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

Maternal and Child Health Plan Benefit Model

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Sample Plan Benefit Key

Recommended Plan Benefits: One of Five Types of Service																	
The Specific Type of Benefit																	
Definition of Benefit		Covered Providers															
A summary definition of the type of benefit and/or rationale for including the benefit.		Covered providers and/or related benefit information.															
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions														
Typically expressed as the maximum amount of benefit covered by the plan.	Plan provisions that reflect unique circumstances and allow for exceptions to be made.	Particular benefits that should be covered by the type of benefit.	Particular benefits that should not be covered by the type of benefit.														
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0%-25%)	Out-of-Pocket Maximum															
Recommendation on copayment (HMO model) or coinsurance (PPO model) amount.	<p>Recommended copayment and coinsurance (in-network) levels correspond to the key summarized below:</p> <table border="0"> <tr> <td>Copayment</td> <td>Coinsurance</td> </tr> <tr> <td>0 = \$0</td> <td>= 0%</td> </tr> <tr> <td>1 = \$10 – \$20</td> <td>= 10%</td> </tr> <tr> <td>2 = \$25 – \$40</td> <td>= 15%</td> </tr> <tr> <td>3 = \$45 – \$60</td> <td>= 20%</td> </tr> <tr> <td>4 = \$75 - \$100</td> <td>= 25%</td> </tr> <tr> <td>5 = \$100+</td> <td>= 25%+</td> </tr> </table>	Copayment	Coinsurance	0 = \$0	= 0%	1 = \$10 – \$20	= 10%	2 = \$25 – \$40	= 15%	3 = \$45 – \$60	= 20%	4 = \$75 - \$100	= 25%	5 = \$100+	= 25%+	<p>Denotes whether individual expenses apply to the maximum expense paid per individual or per family in a single calendar year. After that amount is reached, the health plan will pay 100% of covered charges for the remainder of the calendar year.</p> <p>Individual (1): \$1,500 Individual plus one (2): \$3,000 Family (3+): \$4,500</p>	
Copayment	Coinsurance																
0 = \$0	= 0%																
1 = \$10 – \$20	= 10%																
2 = \$25 – \$40	= 15%																
3 = \$45 – \$60	= 20%																
4 = \$75 - \$100	= 25%																
5 = \$100+	= 25%+																
Actuarial Impact	Cost of Recommended Benefits (PMPM)	Cost Impact															
	The per member per month (PMPM) estimate of the total employer cost of the benefit as it is described in this plan.	One of the following: <ul style="list-style-type: none"> • Decrease • Neutral • Increase 	The estimated employer cost impact will be influenced by an individual employer’s health plan design and administration rules. If an employer’s current health plans were identical to the HMO/PPO 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. Cost-offset values associated with preventive services are excluded from this calculation.														
Citations																	
Source	Actual reference	The strength of the reference, which will be one of the following: <ol style="list-style-type: none"> 1. Evidence-Based Research 2. Recommended Guidance (e.g., Expert Opinion, Expert Consensus, Expert Panel) 3. Federally Vetted 4. Industry Standard 5. Actuarial Analysis 															

II. Recommended Minimum Plan Benefits: Physician / Practitioner Services

A. SERVICES DELIVERED BY A PRIMARY CARE PROVIDER

Definition of Benefit		Covered Providers	
Medical services delivered in the primary care setting that are diagnostic, therapeutic, rehabilitative, or palliative in nature. ^A		Covered services must be furnished by a primary care physician (family physician, general practitioner, internal medicine physician, pediatrician), a medical professional who operates under a physician (e.g., nurse practitioner, physician's assistant), or a specialist physician or medical professional who is licensed to provide primary care services (e.g., certified nurse midwife, OB-GYN ^B).	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
No limits	N/A	All medically necessary care. Medical necessity supported by the Plan Benefit Model definition. May include services related to physical, mental, oral, or vision problems or conditions.	N/A
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
Per visit copayment	1 / 10%	Copayment and coinsurance payments apply toward maximum.	
Actuarial Impact ¹	Cost of Recommended Benefits (PMPM)	Cost Impact	
	\$ 21.88 (HMO) \$ 18.83 (PPO)	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral). The PPO Benchmark Model includes a deductible and 20% member coinsurance. Reducing the coinsurance to 10% is estimated to increase the employer's plan cost by: <ul style="list-style-type: none"> • \$2.13 PMPM / 0.7% of total plan costs (PPO) 	
Citations			
1. PricewaterhouseCoopers	PricewaterhouseCoopers LLP. <i>Actuarial Analysis of the National Business Group on Health's Maternal and Child Health Plan Benefit Model</i> . Atlanta, GA: PricewaterhouseCoopers LLP; August 2007.		Actuarial Analysis

^A Services may be provided in school-based health centers and other non-traditional settings so long as the provider is included in the plan's network.

^B Obstetricians and gynecologists (OB-GYNs) are considered "primary care providers" only when they are providing preconception, prenatal, and postpartum care. They are considered "medical specialists" when providing all other types of services. Copayment/coinsurance amounts should be adjusted accordingly.

II. Recommended Minimum Plan Benefits: Physician / Practitioner Services			
B. SERVICES DELIVERED BY A MENTAL HEALTH / SUBSTANCE ABUSE PROVIDER			
Definition of Benefit		Covered Providers	
Medical services delivered by or under the direction of a mental health professional or primary care provider that are diagnostic, therapeutic, rehabilitative, or palliative in nature.		Covered services must be furnished by or under the direction of a mental health professional (psychiatrist, clinical psychologist, licensed clinical social worker, licensed professional counselor, psychiatric nurse specialist) or a primary care provider (family physician, pediatrician, nurse practitioner, general practitioner, internal medicine physician). ¹	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
No limits for DSM-IV diagnoses. May require referral from a primary care provider.	N/A	All medically necessary care. Medical necessity supported by the Plan Benefit Model definition.	V-codes as described in the DSM-IV. <i>Please refer to "Early Intervention Services for Mental Health / Substance Abuse" for additional coverage information.</i>
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
Per visit copayment	1 / 10%	Copayment and coinsurance amounts apply toward maximum.	
Actuarial Impact ²	Cost of Recommended Benefits (PMPM)	Cost Impact	
	\$ 4.68 (HMO) \$ 5.19 (PPO)	The HMO Benchmark Model includes a copayment of \$25 and the PPO Benchmark Model includes 20% member coinsurance. Reducing the required copayment to \$20 and the member coinsurance to 10% is estimated to increase the employer's plan cost. If either plan has a maximum of 30 mental health visits per year, removing this maximum will increase the employer's plan cost. The estimated total cost increase would be: <ul style="list-style-type: none"> • \$0.74 PMPM / 0.3% of total plan costs (HMO) • \$0.91 PMPM / 0.3% of total plan costs (PPO) 	
Citations			
1. U.S. Department of Health and Human Services, Bureau of Health Professionals	U.S. Department of Health and Human Services, Bureau of Health Professionals. <i>Health Professional Shortage Area Guidelines for Mental Health Care Designation</i> . Available at: http://bhpr.hrsa.gov/shortage/hpsaguidement.htm . Accessed on January 12, 2007.		Recommended Guidance
2. PricewaterhouseCoopers	PricewaterhouseCoopers LLP. <i>Actuarial Analysis of the National Business Group on Health's Maternal and Child Health Plan Benefit Model</i> . Atlanta, GA: PricewaterhouseCoopers LLP; August 2007.		Actuarial Analysis

II. Recommended Minimum Plan Benefits: Physician / Practitioner Services

C. SERVICES DELIVERED BY A SPECIALTY PHYSICIAN OR SURGEON

Definition of Benefit		Covered Providers	
Medical services delivered by a specialty physician or surgeon that are diagnostic, therapeutic, rehabilitative, or palliative in nature.		Covered services must be furnished by or under the direction of a physician trained in a specialty area such as: allergy and immunology, anesthesiology, dermatology, emergency medicine, medical genetics, neurological surgery, neurology/child neurology, nuclear medicine, obstetrics/gynecology ^A , ophthalmology, orthopedic surgery, otolaryngology, pathology, physical medicine and rehabilitation, plastic surgery, psychiatry, radiology, surgery, thoracic surgery, urology, or other recognized medical specialty.	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
No limits. May require a referral from a primary care provider.	Recommend reducing member coinsurance to 10% for treatment of chronic conditions with referral from a primary care provider.	All medically necessary care. Medical necessity supported by the Plan Benefit Model definition. May include services related to physical, mental, oral, or vision problems or conditions	N/A
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
Per visit copayment	1 / 10% if referred by a PCP for treatment of a chronic condition; 2 / 15% in all other circumstances	Copayment and coinsurance amounts apply toward maximum.	
Actuarial Impact ¹	Cost of Recommended Benefits (PMPM)	Cost Impact	
	\$ 61.67 (HMO) \$ 62.33 (PPO)	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral). The PPO Benchmark Model includes a deductible and 20% member coinsurance. Reducing member coinsurance to 15% is estimated to increase the employer's plan cost by: • \$2.47 PMPM / 0.8% of total plan costs (PPO)	
Citations			
1. PricewaterhouseCoopers	PricewaterhouseCoopers LLP. <i>Actuarial Analysis of the National Business Group on Health's Maternal and Child Health Plan Benefit Model</i> . Atlanta, GA: PricewaterhouseCoopers LLP; August 2007.		Actuarial Analysis

^A Obstetricians and gynecologists (OB-GYNs) are considered "primary care providers" only when they are providing preconception, prenatal, and postpartum care. They are considered "medical specialists" when providing all other types of services.

II. Recommended Minimum Plan Benefits: Physician/ Practitioner Services			
D. E-VISITS AND TELEPHONIC SERVICES			
Definition of Benefit		Covered Providers	
Two-way electronic communication (via email or telephone) between a beneficiary and a provider that takes the place of an office visit for a non-urgent problem or question specific to the beneficiary. ¹ Must include clinical decision making, a review of symptoms, and the provision of clinical advice. Communication may be initiated by either the beneficiary or the provider. ^{1,2}		Covered services must be furnished by a physician, a medical professional who operates under a physician (e.g., nurse practitioner, physician's assistant), or a medical professional who is licensed to provide primary care services (e.g., certified nurse midwife).	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
Appropriate uses for e-mail communication include: prescription refills; test results; routine follow-up inquiries; reporting of home health monitoring/self-management of chronic disease ^{1,2} ; and information on how to take medications, apply dressings, and follow pre-and post-operative instructions. ² Appropriate uses for telephonic communication include: calls for provider management of a new problem, including counseling, medical management, and coordination of care not resulting in an office visit within 24 hours; calls for provider management about an existing problem for which the beneficiary was not seen in a face-to-face encounter in the previous 7 days; and calls related to care plan oversight for beneficiaries with special needs in residential settings and those with a chronic disease who require provider supervision over a period of time during a calendar month. ³ No other limits.		All medically necessary care. Medical necessity supported by the Plan Benefit Model definition. May include services related to physical, mental, oral, or vision problems or conditions.	<ul style="list-style-type: none"> • Scheduling. • Appointment reminders and courtesy calls. • Communication that results in an office visit within the subsequent 24 hours. • All others as defined by the health plan.
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
Determined by plan administrator based on negotiated rates.	Determined by plan administrator based on negotiated rates.	Copayment and coinsurance payments apply toward maximum. Employers are encouraged to partner with health plan administrators to test/pilot this benefit in a target market.	
Actuarial Impact ⁴	Cost of Recommended Benefits (PMPM)	Cost Impact	
	Data not available. Employers are encouraged to partner with their health plan administrator(s) to test/pilot this benefit in a target market.	Data not available	
Citations			
1. California Healthcare Foundation	E-Encounters. Health Reports. Oakland, CA: California Healthcare Foundation; 2001.	Industry Standard	
2. American Medical Association	American Medical Association. <i>Young Physicians Section. Guidelines for Physician-Patient Electronic Communications. Updated 2004.</i> Available at: http://www.ama-assn.org/ama/pub/category/2386.html . Accessed on June 12, 2007.	Recommended Guidance	
3. American Academy of Pediatrics	American Academy of Pediatrics. Payment for telephone care. Policy statement. <i>Pediatrics</i> . 2006; 118(4): 1768-1773.	Recommended Guidance: Expert Opinion	
4. PricewaterhouseCoopers	PricewaterhouseCoopers LLP. <i>Actuarial Analysis of the National Business Group on Health's Maternal and Child Health Plan Benefit Model.</i> Atlanta, GA: PricewaterhouseCoopers LLP; August 2007.	Actuarial Analysis	