are paid by the employer and are expressed on a per member per month (PMPM) basis.

Revised Benefit Cost Estimate

- **Employer Impact of Plan Benefit Model (PMPM)** represents the estimated change in the employer costs that are created by applying the Plan Benefit Model recommendations to the total costs. These costs typically reflect recommended changes that were made to the cost-sharing strategy or benefit coverage levels.
- **Total Employer-Adjusted Cost of Plan Benefit Model (PMPM)** represents the employer's share of the combined total estimated cost for the Plan Benefit Model.
- **Member Impact of Plan Benefit Model (PMPM)** represents the member's financial portion of the costs associated with each service recommended in the Plan Benefit Model. The change in value from the PPO/HMO Benchmark Model is typically a function of the change in the recommended cost-sharing levels in the Plan Benefit Model.
- **Percent Change from Current Cost Estimate (% of Total)** represents the percentage change to the employer's share of the combined total estimated cost for the Plan Benefit Model.
- **Rationale for Change** summarizes the changes the Plan Benefit Model makes to the PPO and HMO Plan Design Benchmark Model along with the estimated cost or percentage change to the employer's share of the overall benefit plan costs.
- **Coinsurance or Copayment Amount** summarizes the value of the member's cost-sharing responsibility for a specific service category.
- **Coinsurance or Copayment Frequency** summarizes the frequency that a member will be required to pay the coinsurance or copayment amount.

Summary Points

- The Maternal and Child Health Plan Benefit Model (Plan Benefit Model) proposes a set of evidence-informed, comprehensive, standardized, integrated, and sustainable employer-sponsored health benefits for children and adolescents (ages 0 to 21 years), as well as preconception, pregnant, and postpartum women. It includes recommendations on *minimum* health, pharmacy, vision, and dental benefits; cost-sharing arrangements; and other information pertinent to plan design and administration.
- The Plan Benefit Model supports access to essential care services by removing beneficiary cost barriers wherever possible.
- To help employers understand the cost of adopting the Plan Benefit Model recommendations, the Business Group sponsored an actuarial meta-analysis of the model. This analysis estimated the cost impact of the model's recommendations on typical large-employer health plans (PPO and HMO plan types). If an employer *did not offer any* of the recommended benefits and were to adopt the Plan Benefit Model in full, the recommended PPO plan would cost \$390.31 PMPM or \$9,836 per member per year (PMPY) and the HMO plan would cost \$322.07 PMPM or \$8,116 PMPY. If an employer's current health plans were identical to the PPO/HMO Benchmark Model and the employer were to adopt all of the Plan Benefit Model recommendations, the employer's health plan costs would increase 10% and 6.2%, respectively.

Footnotes

- ^A ICD-9 (2007) diagnosis codes that corresponded to the recommended services were included (ICD-9 diagnosis codes were excluded for general categories of services [e.g., office visits, ED visits]).
- ^B The PPO/HMO Benchmark Model did not include the cost of case management services for children with special health care needs or other populations with complex medical needs. An estimate of the cost of adding flex benefits (as described in the Plan Benefit Model) would need to consider the degree to which these services are already provided in an employer's general case management benefit.

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Figure 2E: Pricing Analysis of the Maternal and Child Health Plan Benefit Model (HMO Plan Design)

HMO Benchmark Model Costs and Changes to Meet Minimum Plan Benefit Model Recommendations

HMO Estimate (2007 Year Dollars)	Current Cost Estimate (PMPM) Average 2007 HMO Cost Per Member Per Month^^			Revised Benefit Cost Estimate				
	Plan Benefit Model Recommendations^	Total Costs (PMPM)	Paid by Members (PMPM)	Paid by Employer (PMPM)	Employer Impact of Plan Benefit Model (PMPM)	Total Employer- Adjusted Cost of Plan Benefit Model (PMPM)	Member Impact of Plan Benefit Model (PMPM)	Percent Employer Change from Current Cost Estimate (% of total)*
I. Preventive Services								
a. Well-Child Services	\$2.24	\$0.37	\$1.87	\$0.37	\$2.24	\$(0.37)	0.1%	
b. Immunizations	\$2.21	\$-	\$2.21	\$-	\$2.21	\$-	0.0%	
c. Preventive Dental Services	\$6.86	\$-	\$6.86	\$-	\$6.86	\$-	0.0%	
d. Early Intervention Services for Mental Health/Substance Abuse	\$-	\$-	\$-	\$4.83	\$4.83	\$-	1.7%	
e. Preventive Vision Services	\$-	\$-	\$-	\$0.32	\$0.32	\$-	0.1%	
f. Preventive Audiology Screening Services	\$-	\$-	\$-	\$0.32	\$0.32	\$-	0.1%	
g. Unintended Pregnancy Prevention Services	\$3.07	\$-	\$3.07	\$-	\$3.07	\$-	0.0%	
h. Preventive Preconception Care	\$-	\$-	\$-	\$-	\$-	\$-	0.0%	
i. Preventive Prenatal Care	\$-	\$-	\$-	\$1.61	\$1.61	\$-	0.6%	
j. Preventive Postpartum Care	\$-	\$-	\$-	\$0.32	\$0.32	\$-	0.1%	
k. Preventive Services (General)	\$-	\$-	\$-	\$3.22	\$3.22	\$-	1.1%	
Category Sub-Total:				\$10.99		\$(0.37)	3.8%	
II. Recommended Levels of Care for Physician/Practitioner Services								
a. Services Delivered by a Primary Care Provider	\$23.72	\$1.85	\$21.88	\$-	\$21.88	\$-	0.0%	
b. Services Delivered by a Mental Health/Substance Abuse Provider	\$4.59	\$0.82	\$3.94	\$0.74	\$4.68	\$-	0.3%	
c. Services Delivered by a Specialty Provider or Surgeon	\$64.21	\$2.53	\$61.67	\$-	\$61.67	\$-	0.0%	
d. E-Visits and Telephonic Visits	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Category Sub-Total:				\$0.74		\$0.00	0.3%	

		Copayment	Copayment Frequency	Estimated Cost-Offset
*Rationale for Change From Current Cost Estimate				
	The HMO Benchmark Model includes a \$10 copayment. Eliminating cost-sharing is estimated to increase the employer's plan cost by 0.1%.	-	N/A	Cost-effective
	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	-	N/A	Children: cost-saving, Adolescents: some cost-effective, some cost-saving in limited populations
	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral). If a plan does not currently provide coverage for preventive dental services, including these services with coverage at 100% will increase the employer's plan cost by 2.3%.	-	N/A	Early preventive care: cost-saving, Dental sealants: cost-effective in high-risk populations, Fluoride varnish: cost-effective in high-risk populations
	The HMO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by 1.7%.	-	N/A	Probably cost-saving
	The HMO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by 0.1%.	-	N/A	Cost-effective
	The HMO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to increase the employer's portion of the plan cost by 0.1%.	-	N/A	Cost-effective
	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral). If a plan does not currently provide coverage for unintended pregnancy prevention services, including these services with coverage at 100% will increase the employer's plan cost by \$3.07 or 1.1%.	-	N/A	Cost-saving
	The HMO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to be cost neutral .	-	N/A	Cost-saving
	The HMO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by 0.6%.	-	N/A	Cost-saving
	The HMO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by 0.1%.	-	N/A	Breastfeeding promotion: cost-saving
	The HMO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by 1.1%.	-	N/A	Cost-saving or cost-effective
	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	1	per visit	N/A
	The HMO Benchmark Model includes a copayment of \$25. Reducing the required copayment to \$20 is estimated to increase the employer's plan cost by 0.10%. If an employer's HMO has a maximum of 30 mental health visits per year, removing this maximum will increase the employer's plan cost by \$0.58 or 0.2%, assuming a typical level of managed care.	1	per visit	N/A
	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	1 or 2	per visit	N/A
		Left to TPA	per visit	N/A

Figure 2E: Pricing Analysis of the Maternal and Child Health Plan Benefit Model (HMO Plan Design)

HMO Benchmark Model Costs and Changes to Meet Minimum Plan Benefit Model Recommendations

HMO Estimate (2007 Year Dollars)	Current Cost Estimate (PMPM) Average 2007 HMO Cost Per Member Per Month^^			Revised Benefit Cost Estimate				
	Plan Benefit Model Recommendations^	Total Costs (PMPM)	Paid by Members (PMPM)	Paid by Employer (PMPM)	Employer Impact of Plan Benefit Model (PMPM)	Total Employer- Adjusted Cost of Plan Benefit Model (PMPM)	Member Impact of Plan Benefit Model (PMPM)	
III. Emergency Care, Hospitalization, and Other Facility-Based Care								
a. Emergency Room Services	\$17.05	\$1.94	\$15.11	1.56	\$16.67	\$(1.56)		
b. Inpatient Substance Abuse Detoxification	\$0.86	\$0.02	\$0.84	\$-	\$0.84	\$-		
c. Inpatient Hospital Service: General Inpatient / Residential Care (Including Mental Health / Substance Abuse)	\$61.82	\$0.59	\$61.24	\$-	\$61.24	\$-		
d. Inpatient Hospital Service or Birth Center Facilities: Labor / Delivery	\$11.14	\$0.09	\$11.05	\$-	\$11.05	\$-		
e. Ambulatory Surgical Facility or Outpatient Hospital Services	\$69.64	\$0.53	\$69.11	\$-	\$69.11	\$-		
f. Mental Health / Substance Abuse Partial-Day Hospital (or Day Treatment) or Intensive Outpatient Care Services	\$0.19	\$0.00	\$0.19	\$-	\$0.19	\$-		
Category Sub-Total				\$1.56		\$(1.56)		
IV. Therapeutic Services / Ancillary Services								
a. Prescription Drugs	\$45.47	\$14.96	\$30.51	\$-	\$30.51	\$-		
b. Dental Services	\$17.07	\$4.52	\$12.55	\$2.81	\$15.36	\$(2.81)		
c. Vision Services	\$4.01	\$0.17	\$3.93	\$-	\$3.93	\$-		
d. Audiology Services	\$1.86	\$0.62	\$1.24	\$-	\$1.24	\$-		
e. Nutritional Services	\$-	\$-	\$-	\$1.03	\$1.03	\$0.26		
f. Occupational, Physical, and Speech Therapy Services	\$1.23	\$0.31	\$0.92	\$-	\$0.92	\$-		
g. Infertility Services	\$6.12	\$0.30	\$5.82	\$-	\$5.82	\$-		
h. Home Health Services	\$1.23	\$0.21	\$1.02	\$-	\$1.02	\$-		
i. Hospice Care	\$0.09	\$0.01	\$0.08	\$-	\$0.08	\$-		
j. Durable Medical Equipment & Supplies	\$2.33	\$0.40	\$1.93	\$0.56	\$2.49	\$0.02		
- Medical Food				\$0.09	\$0.09	\$0.02		
k. Transportation Services	\$0.61	\$-	\$0.61	\$-	\$0.61	\$-		
Category Sub-Total:				\$4.49		\$(2.51)		

			Copayment	Copayment Frequency	Estimated Cost-Offset
Percent Employer Change from Current Cost Estimate (% of total)*	*Rationale for Change From Current Cost Estimate				
0.5%	The HMO Benchmark Model includes a \$100 copayment for ER services. Reducing the required copayment to \$20 for urgent care services is estimated to increase the employer's plan cost by 0.50%.		3 or 5	per visit	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .		4	per admission	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .		4	per admission	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .		4	per admission	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .		3	per admission	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .		3	per episode	N/A
0.5%					
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .		Tiered	per fill/refill	N/A
1.0%	The Plan Benefit Model includes member coinsurance for restorative and orthodontic procedures (20% and 50% respectively) will increase the employer's plan cost by 1.00%.		2	per visit	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .		2	per visit	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .		2	per visit	N/A
0.4%	The HMO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by 0.40%.		2	per visit	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .		2	per visit	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) . If a plan does not currently provide coverage for infertility services, including these services with a \$100+ copayment will increase the employer's cost by \$5.82 or 2.0%.		5	per visit/unit/ or per cycle	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .		2	per visit	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .		5	one time	N/A
0.2%	The HMO Benchmark Model excludes coverage for hearing aids. Adding coverage for hearing aids will increase the employer's plan cost 0.2%.		1	per unit	Cochlear ear implants: cost-effective
0.0%	The HMO Benchmark Model excludes coverage for medical foods. Adding coverage for medical foods will result in a negligible increase to the employer's plan cost (cost neutral) .		1	per unit	Donor breast milk: cost-saving for limited populations
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .		2 or 5	per use	N/A
1.6%					

Figure 2E: Pricing Analysis of the Maternal and Child Health Plan Benefit Model (HMO Plan Design)

HMO Benchmark Model Costs and Changes to Meet Minimum Plan Benefit Model Recommendations							
HMO Estimate (2007 Year Dollars)	Current Cost Estimate (PMPM) Average 2007 HMO Cost Per Member Per Month^^			Revised Benefit Cost Estimate			
Plan Benefit Model Recommendations^	Total Costs (PMPM)	Paid by Members (PMPM)	Paid by Employer (PMPM)	Employer Impact of Plan Benefit Model (PMPM)	Total Employer- Adjusted Cost of Plan Benefit Model (PMPM)	Member Impact of Plan Benefit Model (PMPM)	
V. Laboratory Diagnostic, Assessment, and Testing Services							
a. Laboratory Services	\$6.50	\$-	\$6.50	\$-	\$6.50	\$-	
b. Diagnostic, Assessment, and Testing (Medical and Psychological) Services	\$8.23	\$-	\$8.23	\$-	\$8.23	\$-	
Category Sub-Total:				\$0.00		\$0.00	
Plan Design Total							
				\$17.78	\$309.88	\$(4.44)	
Estimated Impact of Plan Benefit Model							
Impact of Plan Benefit Model Recommendations (Benefit Additions and Modifications):				\$13.34	4.6%		
Impact From Cost-Shifting to Employer/From Member:				\$4.44	1.5%	\$(4.44)	
Total				\$17.78	6.2%		
HMO Benchmark Model Costs							
Total Per Member Per Month (PMPM)	\$322.07	\$29.98	\$292.10	\$17.78		\$(4.44)	
Total Per Employee Per Month (PEPM)	\$676.35	\$62.96	\$613.41	\$37.35		\$(9.32)	
Total Per Employee Per Year (PEPY)	\$8,116	\$755	\$7,361	\$448		\$(112)	

		Copayment	Copayment Frequency	Estimated Cost-Offset
Percent Employer Change from Current Cost Estimate (% of total)*	*Rationale for Change From Current Cost Estimate			
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .	1 - 4	per battery	N/A
0.0%	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .	1 - 4	per battery	N/A
0.0%				
6.2%				
-14.81%				

Notes

Refer to the Maternal and Child Health Model Plan Benefit Model for a description of recommended benefits.

1. The term “member” represents employees and dependents. The Benchmark Model costs are summarized on a per member per month (PMPM) basis.
2. The Benchmark Model average costs shown in this table are for a HMO plan with the following member cost-sharing specifications:
 - Medical: office visit copays = \$10 PCP/ \$25 specialist; outpatient surgery = \$50; ER copay = \$100; inpatient = \$100 per admission.
 - Prescription drugs: \$10 generic and \$25 brand copay for prescriptions (mail order = 2 times retail).
 - Dental services: \$50 deductible, 0%/20%/50% coinsurance for preventive/restorative /orthodontic services, with a \$5,000 maximum benefit per year.
3. A given employer’s health plan costs may vary from the rates shown above due to differences in plan design, member demographics, provider payment rates, or level of managed care practices for medical and mental health services.
4. Unless otherwise noted, changes in coverage to meet the minimum Plan Benefit Model recommendations are applicable to all members.

*Cost estimates for select Plan Benefit Model recommendations are based on assumptions developed by the Business Group for (a) the degree to which the service is currently covered by large-employer health plans, and (b) the prevalence of the condition the service seeks to address.

Figure 2F: Pricing Analysis of the Maternal and Child Health Plan Benefit Model (PPO Plan Design)

PPO Benchmark Model Costs and Changes to Meet Minimum Plan Benefit Model Recommendations							
PPO Estimate (2007 Year Dollars)	Current Cost Estimate^^ Average 2007 PPO Cost Per Member Per Month (PMPM)			Revised Benefit Cost Estimate			
Plan Benefit Model Recommendations^	Total Costs (PMPM)	Paid by Members (PMPM)	Paid by Employer (PMPM)	Employer Impact of Plan Benefit Model (PMPM)	Total Employer- Adjusted Cost of Plan Benefit Model (PMPM)	Member Impact of Plan Benefit Model (PMPM)	
I. Preventive Services							
a. Well-Child Services	\$2.24	\$0.84	\$1.40	\$0.84	\$2.24	\$(0.84)	
b. Immunizations	\$2.21	\$0.83	\$1.38	\$0.83	\$2.21	\$(0.83)	
c. Preventive Dental Services	\$7.60	\$-	\$7.60	\$-	\$7.60	\$-	
d. Early Intervention Services for Mental Health / Substance Abuse				\$5.85	\$5.85	\$-	
e. Preventive Vision Services				\$0.39	\$0.39	\$-	
f. Preventive Audiology Screening Services				\$0.39	\$0.39	\$-	
g. Unintended Pregnancy Prevention Services	\$3.42	\$1.19	\$2.23	\$1.19	\$3.42	\$(1.19)	
h. Preventive Preconception Care				\$-	\$-	\$-	
i. Preventive Prenatal Care				\$1.95	\$1.95	\$-	
j. Preventive Postpartum Care				\$0.39	\$0.39	\$-	
k. Preventive Services (General)				\$3.90	\$3.90	\$-	

		Coinsurance	Coinsurance Frequency	Estimated Cost-Offset
Percent Employer Change From Current Cost Estimate (% of Total)*	*Rationale for Change From Current Cost Estimate			
0.3%	The PPO Benchmark Model includes a deductible and 20% member coinsurance. Eliminating the deductible and coinsurance is estimated to increase the employer's plan cost by 0.3%.	-	N/A	Cost-effective
0.3%	The PPO Benchmark Model includes a deductible and 20% member coinsurance. Eliminating the deductible and member coinsurance is estimated to increase the employer's plan cost by 0.3%.	-	N/A	Children: cost-saving, Adolescents: some cost-effective, some cost-saving in limited populations
0.0%	The PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral). If a plan does not currently provide coverage for preventive dental services, including these services with coverage at 100% will increase the employer costs by 2.5%. If the employer's PPO covers these services but requires 20% member coinsurance, eliminating the coinsurance will increase the employer's plan cost by \$1.52 or 0.5%.	-	N/A	Early preventive care: cost-saving, Dental sealants: cost-effective in high-risk populations, Fluoride varnish: cost-effective in high-risk populations
1.9%	The PPO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by 1.9%.	-	N/A	Probably cost-saving
0.1%	The PPO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by 0.1%.	-	N/A	Cost-effective
0.1%	The PPO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by 0.1%.	-	N/A	Cost-effective
0.4%	The PPO Benchmark Model includes a deductible and 20% member coinsurance. Eliminating the deductible and coinsurance will increase the employer's plan cost by \$1.19 or 0.4%. If a plan does not currently provide coverage for unintended pregnancy prevention services, including these services with coverage at 100% will increase the employer's plan cost by \$1.19 or 1.1%.	-	N/A	Cost-saving
0.0%	The PPO Benchmark Model excludes coverage for these services. Adding coverage for these services is estimated to be cost neutral .	-	N/A	Cost-saving
0.6%	The PPO Benchmark Model excludes coverage for these services. Adding coverage for these services and eliminating cost-sharing is estimated to increase the employer's plan cost by 0.6%.	-	N/A	Cost-saving
0.1%	The PPO Benchmark Model excludes coverage for these services. Adding coverage for these services and eliminating cost-sharing is estimated to increase the employer's plan cost by 0.1%.	-	N/A	Breastfeeding promotion: cost-saving
1.3%	The PPO Benchmark Model excludes coverage for these services. Adding coverage for these services and eliminating cost-sharing are estimated to increase the employer's cost by 1.3%.	-	N/A	Cost-saving or cost-effective

Figure 2F: Pricing Analysis of the Maternal and Child Health Plan Benefit Model (PPO Plan Design)

PPO Benchmark Model Costs and Changes to Meet Minimum Plan Benefit Model Recommendations							
PPO Estimate (2007 Year Dollars)	Current Cost Estimate^^ Average 2007 PPO Cost Per Member Per Month (PMPM)			Current Cost Estimate^^ Average 2007 PPO Cost			
	Plan Benefit Model Recommendations^	Total Costs (PMPM)	Paid by Members (PMPM)	Paid by Employer (PMPM)	Employer Impact of Plan Benefit Model (PMPM)	Total Employer- Adjusted Cost of Plan Benefit Model (PMPM)	Member Impact of Plan Benefit Model (PMPM)
II. Recommended Levels of Care for Physician/Practitioner Services							
a. Services Delivered by a Primary Care Provider	\$26.76	\$10.05	\$16.70	\$2.13	\$18.83	\$(2.13)	
b. Services Delivered by a Mental Health/Substance Abuse Provider	\$5.34	\$1.06	\$4.28	\$0.91	\$5.19	\$(0.13)	
c. Services Delivered by a Specialty Provider or Surgeon	\$74.70	\$14.84	\$59.86	\$2.47	\$62.33	\$(2.47)	
d. E-Visits and Telephonic Visits	N/A	N/A	N/A	N/A	N/A	N/A	
Category Sub-Total:				\$5.51		\$(4.73)	
III. Emergency Care, Hospitalization, and Other Facility-Based Care							
a. Emergency Room Services	\$19.84	\$3.90	\$15.94	\$1.82	\$17.76	\$(1.82)	
b. Inpatient Substance Abuse Detoxification	\$1.17	\$0.12	\$1.05	\$-	\$1.05	\$-	
c. Inpatient Hospital Service: General Inpatient / Residential Care (Including Mental Health / Substance Abuse)	\$84.44	\$9.00	\$75.44	\$0.30	\$75.74	\$(0.30)	
d. Inpatient Hospital Service or Birth Center Facilities: Labor / Delivery	\$15.21	\$1.62	\$13.59	\$-	\$13.59	\$-	
e. Ambulatory Surgical Facility or Outpatient Hospital Services	\$81.02	\$15.93	\$65.09	\$-	\$65.09	\$-	
f. Mental Health / Substance Abuse Partial-Day Hospital (or Day Treatment) or Intensive Outpatient Services	\$0.24	\$0.03	\$0.21	\$-	\$0.21	\$-	
Category Sub-Total:				\$2.12		\$(2.12)	

Per Member Per Month (PMPM)		Coinsurance	Coinsurance Frequency	Estimated Cost-Offset
Percent Employer Change From Current Cost Estimate (% of Total)*	*Rationale for Change From Current Cost Estimate			
0.7%	The PPO Benchmark Model includes a deductible and 20% member coinsurance. Reducing the coinsurance to 10% is estimated to increase the employer's cost by 0.7%.	10%	per visit	N/A
0.3%	The PPO Benchmark Model includes 20% member coinsurance. Reducing the coinsurance to 10% is estimated to increase the employer's cost by 0.1%. If an employer's PPO has a maximum of 30 mental health visits per year, removing this maximum will increase employers cost by \$0.61 or 0.20%, assuming a typical level of managed care.	10%	per visit	N/A
0.8%	The PPO Benchmark Model includes a deductible and 20% member coinsurance. Reducing the coinsurance to 15% is estimated to increase the employer's plan cost by 0.8%.	10% or 15%	per visit	N/A
N/A		Left to TPA	per visit	N/A
1.8%				
0.6%	The PPO Benchmark Model includes 20%-25% member coinsurance and this range is consistent with the Plan Benefit Model (cost neutral). Reducing the urgent care coinsurance to 10% is estimated to increase the employer's cost by 0.6%.	20% or 25%	per visit	N/A
0.0%	The PPO Benchmark Model includes a deductible. Eliminating the deductible will result in a negligible increase to the employer's plan cost (cost neutral).	25%	per episode	N/A
0.1%	The PPO Benchmark Model includes a deductible. Eliminating the deductible is estimated to increase the employer's plan cost by 0.1%.	25%	per episode	N/A
0.0%	The PPO Benchmark Model includes a deductible. Eliminating the deductible will result in a negligible increase to the employer's plan cost (cost neutral).	25%	per episode	N/A
0.0%	The PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	20%	per episode	N/A
0.0%	The PPO Benchmark Model includes a deductible. Eliminating the deductible will result in a negligible increase to the employer's plan cost (cost neutral). This cost estimate assumes there are no changes in managed care practices.	20%	per episode	N/A
0.7%				

Figure 2F: Pricing Analysis of the Maternal and Child Health Plan Benefit Model (PPO Plan Design)

PPO Benchmark Model Costs and Changes to Meet Minimum Plan Benefit Model Recommendations

PPO Estimate (2007 Year Dollars)	Current Cost Estimate^^ Average 2007 PPO Cost Per Member Per Month (PMPM)			Current Cost Estimate^^ Average 2007 PPO Cost					
	Plan Benefit Model Recommendations^	Total Costs (PMPM)	Paid by Members (PMPM)	Paid by Employer (PMPM)	Employer Impact of Plan Benefit Model (PMPM)	Total Employer- Adjusted Cost of Plan Benefit Model (PMPM)	Member Impact of Plan Benefit Model (PMPM)	Percent Employer Change From Current Cost Estimate (% of Total)*	
IV. Therapeutic Services / Ancillary Services									
a. Prescription Drugs	\$58.23	\$21.16	\$37.06	\$-	\$37.06	\$-	0.0%		
b. Dental Services	\$18.90	\$5.01	\$13.90	\$3.11	\$17.01	\$-	1.0%		
c. Vision Services	\$4.77	\$1.73	\$3.03	\$1.73	\$4.77	\$-	0.6%		
d. Audiology Services	\$2.25	\$0.50	\$1.75	\$-	\$1.75	\$-	0.0%		
e. Nutritional Services				\$1.22	\$1.22	\$0.35	0.4%		
f. Occupational, Physical, and Speech Therapy Services	\$1.43	\$0.31	\$1.12	\$0.23	\$1.35	\$(0.23)	0.1%		
g. Infertility Services	\$7.42	\$1.47	\$5.94	\$-	\$5.94	\$-	0.0%		
h. Home Health Services	\$1.43	\$0.52	\$0.91	\$-	\$0.91	\$-	0.0%		
i. Hospice Care	\$0.11	\$0.02	\$0.08	\$-	\$0.08	\$-	0.0%		
j. Durable Medical Equipment & Supplies	\$2.71	\$0.98	\$1.72	\$0.55	\$2.27	\$0.06	0.2%		
- Medical Foods				\$0.11	\$0.11	\$0.03	0.0%		
k. Transportation Services	\$0.70	\$0.26	\$0.45	\$-	\$0.45	\$-	0.0%		
Category Sub-Total:				\$6.95		\$0.21	2.3%		
V. Laboratory Diagnostic, Assessment, and Testing Services									
a. Laboratory Services	\$8.71	\$1.93	\$6.78	\$-	\$6.78	\$-	0.0%		
b. Diagnostic, Assessment, and Testing (Medical and Psychological) Services	\$10.17	\$2.12	\$8.04	\$-	\$8.04	\$-	0.0%		
Category Sub-Total:				\$0.00		\$0.00	0.0%		

Per Member Per Month (PMPM)	Coinsurance	Coinsurance Frequency	Estimated Cost-Offset
*Rationale for Change From Current Cost Estimate			
The PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .	Tiered	per fill/re-fill	N/A
The PPO Benchmark Model includes member coinsurance for restorative and orthodontic procedures (20% and 50% respectively). Decreasing the coinsurance to 15% and setting the annual maximum benefit at \$5,000 will increase the employer's plan cost by 1.0%.	15%	per visit	N/A
The PPO Benchmark Model includes a deductible and 20% member coinsurance. Eliminating the deductible and decreasing the coinsurance to 15% will increase the employer's plan cost by 0.6%.	15%	per visit	N/A
The PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .	15%	per visit	N/A
The PPO Benchmark Model excludes coverage for these services. Adding coverage for these services will increase the employer's plan cost by 0.4%.	15%	per visit	N/A
The PPO Benchmark Model includes a deductible and 20% member coinsurance. Eliminating the deductible, decreasing the coinsurance to 15%, and increasing the annual visit limit from 60 visits to 75 visits will increase the employer's plan cost by 0.1%.	15%	per visit	N/A
The PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) . If a plan does not currently provide coverage for these services, including these services with 25%+ member coinsurance will increase the employer's plan cost by \$5.94 or 2.0%.	25%	per visit/unit or per cycle	N/A
The PPO Benchmark Model includes 20% member coinsurance. Reducing the coinsurance to 10% will result in a negligible increase to the employer's plan cost (cost neutral) .	15%	per visit	N/A
The PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .	25%	one-time	N/A
The PPO Benchmark Model excludes coverage for hearing aids. Adding coverage for hearing aids will increase the employer's plan cost 0.2%.	10%	per unit	Cochlear ear implants: cost-effective
The PPO Benchmark Models excludes coverage for medical foods. Adding coverage for medical foods will result in a negligible increase to the employer's plan cost (cost neutral) .	10%	per unit	Donor breast milk: cost-saving for limited populations
The PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral) .	15% or 25%	per use	N/A
The PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	10% - 25%	per battery	N/A
The PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	10% - 25%	per battery	N/A

Figure 2F: Pricing Analysis of the Maternal and Child Health Plan Benefit Model (PPO Plan Design)

PPO Benchmark Model Costs and Changes to Meet Minimum Plan Benefit Model Recommendations							
PPO Estimate (2007 Year Dollars)	Current Cost Estimate^^ Average 2007 PPO Cost Per Member Per Month (PMPM)			Current Cost Estimate^^ Average 2007 PPO Cost Per Member Per Month (PMPM)			
Plan Benefit Model Recommendations^	Total Costs (PMPM)	Paid by Members (PMPM)	Paid by Employer (PMPM)	Employer Impact of Plan Benefit Model (PMPM)	Total Employer- Adjusted Cost of Plan Benefit Model (PMPM)	Member Impact of Plan Benefit Model (PMPM)	Percent Employer Change From Current Cost Estimate (% of Total)*
Plan Design Total				\$30.31	\$334.10	\$(9.50)	10.0%
Estimated Impact of Plan Benefit Model							
Impact of Plan Benefit Model Recommendations (Benefit Additions and Modifications):				\$20.81	6.9%		
Impact From Cost-Shifting to Employer/From Member:				\$9.50	3.1%	\$(9.50)	-11.0%
			Total:	\$30.31	10.0%		
PPO Benchmark Model Costs							
Total Per Member Per Month (PMPM)	\$390.31	\$86.52	\$303.79	\$30.31		\$(9.50)	
Total Per Employee Per Month (PEPM)	\$819.65	\$181.69	\$637.96	\$63.66		\$(19.95)	
Total Per Employee Per Year (PEPY)	\$9835.9	\$2180.33	\$7655.56	\$763.89		\$(239.40)	

Notes

1. The term “member” represents employees and dependents. The Benchmark Model costs are summarized on a per member per month (PMPM) basis.
2. The Benchmark Model average costs shown in this table are for a PPO plan with the following member cost-sharing specifications:
 - Medical services other than prescription drugs: \$250 deductible, 20% coinsurance, subject to a \$2,500 out-of-pocket limit.
 - Prescription drugs: \$10 copay for generic and \$25 copay for brand prescriptions (mail order = 2 times retail).
 - Dental services: \$50 deductible, 0%/20%/50% coinsurance for preventive/restorative/orthodontic services, with a \$2,500 maximum benefit per year.
3. A given employer’s health plan costs may vary from the rates shown above due to differences in plan design, member demographics, provider payment rates, or level of managed care practices for medical and mental health services.
4. Unless otherwise noted, changes in coverage to meet the minimum Plan Benefit Model recommendations are applicable to all members.
*Cost estimates for select Plan Benefit Model recommendations are based on assumptions developed by the Business Group for (a) the degree to which the service is currently covered by large-employer health plans, and (b) the prevalence of the condition the service seeks to address.

