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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 															

IV. Recommended Minimum Plan Benefits: Therapeutic Services / Ancillary Services

A. PRESCRIPTION DRUGS

Definition of Benefit		Covered Providers	
Medications used to prevent, treat, or manage a medical condition.		Medications may only be dispensed by a state-licensed pharmacist, physician, or provider under the direction of a physician.	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
A diagnosis is required for all prescriptions. Medication is covered when, and only when, it: 1) requires a prescription; and 2) is used to prevent, treat, or manage a specific illness or condition. No other limits.	Consider waiving/reducing the copayment/coinsurance for children with special health care needs; consider offering experimental drugs for children with terminal illnesses.	All medically necessary medications. Medical necessity supported by the Plan Benefit Model definition.	All others as defined by the health plan.
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
Copayment and coinsurance amounts defined by brand, generic, and non-formulary drug categories.	Range: 0-4 / 0%-25% (based on formulary)	Copayment and coinsurance amounts apply toward maximum.	
Actuarial Impact ¹	Cost of Recommended Benefits (PMPM)	Cost Impact	
	\$ 30.51 (HMO) \$ 37.06 (PPO)	The HMO and PPO Benchmark Models are consistent with the Plan Benefit Model (cost neutral).	
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

IV. Recommended Minimum Plan Benefits: Therapeutic Services / Ancillary Services			
B. DENTAL SERVICES			
Definition of Benefit		Covered Providers	
Medical services specifically designed to address oral health. These services may be diagnostic, therapeutic, or rehabilitative in nature.		Covered services must be furnished by or under the direction of a licensed dentist or licensed dental hygienist. Licensed dental hygienists must be overseen by a dentist or primary care provider. Dental services may be provided in the outpatient setting, in emergency rooms, or in the inpatient setting, according to need.	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
Annual limit: \$5,000 per person.	Include provisions for children with complex case-management needs (e.g., flex benefits).	<p>All medically necessary care. Medical necessity supported by the Plan Benefit Model definition. Coverage also includes:</p> <ul style="list-style-type: none"> • Amalgam and resin-based composite restorations (“fillings”).^{1,2} • Extractions (oral surgery) such as simple, surgical, soft tissue and bony impacted teeth.¹ • General anesthesia, intravenous sedation,¹ oral sedation, and nitrous oxide. • Occlusal guards (for bruxism only) —limited to one every 3 years, from the last date of service.¹ • Crowns (prefabricated stainless steel crowns and resin).^{1,2} • Osseous surgery (“periodontics”) —one per quadrant every 3 years, from the last date of service.¹ • Implants.⁴ • Prosthetics.⁴ • Endodontic procedures (e.g., root canal treatment, pulpotomies, pulpectomies).³ • Orthodontics covered only when treatment meets medical necessity criteria.⁴ 	<ul style="list-style-type: none"> • Orthodontics, when not medically necessary.¹ • Dental treatment for cosmetic purposes.¹
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
Per visit copayment. Per visit coinsurance based on negotiated rate.	2 / 15%	Copayment and coinsurance amounts apply toward maximum.	
Actuarial Impact ⁵	Cost of Recommended Benefits (PMPM)	Cost Impact	
	\$ 15.36 (HMO) \$ 17.01 (PPO)	<p>The HMO/PPO Benchmark Model includes member coinsurance for restorative and orthodontic procedures (20% and 50% respectively) and the PPO Benchmark Model includes a \$2,500 annual maximum benefit. Decreasing the member coinsurance to the recommended 15% and setting the annual maximum benefit at \$5,000 for both plans will increase the employer's plan cost by:</p> <ul style="list-style-type: none"> • \$2.81 PMPM / 1.0% of total plan costs (HMO) • \$3.11 PMPM / 1.0% of total plan costs (PPO) 	

IV. Recommended Minimum Plan Benefits: Therapeutic Services / Ancillary Services

B. DENTAL SERVICES *continued*

Citations

1. Federal Employee Health Benefit Plan	U.S. Office of Personnel Management, Federal Employees Health Benefits Program. <i>Sample plan characteristics (Aetna: Individual practice plan with a consumer driven health plan option and a high deductible health plan option)</i> . Available at: https://www.opm.gov/insure/07/brochures/pdt/73-828.pdf . Accessed on January 17, 2007.	Federally Vetted
2. American Academy of Pediatric Dentistry	American Academy of Pediatric Dentistry. <i>Guidelines on Pediatric Restorative Dentistry. Clinical Guidelines Reference Manual 2005-2006</i> ; Revised 2004.	Recommended Guidance: Expert Opinion
3. American Academy of Pediatric Dentistry	American Academy of Pediatric Dentistry. Guidelines on pulp therapy for primary and young permanent teeth. <i>Clinical Guidelines Reference Manual 2005-2006</i> . American Academy of Pediatric Dentistry; 2004.	Recommended Guidance: Expert Opinion
4. Maternal and Family Health Benefits Advisory Board	Maternal and Family Health Benefits Advisory Board. Washington, DC: National Business Group on Health; August 2007.	Recommended Guidance: Expert Opinion
5. 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

IV. Recommended Minimum Plan Benefits: Therapeutic Services / Ancillary Services			
C. VISION SERVICES			
Definition of Benefit		Covered Providers	
Services to assess and address vision problems including refractive exams for eyeglasses and contacts, exams and assessments for other low vision aids, and vision therapy.		Covered services must be furnished by an ophthalmologist or optometrist.	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
Refractive exams (limit 1 per calendar year) ¹ ; treatment of eye diseases and injury; replacement lenses and frames or contact lenses every year or each time a prescription changes.	Include provisions for children with complex case-management needs (e.g., flex benefits).	<ul style="list-style-type: none"> • Refractive eye exams.¹ • Corrective eyeglasses and frames.² • Contact lenses.² • Fitting of contact lenses.² • Eye exercises.^{1,2} 	All others as defined by the health plan.
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
Per visit copayment or per visit coinsurance based on negotiated rate. No copayment/coinsurance on glasses or contacts purchase. Monetary limit on eyeglasses, frames, and contacts: \$200 per calendar year. ³	2 / 15%	Copayment and coinsurance amounts apply toward maximum.	
Actuarial Impact ⁴	Cost of Recommended Benefits (PMPM)	Cost Impact	
	\$ 3.93 (HMO) \$ 4.77 (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. Eliminating the deductible and decreasing the member coinsurance to 15% will increase the employer's cost by: <ul style="list-style-type: none"> • \$1.73 PMPM / 0.6% of total plan costs (PPO) 	
Citations			
1. American Academy of Ophthalmology	Committee on Practice and Ambulatory Medicine, Section on Ophthalmology. American Association of Certified Orthoptists; American Association for Pediatric Ophthalmology and Strabismus; American Academy of Ophthalmology. Eye examination in infants, children, and young adults by pediatricians. <i>Pediatrics</i> . 2003 Apr;111(4 Pt 1):902-7.		Recommended Guidance: Expert Opinion
2. Federal Employee Health Benefit Plan	U.S. Office of Personnel Management, Federal Employees Health Benefits Program. <i>Sample plan characteristics (Aetna: Individual practice plan with a consumer driven health plan option and a high deductible health plan option)</i> . Available at: https://www.opm.gov/insure/07/brochures/pdf/73-828.pdf . Accessed on January 17, 2007.		Federally Vetted
3. Eye Med	Average cost of top 10 child-appropriate frames and polycarbonate lenses from Lens Crafters, Pearle Vision, Target, and Sears Optical.		Industry Standard
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

IV. Recommended Minimum Plan Benefits: Therapeutic Services / Ancillary Services

D. AUDIOLOGY SERVICES

Definition of Benefit		Covered Providers	
Medical services specifically designed to address hearing loss. These services may be diagnostic, therapeutic, or rehabilitative in nature.		Covered services must be furnished by or under the direction of a state-licensed/board-certified audiologist or speech-language pathologist. ¹	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
No limit. Requires pre-certification and/or referral.	Include provisions for children with complex case-management needs (e.g., flex benefits).	<p>All medically necessary assessment and treatment including¹:</p> <ul style="list-style-type: none"> Audiological, tinnitus, vestibular and balance assessment; central auditory, cochlear implant, assistive listening device (ALD), auditory rehabilitation, and hearing aid assessment and fitting. Treatment of audiologic (aural) rehabilitation/habilitation, vestibular and balance, auditory processing, and cerumen management problems. 	All others as defined by the health plan. <i>Please refer to the "Durable Medical Equipment (DME), Supplies & Medical Foods" benefit for additional information on equipment /device coverage.</i>
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
Per visit copayment. Per visit coinsurance based on negotiated rate.	2 / 15%	Copayment and coinsurance amounts apply toward maximum.	
Actuarial Impact ²	Cost of Recommended Benefits (PMPM)	Cost Impact	
	\$ 1.24 (HMO) \$ 1.75 (PPO)	The HMO/PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	
Citations			
1. American Speech-Language-Hearing Association	American Speech-Language-Hearing Association. <i>Model Health Care Benefits, Ideal Health Plan Coverages for Audiology and Speech-Language Pathology Services</i> . Available at: http://www.asha.org/public/add-benefits/model-benefits.htm#speech and http://www.asha.org/public/add-benefits/providers.htm . Accessed on July 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	

IV. Recommended Minimum Plan Benefits: Therapeutic Services / Ancillary Services			
E. NUTRITIONAL SERVICES			
Definition of Benefit		Covered Providers	
<p>Medical services that are diagnostic, therapeutic, or rehabilitative in nature and are specifically designed to address diet and nutrition. These services should include a comprehensive process for defining an individual's nutrition and hydration status using medical, nutrition, and medication intake histories, physical examination, anthropomorphic measures, and laboratory data. Nutritional services may also involve interventions and counseling to promote appropriate nutrition and fluid intake. Nutrition therapy, as a component of medical treatment, includes enteral and parenteral nutrition care.¹</p>		<p>Covered services must be furnished by or under the direction of a physician, nurse practitioner, or other licensed provider (e.g., registered dietitian) working under the direction a physician.</p>	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
Limited to 25 visits per calendar year. Requires pre-certification and/or referral. ²	Include provisions for children with complex case-management needs (e.g., flex benefits).	All medically necessary care. Medical necessity supported by the Plan Benefit Model definition.	All others as defined by the health plan.
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
Per visit copayment. Per visit coinsurance based on negotiated rate.	2 / 15%	Copayment and coinsurance amounts apply toward maximum.	
Actuarial Impact ³	Cost of Recommended Benefits (PMPM)	Cost Impact	
	<p>\$ 1.03 (HMO) \$ 1.22 (PPO)</p>	<p>The HMO and PPO Benchmark Models exclude coverage for these services. Adding coverage for these services is estimated to increase the employer's plan cost by:</p> <ul style="list-style-type: none"> • \$1.03 PMPM / 0.4% of total plan costs (HMO) • \$1.22 PMPM/ 0.4% of total plan costs (PPO) 	
Citations			
1. American Dietetic Association	Definition provided by the American Dietetic Association. Adapted from: Joint Commission on Accreditation of Healthcare Organizations. <i>2007 Standards for Ambulatory Care</i> . 2007:361-362.		Recommended Guidance: Professional Guideline
2. Maternal and Family Health Benefits Advisory Board	Maternal and Family Health Benefits Advisory Board. Washington, DC: National Business Group on Health; August 2007.		Recommended Guidance: Expert Opinion
3. 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

IV. Recommended Minimum Plan Benefits: Therapeutic Services / Ancillary Services

F. OCCUPATIONAL, PHYSICAL, AND SPEECH THERAPY SERVICES

Definition of Benefit		Covered Providers	
<p>Occupational Therapy Services: Medical services designed to:</p> <ul style="list-style-type: none"> • Assist people regain performance skills lost through injury or illness¹ • Develop skills inhibited by a problem present at birth or a developmental delay.² <p>Individualized programs are designed to improve quality of life by recovering or developing competence, maximizing independence, and preventing injury or disability, so that a person can cope with school, work, home, and social life.¹</p> <p>Physical Therapy Services: Medical services designed to relieve symptoms, improve function, and prevent further disability for individuals disabled by chronic or acute disease or injury. Physical therapy services may also be used to help people develop skills inhibited by a problem present at birth or a developmental delay.² Treatment may include various forms of heat and cold, electrical stimulation, therapeutic exercises, ambulation training, and training in functional activities.³</p> <p>Services for Speech, Hearing and Language Disorders: Medical services for beneficiaries with speech, hearing, and language disorders. Services may also be used to help people develop skills inhibited by a problem present at birth or a developmental delay.¹ Services may be diagnostic, rehabilitative, or corrective in nature.⁴</p>		<p>Covered services must be furnished by or under the supervision of a primary care provider (family physician, general practitioner, internal medicine physician, nurse practitioner, pediatrician), licensed occupational therapist, physical therapist, speech pathologist, or speech therapist.</p>	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
Combined total of 75 visits per calendar year. Requires pre-certification and/or referral. ⁵	Include provisions for children with complex case-management needs (e.g., flex benefits). Consider extending benefit for multiple providers.	All medically necessary care. Medical necessity supported by the Plan Benefit Model definition.	<ul style="list-style-type: none"> • Recreational or educational therapy.⁵ • Exercise programs/ hippotherapy (exercise on horseback).⁵
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
Per visit copayment or per visit coinsurance based on negotiated rate.	2 / 15%	Copayment and coinsurance amounts apply toward maximum.	
Actuarial Impact ⁶	Cost of Recommended Benefits (PMPM)	Cost Impact	
	\$ 0.92 (HMO) \$ 1.35 (PPO)	<p>The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral). The PPO Benchmark Model includes a deductible and 20% member coinsurance. Eliminating the deductible, decreasing the member coinsurance to 15%, and increasing the annual visit limit from 60 visits to 75 visits will increase the employer's cost by:</p> <ul style="list-style-type: none"> • \$0.23 PMPM / 0.1% of total plan costs (PPO) 	

IV. Recommended Minimum Plan Benefits: Therapeutic Services / Ancillary Services

F. OCCUPATIONAL, PHYSICAL, AND SPEECH THERAPY SERVICES *continued*

Citations		
1. Aetna Medical Definition	Aetna. <i>Clinical Policy Bulletin</i> . Available at: http://www.aetna.com/cpb/medical/data/200_299/0250.html . Accessed on April 3, 2006.	Industry Standard
2. Maternal and Family Health Benefits Advisory Board	Maternal and Family Health Benefits Advisory Board. Washington, DC: National Business Group on Health; August 2007.	Recommended Guidance: Expert Opinion
3. Aetna Medical Definition	Aetna. <i>Clinical Policy Bulletin</i> . Available at: http://www.aetna.com/cpb/medical/data/300_399/0325.html . Accessed on April 1, 2007.	Industry Standard
4. Kaiser Family Foundation	The Henry J. Kaiser Foundation. <i>Medicaid Benefits: Online Database, Benefits by Service, Definition / Notes (October, 2004)</i> . Available at: http://www.kff.org/medicaid/benefits/sv_foot.jsp#14 . Accessed on January 11, 2007.	Industry Standard
5. Federal Employees Health Benefits Program	Blue Cross Blue Shield. <i>Federal Employee Program Service Benefit Plan., 2006 Benefits. Section 5(a): Medical Services and Supplies Provided by Physicians and Other Health Care Professionals</i> . Available at: http://www.fepblue.org/benefits/benefits06/benifsbpsection5a-06.html#top . Accessed on September 16, 2006.	Federally Vetted
6. 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

IV. Recommended Minimum Plan Benefits: Therapeutic Services / Ancillary Services

G. INFERTILITY SERVICES

Definition of Benefit		Covered Providers	
Medical services designed to diagnose and address infertility.		Covered services must be furnished by or under the direction of a primary care provider (family physician, general practitioner, internal medicine physician, nurse practitioner) or qualified physician specialist (e.g., OB-GYN, fertility specialist).	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
Medications are subject to formulary requirements.	N/A	<p>Covered services include¹:</p> <ul style="list-style-type: none"> • Medically appropriate laboratory examinations and tests; counseling services and patient education. • Examination and treatment. • Testing for diagnosis and surgical treatment of the underlying cause of infertility. • Fertility drugs (oral and injectable). • Artificial insemination (intravaginal insemination [IVI], intracervical insemination [ICI], intrauterine insemination [IUI]). 	<p>Excluded services¹:</p> <ul style="list-style-type: none"> • Assisted reproductive technology (ART) procedures, such as: in vitro fertilization, embryo transfer including, but not limited to, gamete GIFT and zygote ZIFT; and ovulation induction. • Services and supplies related to the aforementioned services. • Reversal of voluntary, surgically-induced sterility. • Treatment for infertility when the cause of the infertility was a previous sterilization with or without surgical reversal. • Infertility treatment of any type when the FSH level is 19 mIU/ml or greater on day 3 of a menstrual cycle. • Sperm processing. • Purchasing, freezing, and storing of donor sperm or donor eggs. • All others as defined by the health plan.
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
Per visit/unit copayment. Per visit/unit coinsurance based on negotiated rate. Cost-sharing for artificial insemination determined per cycle.	5 / 25%+	Does not apply.	
Actuarial Impact ²	Cost of Recommended Benefits (PMPM)	Cost Impact	
	\$ 5.82 (HMO) \$ 5.94 (PPO)	The PPO/HMO Benchmark model is consistent with the Plan Benefit Model (cost neutral).	
Citations			
1. Federal Employee Health Benefit Plan	U.S. Office of Personnel Management, Federal Employees Health Benefits Program. <i>Sample plan characteristics (Aetna: Individual practice plan with a consumer driven health plan option and a high deductible health plan option)</i> . Available at: https://www.opm.gov/insure/07/brochures/pdf/73-828.pdf . Accessed on January 17, 2007.		Federally Vetted
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

IV. Recommended Minimum Plan Benefits: Therapeutic Services / Ancillary Services			
H. HOME HEALTH SERVICES			
Definition of Benefit		Covered Providers	
Medical services that are provided to a beneficiary at his/her place of residence upon physician order as part of a written plan of care.		Covered providers include registered nurses and credentialed home health aides employed by a home health agency. In addition, plans may choose to have home health agencies provide, when medically necessary and ordered by the beneficiary's physician: nutritional services, physical therapy, and occupational therapy services; and speech pathology/audiology services. Alternatively, the plan may allow a home health agency to arrange for therapy services to be provided by professionals at a medical rehabilitation facility. ¹	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
No limit. Requires pre-certification and/or referral.	N/A	<p>All medically necessary care. Medical necessity supported by the Plan Benefit Model definition. Coverage also includes^{1,2}:</p> <ul style="list-style-type: none"> • Respite care including respite inpatient stays when there are no available qualified home health professionals within the geographic area. • Hospice and palliative care services. • Early intervention services as prescribed by a physician. • Medical daycare. • Oxygen therapy. • Intravenous therapy. • Medications. • Nutritional services.³ 	<p>The following services are excluded²:</p> <ul style="list-style-type: none"> • Nursing care requested by, or for the convenience of, the beneficiary or the beneficiary's family. • Transportation. • Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative. • Services provided by a family member or resident in the beneficiary's home. • Services rendered at any site other than the beneficiary's home.
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
Per visit copayment. Per visit coinsurance based on negotiated rate.	1 / 10%	Copayment and coinsurance amounts apply toward maximum.	
Actuarial Impact ⁴	Cost of Recommended Benefits (PMPM)	Cost Impact	
	<p>\$ 1.02 (HMO) \$ 0.91 (PPO)</p>	The HMO Benchmark Model is consistent with the Plan Benefit Model (cost neutral). The PPO Benchmark Model includes 20% member coinsurance. Reducing the member coinsurance to 10% will result in a negligible increase to the employer's cost (cost neutral).	

IV. Recommended Minimum Plan Benefits: Therapeutic Services / Ancillary Services

H. HOME HEALTH SERVICES *continued*

Citations

1. Committee on Child Health Financing, American Academy of Pediatrics	Committee on Child Health Financing, Section on Home Care; American Academy of Pediatrics. Financing of pediatric home health care. <i>Pediatrics</i> . 2006; 118(2): 834-838.	Recommended Guidance: Expert Opinion
2. Federal Employee Health Benefit Plan	U.S. Office of Personnel Management, Federal Employees Health Benefits Program. <i>Sample plan characteristics (Aetna: Individual practice plan with a consumer driven health plan option and a high deductible health plan option)</i> . Available at: https://www.opm.gov/insure/07/brochures/pdf/73-828.pdf . Accessed on January 17, 2007.	Federally Vetted
3. American Dietetic Association	American Dietetic Association. Adapted from: Joint Commission on Accreditation of Healthcare Organizations. <i>2007 Standards for Ambulatory Care</i> . 2007:361-362.	Recommended Guidance: Professional Guideline
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; July 2007.	Actuarial Analysis

IV. Recommended Minimum Plan Benefits: Therapeutic Services / Ancillary Services			
I. HOSPICE CARE			
Definition of Benefit		Covered Providers	
Medical and social services designed to support and care for persons in the last phase of an incurable illness so that they may live as fully and comfortably as possible. ¹		Covered services must be furnished by or under the direction of a licensed and/or accredited hospice.	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
8 months of coverage for beneficiaries with terminal illnesses. ²	Additional periods are available as prescribed / authorized.	<p>All medically necessary care. Medical necessity supported by the Plan Benefit Model definition. Covered services also include²:</p> <ul style="list-style-type: none"> • Routine home care, continuous home care, inpatient respite care, and general inpatient care. • Prescribed physician visits. • Nursing care. • Services of home health aides. • Medical social services. • Physical therapy. • Medical appliances and supplies including durable medical equipment rental. • Prescription drugs. • Bereavement services. 	All others as defined by the health plan.
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
One-time copayment	Recommended copayment for both HMO or PPO plan types: 5	Copayment applies toward maximum.	
Actuarial Impact ³	Cost of Recommended Benefits (PMPM)	Cost Impact	
	\$ 0.08 (HMO) \$ 0.08 (PPO)	The HMO/PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	
Citations			
1. National Hospice and Palliative Care Organization Definition of Hospice	von Gunten CF, Ferris FD, Portenoy RK, Glajchen M. <i>CAPC Manual: How to Establish a Palliative Care Program</i> . New York, NY: Center to Advance Palliative Care, 2001. Available at: http://64.85.16.230/educate/content/elements/nhpcdefinition.html . Accessed January 1, 2007.	Recommended Guidance: Expert Opinion	
2. Hospice Foundation of America	Hospice Foundation of America. <i>Hospice Services and Expenses</i> . Available at: http://www.hospicefoundation.org/hospiceinfo/services.asp . Accessed on January 1, 2007.	Recommended Guidance: Expert Opinion	
3. 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	

IV. Recommended Minimum Plan Benefits: Therapeutic Services / Ancillary Services

J. DURABLE MEDICAL EQUIPMENT (DME), SUPPLIES, & MEDICAL FOODS

Definition of Benefit	Covered Providers
<p>Durable medical equipment (DME) and supplies are necessary medical products suitable for use in the home. DME must be¹:</p> <ol style="list-style-type: none"> 1. Prescribed by an attending physician; 2. Considered medically necessary; 3. Primarily and customarily used only for a medical purpose; 4. Designed for prolonged use; and 5. Intended for a specific therapeutic purpose. <p>Medical foods are foods used to prevent, treat, or manage a medical condition that requires the addition or restriction of a specific dietary component to address:</p> <ul style="list-style-type: none"> • A physical, physiologic, or pathologic condition resulting in inadequate nutrition.² • An inherited metabolic disorder (does not include common hypercholesterolemia).² • A condition resulting in impairment of oral intake that affects normal development and growth.² • A condition, such as prematurity, illness, allergy, or separation that does not allow an infant to be breastfed or fed with its own mother's breast milk.³ 	<p style="text-align: center;">N/A</p>

(continues on page 72)

IV. Recommended Minimum Plan Benefits: Therapeutic Services / Ancillary Services

J. DURABLE MEDICAL EQUIPMENT (DME), SUPPLIES, & MEDICAL FOODS *continued*

Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
<p>A. Covers the rental or purchase (at the plan's option) and the repair and adjustment of durable medical equipment.</p> <p>B. Covers food and formula for special dietary use of accepted medical benefit to cover nutritional support costs over and above usual foods.</p> <p>C. Covers banked human milk, including processing and shipping fees.</p>	<p>Include provisions for children with complex case-management needs (e.g., flex benefits).</p>	<p>All medically necessary equipment. Medical necessity supported by the Plan Benefit Model definition.</p> <p>Covered items include¹:</p> <ol style="list-style-type: none"> 1. Home dialysis equipment. 2. Oxygen equipment. 3. Hospital beds. 4. Wheelchairs, braces, crutches, and walkers. 5. Continuous passive motion (CPM) and dynamic orthotic cranioplasty (DOC) devices. 6. High-quality breast pumps for assistance with breastfeeding. Limit one per lifetime.⁴ <p>Covered devices include⁵:</p> <ol style="list-style-type: none"> 1. Hearing aids, ALDs, and cochlear implants with accessories. Limit: \$2,000 for a hearing aid or ALD allowance per ear every 2 years; replacement earmolds covered in full up to four times per year for children 7 years of age or under; \$2,000 cochlear implant speech processor allowance every 5 years; an ALD for use specifically with a cochlear implant covered in full once every 5 years. <p>Covered medical foods include:</p> <ol style="list-style-type: none"> 1. Foods for supplying particular dietary needs that exist by reason of a physical, physiologic, pathologic, or other condition.² 2. Foods for supplying particular dietary needs which exist by reason of age.² 3. Foods for supplementing or fortifying the ordinary or usual diet with medically necessary vitamins, minerals, or other dietary properties.² 4. Coverage for all medical equipment and medical supplies necessary for the delivery of foods for special dietary use, including, but not limited to, administration tubing, bags, and pumps.² 5. Banked donor human milk and requisite supplies: \$2,500 limit per infant.³ 	<p>Excluded items¹:</p> <ol style="list-style-type: none"> 1. Exercise equipment. 2. Lifts (e.g., seat, chair, or van lifts). 3. Car seats. 4. Air conditioners, humidifiers, dehumidifiers and purifiers. 5. Equipment for cosmetic purposes. 6. Topical Hyperbaric Oxygen Therapy (THBO). 7. Computer equipment, devices, and aids (including computer equipment) such as story boards or other communication aids. 8. All others as defined by the plan.

IV. Recommended Minimum Plan Benefits: Therapeutic Services / Ancillary Services

J. DURABLE MEDICAL EQUIPMENT (DME), SUPPLIES, & MEDICAL FOODS *continued*

Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum
<p>Per unit coinsurance.</p> <p>Annual limit: \$25,000 per person.</p> <p><i>Please refer to "Inclusions" list for line-item amounts.</i></p>	<p>Recommended coinsurance for both HMO or PPO plan types: 10%</p>	<p>Coinsurance applies toward maximum.</p>
Actuarial Impact ⁶	Cost of Recommended Benefits (PMPM)	Cost Impact
	<p>DME:</p> <p>\$ 2.49 (HMO)</p> <p>\$ 2.27 (PPO)</p> <p>Medical foods:</p> <p>\$ 0.09 (HMO)</p> <p>\$ 0.11 (PPO)</p>	<p>DME: The HMO/PPO Benchmark Model excludes coverage for hearing aids. Adding coverage for hearing aids will increase the employer's plan cost by:</p> <ul style="list-style-type: none"> • \$0.56 PMPM / 0.02% of total plan costs (HMO) • \$0.55 PMPM / 0.02% of total plan costs (HMO) <p>Medical foods: The HMO/PPO 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).</p>
Citations		
<p>1. Federal Employees Health Benefits Program</p>	<p>Blue Cross Blue Shield. <i>Federal Employee Program Service Benefit Plan, 2006 Benefits. Section 5(a): Medical Services and Supplies Provided by Physicians and Other Health Care Professionals.</i> Available at: http://www.fepblue.org/benefits/benefits06/benfitsbpbsection5a-06.html#top. Accessed on September 12, 2006.</p>	<p>Federally Vetted</p>
<p>2. American Academy of Pediatrics</p>	<p>Committee on Nutrition; American Academy of Pediatrics. Reimbursement for foods for special dietary use. Policy Statement. <i>Pediatrics.</i> 2003; 111(5): 1117-1119.</p>	<p>Recommended Guidance: Expert Opinion</p>
<p>3. United States Breastfeeding Committee</p>	<p>Association of Women's Health, Obstetric and Neonatal Nurses. <i>United States Breastfeeding Committee Recommendations.</i> Available at: http://www.usbreastfeeding.org/breastfeeding/index.htm. Accessed on February 1, 2007.</p>	<p>Recommended Guidance: Expert Opinion</p>
<p>4. American Academy of Pediatrics</p>	<p>Section on Breastfeeding. Breastfeeding and the use of human milk. <i>Pediatrics.</i> 2005;115(2):496-506.</p>	<p>Recommended Guidance: Expert Opinion</p>
<p>5. American Speech-Language-Hearing Association</p>	<p>American Speech-Language-Hearing Association. <i>Model Health Care Benefits, Ideal Health Plan Coverages for Audiology and Speech-Language Pathology Services.</i> Available at: http://www.asha.org/public/add-benefits/model-benefits.htm#speech and http://www.asha.org/public/add-benefits/providers.htm. Accessed on July 12, 2007.</p>	<p>Recommended Guidance</p>
<p>6. PricewaterhouseCoopers</p>	<p>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.</p>	<p>Actuarial Analysis</p>

IV. Recommended Minimum Plan Benefits: Therapeutic Services / Ancillary Services			
K. TRANSPORTATION SERVICES			
Definition of Benefit		Covered Providers	
Transportation by ground ambulance or emergency medical service to the nearest hospital for emergency treatment.		N/A	
Recommended Benefit Coverage Limits	Recommended Exceptions	Inclusions	Exclusions
Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat the condition. May require prior approval for lengthy trips. ¹	N/A	Transportation for ground, air, or watercraft when medically appropriate, and when 1) associated with covered hospital inpatient care, 2) related to a medical emergency, or 3) associated with covered hospice care. ¹	<ul style="list-style-type: none"> Ambulance transportation to receive non-emergent outpatient or inpatient services. "Ambulette" / "cabulance" service. Air ambulance without prior approval.
Recommended Cost-Sharing	Copayment / Coinsurance Level (0-5 / 0-25%)	Out-of-Pocket Maximum	
Per unit copayment. Per unit coinsurance based on negotiated rate.	2 / 15% (emergency); 5 / 25%+ (non-emergency)	Copayment and coinsurance amounts apply toward maximum.	
Actuarial Impact ²	Cost of Recommended Benefits (PMPM)	Cost Impact	
	\$ 0.61 (HMO) \$ 0.45 (PPO)	The HMO/PPO Benchmark Model is consistent with the Plan Benefit Model (cost neutral).	
Citations			
1. Kaiser Family Foundation	The Henry J. Kaiser Foundation. <i>Medicaid Benefits: Online Database, Benefits by Service, Definition / Notes (October, 2004)</i> . Available at: http://www.kff.org/medicaid/benefits/sv_foot.jsp#14 . Accessed on January 1, 2007.		Industry Standard
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