OLIVER WYMAN

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ANALYSIS OF MISSOURI'S BENEFIT BENCHMARK PLAN OPTIONS

MISSOURI DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS, AND PROFESSIONAL REGISTRATION

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Introduction

The Missouri Department of Insurance, Financial Institutions, and Professional Registration (the Department or "DIFP") engaged Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) to estimate the relative value of ten plans currently in the health insurance market that could be selected as the benchmark plan for determining the Essential Health Benefits (EHBs) for Missouri. This report was prepared for the sole use of the Department for the purpose of informing the selection of the benchmark plan. All decisions in connection with the implementation or use of analysis contained in this report are the sole responsibility of the Department. This report is intended to be read and used as a whole and not in parts.

This report is not intended to provide a recommendation to the Missouri DIFP or other regulatory or executive entities regarding whether Missouri should, or should not, select a benchmark plan for the State or rely on the default benchmark selection process. Furthermore, this report is not intended to convey a recommendation as to which plan Missouri should select if the State defines a benchmark option.

Oliver Wyman's consent to any distribution of this report (whether herein or in the written agreement pursuant to which this report has been issued) to parties other than the Department does not constitute advice by Oliver Wyman to any such third parties and shall be solely for informational purposes and not for purposes of reliance by any such third parties. Oliver Wyman assumes no liability related to third party use of this report or any actions taken or decisions made as a consequence of the results, advice or recommendations set forth herein. This report should not replace the due diligence on behalf of any such third party.

For our analysis, we relied on data and information provided by the Department without independent audit. Though we have reviewed the data for reasonableness and consistency, we have not audited or otherwise verified this data. However, detailed summaries were provided to the insurance carriers to confirm our understanding of the benefits covered by each plan. It also should be noted that our review of data may not always reveal imperfections to the data. We have assumed that the data provided is both accurate and complete. The results of our analysis are dependent on this assumption. If this data or information is inaccurate or incomplete, our findings and conclusions may need to be revised.

TABLE OF CONTENTS

1. Executive Summary 1
   - Key Findings 3

2. Background 4

3. Methodology 7
   - Identification of Benchmark Options 7
   - Initial Comparison of Current Benefits 8
   - Categorized and Supplemented Benefits 8
   - Missouri Mandated Benefit Comparison 11
   - Analysis for Benchmark Selection 12

4. Results of Pricing Analysis 13
   - Relative Value of Benchmark Plan Options 13
   - Benefits Causing the Difference in Plan Values 14
   - Key Findings 15

5. Comparison of Current Benefits 18

6. Comparison of Supplemented Plans 27

7. Comparison of Outlier Benefits 29

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1

Executive Summary

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act (ACA) requires all non-grandfathered health insurance plans offered in the small group and individual markets to cover all Essential Health Benefits (EHBs) beginning on January 1, 2014.[1,2] The ACA defines EHBs to include ten broad categories of health benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. The ACA charges the Secretary of the U.S. Department of Health and Human Services (HHS) with further defining the EHBs, and instructs the Secretary to ensure that they are equal to the scope of benefits provided under a typical employer plan.

In guidance issued in December 2011, HHS gave states the option to define EHBs at the state level for 2014 and 2015. Under this process, states may choose a "benchmark" plan from a list of federally designated options. Final rules were released in July 2012 regarding the data collection standards necessary to support HHS's determination of the definition of essential health benefits. As part of this final rule, HHS provided some clarification of the benchmark plans. Specifically, HHS defines the plan as a unique combination of benefits that may include both optional and mandatory riders. In Missouri the benchmark options available are shown in the following table.

Category of Eligible Plan	Missouri Plan Options
State Employee Health Plans	• Missouri Consolidated Health Care Plan • University of Missouri Choice Health Program • Missouri Department of Transportation Health Plan

[1] ACA Section 2707(a); ACA Section 1302(a)

[2] Applies both in and out of the Exchange. Self-insured employer plans, grandfathered plans and large group health plans are not required to offer EHBs. However, if they do provide any benefits that are EHBs, the ACA prohibits them from applying any annual or a lifetime limit to those benefits. Additionally, these plans must phase out annual dollar limits for any EHB by 2014, with the exception of grandfathered individual health plans.

Category of Eligible Plan	Missouri Plan Options
FEHBP Plans	• FEHBP Option 1: BCBS Standard Option • FEHBP Option 2: BCBS Basic Option • FEHPB Option 3: GEHABP Standard Option
Small Group Insurance Plans	• Small Group Option 1: Anthem Blue Access Choice PPO • Small Group Option 2: United HealthCare Choice Plus POS • Small Group Option 3: BCBS of Kansas City Preferred Care Blue PPO
Largest Non-Medicaid HMO Plan	• Blue Care HMO

In designating a benchmark plan, the state is choosing the entire benchmark plan's benefit package. If a benchmark plan does not contain all ten categories of benefits identified in the ACA, the state must supplement the benchmark by selecting the missing benefits from one or more of the other benchmark options for that state. However, there are special rules that apply for supplementing service categories, such as habilitiative care, pediatric oral care and pediatric vision when they are not covered by any of the benchmark options.

States may still mandate that specific benefits be covered in the individual and small group markets. However, if the designated benchmark plan does not include one or more services that state law mandates small group and/or individual plans to cover, the ACA requires states to pay for the costs of those mandated services. It is unclear whether this includes Qualified Health Plan (QHP) enrollees outside of the Exchange, and the HHS has not provided final guidance on this issue. Additionally, because the EHBs are based on the benchmark plan's benefits in effect during the first quarter of 2012, the state's EHB package will be unaffected by any changes to state mandated benefits effective after the first quarter of 2012.

Key Findings

This report will inform the selection of the benchmark plan as follows:

1. All of the benchmark plan options will need to be supplemented to provide coverage for habilitative services,[3] pediatric vision and oral services. This will increase premiums in the individual and small group markets regardless of the plan selected as the benchmark plan.

2. The estimated values of all ten benchmark plan options are within a relatively small range of roughly two percentage points. The Missouri Consolidated Health plan and the FEHBP Basic Option plan are estimated to have higher costs than the remaining benchmark plan options. This is the result of a richer vision coverage and bariatric surgery in the Missouri Consolidated Health plan and a comprehensive dental benefit included in the FEHBP Basic Option package.

3. The three State employee plan options and the three FEHBP plan options do not include all of the state mandated benefits to the extent mandated. If any of these options are selected as the benchmark plan, Missouri would be required to pay the cost of the additional mandated benefits for enrollees in Qualified Health Plans; however, it is unclear whether this includes QHP enrollees outside of the Exchange. The estimated cost of the mandated benefits not covered by FEHBP plans range from $5.00 to $5.20 PMPM. The State employee plan options do not provide the state mandated coverage for “First Steps” which is estimated to cost less than $0.70 PMPM.

[3] It should be noted that the largest small group plan, Anthem Blue Access Choice PPO, covers habilitative services in a manner similar to our definition employed. However, since habilitative services are required EHBs all plans are required to provide this coverage. As such, these services have been added to the other plans and this has no impact on the results of our analysis.

2

Background

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act (ACA), requires significant changes in how health insurance is purchased, sold and regulated in the states. Among other things, the ACA creates new standards for health benefit plans offered to individuals and small groups, including requirements that all such plans offer a comprehensive package of Essential Health Benefits (EHBs).

Beginning on January 1, 2014, the ACA requires all non-grandfathered plans offered in the small group and individual markets to cover all EHBs both inside and outside of an Exchange.[4]

The ACA defines EHBs to include ten broad categories of health benefits.[5] These are:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services, including oral and vision care.

The ACA charges the Secretary of HHS with further defining the EHBs, and instructs the Secretary to ensure that they are equal to the scope of benefits provided under a typical employer plan.

EHBs define a standard set of services that must be covered by applicable plans without regard to cost sharing. While EHBs may include limits on the duration and scope of covered services, they may not include annual or lifetime dollar limits and must not be discriminatory. The ACA separately regulates cost sharing requirements, including limits on cost sharing and mandates regarding levels of coverage. EHBs are the full package of covered benefits to which insurers

[4] ACA Section 2707(a); ACA Section 1302(a)

[5] ACA Section 1302(b)(1)(A-J)

will apply cost sharing requirements, resulting in levels of coverage (bronze/ silver/ gold/ platinum) and their accordant actuarial values[6] (60/70/80/90) outlined in the ACA.

States may still mandate that specific benefits be covered in the individual and small group markets. However, if the designated benchmark plan does not include one or more services that state law mandates small group and/or individual plans to cover, the ACA requires states to pay for the costs of those mandated benefits. It is unclear whether this includes Qualified Health Plan (QHP) enrollees outside of the Exchange, and the HHS has not provided final guidance on this issue.

On December 16, 2011, HHS issued an EHB Bulletin, outlining an approach for defining EHB packages in plan years 2014 and 2015, and taking into account the need to “balance comprehensiveness, affordability, and state flexibility and to reflect public input received to date.”[7] The Bulletin notes that HHS “intends to assess the benchmark process for the year 2016 and beyond based on evaluation and feedback.”

In the approach outlined for 2014 and 2015, HHS allows each state the flexibility to designate a benchmark plan to serve as the state’s EHB. States have a choice from among the following ten possible benchmark plans:

- The largest plan in any of the three largest small group products in the state by enrollment;
- The three largest state employee health plans by enrollment;
- The three largest FEHBP options by enrollment; or
- The largest HMO plan offered in the state’s commercial market by enrollment.

If a benchmark plan does not contain all ten categories of benefits identified in the ACA, the state must supplement the benchmark by selecting the missing benefits from one or more of the other benchmark options for that state. Certain categories, such as habilitative care, may not be provided in any benchmark option. In those instances, HHS has outlined special rules for supplementing the benefits.

Figure 2.1 - Process for EHB Analysis

[6] Actuarial value is a measure of the percentage of expected health care costs a health plan will cover.

[7] http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

On July 20, 2012, HHS released the final rule on EHB data collection. The rule provides further guidance on the selection of the benchmark plans to be analyzed in the determination of the EHB. HHS uses the definition of a "portal plan" as the basis for the determination of a health plan. A portal plan is a unique combination of benefits that may include optional benefits, such as riders, and benefits that are legally considered riders but not optional for consumers. It is important to understand, the benchmark plans options are defined to include all riders with the largest enrollment and would be defined as an EHB.

If a state does not select a benchmark plan, HHS will designate the small group plan with the largest enrollment as the benchmark, referred to in this report as the "default benchmark plan." Supplemental benefits for the default benchmark plan will be determined by a process dictated by federal guidance that looks first to the second-largest small group market benchmark plan, then to the third and then, if none of the small group plans offer benefits in a missing category, to the FEHBP benchmark plan with the highest enrollment.

3

Methodology

Identification of Benchmark Options

Federal guidance provides Missouri the option to select one of ten plans as a benchmark plan for 2014 and 2015. The Department identified the ten benchmark options and provided this information to Oliver Wyman, which is shown in Figure 3.1 below.

Figure 3.1 – Benchmark Plan Options

Plans Eligible for Benchmark Status	Missouri Plans	State Enrollment
State Employee Health Plans	• Missouri Consolidated Health CarePlan • University of Missouri Choice Health Care Program • Missouri Department of Transportation Health Plan	97,670 37,579 13,355
Federal Employee Health Benefit Plans (FEHBP)	• BCBS Standard Option • BCBS Basic Option • GEHABP Standard Option	N/A N/A N/A
Small Group Insurance Plans	• Option 1: Anthem Blue Access Choice PPO • Option 2: United HealthCare Choice Plus POS • Option 3: BCBS of Kansas City Preferred Care Blue PPO	89,477 51,462 27,390
Largest HMO Plan	• Blue Care HMO	5,780

At this time, the Department did not identify any riders that should be included in the analysis based on the most recent rules released by HHS. It should be noted that the benchmark plan is defined to include riders with the most significant membership. The results of this analysis could be impacted if any riders should have been included in the benchmark options.

Initial Comparison of Current Benefits

The Department provided a detailed matrix summarizing and comparing the benefits of the seven plans specific to Missouri. As part of the analysis, the Department shared the summarized benefits of the four benchmark plan options that are specific to Missouri with the insurers, but the State employee plans and FEHBP plans were not reviewed by the plan administrator. The insurers provided feedback on the initial analysis and adjustments were made where needed.

Oliver Wyman reviewed the benefit comparison provided by the Department. When potential discrepancies were observed during the course of the analysis, these were discussed with the Department and, in certain circumstances modifications were made to the benefit comparison.

Benefit booklets for each of the potential benchmark plan options were provided to Oliver Wyman.[8] When we had clarifying questions about the benefits, we reviewed the language in the benefit booklets for additional clarification. The language used in the benefit booklets is not standardized across insurers and, in certain circumstances, is open to interpretation. Thus, the comparison occasionally required interpretation based on our experience of industry practices, particularly in instances where benefits were not specifically listed in the booklets as either a covered or excluded benefit.

Because the guidance provided by HHS indicates that the benchmark plan will reflect both the benefits that are covered as well as any limits on duration or scope of those benefits, the comparison analysis included any applicable limits. While annual or lifetime dollar limits are not permitted for EHBs under the ACA, it was assumed that the actuarial equivalent of such limitations would apply. Restrictions on provider networks and formularies were not considered since these are not part of the EHB definition.

A final summary of the comparison of current benefits is included in Appendix A.

Categorized and Supplemented Benefits

The benefits grid was then examined to determine whether all of the services described in the ten broad EHB categories were covered in the benchmark plan options. As anticipated, all of the plans contain most of the services required. However, as the HHS EHB Bulletin anticipates, most plans do not cover habilitative services or pediatric oral and vision services.

The ACA requires that certain prescribed benefits be included as part of the EHB package for all plans. Therefore, in developing a set of benefits that would represent the EHB package, each plan was supplemented to ensure it contained the following:

- Women's wellness benefits;[9]

[8] A benefit booklet was not available for the Missouri Consolidated Health Plan. However, the state agency provided verification of the benefit summary grid.

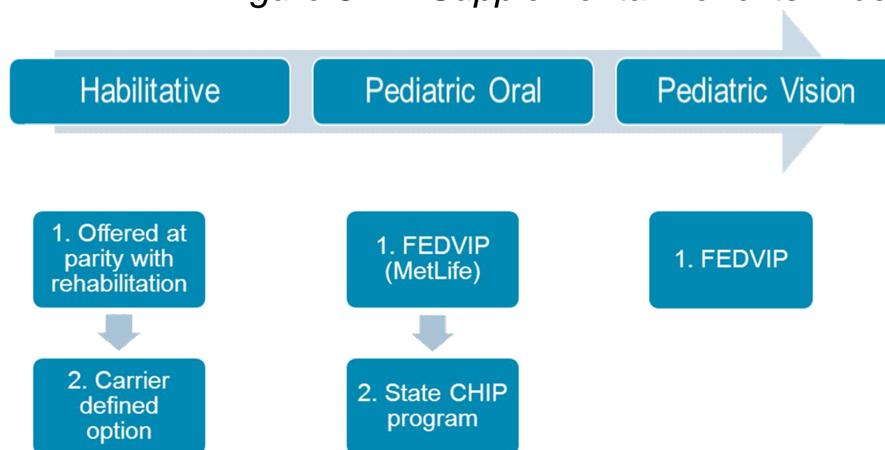
[9] As required under the ACA §1302(b)(1)(I) as further defined in 45 CFR Part 147.130 (a)(1)(iv)

- A and B recommendations from the U.S. Preventive Services Task Force (USPSTF);[10]
- Benefits included in the Bright Futures/American Academy of Pediatrics guidelines,[11] habilitative services,[12] and pediatric oral and vision services; and[13]
- Parity requirements in The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)[14]

Detailed regulations have not been promulgated by HHS specifying final rules for supplementing benefits. Additionally, the EHB bulletin is not detailed enough to know with certainty how benefits must be supplemented. For this analysis, it was assumed that MHPAEA parity requirements will not permit limits to be applied to non-biologically based mental illnesses. In general, such limits are common in the benchmark plan options however most of the benchmark plans offered in Missouri provide mental health benefits at full parity.

HHS guidance provides various options to states when supplementing benchmark options for habilitative and pediatric oral and vision services. Figure 3.2 shows the general process outlined by HHS for the determination of supplemental benefits in the EHBs.

Figure 3.2 – Supplemental Benefits Procedures



[10] As required under the ACA §1302(b)(1)(I) as further defined in 45 CFR Part 147.130 (a)(1)(i)

[11] As required by the ACA §1302(b)(1)(I) as further defined in 45 CFR Part 147.130 (a)(1)(iii)

[12] As required by the ACA §1302(b)(1)(G)

[13] As required by the ACA §1302(b)(1)(J)

[14] As indicated in the December 16, 2011 EHB Bulletin, http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

For this analysis, it was assumed that habilitative services would be offered at parity with rehabilitative services, and that the definition of these services would be consistent with the definitions currently used in the commercial market. Specifically, these definitions focus on creating skills and functions, rather than “keeping” or “maintaining” function. It should be noted that one of the products in the small group market, the Anthem PPO plan uses a definition consistent with our assumption and does not distinguish between habilitative and rehabilitative services. In other words, both would be covered but subject to the rehabilitative limits within the contract.

In supplementing benchmark plans for pediatric oral services, this analysis used the estimated costs that are equivalent to the state Child Health Insurance Program (CHIP) program, as published by the National Association of Dental Plans (NADP). The CHIP plan includes preventive and basic dental services as well as advanced dental services. The analysis used the CHIP plan that does not include orthodontia.

Plans that do not contain pediatric vision services must be supplemented with benefits covered by the Federal Employees Dental and Vision Insurance Program (FEDVIP) vision plan with the largest enrollment. HHS guidance indicates that the FEDVIP vision plan with the highest enrollment in 2010 covers routine eye exams with refraction, corrective lenses and contact lenses. Further, the 2012 FEDVIP vision plans include both service and dollar limits in its coverage. As an example, the FEDVIP BlueVision plan covers one set of contact lenses per year, up to $130. This combination of both a limit on the frequency with which vision hardware may be replaced, and a dollar limit on the cost of the hardware, could be considered to effectively create an overall annual dollar limit on the vision hardware benefit that is prohibited by the ACA. For this analysis, an assumption was made that a scheduled dollar allowance per set of vision hardware will be allowed to remain, however restrictions on the frequency with which the hardware may be replaced are lifted. The resulting benefit becomes a benefit with a scheduled allowance per service. It is important to note that a scheduled dollar allowance per service with no limitation on the number of services differs from the prohibition on annual dollar limits.

This benchmark option comparison analysis is not impacted by which option is used for supplementing the benchmark package to include coverage for required habilitative services and pediatric oral and vision coverage. Since any plan selected as the benchmark would be required to cover these benefits, the additional cost added to each plan is the same.

For the purposes of this analysis, each of the plans was supplemented, resulting in a complete set of benefits that would be required should the plan be selected as the state’s benchmark plan and assuming that state mandated benefits continue to be required to be covered.

Missouri Mandated Benefit Comparison

Missouri law requires certain benefits to be covered by each individual or small group plan offered in the State. Appendix B contains a comparison of the State mandated benefits currently covered by each of the benchmark plan options. The list of mandated benefits was provided by the Department and was limited to mandates on covered services, as opposed to requirements related to administration of the plan.

For the purposes of this analysis, each of the benchmark plan options were supplemented, resulting in a complete set of benefits that would be required to be covered in the EHB. The three small group benchmark plan options and the HMO benchmark plan option were found to cover every State mandated service. However, the State employee plans and the FEHBP plans appear to be missing some of the Missouri state mandates, as shown in Appendix B. Therefore, if the State selected one of the State employee plans or one of the FEHBP plans as its benchmark plan, some of the State mandated benefits would not be included in the EHB and the State would be required to cover the cost of these services for anyone enrolled in a QHP. For example, the FEHBP plans do not cover services associated with autism. If one of the FEHBP plans are chosen, the State would be responsible for covering the cost of autism benefits, as required by the mandate, for those individuals enrolled in a QHP.

The State would be required to cover the cost of these mandated benefits if one of the State employee or FEHBP plans were selected as the benchmark plan. For the FEHBP plans, Oliver Wyman estimates this could cost the State between $5.00 and $5.20 per member per month for each individual enrolled in a QHP.

Other Considerations with Mandated Benefits

It is our understanding based on the requirements of ACA, benefits that are defined as an EHB will not be allowed to have annual or lifetime dollar maximums. As such, the current Missouri mandated benefit for autism and applied behavioral analysis services may not meet the requirements of the ACA since it contains a $40,000 annual limit. In addition, it is our understanding that Missouri law further requires that other limits such as the number of services are not allowed for autism benefits. A potential resolution, while retaining the autism mandate, would be to require services without an annual dollar maximum.

There are many issues to consider when estimating the cost of services associated with an unlimited benefit for autism and applied behavior analysis. The adequacy of the provider networks across the state for these services impact the estimated costs. The infrastructure necessary to deliver services was still growing in 2011 in order to deliver these services to a broad population.[15] In addition, education and information needs to be readily available to parents regarding the services available. We estimate the long-range cost for these services on

[15] Annual Report to the Missouri Legislature, Insurance Coverage for Autism Treatment & Applied Behavior Analysis, DIFP, January 31, 2012, page 9.

an unlimited basis is between 0.4% and 1.0% of total medical costs. Short range cost estimates of these services are likely to be lower based on the issues previously discussed. However, there has been anecdotal evidence that the costs for these benefits impact the individual market much more.

Analysis for Benchmark Selection

Using the supplemented benefit packages described above, outlier benefits were identified. Outlier benefits are those where the benefits after supplementation differ among the benchmark plan options. Benefits that are not outliers – those that are common to all plans – were priced to estimate the claim cost that is assumed to be common to all plans. For the outlier benefits, actuarial analysis of each variation of the benefit was performed separately to determine the estimated cost of the benefit for each benchmark plan option. A comparison of the outlier benefits is provided in Appendix C.

The sum of the common benefit claim cost and the outlier claim cost specific to each plan determined the estimated claim cost for each plan. A relative claim cost was then developed for each plan. The largest small group plan (Anthem Blue Access Choice PPO) was selected as a reference plan and the cost of each plan was compared to the cost of the reference plan to determine the relative value. Analysis was based largely on Oliver Wyman's internal pricing model. For benefits that are not commonly covered in today's commercial market therefore limiting the available data, analysis of publicly available studies was used to supplement the analysis. For plans that contain benefits which currently have annual dollar limits applied, it was assumed those limits apply in our analysis. However, should a plan with any of these limits be selected as the benchmark plan, the annual dollar limit will need to be removed and an actuarially equivalent benefit added. This substitution would have no impact on the overall relative cost between the plans.

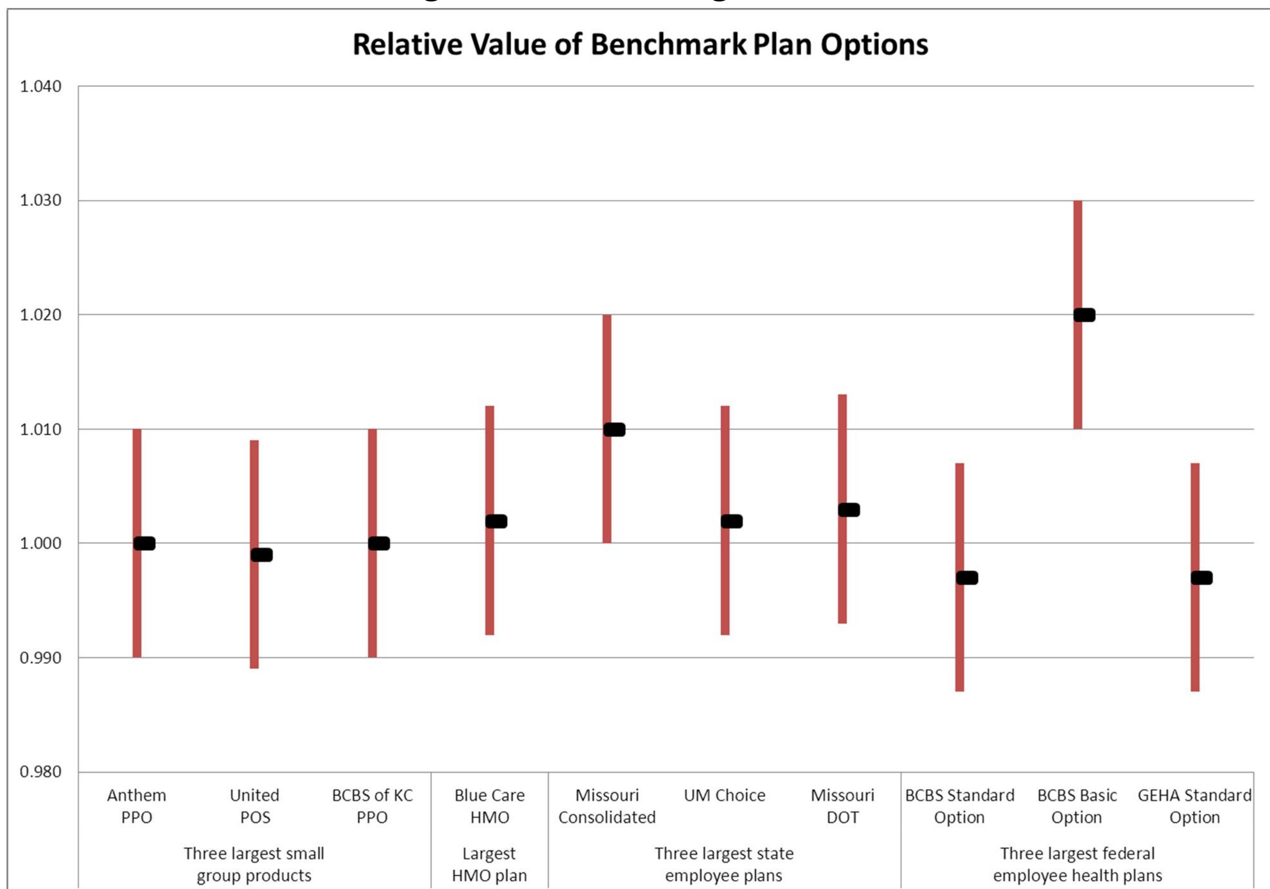
4

Results of Pricing Analysis

Relative Value of Benchmark Plan Options

The results of the relative value analysis are shown graphically below. The graph shows the point estimate of the relative value as well as a +/- 1% margin around the point estimate. This is intended to depict the uncertain nature of the estimates. In addition, different insurers may assign different values to the benefits than is included in our estimates. The value of the plans does not reflect any difference in costs by insurer. Rather it only is intended to show the estimated difference in the value of benefits assuming all else, such as network, provider contracts, and utilization management, is equal.

Figure 4.1 – Pricing Results



The chart shows that, with the exception of the Missouri Consolidated Health Plan and the FEHBP BCBS Basic Option plan, there is relatively little difference in the aggregate allowed cost for each benchmark plan option. This indicates that while there are differences in the outlier benefits in each plan, either the value of the benefits is relatively the same across plans or the value of the outlier benefits is small relative to the total. The driver of the higher cost for FEHBP BCBS Basic Option is the generous dental benefit. Recognizing that the aggregate cost of most benchmark plans' benefits are approximately actuarial equivalent, the impact on premiums in the individual and small group market is not highly dependent upon the benchmark plan option selected, with the exception of the FEHBP BCBS Basic Option. The main drivers of the higher relative value for the Missouri Consolidated Health Plan are benefits for routine eye care for adults and bariatric surgery. The routine eye care for adults benefit is generally richer than eye care benefits offered by other benchmark plans (if these benefits are even covered). The benchmark plans offered to small groups in Missouri do not cover bariatric surgery, which adds to the relative value of the Missouri Consolidated Health Plan.

There is relatively little difference in the aggregate allowed cost for each benchmark plan option.

Benefits Causing the Difference in Plan Values

It is important to understand which benefits are causing the relative values shown. First, if a benchmark plan is chosen that does not include Missouri mandated benefits, then Missouri will have to pay the cost of these additional benefits for QHP enrollees, unless the mandated benefits are repealed prior to 2014. However, it is unclear whether Missouri would have to pay the cost for only those QHP enrollees who purchase coverage in the Exchange or for all QHP enrollees both inside and outside the Exchange. HHS has not provided final guidance related to this issue. Second, if policymakers prefer that certain benefits are included for medical efficacy or social reasons, then it is important to know which benefits cause the difference in values. If final rules allow insurers to substitute benefits, however, then this second consideration may become less important.

The majority of the difference between the value of the Missouri specific benchmark plan options and the FEHBP options are driven by mandated benefits. The mandated benefits that drive the majority of the difference in value are: services to treat autism spectrum disorder, including applied behavioral analysis and early intervention. Therefore, if a FEHBP plan option is selected as the benchmark plan there could be significant costs that must be paid by the State. We estimated that the difference in cost of all of the mandated benefits between the Missouri specific plans and the FEHBP plans is roughly $5.00 - $5.20 per member per month in 2010 dollars.

Key Findings

The key findings from the pricing analysis that will inform the selection of the benchmark plan are as follows:

1. All of the benchmark plan options will need to be supplemented to provide coverage for habilitative services,[16] pediatric vision and oral services. This will increase premiums in the individual and small group markets regardless of the plan selected as the benchmark plan.

2. The estimated values of all ten benchmark plan options are within a relatively small range of roughly two percentage points. The Missouri Consolidated Health plan and the FEHBP Basic Option plan are estimated to have higher costs than the remaining benchmark plan options. This is the result of a richer vision coverage and bariatric surgery in the Missouri Consolidated Health plan and a comprehensive dental benefit included in the FEHBP Basic Option package.

3. The three State employee plan options and the three FEHBP plan options do not include all of the state mandated benefits to the extent mandated. If any of these options are selected as the benchmark plan, Missouri would be required to pay the cost of the additional mandated benefits for enrollees in Qualified Health Plans; however, it is unclear whether this includes QHP enrollees outside of the Exchange. The estimated cost of the mandated benefits not covered by FEHBP plans range from $5.00 to $5.20 PMPM. The State employee plan options do not provide state mandated coverage for “First Steps” which is estimated to cost less than $0.70 PMPM.

[16] It should be noted that the largest small group plan, Anthem Blue Access Choice PPO, covers habilitative services in a manner similar to our definition employed. However, since habiliative services are required EHBs all plans are required to provide this coverage. As such, these services have been added to the other plans and this has no impact on the results of our analysis.

5

Policy Considerations in Selecting a Benchmark Plan

Although HHS has not provided a specific list of criteria to be used in selecting the benchmark plan, there are several considerations that could influence the State's choice of a benchmark plan.

State Mandated Benefits

Any state mandated benefits that are not covered by the plan selected as the benchmark must be added to the benchmark benefits and the State must cover the cost of the mandated benefits added for any individual enrolled in a QHP. This assumes the State would not repeal the mandated benefit. For example, the Missouri mandated benefit for autism benefits and First Steps are not covered by the FEHBP plans.

Small Group Market Disruption

The State should also consider the market disruption that may be caused by each of the benchmark options. Market disruption can be defined by covered benefits or additional cost. States must consider what benefits will be foregone or added and how these benefits impact the current individual and small group markets. Each benchmark plan option represents a market basket of services that would be required to be covered if selected as the benchmark. If the market basket included in one benchmark is more expensive than another, selecting the plan with the more expensive market basket would mean mandating a premium increase to individuals that currently have plans with a leaner market basket.

Individual Market Disruption

Additionally, since the benchmark selected would also impact the individual market, some states have also performed a detailed analysis of the most common plans in the individual market to gauge the disruption that will occur. In Missouri, not all individual benefit plans are required to provide coverage for State mandated benefits. For example, the mandated benefit for autism is required for the small and large group markets but is only required as a mandated offer in the individual market. This would add additional pressure to the costs in the individual market and could cause market disruption.

Specific Benefits Covered

Specific benefits that are covered in one benchmark plan option but not another can also be considered. We refer to these as "outlier benefits." It then becomes a policy decision as to which benefits might be more important to cover (e.g., private duty nursing vs. bariatric surgery). By examining the outlier benefits the State can be sure that the plan selected as the benchmark

ensures medical efficacy and coverage of treatments that adequately prevent, ameliorate or cure conditions and diseases as effectively as possible.

Affordability

Given the benchmark plan will serve as a basis for defining the EHB package for Missouri, it essentially places a floor on the services that must be covered. While selecting a benchmark option with more comprehensive services may provide broader coverage, it comes with a cost. While selecting the Anthem PPO plan may result in the least amount of disruption in the current small group market, it is also the more expensive than the second largest small group plan and would result in higher premiums.

Consumer and Stakeholder Input

The State may wish to seek the input of consumers and other stakeholders. Some states have held consumer focus groups and/or public meetings to gather input and feedback related to the benchmark options available. Other states have solicited comments and feedback via other means, such as mail or email.

Ease of Administration by Carriers

Administration of benefits can vary based on the type of benefit. Selecting a benefit package that requires more manual administration of benefits could lead to higher administrative expenses and in turn higher premiums.

Appendix A

Comparison of Current Benefits

Key: pmpcy=per mem per cal yr pmppy=per member per plan yr x=covered no=not covered pc=prob cov/pnc=prob not cov	OPTION 1 Largest plans in the three largest small group products in Missouri			OPTION 2 Largest HMO in Missouri	OPTION 3 Three largest state employee plans in Missouri			OPTION 4 Three largest federal employee health plans		
	Anthem "Blue Access Choice PPO"	United HealthCare Choice Plus POS	BCBS of Kansas City Preferred Care Blue PPO	Blue Care HMO	Missouri Consolidated Health Care Plan	University of Missouri Choice Health Care Program UM CHOICE	Mo DOT Health Plan	BCBS Standard Option	BCBS Basic Option	GEHA Standard Option
I. Hospitalization										
Bariatric surgery	no	no	no	no	x	x - only network providers	no	x	x	x
Bone marrow transplants for breast cancer	x	x	x	x	x	x	x	at cancer research facility	at cancer research facility	x
Inpatient hospice	x	x	14 days combined inpatient and home	14 days combined inpatient and home	x	x	x	7 days per admit; must be 21+ days between admits	7 days per admit; must be 21+ days between admits	$15,000 limit, combined with outpatient hospice
Inpatient services in a general hospital	X	x	x	x	x	x	x	x	x	x
Inpatient services in a skilled nursing facility	90 days pmpcy	60 days pmpcy	30 days pmppy	30 days pmpcy	x	90 days pmpcy	x	Only if member has Med Part A (pays Part A copays up to day 30)	no	$700 per day for 14 days only
Inpatient services in a rehab. hospital	60 days pmpcy	60 days pmpcy	x	x	x	x	x - short term	x	x	x
Inpatient physician and surgical services	x	x	x	x	x	x	x	x	x	x
Transplants	x	x	x	x	x	x	x	x	x	X [$1,000 transportation for transplant]
Online Physician/Nurse Visits	Covered (includes Telehealth)	no	Covered (E-Visits through internet portal)	Covered ("E-Visits")	no	no	no			
Accidental Dental	up to $3000	up to $3000	x	x	x	x	x	x	x	x
II. Emergency Room Services										
Emergency room services	x	x	x	x	x	x	x	x	x	x
Emergency transportation/ambulance (ground or air)	x	x	$500 max per use	$500 max per use	x	x	x	x	x	x

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	Anthem "Blue Access Choice PPO"	United HealthCare Choice Plus POS	BCBS of Kansas City Preferred Care Blue PPO	Blue Care HMO	Missouri Consolidated Health Care Plan	University of Missouri Choice Health Care Program UM CHOICE	Mo DOT Health Plan	BCBS Standard Option	BCBS Basic Option	GEHA Standard Option
III. Ambulatory Services										
Acupuncture	no	no	no	no	no	no	no	By MD only; 24 visits pmpcy	By MD only	20 procedures pmpcy
Allergy testing	x	x	x	x	x	x	x	x	x	$500 pmpcy
Allergy injections	x	x	x	x	x	x	x	x	x	x
Chiropractor – lab and X-ray outpatient	x	x	x	x	x	x	x - 1 x-ray	1 x-ray pmpcy	1 x-ray pmpcy	$25 pmpcy for x-rays
Chiropractor – medical care services including spinal manipulation	26 visits pmpcy	26 visits pmpcy	x	x	x	x - up to $1,000	30 visits pmpcy	1 office visit pmpcy; 12 manipulative visits pmpcy (combined with osteopathic manipulative	1 office visit pmpcy; 12 manipulative visits pmpcy (combined with osteopathic manipulative	12 visits pmpcy
Clinical trials to treat cancer	x	x	x	x	x	x	x	x	x	x
Dental services, preventive and restorative	no	no	no	no	no	no	no	Schedule	Schedule	Schedule
Home health care services	100 visits	60 visits	60 visits	60 visits	x	x	x	25 visits pmpcy	25 visits pmpcy	50 visit pmpcy
Home visit – physician or other professional	x	x	x	x	x	x	x	x	x	pc
Home hospice for terminally ill	x	x	14 days combined inpatient and home	14 days combined inpatient and home	x	x	x	x	x	$15000 limit, combined with inpatient hospice
Non-emergency transportation/ambulance (ground or air)	x - med. nec. Between fac.	no	no	no	x - med. nec. only	x - med. nec. Between fac.	no	x	x	pc
Other practitioner office visit (nurse practitioner, nurse midwife)	x	x	x	x	x	x	x	x	x	x
Dialysis	x	x	x	x	x	x	x	x	x	x
Outpatient surgery physician/surgical services	x	x	x	x	x	x	x	x	x	x

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Oxygen	x	x	x	x	x	x	x	x	x	x
Primary care visit to treat an injury or illness	x	x	x	x	x	x	x	x	x	x
Private duty nursing	no	no	x	x	no		x	Covered only for continuous home hospice up to 7 days per episode (episodes must be separated by 21 days of traditional	Covered only for continuous home hospice up to 7 days per episode (episodes must be separated by 21 days of traditional	IP-no Home health - x, up to 2 hours per day, included in 50 visit home health limit
Radiation and chemotherapy	x	x	x	x	x	x	x	x	x	x
Removal of impacted teeth	no	no	no	no	no	no	no	x	x	x
Removal of 7 or more permanent teeth	no	no	no	no	no	no	no	pnc	pnc	pnc
Respiratory therapy	x	x	x	x	x	x	x	pc	pc	x
Routine eye care, adult	no	1 exam pm/24 months	no	1 exam pm/24 months	1 exam per pmpcy	no		no	no	no
Routine foot care	no	no	no	x - only certain conditions	x - only certain conditions and med. nec.		no	Routine with vascular condition	Routine with vascular condition	Routine with vascular condition
Second opinion	x	x	x	x	x	x	x	For surgery	For surgery	For surgery
Specialist visit	x	x	x	x	x	x	x	x	x	x
Special medical formulas - mandated PKU Testing and Formulary	x	x	x	x	x	x	x	Medical foods for children with certain conditions	Medical foods for children with certain conditions	pnc

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TMJ and Cranial Jaw Surgery	x		x	x	x - surgery only	x	x	Covered (Surgery Only)	Covered (Surgery Only)	Covered (Surgery Only)
Routine hearing screening	x	x	x	x	x			no	no	x
Home infusion therapy	x				x			x	x	x
Cochlear implants	x	no	x	x	x - with limits	Child only	Child only	x	x	x
Lens surgery	Intraocular lens implantation post cataract surgery covered	no	Corneal transplants covered; post cataract		x - post pataract	no	no	Covered as relates to surgical correction of an eye injury, intraocular surgery & other specific medical conditions.	Covered as relates to surgical correction of an eye injury, intraocular surgery & other specific medical conditions.	Covered as relates to surgical correction of an eye injury and/or intraocular surgery
Podiatry			x	Covered if treatment for diabetes only	x	x	Covered if medically necessary	Covered if for treatment for a metabolic or peripheral vascular disease, such as diabetes	Covered if for treatment for a metabolic or peripheral vascular disease, such as diabetes	Covered if for treatment for a metabolic or peripheral vascular disease, such as diabetes
Gastric bypass surgery	no	no	no	no	x	x	no	x	x	x
Medically necessary breast reduction					x	x		x	x	x
Medically necessary impotence treatment					x		x	pc	pc	no
Oral surgery	x	x			x		x	x	x	x

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IV. Maternity and Newborn Care										
Certified nurse midwife	x	x	x	x	x	x	x	x	x	x
Delivery and all inpatient services for maternity care	x	x	x	x	x	x	x	x	x	x
Hearing screening for newborns	x	x	x	x	x	x	x	x	x	pc
Infertility - assisted reproductive technology (ART)	no	no	no	no	no	no	no	no	no	no
Infertility services other than ART	no	no	no	no	no	no	no	x	x	$3000 pmpcy (excludes fertility drugs)
Prenatal and postpartum care	x	x	x	x	x	x	x	x	x	x
V. Behavioral Health										
Behavioral health inpatient services in general hospital, mental health facility or substance abuse facility	x	x	x	x	x	x	x	x	x	x
Behavioral health outpatient services	x	x	x	x	x	x	x	x	x	x
VI. Prescriptions Drugs										
Generic drugs	x	x	x	x	x	x	x	x	x	x
Preferred brand drugs	x	x	x	x	x	x	x	x	x	x
Non-preferred brand drugs	x	x	x	x	x	x	x	x	x	x
Specialty drugs	x	x	x	x	x	x	x	x	x	x
Diabetes-related supplies	x	x	x	x	x	x	x	x	x	x
Hormone replacement therapy	no	Growth hormone - kids	Growth hormone - kids	Growth hormone - kids	x		Growth hormone	pc	pc	pc

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VII. Rehabilitative and Habilitative Services and Devices										
Cardiac rehabilitation Services	x	x	x	x	x	x	x	x	x	x
Cognitive rehabilitation therapy	x	x	no	no	x		x -limited	x	x	pc
Diabetic shoes	x		1 pair	1 pair	x - with limits			pnc	pnc	$150 per pair pmpcy
Durable medical equipment	x, with limits	x - $2500 limit	x - as Medicare	x	x - prior auth over $1500	x - prior auth over $1000	x - prior auth over $1000	x	x	x
First Steps: coverage for early intervention services for children from birth to age three identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq. Such coverage shall be limited to three thousand dollars for each covered child per policy per calendar year, with a maximum of nine thousand dollars per child. "early intervention services" means medically necessary speech and language therapy, occupational therapy,	Complies - see Exclusions	Complies by Amendment	Complies	Complies	no	Does not comply - not required to comply as self-funded health plan	Does not comply - not required to comply as this is self-funded health plan	pnc	pnc	pnc
Eyeglasses for Post Cataract	x	no	x	1 pair	x	1 pair	x	1 pair per condition	1 pair per condition	First pair of contact lenses after surgery
Foot orthotics		no	no	no	x	x	Diabetic disease only	x	x	no
Hearing aids	no	x	newborns only	newborns only	x	1 per year for dep children		$1250 limit per ear per cy up to 22, then per ear per 36 months	$1250 limit per ear per cy up to 22, then per ear per 36 months	Implanted – to allowance External - $250 limit per ear per 5 yrs
Prosthetic devices	x	x - with limits	x	x	x	x -with limits	x	x	x	x

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Rehabilitation and habilitation services for autism, including ABA	$40000 per year	$40000 per year	$40000 per year	$40000 per year	$40000 per year	x	x	no	no	pnc
Short-term physical therapy	20 visits pmpcy	20 visits pmpcy	20 visits pmppy	40 visits pmpcy comb with OT	60 visits pmpcy comb with OT/ST	60 visits pmpcy	60 visits pmpcy comb with OT/ST	75 visit pmpcy, PT, OT, ST combined	50 visit pmpcy, PT, OT, ST combined	60 visits pmpcy, PT, OT combined
Short-term occupational therapy	20 visits pmpcy	20 visits pmpcy	20 visits pmppy	40 visits pmpcy comb with PT	60 visits pmpcy comb with PT/ST	60 visits pmpcy	60 visits pmpcy comb with PT/ST			
Short-term speech therapy	x	x	20 visits pmpcy	20 visits pmpcy	60 visits pmpcy comb with PT/OT	60 visits pmpcy	60 visits pmpcy comb with PT/OT			30 visits pmpcy
Speech generating or communication device	no		no	no	x			$1250 pmpcy	$1250 pmpcy	no
Wigs	limit - 1	no	no	no	x - with limits	$100 pmpcy		$350 per lifetime	$350 per lifetime	no
VIII. Laboratory Services										
Diagnostic test (X-ray and laboratory tests)	x	x	x	x	x	x	x	x	x	x
Imaging (CT and PET Scans, MRIs)	x	x	x	x	x	x	x	x	x	x
Human leukocyte antigen testing	x	x	x	x	x	x	x	pnc	pnc	pnc
Mammogram	x	x	x	x	x	x	x	x	x	x
IX. Preventive and Wellness Services and Chronic Disease Management										
Diabetes education	x	x	x	x	x	x	x	x	x	$250 pmpcy
Family planning		x	x	x	x			x	x	x
Fitness program	no	no	no	no	no			Specific programs	Specific programs	pnc
Nutritional counseling	ESRD only	x	x	x	x			x	x	$250 pmpcy
Preventive care/ screening/ immunization	x	x	x	x	x	x	x	x	x	x

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Smoking cessation, treatment	no	no	no	no	x	no	no	x	x	2 attempts pmpcy, up to 4 counseling sessions per attempt
Smoking cessation, Rx	no	no	x	x	x	x	x	x	x	x
X. Pediatric Services, Including Oral and Vision Care										
Dental for children	no	Available	no	no	no	no	no	x	x	x
Eye glasses for children	no	Available	no	no	no	no	no	no	no	no
Lead poisoning screening	x	x	x	x	x	pc	x	pc	pc	pc
Eye exam for children	screeing only	1 exam pm/24 months	x - for all	1 exam pm/24 months	1 exam pm/24 months	no	no	x (screening only)	x (screening only)	1 exam pmpcy

Appendix B

Comparison of Mandated Benefits

	OPTION 1 Largest plans in the three largest small group products in Missouri			OPTION 2 Largest HMO in Missouri	OPTION 3 Three largest state employee plans in Missouri			OPTION 4 Three largest federal employee health plans		
	Anthem "Blue Access Choice PPO"	United HealthCare Choice Plus POS	BCBS of Kansas City Preferred Care Blue PPO	Blue Care HMO	Missouri Consolidated Health Care Plan	University of Missouri Choice Health Care Program UM CHOICE	Mo DOT Health Plan	BCBS Standard Option	BCBS Basic Option	GEHA Standard Option
Newborn Coverage (Section 376.406)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Clinical Trials (Section 376.429)	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Alcoholism (Section 376.779)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mammography (Section 376.782)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Adoptive Children (Section 376.816)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Direct Access to Women's Health Care (Section 376.1199)	Yes	Yes	Yes	Yes	Yes	Yes	Limits on IUD and implants	Yes	Yes	Yes
Reconstructive Surgery (Section 376.1209)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Maternity Care (Section 376.1210)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Childhood Immunizations (Section 376.1215)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
First Steps (Section 376.1218)	Yes	Yes	Yes	Yes	No	No	No	No	No	No
PKU Testing and Formula (Section 376.1219)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Newborn Hearing Screening (Section 376.1220)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Autism - ABA Services (Section 376.1224)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
Hospital Dental Coverage (Section 376.1225)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Chiropractic Care (Section 376.1230)	Yes	Yes	Yes	Yes	Yes	Yes	Limited to manual manipulation & x-rays	Limited 12 manipulative	Limited to 12 manipulative visits	Limit to 12 visits
376.1250)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Cancer Second Opinion (Section 376.1253)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No - for surgery	No - for surgery	No - for surgery
Antigen Testing (Section 376.1275)	Yes	Yes	Yes	Yes			Yes	No	No	No
Lead Testing (Section 376.1290)	Yes	Yes		Yes			Yes	No	No	No

Appendix C

Comparison of Outlier Benefits

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I. Hospitalization										
Bariatric surgery	no	no	no	no	x	x - only network	no	x	x	x
Inpatient hospice	x	x	14 days combined inpatient and home	14 days combined inpatient and home	x	x	x	7 days per admit; must be 21+ days between	7 days per admit; must be 21+ days between	$15,000 limit, combined with outpatient hospice
Inpatient services in a skilled nursing facility	90 days pmpcy	60 days pmpcy	30 days pmppy	30 days pmppy	x	90 days pmppy	x	Only if member has Med Part A (pays Part A copays up to	no	$700 per day for 14 days only
hospital	60 days pmpcy	60 days pmpcy	x	x	x	x	x - short term	x	x	x
Online Physician/Nurse Visits	Covered (includes Telehealth)	no	Covered (E-Visits through internet	Covered ("E-Visits")	no	no	no			
Accidental Dental	up to $3000	up to $3000	x	x	x	x	x	x	x	x
II. Emergency Room Services										
Emergency transportation/ambulance (ground or air)	x	x	$500 max per use	$500 max per use	x	x	x	x	x	x
III. Ambulatory Services										
Acupuncture	no	no	no	no	no	no	no	By MD only; 24 visits pmpcy	By MD only	20 procedures pmpcy
Allergy testing	x	x	x	x	x	x	x	x	x	$500 pmpcy
Chiropractor – lab and X-ray outpatient	x	x	x	x	x	x	x - 1 x-ray	1 x-ray pmpcy	1 x-ray pmpcy	$25 pmpcy for x-rays

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Chiropractor – medical care services including spinal manipulation	26 visits pmpcy	26 visits pmpcy	x	x	x	x - up to $1,000	30 visits pmpcy	1 office visit pmpcy; 12 manipulative visits pmpcy (combined with osteopathic manipulative treatment)	1 office visit pmpcy; 12 manipulative visits pmpcy (combined with osteopathic manipulative treatment)	12 visits pmpcy
Dental services, preventive and restorative	no	no	no	no	no	no	no	Schedule	Schedule	Schedule
Home health care services	100 visits	60 visits	60 visits	60 visits	x	x	x	25 visits pmpcy	25 visits pmpcy	50 visit pmpcy
Home hospice for terminally ill	x	x	14 days	14 days		x	x	x	x	$15000 limit,
Non-emergency transportation/ambulance (ground or air)	x - med. nec. Between fac.	no	no	no	x - med. nec.	x - med. nec. Between fac.	no	x	x	pc
Private duty nursing	no	no	x	x	no		x	Covered only for continuous home hospice up to 7 days per episode (episodes must be separated by 21 days of traditional home hospice)	Covered only for continuous home hospice up to 7 days per episode (episodes must be separated by 21 days of traditional home hospice)	IP-no Home health - x, up to 2 hours per day, included in 50 visit home health limit
Removal of impacted teeth	no	no	no	no	no	no	no	x	x	x
Routine eye care, adult	no	1 exam pm/24 months	no	1 exam pm/24 months	1 exam pmpcy	no		no	no	no
Routine foot care	no	no	no	x - only certain conditions	x- only certain conditions and med. nec.		no	Routine with vascular condition	Routine with vascular condition	Routine with vascular condition
Second opinion	x	x	x	x	x	x	x	For surgery	For surgery	For surgery

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Special medical formulas - mandated PKU Testing and Formulary	x	x	x	x	x	x	x	Medical foods for children with certain conditions	Medical foods for children with certain conditions	pnc
TMJ and Cranial Jaw Surgery	x		x	x	x - surgery only	x	x	Covered (surgery only)	Covered (surgery only)	Covered (surgery only)
Cochlear implants	x	no	x	x	x	Child only	Child only	x	x	x
Lens surgery	Intraocular lens implantation post cataract surgery covered	no	Corneal transplants covered; post cataract		x - post cataract surgery	no	no	Covered as relates to surgical correction of an eye injury, intraocular surgery & other specific medical conditions	Covered as relates to surgical correction of an eye injury, intraocular surgery & other specific medical conditions	Covered as relates to surgical correction of an eye injury and/or intraocular surgery
Podiatry			x	Covered if treatment for diabetes only	x	x	Covered if medically necessary	Covered if for treatment for a metabolic or peripheral vascular disease, such as diabetes	Covered if for treatment for a metabolic or peripheral vascular disease, such as diabetes	Covered if for treatment for a metabolic or peripheral vascular disease, such as diabetes
IV. Maternity and Newborn Care										
Infertility services other than ART	no	no	no	no	no	no	no	x	x	$3000 pmpcy (excludes fertility drugs)
V. Behavioral Health										
VI. Prescriptions Drugs										
Hormone replacement therapy	no	Growth hormone - kids	Growth hormone - kids	Growth hormone - kids	x		Growth hormone	pc	pc	pc

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VII. Rehabilitative and Habilitative Services and Devices										
Cognitive rehabilitation therapy	x	x	no	no	x		x -limited	x	x	pc
Diabetic shoes	x		1 pair	1 pair	x - with limits			pnc	pnc	$150 per pair pmpcy
First Steps: coverage for early intervention services for children from birth to age three identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq. Such coverage shall be limited to three thousand dollars for each covered child per policy per calendar year, with a maximum of nine thousand dollars per child. "early intervention services" means medically necessary speech and language therapy, occupational therapy,	Complies - see Exclusions	Complies by Amendment	Complies	Complies	no	Does not comply - not required to comply as self-funded health plan	Does not comply - not required to comply as this is self-funded health plan	pnc	pnc	pnc
Eyeglasses for Post Cataract	x	no	x	1 pair	x	1 pair	x	1 pair per condition	1 pair per condition	First pair of contact lenses after surgery
Foot orthotics		no	no	no	x	x	Diabetic disease only	x	x	no
Hearing aids	no	x	newborns only	newborns only	x	1 per year for dep children		$1250 limit per ear per cy up to 22, then per ear per 36 months	$1250 limit per ear per cy up to 22, then per ear per 36 months	Implanted – to allowance External - $250 limit per ear per 5 yrs
Prosthetic devices	x	x -with limits	x	x	x	x -with limits	x	x	x	x
Rehabilitation and habilitation services for autism, including ABA	$40000 per year	$40000 per year	$40000 per year	$40000 per year	$40000 per year	x	x	no	no	pnc

Key: pmpcy=per mem per cal yr pmppy=per mem per plan yr x=covered no=not covered pc=prob cov/pnc=prob not cov	OPTION 1 Largest plans in the three largest small group products in Missouri			OPTION 2 Largest HMO in Missouri	OPTION 3 Three largest state employee plans in Missouri			OPTION 4 Three largest federal employee health plans		
	Anthem "Blue Access Choice PPO"	United HealthCare Choice Plus POS	BCBS of Kansas City Preferred Care Blue PPO	Blue Care HMO	Missouri Consolidated Health Care Plan	University of Missouri Choice Health Care Program UM CHOICE	Mo DOT Health Plan	BCBS Standard Option	BCBS Basic Option	GEHA Standard Option
Short-term physical therapy	20 visits pmpcy	20 visits pmpcy	20 visits pmppy	40 visits pmpcy comb with OT	60 visits pmpcy comb with OT/ST	60 visits pmpcy	60 visits pmpcy comb with OT/ST	75 visit pmpcy, PT, OT, ST combined	50 visit pmpcy, PT, OT, ST combined	60 visits pmpcy, PT, OT combined
Short-term occupational therapy	20 visits pmpcy	20 visits pmpcy	20 visits pmppy	40 visits pmpcy comb with PT	60 visits pmpcy comb with PT/ST	60 visits pmpcy	60 visits pmpcy comb with PT/ST			
Short-term speech therapy	x	x	20 visits pmpcy	20 visits pmpcy	60 visits pmpcy comb with PT/OT	60 visits pmpcy	60 visits pmpcy comb with PT/OT			30 visits pmpcy
Speech generating or communication device	no		no	no	x			$1250 pmpcy	$1250 pmpcy	no
Wigs	limit - 1	no	no	no	x - with limits	$100 pmpcy		$350 per lifetime	$350 per lifetime	no
VIII. Laboratory Services										
Human leukocyte antigen testing	x	x	x	x	x	x	x	pnc	pnc	pnc
IX. Preventive and Wellness Services and Chronic Disease Management										
Diabetes education	x	x	x	x	x	x	x	x	x	$250 pmpcy
Fitness program	no	no	no	no	no			Specific programs	Specific programs	pnc
Nutritional counseling	ESRD only	x	x	x	x			x	x	$250 pmpcy
Smoking cessation, treatment	no	no	no	no	x	no	no	x	x	2 attempts pmpcy, up to 4 counseling sessions per attempt
Smoking cessation, Rx	no	no	x	x	x	x	x	x	x	x
X. Pediatric Services, Including Oral and Vision Care										
Dental for children	no	Available	no	no	no	no	no	x	x	x
Eye glasses for children	no	Available	no	no	no	no	no	no	no	no
Eye exam for children	screeing only	1 exam pm/24 months	x - for all	1 exam pm/24 months	1 exam pm/24 months	no	no	x (screening only)	x (screening only)	1 exam pmpcy

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