MILLIMAN REPORT

Analysis of Reducing or Eliminating Cost Sharing for Maternity Services in Washington State

Prepared for the Washington Office of Insurance Commissioner

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Executive Summary

Substitute Senate Bill 5581 directs the Washington Office of the Insurance Commissioner (“WA OIC”) to develop strategies and policy options to reduce or eliminate cost sharing for maternity health services, including prenatal care, labor and delivery, and postpartum care. The strategies must be informed by external actuarial analysis completed by July 1, 2024. At the request of the WA OIC, Milliman, Inc. (“Milliman”) provides this actuarial analysis describing the financial impact of reducing or eliminating deductibles and other cost-sharing requirements for maternity care services. Other cost-sharing requirements include copayments and coinsurance.

The WA OIC sent a survey to 14 commercial carriers in Washington State to understand how they define maternity care services and how both maternity and non-maternity services are covered and reimbursed under the three highest enrollment health plans for each source of health benefits described above offered by each carrier in 2023. Under Senate Bill 5581, carriers with greater than one percent market share are required to respond to the WA OIC surveys. All 12 carriers meeting this requirement responded to the survey. We used information gathered from this survey to understand the current landscape of maternity benefits, reimbursement methodologies, and to model the impact of several maternity cost sharing elimination scenarios.

The definition of maternity care services was fairly consistent across carriers. It included prenatal care, labor and delivery, postpartum care, behavioral health, and miscarriage and stillborn care. Only one of the 12 carriers reported coverage of doula services.

The plan designs we reviewed did not differentiate cost sharing between maternity and non-maternity services, other than for prenatal and postnatal visits. Most inpatient services and imaging are subject to deductibles which range from $100 to $7,550. Treatment of the newborn’s inpatient admission varies with some carriers including it on the mother’s deductible accumulators and others treating the newborn as a separate enrollee with their own accumulators.

Carrier definitions of maternity care services considered preventive under section 2713 of Federal Public Health Services Act (and are thus exempt from cost sharing under federal regulation) varied. All carriers considered some services in the prenatal and postpartum periods preventive, but definitions of preventive services were highly variable across carriers. Given the variation among carriers, any legislation or regulation should be specific in its definition of maternity services subject to the cost sharing elimination/reduction.

According to the survey responses, fee for service is the most frequently used reimbursement methodology for maternity care services. Per diem and case rates were cited second and third most frequently. Under per diem reimbursement, providers or facilities are paid a flat rate for each day a patient is under their care regardless of the number of services received. Case rates are a single payment for all services related to a specific treatment or condition, possibly spanning multiple providers in multiple settings.

Nationally, there are four states, Maryland, Massachusetts, California and New York, which have considered or passed legislation related to reducing or eliminating cost sharing for maternity care services, with wide variation across the definition of what constitutes maternity care services. However, no state has passed legislation completely eliminating cost sharing for maternity care services as of the date of this report.

Essential health benefit (EHB) benchmark plans are used to define which benefits are covered in a state's EHB and any internal limits (e.g., annual visit limits), but do not impact what the cost sharing is for these benefits. Maryland, Massachusetts and California have specified maternity care services in their Essential Health Benefits (EHB) benchmark plans. All three states categorized prenatal outpatient visits as preventative and require coverage of labor and delivery services and postnatal follow-up benefits, but other maternity care benefits varied. For example, California’s EHB benchmark includes family planning coverage including termination and discusses the responsibility of the insured as it relates to surrogacy arrangements. In Massachusetts, childbirth classes are covered.

In addition to providing a landscape of maternity care services, we performed a financial analysis. The proposals under consideration for this report would require commercial health insurers in Washington State to reduce cost sharing by eliminating cost sharing for a subset of maternity care services or eliminating enrollee cost sharing for all

maternity care services. The WA OIC selected five scenarios to be modeled to represent different cost sharing elimination options. These scenarios are defined as follows:

- Scenario 1: Cost sharing eliminated for all maternity care services
- Scenario 2: Cost sharing eliminated for prenatal maternity care services
- Scenario 3: Cost sharing eliminated for postnatal maternity care services
- Scenario 4: Cost sharing eliminated for labor and delivery maternity care services
- Scenario 5: Cost sharing eliminated for labor, delivery and postnatal maternity care services

For each of these scenarios, this report includes estimates of the reduction or elimination of enrollee cost sharing and the corresponding increase to plan premiums and actuarial values. The plan premiums increase because the portion of the claims that were enrollee cost sharing are shifted to the plan. This increase in the plan's financial responsibility is recovered through increasing enrollee premiums. The actuarial value is calculated as the percentage of claims that are paid for by the plan. Because the plan's financial responsibility increases, the actuarial value increases. Results are included for the following sources of health benefits: Cascade Select individual health plans, all other individual health plans, small group, large group excluding public employee health plans, and public employee health plans. Exhibit 1 on the following page contains the projected cost sharing and premium impacts for each scenario across all sources of health benefits. The Financial Evaluation section of this report contains similar results by source of health benefits.

The enrollee cost sharing and premium impacts were developed by modeling changes to the benefit design of the three highest enrollment health plans by source of health benefits offered by each commercial health insurance carrier in Washington State based on 2023 plan benefit designs. In total, we modeled 78 plan designs, which accounts for approximately 35% of the impacted enrollees. The analysis assumes that the top three most popular plan designs for each carrier and source of health benefits represent reasonable average plan designs. Should the plans not modeled in this analysis greatly vary from the plans modeled, the actual enrollee cost sharing, premium, and actuarial value impacts may differ from the values produced by this analysis. Results contained in this report are intended as estimates of the impact that reduction or elimination of maternity care cost sharing may have on enrollee cost sharing and plan premiums. These estimates are intended to be reasonable estimates rather than precise estimates or estimates reflective of any specific health plan.

A summary of the results for the total commercial market by scenario is in Exhibit 1. The baseline premium and enrollee cost sharing per member per month (PMPM) is the average premium and enrollee cost sharing for the 78 plan designs modeled, weighted by enrollment. The post mandate premium and enrollee cost share are the resulting premium and enrollee cost sharing if the cost sharing scenario went into effect. The impacts are shown in PMPM and total annual dollars. The total annual dollars are calculated as the impacts of the plans modeled to all enrollees with individual, small group, large group, and public employee plans. The PMPM impacts are calculated across all enrollees, not just enrollees using maternity care services. Enrollees using maternity care services would see a larger reduction in cost sharing. Based on the 78 plan designs modeled, the average reduction in cost sharing ranges from approximately $2 PMPM for Scenario 3, cost sharing removed on postnatal services only, to approximately $100 PMPM on average for Scenario 1, cost sharing removed on all maternity services. The estimated savings per enrollee using maternity care services varies by plan design.

When reviewing the results, it is important to remember that deductibles and out-of-pocket maximums are cumulative. Removing cost sharing from one type of maternity care service may not actually save enrollees cost share but rather shift the enrollees' payments to different services. For example, if prenatal services are no longer subject to cost sharing, enrollees may not pay anything for prenatal services but still pay their out-of-pocket maximum on labor and delivery services, resulting in no savings to the enrollee.

Scenario 1, removing cost sharing for all maternity care services, yields the largest enrollee cost share savings of $2.82 PMPM. Scenario 3, removing cost sharing for postnatal services, results in the lowest enrollee cost share savings of $0.06 PMPM because postnatal services make up the smallest percentage of the total claims and many enrollees will have already met out-of-pocket maximums on labor and delivery services. Scenario 4, eliminating cost

sharing for labor and delivery only, results in an average enrollee cost share savings of $1.37 PMPM because this is the most expensive component of maternity care services and is often subject to deductibles and coinsurances.

EXHIBIT 1: SUMMARY OF THE IMPACT OF ELIMINATING MATERNITY COST SHARING BY SCENARIO

	Scenario 1 All Maternity Services	Scenario 2 Prenatal Only	Scenario 3 Postnatal Only	Scenario 4 Labor and Delivery Only	Scenario 5 Labor and Delivery and Postnatal
Baseline - Per Member Per Month					
Premium	$664.15	$664.15	$664.15	$664.15	$664.15
Enrollee Cost Share	$92.52	$92.52	$92.52	$92.52	$92.52
Actuarial Value	0.878	0.878	0.878	0.878	0.878
Post Mandate - Per Member Per Month					
Premium	$667.12	$664.67	$664.21	$665.57	$665.64
Enrollee Cost Share	$89.70	$92.02	$92.46	$91.14	$91.08
Actuarial Value	0.881	0.878	0.878	0.880	0.880
Difference - Per Member Per Month					
Premium	$2.97	$0.52	$0.06	$1.42	$1.49
Enrollee Cost Share	-$2.82	-$0.49	-$0.06	-$1.37	-$1.43
Actuarial Value	0.004	0.001	0.000	0.002	0.002
Difference - Total Annual Dollars					
Premium	$64,278,000	$11,127,000	$1,291,000	$31,456,000	$30,169,000
Enrollee Cost Share	-$62,120,000	-$10,715,000	-$1,241,000	-$30,709,000	-$29,532,000
Difference (as a % of baseline)					
Premium	0.4%	0.1%	0.0%	0.2%	0.2%
Enrollee Cost Share	-3.0%	-0.5%	-0.1%	-1.5%	-1.5%

Introduction

Substitute Senate Bill 5581 directs the Washington Office of the Insurance Commissioner (WA OIC) to develop strategies and policy options to reduce or eliminate cost sharing for maternity health services, including prenatal care, labor and delivery, and postpartum care. Cost sharing includes deductibles, copayments, and coinsurance. The strategies must be informed by external actuarial analysis completed by July 1, 2024.

At the request of the WA OIC, Milliman, Inc. ("Milliman") provides this actuarial analysis describing the financial impact of reducing or eliminating deductibles and other cost-sharing requirements for maternity care services.

The WA OIC with input from the Washington Health Care Authority provided input to Milliman on how they would like to define maternity care services. For the purposes of this analysis, maternity care services are defined as routine health care services provided during the prenatal period, labor and delivery, and postnatal period, as well as care related to medical conditions exacerbated by pregnancy. Home birth services and supplies, doula services, behavioral health services, prescription drugs and therapy services, lactation services, and miscarriage and stillborn care are included in the definition. This is a broader definition than what is often considered maternity care services, i.e. prenatal visits, ultrasounds, screenings, labor and delivery, and post-delivery follow-up visits. Under the broader definition, maternity care services account for approximately 70% of a pregnant person's annual claims.

This report includes an analysis of commercial health plans offering maternity care services in Washington State including how health plans currently define maternity care services, to what extent these services are subject to deductibles or other cost-sharing requirements, and the most commonly used reimbursement methodologies, including a description of bundled payment methodologies when applicable.

The report also includes a financial impact assessment. It provides analysis of the extent to which eliminating cost sharing for a range of maternity care services would impact the total and per member per month cost of health plan premiums, cost sharing, and actuarial values for the following sources of health benefits:

- Cascade Select health plans
- Individual health plans other than Cascade Select plans
- Small group health plans
- Large group health plans
- Health plans offered to public employees including Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB)
- All health plans in the aggregate

Health savings account (HSA) qualified plans were excluded from this analysis. HSAs are federally regulated and require that all services be subject to the health plan deductible, with the exception of some preventive services as defined by the Internal Revenue Service. If the legislature were to apply cost-sharing restrictions to HSA qualified plans, language would likely be added to the statute noting that the restrictions would be applied only to the extent that they would not jeopardize an enrollee's ability to contribute to an HSA.

Exhibit 2 shows the number of carriers and plans modeled by source of health benefits.

EXHIBIT 2: COUNTS OF CARRIERS AND PLANS MODELED

	Individual Cascade	Individual Non-Cascade	Small Group	Large Group	Public Employee	All Health Plans
Number of Plans Modeled	6	21	22	21	8	78
Number of Carriers that Responded to Survey	3	8	8	8	3	12

To complete this analysis, WA OIC provided Milliman with a list of cost sharing reduction scenarios which eliminate cost sharing for a subset of maternity care services and a full cost sharing elimination scenario. Milliman estimated the impact of eliminating all cost-sharing for the services listed in the following five scenarios:

1. All maternity care services
2. Only prenatal services
3. Only postnatal services
4. Only labor and delivery services
5. Labor and delivery and postnatal services

This report also includes a summary of similar maternity cost-sharing reduction or elimination policies in other states, including a description of the state's policy and any analysis or research related to the implementation and outcomes of the policy.

Commercial Carrier Maternity Service Coverage

We surveyed 12 commercial insurance carriers in Washington State about their current maternity care benefit design and reimbursement methodologies across their individual, small group, large group, and public employee sources of health benefits. We received responses from all 12 carriers surveyed. Appendix A includes the survey questions sent to carriers.

CARRIER DEFINITIONS OF MATERNITY CARE SERVICES

All carriers reported that the following maternity care services are offered across all sources of health benefits and plan designs:

- Prenatal Care: Office visits, laboratory services, ultrasound/imaging, prenatal screening tests (cell free DNA, carrier screening, amniocentesis, chorionic villus), prescription drugs, and prenatal vitamins.
- Childbirth and delivery: Facility and professional fees, and prescription drugs
- Medically necessary supplies for home birth
- Postpartum care: Office visits, lactation specialists, follow-up care for cesarian section, laboratory services, ultrasounds/imaging, prescription drugs
- Behavioral health: prescription drugs, counseling and therapy services
- Miscarriage and stillborn care: dilation and curettage, prescription drugs, childbirth and delivery, laboratory services.

In addition to the list above, some carriers reported coverage of the following services:

- Doula services, 1 carrier.
- DME supplies including home blood pressure monitors, breast pumps and breast-feeding supplies, 3 carriers.
- Midwives, 3 carriers. Carriers did not specify if licensed midwives and advanced registered nurse practitioner midwives are included.

The survey provided to the carriers lists common maternity care services, asks if the services are covered, and asks the carrier to add any additional services that are covered but not listed in the survey. The list above may be incomplete to the extent that carriers did not provide additional services that they define as maternity care services. There may be some services that could be used in maternity care but were not called out as such by the carriers. For example, breast pumps and breast-feeding supplies were not mentioned by all carriers but are required to be covered for most fully insured commercial plans under the Affordable Care Act. Midwives were also not specifically called out in the survey and were added to the list by three carriers. It is possible that the other carriers do cover midwives but did not list them separately on the survey.

COST SHARING FOR MATERNITY CARE SERVICES

Most maternity care services are currently subject to deductibles and other cost-sharing. The carriers provided cost sharing information for maternity care services for their three highest enrollment health plans based on 2023 membership for each source of health benefits.

Of the 78 plan designs submitted by the carriers, a few patterns were noted regarding which services the deductible applies to, if applicable at all. These patterns are summarized as follows, with the services that are most often subject to deductible listed at the top.

- Approximately 94% of the plan designs provided by the carriers have a deductible. Of the plans with a deductible, the deductibles range from $100 to $7,550. Once the deductible is met, services subject to the deductible are typically subject to coinsurance. Of the plans with coinsurance, the enrollee coinsurances range from 10% to 50%.
- Approximately 80% to 95% of the plans surveyed indicated the following services are subject to the deductible, whether provided for maternity or non-maternity care services:
  - Inpatient facility and professional services,
  - Outpatient surgery facility and professional services,
  - Outpatient emergency room facility and professional services,
  - Outpatient imaging facility and professional services, and
  - Professional bundled services.
- Approximately 50% to 80% of the plans surveyed indicated the following services are subject to the deductible, whether provided for maternity or non-maternity care services:
  - Outpatient lab facility and profession services,
  - Professional labs and imaging office visits, and
  - Non-preferred brand and specialty pharmacy.
- Approximately 20% to 50% of the plans surveyed indicated the following services are subject to the deductible, whether for maternity care or non-maternity care services:
  - Outpatient physical therapy, occupational therapy, and speech therapy facility and professional services,
  - Urgent care visits,
  - Specialist physician office visits, and
  - Non-preferred generic and preferred brand pharmacy.
- Approximately 0% to 20% of the plans surveyed indicated the following services are subject to the deductible, whether for maternity care or non-maternity care services:
  - Outpatient preventive facility and professional services,
  - Primary care physician office visits,
  - Behavioral health office visits, and
  - Preferred generic and preventive pharmacy.

Of the plan designs provided by the carriers, a few patterns were noted regarding which services are subject to fixed copays. These patterns are summarized as follows:

- Services for which more than 40% of the plans surveyed require a copay include the following:
  - Emergency room visits,
  - Urgent care visits,
  - Primary care and specialist office visits,
  - Physical therapy professional services,
  - Behavioral health office visits, and
  - All pharmacy tiers except preventive.

- Services for which less than 40% of the plans surveyed require a copay include the following:
  - Facility fees such as room and board or other non-physician services provided in an inpatient or outpatient setting, except for emergency room,
  - Inpatient professional visits,
  - Outpatient surgery,
  - Laboratory and imaging professional services and office visits, and
  - Preventive care, including preventive pharmacy.
- If copayments are required for a service, there is often little distinction by the plan between maternity care services and non-maternity care services. For example, if a plan requires a copay for an inpatient admission, the copay would often be required regardless of whether the inpatient admission is for a maternity-related purpose. One significant exception relates to primary care and specialist visits for prenatal and postnatal visits. Almost half of the plans reviewed that require copays for non-maternity primary care and specialist visits do not require a copay for prenatal or postnatal visits.

PREVENTIVE CARE

Carrier definitions of maternity care services considered preventive under section 2713 of Federal Public Health Services Act (and are thus exempt from cost sharing under federal regulation) varied. Exhibit 3 describes the number of carriers that considered at least some services under each maternity care service category as preventive and provides details on which services are preventive and exempt from cost sharing.

Services that are not considered preventive and thus exempt from cost sharing by any carrier include:

- Prenatal and postpartum ultrasounds and imaging
- Labor and delivery services
- Doula services
- Medically necessary home birth supplies
- Follow-up care for cesarian section
- Behavioral health prescription drugs
- Miscarriage and stillbirth services

All 12 carriers considered some services in the prenatal and postpartum periods preventive, but definitions of preventive services were highly variable across carriers (Exhibit 3). For example, during the prenatal period, seven carriers considered certain routine office visits preventive, but the number of visits considered preventive varies by carrier. Other prenatal services that were considered preventive by some carriers included:

- Laboratory services for prenatal screening of certain conditions to be preventive (11 carriers)
- Over-the-counter (OTC) prenatal vitamins with folic acid and behavioral health condition screening preventive (11 carriers)
- One carrier considered all types of prenatal genetic screening and diagnostic tests preventive. Additionally, prior authorization is required by six plans for prenatal cell free DNA and by most plans for carrier screening tests.
- Two carriers that use a bundled payment reported that all prenatal services are reimbursed within the bundle and do not consider these services preventive with the exception of carrier screening tests when certain criteria apply. Reimbursement methods are discussed in more detail below.

Far fewer services were considered preventive during the postpartum period. A few carriers considered certain routine postpartum office visits preventive and three carriers reported that postpartum contraceptives are considered preventive. Almost all providers reported lactation services as preventive.

EXHIBIT 3: SERVICES CONSIDERED PREVENTIVE AND EXEMPT FROM COST-SHARING AS REPORTED BY CARRIERS

SERVICE CATEGORY	COUNT OF CARRIERS THAT REPORT SERVICE AS PREVENTIVE
Prenatal Care	
Office Visits	7
Laboratory Services	11
Ultrasounds/Imaging	0
Screening Tests - Cell Free DNA	1
Screening Tests - Carrier Screening	2
Diagnostic Tests - Amniocentesis	1
Diagnostic Tests - Chorionic villus sampling	1
Prescription Drugs	3
OTC Drugs (ex. Prenatal Vitamins)	10
Postpartum	
OB/GYN Office Visits	3
Lactation Specialists	9
Follow-up care for cesarian section	0
Laboratory Services	3
Ultrasounds/Imaging	0
Prescription Drugs	3
Behavioral Health	
Prescription drugs	0
Counseling/Therapy services	8

Some carriers provided caveats required for counseling/therapy services to count as preventive. Most carriers indicated that only postpartum screening was considered preventive. Others included counseling for healthy weight gain. Some carriers indicated that counseling services are only preventive if they are provided during a recommended preventive medical visit. Only two carriers indicated that postpartum depression counseling is considered preventive.

MATERNITY CARE REIMBURSEMENT METHODOLOGIES

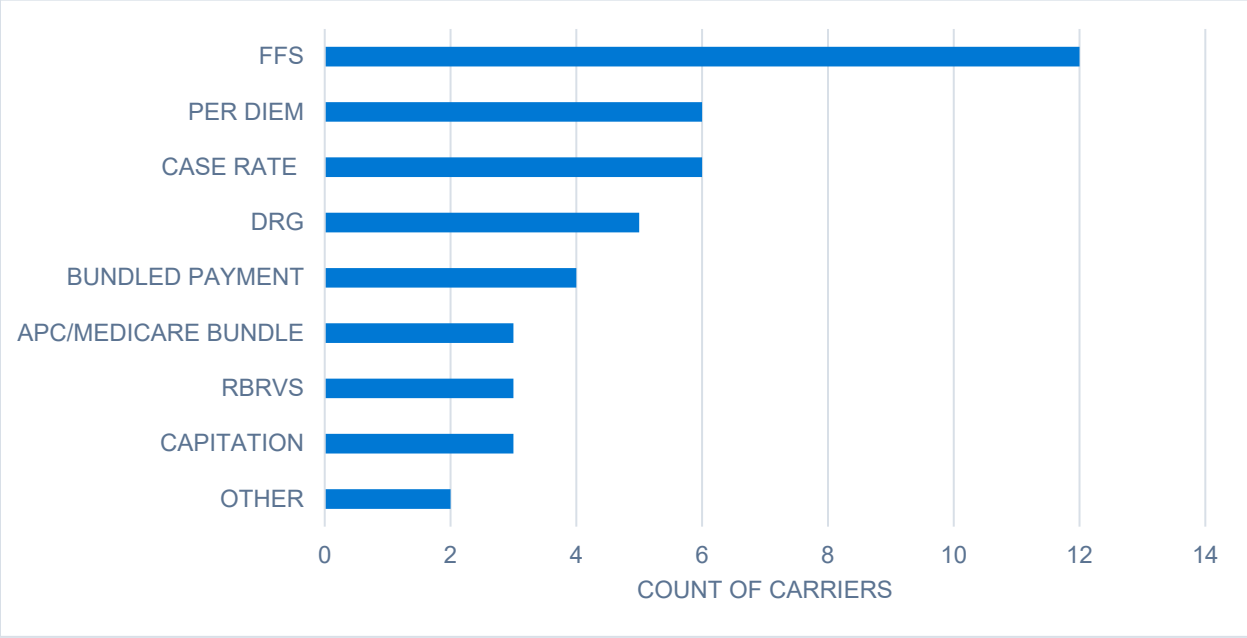
Maternity care reimbursement methods varied across carriers, but carriers did not vary their methods by source of health benefits. Commonly named reimbursement methods included:

- **Fee-for-Service (FFS):** Each service is paid for separately. The fee may be based on a fee schedule, percentage of charges billed by the provider per service, or percentage of charges for the services under a benchmark rate, such as Medicare.
- **Per Diem:** A daily payment system. Providers or facilities are paid a flat rate for each day a patient is under their care regardless of the number of services received.
- **Case Rate:** A single payment is made for all services related to a specific treatment or condition, possibly spanning multiple providers in multiple settings.

- **Bundled Payment:** This is a single payment for all services related to a treatment or condition, possibly spanning multiple providers in multiple settings.
- **Resource-Based Relative Value Scale (RBRVS):** This reimbursement system is used to determine how much medical providers should be paid for their professional services. It is based on the relative resources typically required to provide the service and was originally developed for the Medicare program.
- **Diagnosis Related Group (DRG):** This is a system to classify inpatient hospital cases into one of approximately 500 groups, also referred to as DRGs, expected to have similar hospital resource use.
- **Ambulatory Payment Classification (APC)/ Medicare Bundling**: The method used by the Centers for Medicaid and Medicare Services for paying for facility outpatient services for the Medicare program. Similar to the DRG system, APCs group outpatient services into APCs. A flat fee is paid for all services provided under the APC. Providers are reimbursed for their professional services via other methodologies, such as Current Procedural Terminology (CPT) codes.
- **Capitation:** Health plan pays a set amount for each enrolled person assigned to the provider, per period of time, whether or not that person seeks care.

Carriers generally use a combination of reimbursement methods. Only one carrier surveyed exclusively used fee-for-service for all facility and professional charges across all stages of maternity care. A summary of top reimbursement methodologies by count of carriers is reported in Exhibit 4 below.

EXHIBIT 4: TOP REIMBURSEMENT METHODOLOGIES REPORTED BY INSURANCE CARRIERS



Fee-for-service (FFS) is the most common reimbursement method reported by 12 carriers and is primarily used for professional services. The majority of prenatal care and postpartum care, including office visits, screening tests, laboratory services, imaging and prescription drugs, are reimbursed by FFS.

Some plans have a small percentage of prenatal and postpartum services reimbursed through another method such as capitation (3 carriers), or RBRVS (3 carriers).

Three carriers reported Medicare bundling or ambulatory payment classification (APC). They reported that these services apply to prenatal care and postpartum care. It is unclear what is meant as a “Medicare bundle” as maternity care services are not typically provided to Medicare recipients.

Facility charges are primarily reimbursed using DRGs (5 carriers), FFS (12 carriers), case rates (6 carriers) and/or per diem rates (6 carriers). The majority of facility charges typically occur as a part of labor and delivery and miscarriage or stillborn care. Prenatal diagnostic and screening tests may also have facility charges associated with the service.

Four carriers surveyed use at least one bundled payment, discussed in detail below, and two reported other reimbursement methodologies.

Services included in Bundled Payments

Four carriers we surveyed use at least one bundled payment arrangement to reimburse maternity health services. Two carriers have a single bundled payment which includes prenatal office visits, ultrasounds/imaging, professional services during labor and delivery, and postpartum OB/GYN office visits and follow up cesarean care. The other carriers use multiple bundled payment arrangements that cover different stages of maternal health care (e.g. all maternal services, prenatal care only, delivery only, delivery and postpartum care, or postpartum care only). Services in these bundles include prenatal office visits, urinalysis and ultrasounds/imaging, professional services and admission to the hospital during labor and delivery, postpartum OB/GYN office visits and follow up cesarean care. They do not include services for all conditions exacerbated by pregnancy.

NEWBORN CARE

Insurance carriers are not consistent with their treatment of newborn care reimbursement and cost sharing. For example, five carriers noted that newborns are automatically covered on the mother’s plan at birth for a number of days following birth, ranging from 21 to 30 days. The newborn services accumulate to the mother’s deductible and out of pocket maximums. However, one of these carriers noted that if the newborn is added to the mother’s insurance in the first 31 days, the newborn will be considered a dependent and their claims will be processed under their own deductible and out of pocket maximum.

One carrier noted that their contracts vary. Sometimes the newborn and the mother are on the same claim and other times they have separate claims and accumulators.

All other carriers reported that the newborn has its own independent cost sharing with its own accumulators.

Given the variation among carriers, if maternity cost sharing for labor and delivery services is eliminated, any legislation or regulation should be specific in its definition of how newborn birth hospital admissions are treated so that people using labor and delivery services are not surprised if they receive a hospital bill for their newborn’s hospital stay. To the extent that newborns’ claims remain under the mother’s member ID in the claims following delivery in the data underlying our analysis, then the newborns’ claims are classified as pregnancy-related services for the purpose of our analysis.

Financial Evaluation

The following service categories are considered in our analysis of maternity care services:

- Prenatal services - The prenatal period begins 270 days prior to the delivery or pregnancy end date. Services include office visits, laboratory services, ultrasound/imaging, prenatal screening tests (cell free DNA, carrier screening, amniocentesis, chorionic villus sampling), prescription drugs, and prenatal vitamins. This also includes treatment for any conditions that may impact the health outcomes of the pregnant person or baby during the prenatal period.
- Labor and Delivery – This includes all professional and facility charges for services received during the hospital stay for childbirth and delivery. It also includes miscarriage and stillborn care.
- Postnatal Services - The postnatal period is defined as the 12-week period following the delivery. This includes services such as office visits, lactation specialists, follow-up care for delivery, laboratory services, ultrasounds/imaging, behavioral health services, prescription drugs, as well as care for conditions exacerbated by pregnancy. The postnatal period for services that arise due to a complication associated with pregnancy, including mental and behavioral health care, extend up to one year following the delivery.

Elective pregnancy termination services do not have cost sharing effective January 1, 2024, and were not included in our analysis.[1]

Although the prenatal, labor and delivery, and postnatal period span greater than one year, our analysis captures the utilization of services in a single year, 2022, and trends them to 2025. This one-year snapshot does not capture the entire prenatal to postnatal experience for most women but does reflect a mix of prenatal, labor and delivery, and postnatal services that would be administered in a single year.

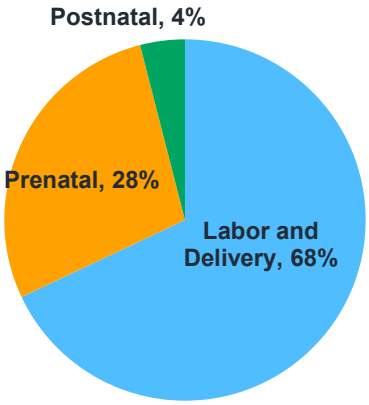
The cost and utilization of maternity care services vary by source of health benefits. Sources of health benefits with more enrollees of reproductive age and sex have a greater percentage of enrollees using maternity care services. Variation is also caused by whether an enrollee lives in an urban or rural region.

For enrollees using maternity care services, the estimated 2025 allowed claims per member per month (PMPM) is approximately $1500. This varies depending on the demographic and geographic mix of the enrolled population in each source of health benefits. The allowed claims include the health carrier paid and enrollee paid portions of the services. Of the total allowed claims, maternity care services account for 3% to 4% of the total allowed amount dollars. Enrollees using maternity care services account for 2% to 3% of total enrollees in each source of health benefits.

The distribution of maternity care services is displayed in Exhibit 5 below. Labor and Delivery accounts for 68% of total allowed charges, prenatal accounts for 28% of total allowed charges, and postnatal services account for 4% of total allowed charges.

[1] HB 1115

EXHIBIT 5: DISTRIBUTION OF ALLOWED COSTS FOR MATERNITY CARE SERVICES



The analysis calculates the premium and enrollee cost share impact if cost sharing is removed for maternity care services for the following five scenarios:

1. No cost sharing for all maternity care services
2. No cost sharing for prenatal services only
3. No cost sharing for postnatal services only
4. No cost sharing for labor and delivery services
5. No cost sharing for labor and delivery and postnatal services

To perform our analysis, we surveyed carriers requesting plan designs, premiums, and enrollment for the three highest enrollment plans for each source of health benefits as of October 1, 2023. Exhibit 6 below shows the membership modeled compared to the entire market membership as reported by the carriers. The corresponding premiums provided were trended to 2025 and weighted using plan enrollment to determine a baseline premium. These premiums represent the three highest enrollment plan design premiums, not the entire market premiums. The baseline premium reflects the current maternity care services benefits.

The three highest enrollment health plans represent nearly a third of the small group market, nearly 50% of the individual market and over 80% of the public employee market. The three highest enrollment health plans reflect only 6% of the large group market. This is because large group plans are more customizable than individual and small group health plans. For example, a large group plan may be filed with the insurance commissioner with cost sharing ranges instead of specific deductibles and copayments and the large group administrator may customize their plan using cost sharing within the ranges. In order to provide specific cost sharing, carriers provided their plan designs for the three largest employer groups by enrollment, which is a small portion of the total large group market.

EXHIBIT 6: PERCENTAGE OF MARKET MODELED AS OF OCTOBER 1, 2023

	Individual Cascade	Individual Non-Cascade	Small Group	Large Group	Public Employee	All Health Plans
Enrollment for Modeled Plans	49,400	92,500	102,200	43,700	353,500	641,300
Enrollment for Entire Market from Carrier Surveys	112,200	197,500	320,400	763,200	429,500	1,822,800
Percentage of the Market Modeled	44%	47%	32%	6%	82%	35%

For each plan provided, the actuarial value (i.e., which is the percentage of claims paid by the insurance company) was calculated for the baseline scenario and the five maternity service cost sharing scenarios described on page 12.

The actuarial values of each of the five maternity care service cost sharing scenarios were compared to the baseline to calculate the percentage impact on the premium.

When reviewing the premium and cost sharing impacts below, it is important to remember that the premium and cost sharing impacts were calculated using the three highest enrollment health plans from each carrier. Should the plans not modeled in this analysis vary greatly from the plans modeled, the actual enrollee cost sharing, premium, and actuarial value impacts may differ from the values produced by this analysis. These projections assume that the top highest enrollment health plans for each carrier and source of health benefits represent reasonable average plan designs.

The following five tables contain the results of this analysis by source of health benefits. For each of these scenarios, when cost sharing is eliminated, the modeling assumes that the services also will not be subject to deductible. The cost sharing values shown in these tables represent overall cost sharing for the plan and are not limited to only maternity care services.

EXHIBIT 7: NO COST SHARING FOR ALL MATERNITY CARE SERVICES

	Individual Cascade	Individual Non-Cascade	Small Group	Large Group	Public Employee	All Health Plans
Baseline - Per Member Per Month						
Premium	$559.74	$673.46	$656.92	$704.80	$673.38	$664.15
Enrollee Cost Share	$122.98	$177.30	$114.93	$62.08	$65.83	$92.52
Actuarial Value	0.820	0.792	0.851	0.919	0.911	0.878
Post Mandate - Per Member Per Month						
Premium	$563.57	$678.51	$662.00	$706.83	$675.13	$667.12
Enrollee Cost Share	$119.27	$172.36	$110.05	$60.15	$64.09	$89.70
Actuarial Value	0.825	0.797	0.857	0.922	0.913	0.881
Difference - Per Member Per Month						
Premium	$3.83	$5.05	$5.08	$2.03	$1.75	$2.97
Enrollee Cost Share	-$3.71	-$4.95	-$4.88	-$1.93	-$1.75	-$2.82
Actuarial Value	0.005	0.006	0.006	0.003	0.002	0.004
Difference - Total Annual Dollars						
Premium	$5,156,000	$11,963,000	$19,518,000	$18,615,000	$9,026,000	$64,278,000
Enrollee Cost Share	-$5,000,000	-$11,722,000	-$18,770,000	-$17,634,000	-$8,994,000	-$62,120,000
Difference (as a % of baseline)						
Premium	0.7%	0.7%	0.8%	0.3%	0.3%	0.4%
Enrollee Cost Share	-3.0%	-2.8%	-4.2%	-3.1%	-2.7%	-3.0%
Enrollment	112,200	197,500	320,400	763,200	429,500	1,822,800

Eliminating cost sharing for all maternity care services results in an estimated 0.4% total premium increase, with impacts ranging from 0.3% in the large group and public employee sources of health benefits to 0.8% in the small group source of health benefits. Individual and small group plans show a larger impact due to higher deductibles, copayments, and out-of-pocket maximums for maternity care services than their large group and public employee counterparts. This increase in premium is accompanied by a 3.0% reduction in the enrollee cost share. Enrollee cost share reductions range from 2.7% to 4.2%.

EXHIBIT 8: NO COST SHARING FOR PRENATAL SERVICES

	Individual Cascade	Individual Non-Cascade	Small Group	Large Group	Public Employee	All Health Plans
Baseline - Per Member Per Month						
Premium	$559.74	$673.46	$656.92	$704.80	$673.38	$664.15
Enrollee Cost Share	$122.98	$177.30	$114.93	$62.08	$65.83	$92.52
Actuarial Value	0.820	0.792	0.851	0.919	0.911	0.878
Post Mandate - Per Member Per Month						
Premium	$560.54	$674.47	$657.66	$705.15	$673.68	$664.67
Enrollee Cost Share	$122.20	$176.31	$114.24	$61.74	$65.53	$92.02
Actuarial Value	0.821	0.793	0.852	0.919	0.911	0.878
Difference - Per Member Per Month						
Premium	$0.79	$1.01	$0.74	$0.36	$0.30	$0.52
Enrollee Cost Share	-$0.78	-$1.00	-$0.69	-$0.34	-$0.30	-$0.49
Actuarial Value	0.001	0.001	0.001	0.000	0.000	0.001
Difference - Total Annual Dollars						
Premium	$1,068,000	$2,396,000	$2,827,000	$3,272,000	$1,564,000	$11,127,000
Enrollee Cost Share	-$1,049,000	-$2,368,000	-$2,640,000	-$3,098,000	-$1,560,000	-$10,715,000
Difference (as a % of baseline)						
Premium	0.1%	0.2%	0.1%	0.1%	0.0%	0.1%
Enrollee Cost Share	-0.6%	-0.6%	-0.6%	-0.5%	-0.5%	-0.5%
Enrollment	112,200	197,500	320,400	763,200	429,500	1,822,800

Eliminating cost sharing for prenatal services results in an estimated 0.1% total premium increase. This increase in premium is accompanied by a 0.5% reduction in the enrollee cost share. The effects of eliminating prenatal cost sharing are significantly smaller than eliminating all maternity cost sharing because prenatal services are less than a third of total maternity costs. This result also reflects that prenatal services are primarily subject to copayments, rather than deductibles and coinsurances.

EXHIBIT 9: NO COST SHARING FOR POSTNATAL SERVICES

	Individual Cascade	Individual Non-Cascade	Small Group	Large Group	Public Employee	All Health Plans
Baseline - Per Member Per Month						
Premium	$559.74	$673.46	$656.92	$704.80	$673.38	$664.15
Enrollee Cost Share	$122.98	$177.30	$114.93	$62.08	$65.83	$92.52
Actuarial Value	0.820	0.792	0.851	0.919	0.911	0.878
Post Mandate - Per Member Per Month						
Premium	$559.82	$673.56	$657.01	$704.84	$673.42	$664.21
Enrollee Cost Share	$122.91	$177.20	$114.86	$62.03	$65.79	$92.46
Actuarial Value	0.820	0.792	0.851	0.919	0.911	0.878
Difference - Per Member Per Month						
Premium	$0.08	$0.10	$0.08	$0.04	$0.04	$0.06
Enrollee Cost Share	-$0.08	-$0.10	-$0.08	-$0.04	-$0.04	-$0.06
Actuarial Value	0.000	0.000	0.000	0.000	0.000	0.000
Difference - Total Annual Dollars						
Premium	$104,000	$245,000	$316,000	$400,000	$226,000	$1,291,000
Enrollee Cost Share	-$101,000	-$239,000	-$293,000	-$383,000	-$225,000	-$1,241,000
Difference (as a % of baseline)						
Premium	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Enrollee Cost Share	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%
Enrollment	112,200	197,500	320,400	763,200	429,500	1,822,800

Eliminating cost sharing for postnatal services results in an estimated 0% total premium increase, and the enrollee cost share is estimated to be reduced by 0.1%. The effects of eliminating postnatal cost sharing are significantly smaller than eliminating all maternity cost sharing because postnatal services are less than 5% of total maternity costs and by time a person has postnatal visits, their maximum out-of-pocket is likely to have been already met by the costs of labor and delivery.

EXHIBIT 10: NO COST SHARING FOR LABOR AND DELIVERY SERVICES

	Individual Cascade	Individual Non-Cascade	Small Group	Large Group	Public Employee	All Health Plans
Baseline - Per Member Per Month						
Premium	$559.74	$673.46	$656.92	$704.80	$673.38	$664.15
Enrollee Cost Share	$122.98	$177.30	$114.93	$62.08	$65.83	$92.52
Actuarial Value	0.820	0.792	0.851	0.919	0.911	0.878
Post Mandate - Per Member Per Month						
Premium	$561.28	$675.38	$659.94	$705.76	$674.23	$665.57
Enrollee Cost Share	$121.45	$175.39	$111.98	$61.16	$64.99	$91.14
Actuarial Value	0.822	0.794	0.855	0.920	0.912	0.880
Difference - Per Member Per Month						
Premium	$1.54	$1.92	$3.02	$0.97	$0.85	$1.42
Enrollee Cost Share	-$1.53	-$1.92	-$2.95	-$0.92	-$0.85	-$1.37
Actuarial Value	0.002	0.002	0.004	0.001	0.001	0.002
Difference - Total Annual Dollars						
Premium	$2,076,000	$4,549,000	$11,601,000	$8,856,000	$4,374,000	$31,456,000
Enrollee Cost Share	-$2,061,000	-$4,548,000	-$11,355,000	-$8,385,000	-$4,360,000	-$30,709,000
Difference (as a % of baseline)						
Premium	0.3%	0.3%	0.5%	0.1%	0.1%	0.2%
Enrollee Cost Share	-1.2%	-1.1%	-2.6%	-1.5%	-1.3%	-1.5%
Enrollment	112,200	197,500	320,400	763,200	429,500	1,822,800

Eliminating cost sharing for labor and delivery services results in an estimated 0.2% total premium increase. This increase in premium is accompanied by a 1.5% reduction in the enrollee cost share. The effects on the different sources of health benefits are similar to the first scenario with all maternity cost sharing removed but on a smaller scale.

EXHIBIT 11: NO COST SHARING FOR LABOR, DELIVERY, AND POSTNATAL SERVICES

	Individual Cascade	Individual Non-Cascade	Small Group	Large Group	Public Employee	All Health Plans
Baseline - Per Member Per Month						
Premium	$559.74	$673.46	$656.92	$704.80	$673.38	$664.15
Enrollee Cost Share	$122.98	$177.30	$114.93	$62.08	$65.83	$92.52
Actuarial Value	0.820	0.792	0.851	0.919	0.911	0.878
Post Mandate - Per Member Per Month						
Premium	$561.36	$675.48	$660.03	$705.81	$674.27	$665.64
Enrollee Cost Share	$121.38	$175.28	$111.90	$61.12	$64.94	$91.08
Actuarial Value	0.822	0.794	0.855	0.920	0.912	0.880
Difference - Per Member Per Month						
Premium	$1.62	$2.02	$3.10	$1.01	$0.89	$1.49
Enrollee Cost Share	-$1.61	-$2.02	-$3.03	-$0.96	-$0.89	-$1.43
Actuarial Value	0.002	0.002	0.004	0.001	0.001	0.002
Difference - Total Annual Dollars						
Premium	$4,243,000	$3,921,000	$9,279,000	$6,821,000	$3,357,000	$30,169,000
Enrollee Cost Share	-$4,231,000	-$3,868,000	-$9,083,000	-$6,463,000	-$3,346,000	-$29,532,000
Difference (as a % of baseline)						
Premium	0.3%	0.3%	0.5%	0.1%	0.1%	0.2%
Enrollee Cost Share	-1.3%	-1.1%	-2.6%	-1.5%	-1.4%	-1.5%
Enrollment	112,200	197,500	320,400	763,200	429,500	1,822,800

Eliminating cost sharing for labor and delivery and postnatal services results in an estimated 0.2% total premium increase. This increase in premium is accompanied by a 1.5% reduction in the enrollee cost share. These results are very similar to removing cost sharing on labor and delivery only.

The premium impacts contained in Exhibits 7 to 11 assume no additional benefit changes from those described by the scenario. For example, if a premium impact of 1% is shown, that 1% is purely due to the maternity cost sharing reduction assumed in the scenario. In actuality, plans may make other benefit changes to offset any impacts produced by the reduction of maternity cost sharing such as reducing the richness of non-maternity benefits or increasing the deductible. Such offsetting benefit changes are not modeled as part of these projections.

The impacts do not assume any additional utilization of maternity care services due to elimination of cost sharing. To determine induced utilization of maternity care services, we would need to understand which enrollees are not currently using maternity care services due to cost sharing. It is possible that elimination of maternity cost sharing would increase the number of services. Depending on the additional services used, it is possible that the increase in services would result in lower maternity costs. For example, if more enrollees get tested for gestational diabetes due to cost sharing elimination, it may result in a reduction in total cost due to better management of the condition and a reduction in complications.

National Landscape of Proposed Benefits

Several states have considered proposals to mandate insurance coverage of maternity care services, with wide variation across the definition of what constitutes maternity care services and consideration of a range of benefits and drawbacks of such mandates. This section describes a selection of state policies and policy proposals related to health insurance mandates that require insurance coverage of maternity care services. We also discuss maternity and pregnancy related benefits included in a selection of states' Essential Health Benefit (EHB) benchmark plans.

POLICY ANALYSIS BY STATE

MARYLAND

Policy: As proposed, Senate Bill 535[2], *Health Insurance - Labor and Delivery Services – Cost-sharing Requirements*

Last Action: (2/14/2024) Senate Finance Committee Public Hearing

Summary

During the 2023 regular legislative session, the Maryland General Assembly considered proposed Senate Bill 784, which would require insurers to provide coverage for labor and delivery services without cost sharing. The proposal applied to group and individual insurance contracts provided by insurers and nonprofit health service plans.

The Finance Committee held a public hearing on the proposed bill on March 8, 2023, which garnered support from several Maryland-based organizations including the Maryland Affiliate of the American College of Nurse Midwives[3], the Maryland chapter of the American College of Obstetrics and Gynecology[4], and the Women's Law Center of Mayland[5]. Favorable testimony cited high average out-of-pocket costs for labor and delivery services and highlighted the mandate as an essential element of the broader campaign to protect access to and the provision of reproductive health care services.

The League of Life and Health Insurers of Maryland delivered opposing testimony[6], citing considerable impacts to premium affordability if plans were required to cover these services with no cost-sharing.

While the proposal ultimately did not pass, the Health and Government Operations committee requested that the Maryland Health Care Commission (MHCC) evaluate the proposal, under its charge in accordance with Insurance Article 15-1501. The Insurance Article requires the MHCC's analysis to address the social, medical, and financial impacts of health insurance mandate policies. MHCC contracted with Milliman to perform the analysis[7].

- The study highlights that the American College of OBGYNs and AAP advise that hospitals and accredited birthing centers are the safest places to give birth. The medical impact of mandated reduction or elimination of cost-sharing for labor and delivery services could lead to more individuals electing to labor and deliver at hospitals and accredited birthing centers.
- Eliminating cost sharing on labor and delivery would allow commercially insured families to allocate these savings toward other expenses, including child rearing related expenses, and reduce financial stress.
- Many large group plans in Maryland's market already cover labor and delivery services with zero cost-sharing.

In the 2024 Legislative Session, the legislation was reintroduced as Senate Bill 535. The proposal is materially the same as Senate Bill 784 from 2023. A public hearing was held for the proposal in the Senate Finance committee on February 14, 2024. Testimony for this bill is similar to that received for the 2023 version of the bill, with the only unfavorable testimony delivered by the League of Life and Health Insurers of Maryland. The proposal did not pass prior to the close of Maryland's legislative session.

[2] Legislation - SB0535 (maryland.gov)
[3] Talking Points to discuss with your Legislator (maryland.gov)
[4] SB 784 Letter of Support (maryland.gov)
[5] Testimony of the Women's Law Center of Maryland (maryland.gov)
[6] SB 784 Letter of Opposition (maryland.gov)
[7] HB0937 Evaluation Report (maryland.gov)

MASSACHUSETTS

Policy: As proposed, House Bill 1137[8] and Senate Bill 646[9] (companion bills) *An Act ensuring access to full spectrum pregnancy care.*

Last Action: (3/7/2024) Reported favorably to the committee on Health Care Financing.

Summary

The Massachusetts legislature has considered similar proposals to remove cost sharing for "full spectrum pregnancy care" over the course of several legislative sessions. In 2021, companion bills H.1196 and S.673 were introduced but ultimately referred to the Massachusetts Center for Health Information and Analysis (CHIA) by the Joint Committee on Financial Services. Under Massachusetts law, CHIA reviews legislation that proposes to add a new health benefit mandate for health plans offered within the Commonwealth. CHIA's benefit mandate review includes an assessment of the medical efficacy of the treatment or services included in each mandated benefit bill, as well as the fiscal impact, including changes to premiums and administrative expenses.

Relevant findings from the CHIA's report[10] on the companion bills are summarized below:

Defining Maternity Services CHIA's report categorizes maternity services in three ways: Prenatal care, childbirth, and postpartum care. The report refers to the US Preventive Services Taskforce (USPSTF) and Centers for Medicare and Medicaid services (CMS) preventive care recommendations for pregnant, perinatal, and postpartum women. It highlights that the ACA requires non-grandfathered health plans in the individual and small group markets to cover EHBs, which include maternity and newborn care. Services covered as a part of EHBs are defined by a given state's EHB benchmark plan. In Massachusetts, the benchmark plan covers prenatal care with no cost sharing, and childbirth and postpartum care with no cost sharing after the deductible for inpatient hospital services is met.

Estimated Cost Impact CHIA's analysis estimates that the mandate, if implemented as proposed, could increase fully insured premiums by 0.28% over the five years following implementation, equivalent to an average annual expenditure of $42.9 million. This includes the removal of cost sharing for abortion services and maternity care. CHIA used 2018 claims data from the state's All Payer Claims Database (APCD) to estimate the 2018 member cost sharing associated with both abortion related services and maternity services. Based on this data, the PMPM estimate for member cost sharing for maternity services was $1.24. CHIA's analysis used this PMPM cost estimate to project costs into the period following implementation of the proposed benefit mandate.

CALIFORNIA

Policy: Requirements related to maternity services

Summary

The California Health Benefits Review Program (CHBRP) prepares independent analyses of health insurance benefit mandates at the request of the California Legislature. As of its November 14, 2023 report[11], California mandates insurance coverage of four categories of maternity care services:

- Copayment or deductible for inpatient services: limits copayments and deductibles for inpatient hospital maternity services and ambulatory care maternity services to the "most common amount of the copayment or deductible contained in the policy for inpatient services provided for other covered medical conditions"
- Maternal mental health: requires health insurers to establish a maternal mental health program. The policy includes the following definition of maternal mental health: "a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

[8] Bill H.1137 (malegislature.gov)

[9] Bill S.646 (malegislature.gov)

[10] MBR-Access-to-Full-Spectrum-Pregnancy-Care.pdf (chiamass.gov)

[11] CA Mandates FINAL 111423.pdf (chbrp.org)

- Maternity Services: defines Maternity Services that must be covered by group and individual health insurance plans as "prenatal care, ambulatory care maternity services, involuntary complications of pregnancy, neonatal care, and inpatient hospital maternity care, including labor and delivery and postpartum care."
- Minimum Length of Stay: for group and individual health insurance policies, prohibits certain coverage restrictions as it relates to benefits, length of stay or prescribed home visits. This is in line with federal requirements. In general, group and individual health insurance plans are required to provide coverage for a hospital stay that is not less than 48 hours following a vaginal delivery and 96 hours following a delivery by cesarean section[12].

NEW YORK

On January 4, 2024, New York's Governor Kathy Hochul announced[13] a sharp policy focus on the Maternal and Infant Mortality Crisis with a "comprehensive six-point plan." The plan describes an effort that the Governor will undertake to eliminate copays and other out-of-pocket costs for those enrolled in New York's Essential Plan and qualified health plans. The Governor's policy proposals reference the approximately 1.3 million New York residents that would be impacted by the change to cost sharing, which would increase access to routine pregnancy-related care. At the time of this analysis, there is not yet a published legislative proposal to implement the Governor's proposed policy, but the state's General Assembly is considering a number of proposals related to increasing access to maternity care services.

The Governor's proposed plan to address the Maternal and Infant Mortality Crisis in New York also includes an initiative to cover doula services for maternity care. Doula services would be required to be covered in the same way that midwife services are currently required as a component of maternity services. New York's General Assembly continues to consider several other proposals related to the provision and coverage of doula services as they relate to maternity care.

EHB BENCHMARK PLAN SUMMARY INFORMATION

Under the Affordable Care Act (ACA), qualified health plans (QHPs) must cover ten categories of benefits, otherwise known as Essential Health Benefits (EHBs). States are required to designate an EHB Benchmark plan for QHPs offered in the state. An EHB benchmark plan is the plan a state designates as their standard for EHBs relative to other plans in the insurance exchange or Marketplace. For QHPs to be offered on a state's marketplace, (the Health Benefit Exchange in Washington state) issuers must cover the services included in the selected benchmark plan. Maternity and newborn care and preventive and wellness services are two of the ten required EHBs.

EHB benchmark plans are used to define which benefits are covered in a state's EHB and any internal limits (e.g., annual visit limits), but do not impact what the cost sharing is for these benefits. However, the EHB benchmark plan options were selected as plans that were reasonably representative of a typical plan available to consumers in each state and are a helpful benchmark to consider when evaluating cost sharing patterns in a state. In this section, we describe maternity care and women's preventive health care attributes found in states' EHB benchmark plans.

California Benchmark Plan Information[14]

California designated the Kaiser Permanente Small Businesses $30 Copayment Plan as its EHB benchmark plan for plan years 2017 through 2025.

- Deductible: None
- Out-of-Pocket Maximum: $3,000 individual, $6,000 family (two or more members)

The plan covers well-woman exams as routine physical maintenance exams at no charge. Additionally, it covers outpatient care after confirmation of pregnancy and the normal services of regularly scheduled preventive prenatal

[12] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet

[13] https://www.governor.ny.gov/news/governor-hochul-unveils-third-proposal-2024-state-state-taking-maternal-and-infant-mortality

[14] https://www.cms.gov/cciio/resources/data-resources/downloads/2017-bmp_ca.zip

care exams at no charge. Additionally, the first postpartum follow-up consultation and exam is covered with no charge.

Family planning coverage includes termination of pregnancy at a $30 copayment per procedure. The plan also discusses the responsibility of the insured as it relates to surrogacy arrangements. If a member enters into a surrogacy arrangement, it does not affect any cost share obligation, but the contract discusses how the plan interfaces with the financial responsibility of the legal parents of the child or children as a result of the surrogacy.

The plan also includes limited coverage for urgent care services related to pregnancy, childbirth, and immediate postpartum services in the event that they occur at an out-of-network facility or are provided by out-of-network provider(s).

Massachusetts Benchmark Plan Information[15]

Massachusetts designated the BlueCross BlueShield of Massachusetts (BCBSMA) HMO Blue New England $2,000 deductible option plan as its EHB benchmark plan for plan years 2017 through 2025.

- Deductible: $2,000 individual; $4,000 family
- Out-of-pocket maximum: $5,350 individual, $10,700 family

The EHB benchmark plan includes the following maternity or pregnancy related services as described in the plan documents:

- Maternity services are listed as covered with “no charge after the deductible for inpatient hospital services” including delivery and postnatal care.
  - Includes minimum length of stay coverage consistent with federal requirements.
  - Payment for prenatal and postnatal care by an in-network physician or nurse midwife in conjunction with delivery costs.
  - Coverage is included for childbirth classes for up to $90 for one childbirth course for each covered expectant mother, and $45 for each refresher course.
- Prenatal care and well newborn care during an enrolled mother’s maternity admission are both covered at no charge and are not subject to the deductible.
- No benefits are provided for home birth, except in the event of an emergency or unplanned delivery at home prior to being admitted to a hospital or for maternity services furnished outside of Massachusetts.
- Well newborn inpatient care is covered when it occurs during the enrolled mother’s inpatient maternity stay, including pediatric care by a pediatrician or nurse practitioner and routine circumcision.
- Routine nursery charges that are furnished during an enrolled mother’s maternity admission are covered and not included in “non-covered” services or supplies received when a member was not enrolled in the health plan.
- Prescription drug coverage under this plan includes coverage for prescription prenatal vitamins and pediatric vitamins with fluoride.

The EHB benchmark plan defines preventive health services for women as those recommended by the US Department of Health and Human Services, including yearly well-woman visits; domestic violence screening; HPV DNA testing; screening for HIV; birth control methods and counseling; screening for gestational diabetes; and breastfeeding support and breast pumps (as durable medical equipment). One routine gynecological exam is covered for each member in each calendar year by an in-network provider, which may be a physician, nurse practitioner or nurse midwife. This includes one routine Pap smear test for each member each calendar year.

Maryland Benchmark Plan Information[16]

Maryland chose the CareFirst BlueChoice HMO group plan for its EHB benchmark plan for plan years 2017 through 2025.

[15] https://www.cms.gov/cciio/resources/data-resources/downloads/2017-bmp-summary_ma_4816.zip

[16] https://www.cms.gov/cciio/resources/data-resources/downloads/md-bmp.zip

- Deductible: $1,500 individual, $3,000 family
- Out-of-pocket maximum: $4,000 individual, $8,000 family

Maternity and related services are included in the plan's definition of preventive services. The plan uses the standard of evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the USPSTF. These preventive services as they relate to maternity services include:

- Preventive outpatient obstetrical care of an uncomplicated pregnancy including prenatal evaluation and management office visits, and one postpartum office visit.
- Prenatal lab test and diagnostic services relative to the above outlined outpatient prenatal care. These services must also be consistent with the USPSTF's "A" and "B" ratings or provided in the comprehensive guidelines for women's preventive health supported by the US Health Resources and Services Administration.
    - Preventive lab tests and services for a newborn rendered during the delivery hospitalization. These services must also be consistent with the same guidance as prenatal lab tests and the periodicity schedule of the Bright Futures Recommendations for the Pediatric Preventive Health Care and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, including the collection of adequate samples for hereditary and metabolic newborn screening and newborn hearing screening.
    - Breastfeeding support, supplies, and consultation.

Methodology and Assumptions

OVERALL APPROACH

We developed a cost model that estimates total medical and pharmacy claims costs per member per month (PMPM). The claims costs estimates were developed using data from Washington State in Milliman's proprietary Consolidated Health Cost Guidelines Sources Database (CHSD). These estimates were normalized for demographics and area mix to Washington's total commercial population by using data from Washington's All Payer Claims Databases (APCD). The claims are separated into member cost sharing (in the form of copays, coinsurance, and deductibles) and insurance carrier share of cost. Cost sharing is applied by maternity stage (prenatal, labor and delivery, and postnatal) and at detailed types of service.

We requested the top three plan designs for each source of health benefits from each insurance carrier and used these plan designs to develop estimated premium impacts for the following markets:

- Individual health plans other than Cascade Select plans
- Cascade Select health plans
- Small group health plans
- Large group health plans
- Public employee health plans (PEBB and SEBB)
- All health plans in aggregate

We applied the benefit design as received from the carriers to calculate the "Baseline" premium, claims, and cost-sharing. We then calculated the premium, claims, and cost-sharing for each scenario by changing the benefit design input into the model by removing corresponding cost sharing for the scenario being modeled. For example, to calculate the "all maternity care services" scenario $0 cost sharing was applied to all maternity care services. The premium claims and cost-sharing impacts of each scenario were calculated as the difference between each scenario and baseline (premium, claims, and cost-sharing).

DATA AND CLAIMS CLASSIFICATION

The data used to develop our pricing model comes from Milliman's proprietary CHSD. We used claims incurred in 2022, with lookback periods to 2021 where necessary, for members located in Washington. We assessed that 2022 data was appropriate to use for projection purposes because it is the latest year of complete data available and based on a review of birthrates over the time period from 2019 through 2022, 2022 is representative of a typical year. The population size in the CHSD remained consistent throughout this time period and we did not observe any deviations (upwards or downwards) in birth rates during the COVID-19 pandemic or following it.

A team of clinical experts at Milliman put together a detailed analysis plan to identify pregnancy-related claims in the following time periods: prenatal, delivery, postnatal period 1, postnatal period 2, and pregnancy end. The following steps detail how we classified claims for our modeling. We required that members have both medical and pharmacy coverage.

Step 1: Identified population with pregnancy-related services

The Milliman clinical team provided a list of procedure codes, diagnosis codes, and national drug codes (NDCs) that identify pregnancy-related services. These are broken out by prenatal, delivery, postnatal, and pregnancy end. We identified all members who had at least one medical claim classified as pregnancy-related and pulled a subset of claims for these members. Members could not be classified as maternity members based solely on pharmacy claims. Claims for all other members are set aside until the end and are classified as non-pregnancy-related.

Step 2: Assigned delivery or pregnancy end dates and types

For members who have been flagged with delivery or pregnancy end claims, we identified the delivery or pregnancy end date at a member level. For members with a pregnancy end code, we assigned the type as either induced, spontaneous, or no assignment.

Step 3: Assigned begin and end dates for prenatal and postnatal periods

These dates were assigned on a hierarchy based on what types of claims were identified for each member.

- For members with delivery or pregnancy end claims:[17]
  - The prenatal period starts 270 days prior to the delivery or pregnancy end and ends one day before it.
  - The first postnatal period starts the day after the delivery or pregnancy end and lasts seven weeks (84 days) or until the end of the analysis period.[18]
  - The second postnatal period starts the day after the first postnatal period and lasts until one year after the delivery or pregnancy end date.
- For members with prenatal claims, but not delivery or pregnancy end:
  - Prenatal period starts at earliest date in analysis period with a claim identified as prenatal and ends at the earliest of the last date in the analysis period with a claim identified as prenatal, 270 days later, or the last date of the analysis period.
  - Postnatal period 1 starts the day after the prenatal period end date and ends at the earliest of 84 days after the start of the period or at the end of the analysis period.
  - Postnatal period 2 starts the day after the first postnatal period ends and it ends at the earliest of the first postnatal period's end date plus 281 days or at the end of the analysis period.
- For members with postnatal claims, but not prenatal, delivery, or pregnancy end claims:
  - Postnatal period 1 starts from the earliest postnatal claim and ends at the earliest of the last postnatal claim, 84 days after the start of the period, or at the end of the analysis period.
  - Members whose postnatal 1 period ended with the last postnatal claim do not have a second postnatal period. For others, the second postnatal period starts the day after the first postnatal period ends and it ends at the earliest of the first postnatal period's end date plus 281 days or at the end of the analysis period.

Given the extended length of the postnatal period (up to one year post-delivery), members with a second pregnancy can have dates falling in multiple periods. When a member is in more than one period at a time, we use the following hierarchy to assign pregnancy-related claims to just one period:

- Delivery
- Prenatal
- Postnatal period 1
- Postnatal period 2

Step 4: Pulled all claims for members in the relevant time period

Starting from the subset of claims for members with a pregnancy-related claim, we further subset the data by pulling only medical claims that fall within the data ranges for members' prenatal, delivery, and postnatal periods. We also pull pharmacy claims during these time periods and include an additional three months of claims before the start of the prenatal period for an extended lookback.

Step 5: Constructed inpatient, outpatient surgery, and emergency department (ED) / observation cases for identification of pregnancy-related services

Services are bundled into inpatient cases or outpatient cases using dates of service in this hierarchical order:

- Using the Medicare severity diagnosis related group (MS-DRG) for the inpatient case, each inpatient admit was assigned to a family grouping.
- For outpatient surgery and emergency department / observation cases, the claim line with the highest allowed amount was identified and assigned to a family.

[17] This includes members with 2021 pregnancies whose postnatal claims fall in the analysis period.

[18] The analysis period is calendar year 2022.

For inpatient admits, all services that occurred between the admission date and the discharge date were bundled into the admit as a case. For outpatient surgery and ED / observation, all services that occur on the day of the encounter are bundled into a case.

Step 6: Identified and excluded services related to pregnancy end

Pregnancy end services already have cost-sharing covered, so we must explicitly identify and exclude these services. For members with a pregnancy end date and pregnancy end type of "induced," we identify and exclude pregnancy end-related procedural services during any time period for that member. Pregnancy end-related procedural services include:

- Abortion-related inpatient cases, identified by MS-DRGs
- ED / observation cases identified by pregnancy end procedure codes on any claim in the case
- Outpatient surgery cases with a pregnancy end procedure code on any claim in the case
- Any drugs with a national drug code (NDC) identified as a pregnancy end-related drug

Step 7: Classified claims by time period and whether they are pregnancy-related

Inpatient stays were categorized as pregnancy-related according to the following logic:

- Prenatal and delivery stays were always pregnancy-related, regardless of diagnosis codes. These were identified by the family of the MS-DRG on the admit.
- Certain MS-DRG families that occurred in the first postnatal period were always considered pregnancy-related.
- Others will require an accompanying pregnancy-related diagnosis code.
- All MS-DRG families that occurred in the second postnatal period did not require an accompanying pregnancy-related diagnosis code.

ED / observation stay cases are categorized as pregnancy-related according to the following logic:

- ED / observation stay cases are categorized as pregnancy-related when the case includes a pregnancy-related diagnosis code on any claim included in the case during the prenatal or first postnatal period.
- Other cases during the first postnatal period require a pregnancy-related diagnosis code or a complication-related diagnosis code.
- All MS-DRG families that occur in the second postnatal period do not require an accompanying pregnancy-related diagnosis code.

Outpatient surgery cases are categorized as pregnancy-related according to the following logic:

- Outpatient delivery cases are always pregnancy-related and are identified by a procedure code.
- Outpatient surgery cases are pregnancy-related when the case includes a pregnancy-related diagnosis on any claim included in the case during the prenatal period or the first postnatal period.
- Other cases during the first postnatal period require a pregnancy-related diagnosis code or a complication-related diagnosis code.
- Outpatient surgery cases are categorized as pregnancy-related in the second postnatal period when there is a pregnancy or complication-related diagnosis indicated as being applicable to this period.
  - This is a subset of the pregnancy-related codes that apply during the other time periods.

Home and office visits are categorized as pregnancy-related according to the following logic:

- For obstetrics/gynecology, certified nurse midwife and birthing center specialties, all office visits are pregnancy-related, regardless of diagnosis codes, during the prenatal and both postnatal periods.
- For all other specialties, office and home visits (including telehealth) are pregnancy-related when the claim includes a pregnancy-related or complication-related diagnosis code in any position during the prenatal period or the first postnatal period.
- Office and home visits in the second postnatal period are categorized as pregnancy-related when the accompanying diagnosis code is indicated as being applicable to this time period.

Lactation services, home birth medical supplies, and doula services are categorized as pregnancy related according to the following logic:

- Identify pregnancy-related other services (lactation services, home birth medical supplies, doula services) by families when the claim line includes a pregnancy-related diagnosis code in any position during the prenatal period or the first postnatal period.
- Other claims during the first postnatal period require a pregnancy-related diagnosis code or a complication-related diagnosis code.
- Other services are categorized as pregnancy-related in the second postnatal period when there is a pregnancy or complication-related diagnosis indicated as being applicable to this period.
  - This is a subset of the pregnancy-related codes that apply during the other time periods.

Step 8: Pharmacy claims classification

For scripts filled in the prenatal period, we first identified the script's therapeutic class. We looked in the 30 days prior to the prenatal period start date to see if there is a days' supply of a drug in the same therapeutic class. If no days' supply in the same therapeutic class is observed in that time period, then the script is designated as pregnancy-related. If there is a days' supply in the same therapeutic class in the 30 days prior to start of the prenatal period, then the script is not designated as pregnancy-related. For scripts where the patient does not have 30 days of enrollment before the prenatal period start date, no scripts in the prenatal period are designated as pregnancy-related.

For scripts filled in either postnatal period, we first identified the script's therapeutic class. We looked in the 30 days prior to the first postnatal period start date to see if there is a days' supply of a drug in the same therapeutic class. If no days' supply in the same therapeutic class is observed in that time period, then the script is designated as pregnancy-related. If there is a days' supply in the 30 days prior to pregnancy end or delivery date of a drug in the same therapeutic class AND that days' supply is from a script (which would have been filled during the prenatal period) that has been deemed pregnancy-related, then designate the script in the postnatal period is also designated as pregnancy-related. If that prenatal period script has not been designated as pregnancy-related, then the postnatal script is not designated as pregnancy-related. For scripts identified in the postnatal periods where 30 days are not observed prior to the delivery or pregnancy end date, these scripts are not designated as pregnancy-related.

AVERAGE COST AND UTILIZATION

We calculated average cost per service and annual utilization per thousand by the following categories:

Demographics

We grouped the data into age/sex bands and separated the data by urban or rural. We also separated the data by whether the member had a maternity claim in the assignment period.

Service Type

We separated average cost and utilization by the following service types:

FACILITY/PROFESSIONAL/RX	SERVICE TYPE
Facility	Inpatient
Facility	Skilled Nursing Facility
Facility	Outpatient Emergency Department
Facility	Outpatient Surgery
Facility	Outpatient Laboratory
Facility	Outpatient Imaging
Facility	Outpatient Habilitative and Rehabilitative Services
Facility	Outpatient Behavioral Health
Facility	Outpatient Preventive Services
Facility	Outpatient Other

FACILITY/PROFESSIONAL/RX	SERVICE TYPE
Professional	Inpatient
Professional	Outpatient Emergency Department
Professional	Outpatient Surgery
Professional	Urgent Care
Professional	Primary Care Office Visits
Professional	Specialist Office Visits
Professional	Laboratory
Professional	Imaging
Professional	Physical Therapy
Professional	Outpatient Behavioral Health
Professional	Preventive Services
Professional	Other
Rx	Preferred Generic
Rx	Non-preferred Generic
Rx	Preferred Brand
Rx	Non-preferred Brand
Rx	Specialty
Rx	Preventive

For each of the service types listed above we also separated average cost and utilization by the following maternity service groups:

- Non-maternity related services
- Prenatal
- Labor and Delivery
- Postnatal Period 1
- Postnatal Period 2
- Pregnancy End
- Lactation
- Medical Supplies

For each source of health benefits and service type, we blended the average cost per service and annual utilization per thousand based on the percentage of members in each demographic category from the Washington APCD.

TREND

We trended the claims data summarized by source of health benefits, age, sex, geography and type of service, from 2022 to 2025 to model the impact on 2025 commercial premiums. We relied on Milliman Health Cost Guidelines (HCGs) and Milliman Health Trend Guidelines (HTGs) to determine annual trends from 2022 to 2025. The HTGs contain historical statewide trends. Comparing Washington trends to nationwide averages shows that Washington was approximately 1.5% greater than nationwide average trends. The following table shows the annualized trends that we applied by broad service category:

EXHIBIT 12: SERVICE CATEGORY UTILIZATION AND UNIT COST TRENDS

SERVICE CATEGORY	UTILIZATION TREND	UNIT COST TREND
Inpatient Facility	0.25%	3.75%
Outpatient Facility	0.75%	7.50%
Professional	0.00%	5.25%
Prescription Drug	2.00%	6.40%

Using the age, sex, and geographic distribution by source of health benefits from the Washington APCD, the trended detailed claims data are aggregated. These trended values reflect population utilization and cost differences by source of health benefits.

COST MODEL

We built a cost model based on the data described above and the Milliman Managed Care Rating Model. Our cost model includes great detail for maternity specific services as mentioned in the Average Cost and Utilization section above. Utilization and costs projected for non-maternity services and enrollees are also included. This allows us to project total allowed costs and net plan costs for the entire population, as plans would in developing premiums, while varying maternity cost-sharing scenarios.

For each plan and service type, we take the average annual utilization per thousand multiplied by the average cost per service divided by 12,000 to get the gross cost PMPM. We then subtract the average cost sharing PMPM to get the net cost PMPM prior to considering the value of the deductible and enrollee maximum out-of-pocket (MOOP).

To calculate the value of the deductible and MOOP, we use a claim probability distribution (CPD). A CPD represents the likelihood of different total claim amounts for a member for the year. To best model the value of the deductible and MOOP we use CPDs that only include services where the deductible and MOOP apply for a plan, so we developed several custom CPDs using Milliman's data in Washington State. Services that have no member cost-sharing are excluded from the deductible and MOOP calculations. This includes preventive services and certain maternity care services under the various scenarios. The list of included services for each custom CPD is included below.

- All Services
- Medical Services Only
- Inpatient Services Only
- Inpatient and Outpatient Surgery Services Only
- Inpatient, Outpatient Surgery, and Emergency Department Services Only
- Inpatient, Outpatient Surgery, Emergency Department, and Imaging Services Only
- Prescription Drugs Only

These CPDs include different mixes of services where deductibles commonly apply for health plans.

We have four versions of each of the previously mentioned seven CPDs to account for removing maternity cost sharing for some services and thus having the deductible not apply for those services. These versions of the CPDs are used to model the deductible under the scenarios listed above. We have our original CPDs with no alteration to represent services where the deductible applies for plans currently. Next, we have a version of each CPD where all maternity care services are removed to represent the deductible not applying for all maternity care services. Then we have a version where only prenatal services are removed from the CPD. And lastly, we have a version where only labor and delivery services are removed. The CPDs are adjusted to match the gross cost PMPM mentioned above.

The values of the deductible and MOOP for each plan are calculated from these adjusted CPDs. The value of the deductible is the PMPM for the entire CPD less the PMPM for claims greater than the deductible from the CPD. The

value of the MOOP is the PMPM for claims greater than the MOOP trigger amount. The MOOP trigger amount is the total claim amount where a member's cost sharing would meet the MOOP.

The total net plan cost is the net cost PMPM prior to the deductible discussed above, adjusted for the value of the deductible and the value of the MOOP plus the net cost PMPM for services not subject to the deductible.

We first calculated the total net plan cost for maternity and non-maternity services for all members under the baseline scenario with no adjustments from how plans currently operate. We then calculated it under each scenario listed above. We calculated a benefit relativity for each scenario by taking the ratio of the total net plan cost under the scenario to the total net plan cost under the baseline scenario.

The October 2023 premium provided by the carriers was trended to 2025. For individual and small group plans, we used the Washington OIC published rate increases by carrier and source of health benefits from 2023 to 2024. For all other plans, we assumed a rate increase of 6.75% from 2023 to 2024. We assumed an additional 6.75% premium increase from 2024 to 2025 for all sources of health benefits. Premiums are trended by source of health benefits from 2023 to 2024 where premium increases are known. From 2024 to 2025, premiums are trended by 6.75%, which is roughly the composite of the service category trends applied to claims and within the range of 2023 to 2024 plan premiums. For public employee premiums not provided, we used public sources to determine the plan premium and trended as described above. The benefit relativity is applied to the plan's premium to determine the amount premiums may increase under that scenario. Estimated premium increases are averaged by source of health benefits and multiplied by estimated total enrollment to calculate the total annual dollar impact of the scenario.

To calculate the total premium and enrollee cost share impact, we multiplied the premium PMPM impacts by the total non-HSA enrollment by source of health benefits as provided by the carriers. One carrier provided combined Cascade Select and Individual enrollment. We allocated half of the carrier's enrollment to Cascade Select and half to all other individual plans.

We also calculated the actuarial value for each plan by taking net plan costs over gross costs and calculated the change in actuarial value between the baseline and modelled scenario.

Considerations and Limitations

- We relied on carrier surveys for the premium and enrollment information provided in this report. Carriers provided the three most popular plan designs by source of health benefits. We assumed these responses are reflective of the entire non-HSA qualified plan market. Should the plans not modeled in this analysis greatly vary from the plans modeled, the actual enrollee cost sharing, premium, and actuarial value impacts may differ from the values produced by this analysis. These projections assume that the top three most popular plan designs for each carrier and source of health benefits represent reasonable average plan designs.
- The top three plan designs by enrollment represent only 6% of the total large group market.
- Two carriers provided blended enrollment for Cascade Select and all other individual plans. They did not carve out HSA qualified plans enrollment from this count. The total enrollment for Cascade Select and individual plans may be overstated and misallocated between the two sources of health benefits.
- The premiums only reflect the premiums of the top three plan designs. Total plan premiums were requested but were not consistently provided by the carriers. Individual and small group premiums were trended using published 2024 rate filing increases by carriers. Rate increases are likely to differ by plan design. Large group and public employee premiums were assumed to increase 6.75% from 2023 to 2024. Premiums for all sources of health benefits were assumed to increase by 6.75% from 2024 to 2025. The total premium impact estimates will vary from actuals to the extent that 2025 premiums vary from what was assumed.
- Maternity care services are broadly defined for this analysis. Some services that are commonly used for maternity care may sometimes be used for conditions unrelated to pregnancy. While our logic identifies exclusions to remove this utilization from the maternity classification, it is possible that some utilization of services attributed to maternity care is not related to pregnancy.

- Our analysis does not consider the family deductible in the determination of the impact of eliminating cost sharing from maternity care services.
- Our analysis does not consider additional utilization of services from the elimination of cost sharing on maternity care services. It is possible that enrollees may receive more prenatal or postnatal services as a result of cost sharing elimination. The results of this analysis are understated to the extent that users increase their utilization of all medical services in response to cost sharing elimination on maternity care services. However, if the additional services that enrollees receive as a result of cost sharing elimination result in fewer complications and better outcomes, then the overall cost of maternity care services would decrease, and our modeled premium increases are overstated.
- Offsetting benefit change impacts resulting from the maternity cost sharing scenarios are not modeled. For example, if a scenario estimates a 1% increase to plan premiums due to the maternity cost sharing change assumed, plans may decide to offset this increase through other benefit changes. Such changes are not modeled so that the premium change impact may be better understood, absent of other benefit changes.
- These results rely on the response received from the carriers. To the extent that actual plan designs, enrollment, or premiums do not align with the responses received, these results may be impacted.
- As discussed in this report, carriers are not consistent in how newborn hospital stays are treated. In some cases, they may be on the mother's claim. In others they are billed separately. Our analysis does not include standalone newborn claims. However, the labor and delivery charges may include the charges where the newborn is included on the mother's claim. In these cases, we assumed no cost sharing for both the maternity care services and the newborn.
- The total enrollment data provided by the carriers is not consistent with enrollment data from the all-payer claims database and other public sources. It also does not include data from two carriers who did not respond to the survey because they each have less than 1% market share, which may understate the total enrollment. We used the carrier provided data to perform this analysis to be consistent with the other data provided and because carriers were asked to only include enrollment for all Non-HSA qualified plans. An option to select enrollment for non-HSA qualified health plans only is not available in any other data source.

Variability of Results

Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made in this model. It is almost certain that actual experience will not conform exactly to the assumptions used in this model. Actual amounts will differ from projected amounts to the extent that the actual experience is better or worse than expected.

Model and Data Reliance

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate the impact of removing cost sharing for maternity care services, including prenatal, labor and delivery, and postpartum services. We have reviewed this model, including its inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We have relied upon certain data and information for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

Milliman's data and information reliance includes:

- Enrollment Data from Washington's All Payer Claims Database, as summarized by Washington OIC
- Carrier survey responses
- Washington individual and small group rate increases
- All other sources mentioned inline and in references.

The models, including all input, calculations, and output may not be appropriate for any other purpose.

We have performed a limited review of the data used directly in our analysis for reasonableness and consistency. The enrollment data sources are inconsistent. While total enrollment is consistent across sources, there is variation between sources for all sources of health benefits. However, the total enrollment data provided by the carriers is not consistent with enrollment data from the all-payer claims database and other public sources. It also does not include data from two carriers who did not respond to the survey because they each have less than 1% market share, which may understate the total enrollment. We used the carrier provided data to perform this analysis to be consistent with the other data provided and because carriers were asked to only include enrollment for all Non-HSA qualified plans. An option to select enrollment for non-HSA qualified health plans only is not available in any other data source.

We have not found additional material defects in the data. If there are additional material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our investigation.

Qualifications to Perform Analysis

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Casey Hammer, Riley Heckel, Matt Caverly and Aleece Blake are members of the American Academy of Actuaries and meet the qualification standards for performing this analysis.

Distribution and Usage

This report is intended to analyze the impact of eliminating cost sharing on maternity care services in Washington State. It may not be appropriate, and should not be used, for other purposes.

Milliman's work is prepared solely for the use and benefit of OIC in accordance with its statutory and regulatory requirements. Milliman recognizes that this report will be public record subject to disclosure to third parties. To the extent that the information contained in this report is provided to any third parties, the report should be distributed in its entirety. We do not intend this information to benefit, or create a legal liability to, any third party, even if Milliman consents to the release of its work product to such third party. Similarly, third parties are instructed to place no reliance upon this report prepared by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. It is the responsibility of any recipient of this report to make an independent determination as to the adequacy of the proposed results for their organization.

Appendix A – Carrier Survey

The following is a list of survey questions sent to the carriers to understand maternity care services cost sharing. The original survey was sent in an Excel file with the responses provided in grids. It was reformatted here for the purpose of displaying it in this report.

Question 1: What is the name of the Insurer? Is the data provided for an individual, small group, or large group plan?

- Please enter the requested information for each individual plan, small group plan, or large group plan you administer. If you enter data for multiple companies (different NAIC #s) please complete separate questions for each company (unique NAIC #).
  - *Carrier Name:*
  - *NAIC Number:*
  - *Plan Type (Enter Individual, Small Group, or Large Group):*
  - *Submitter Name:*
  - *Submitter Email:*

Question 2: Are there additional services the insurance carrier would consider to be maternity care services that are missing from this list? Please refer to the list of maternity care services below to answer the question.

- **Prenatal Care**: Office Visits, Laboratory Services, Ultrasounds/Imaging, Prenatal Screening Tests – Cell Free DNA, Prenatal Screening Tests – Carrier, Prenatal Diagnostic Tests – Amniocentesis, Prenatal Diagnostic Tests – Chorionic, Prescription Drugs, OTC Drugs (ex. Prenatal Vitamins)
- **Childbirth and Delivery**: Facility, Professional, Prescription Drugs
- **Doula Services**: Doula Services
- **Necessary supplies for home birth**: Medically necessary supplies for home birth
- **Postpartum care**: OB/GYN Office Visits, Lactation Specialists, Follow-up care for cesarian section, Laboratory Services, Ultrasounds/Imaging, Prescription Drugs
- **Behavioral Health**: Prescription drugs, Counseling/Therapy Services
- **Miscarriage/Stillborn care**: Dilation and curettage, Prescription Drugs, Childbirth and Delivery, Laboratory Services

Question 3: Please refer to the list of maternity care services from Question 2 to answer the following six (6) questions.

- For each service listed above, does the insurance carrier cover all of the maternity care services?
- Is the service offered on all health plans?
- Are there any benefit restrictions or limits in place on any of the services?
- Is prior authorization required for any of the services?
- Which services are considered preventive under section 2713 of the federal public health services act?
- Which services are exempt from cost sharing under federal regulations?
- Any general comments, clarifications, or additional Information?

Question 4: Please list, in no specific order, the five (5) most commonly used maternity care reimbursement methodologies. Then, refer to the list of maternity care services from Question 2 to determine which of the services are reimbursed by each methodology, including professional, facility, and other specific components of care.

Question 5: If you listed one or more bundled payment(s) in question 4, describe in plain English the services included in each bundled and any quantity limits that apply.

Question 6: Please use the five (5) most commonly used maternity care reimbursement methodologies that were entered for Questions 4 and 5. Then refer to the list of maternity care services from Question 2 to determine how frequently the reimbursement methodologies listed in your response are used. For example, bundled payment is used 95% of the time to reimburse prenatal/labor/delivery services. Fee for service payments are used to reimburse supplies for prenatal/labor/delivery services 5% and home birth 100% of the time.

Question 7: Please answer the following questions:

- How is the newborn's inpatient medical care treated as it relates to reimbursement and patient cost sharing?
- Is any portion of newborn care included in your bundled payment or other reimbursement methodology?

Question 8: Please provide SERFF filing numbers for the Summary Plan Description (SPD) (the long form benefits description approximating 100 pages) for the three most popular non-HSA qualified plan designs by enrollment for each line of business. Up to fifteen (15) SPDs in total if the carrier offers plan designs in all lines of business.

- Please provide the SERFF Filing number(s) below for the most recently approved form filed with the OIC. This will likely reduce the number of emails, prevent the need to transmit large file sizes, and avoid technical difficulties that may accompany these transmissions.
- If for any reason the SPD needs to be sent instead of providing the filing number, please use the OIC's Secure File Transfer portal on the OICs Website. A link is provided in the instructions document. Given the potential number of documents, please be sure to include Carrier Name, NAIC #, Submitter Name, Non-HSA Plan plus any other information that may clarify the identity of the insurer. (NOTE: Do not provide links to secure email or file share locations. The OIC is unable to access these locations to download documents).

Question 9: Populate the enrollment table and premium per member per month (PMPM) table below corresponding to the SPDs in response to Question 8. Use data as of October 1, 2023 to populate the below tables.

Question 9a: Enrollment as of October 1, 2023

Line of Business	Plan 1	Plan 2	Plan 3	All other Non-HSA Plans
Cascade Select				
Individual other than Cascade Select				
Small Group				
Large Group				
Public Employee Plan				

Question 9b: Premium PMPM as of October 1, 2023

Line of Business	Plan 1	Plan 2	Plan 3	All other Non-HSA Plans
Cascade Select				
Individual other than Cascade Select				
Small Group				
Large Group				
Public Employee Plan				

Appendix B – Plans Modeled

	Carrier Name	Source of Health Benefits	Plan Name
1	Coordinated Care Corporation	Individual Cascade	Ambetter Cascade Select Bronze
2	Coordinated Care Corporation	Individual Cascade	Ambetter Cascade Select Silver
3	Coordinated Care Corporation	Individual Cascade	Ambetter Cascade Select Gold
4	Lifewise Washington	Individual Cascade	LifeWise Cascade Select Bronze
5	Molina Healthcare of Washington, Inc.	Individual Cascade	Molina Cascade Bronze
6	Molina Healthcare of Washington, Inc.	Individual Cascade	Molina Cascade Gold
7	Aetna Life Insurance Company	Individual Non-Cascade	Seattle University
8	Aetna Life Insurance Company	Individual Non-Cascade	Saint Martin's University (Washington Consortium)
9	Aetna Life Insurance Company	Individual Non-Cascade	Western Washington University (Washington Consortium)
10	Coordinated Care Corporation	Individual Non-Cascade	Ambetter Balanced Care 4
11	Coordinated Care Corporation	Individual Non-Cascade	Ambetter Cascade Bronze
12	Coordinated Care Corporation	Individual Non-Cascade	Ambetter Cascade Silver
13	Kaiser Foundation Health Plan of the Northwest	Individual Non-Cascade	KP WA Gold 0/15
14	Kaiser Foundation Health Plan of the Northwest	Individual Non-Cascade	KFHPNW Cascade Bronze Plan
15	Kaiser Foundation Health Plan of the Northwest	Individual Non-Cascade	KFHPNW Cascade Silver Plan
16	Kaiser Foundation Health Plan of Washington	Individual Non-Cascade	HBE Individual Flex Bronze
17	Kaiser Foundation Health Plan of Washington	Individual Non-Cascade	HBE Individual Cascade Bronze
18	Kaiser Foundation Health Plan of Washington	Individual Non-Cascade	HBE Individual Cascade Gold
19	Lifewise Washington	Individual Non-Cascade	LifeWise Essential Bronze
20	Lifewise Washington	Individual Non-Cascade	LifeWise Cascade Bronze
21	Molina Healthcare of Washington, Inc.	Individual Non-Cascade	Constant Care Silver 1
22	Premera Blue Cross	Individual Non-Cascade	49831WA194000301 - PBC Preferred Bronze EPO 6350
23	Premera Blue Cross	Individual Non-Cascade	PBC Preferred Gold EPO 1500
24	Premera Blue Cross	Individual Non-Cascade	PBC Cascade Bronze
25	Regence BlueShield	Individual Non-Cascade	Regence Cascade Bronze
26	Regence BlueShield	Individual Non-Cascade	Regence Cascade Silver
27	Regence BlueShield	Individual Non-Cascade	Regence Cascade Gold
28	Aetna Life Insurance Company	Small Group	CF BRIDGEPORT LLC
29	Aetna Life Insurance Company	Small Group	PETES INC DBA SECOND STREET GRILL
30	Aetna Life Insurance Company	Small Group	COOL KIDZ LLC DBA THE GODDARD SCHOOL
31	Kaiser Foundation Health Plan of the Northwest	Small Group	KP WA Gold 1000/20 w/VX
32	Kaiser Foundation Health Plan of the Northwest	Small Group	KP WA Silver 3000/45
33	Kaiser Foundation Health Plan of the Northwest	Small Group	KP WA Silver 3000/45 w/Vx
34	Kaiser Foundation Health Plan of Washington	Small Group	HMO Visits Plus Gold
35	Kaiser Foundation Health Plan of Washington	Small Group	HMO Visits Plus Platinum
36	Kaiser Foundation Health Plan of Washington	Small Group	Core VisitsPlus Silver LX
37	Kaiser Foundation Health Plan of Washington Options, Inc.	Small Group	Access PPO VisitsPlus Gold LX
38	Kaiser Foundation Health Plan of Washington Options, Inc.	Small Group	Access PPO VisitsPlus Platinum LX
39	Kaiser Foundation Health Plan of Washington Options, Inc.	Small Group	Access PPO VisitsPlus Silver LX
40	Premera Blue Cross	Small Group	NGF BALANCE GOLD PCP 500
41	Premera Blue Cross	Small Group	NGF BALANCE GOLD PCP 1500
42	Regence BlueShield	Small Group	Regence EmployeeChoice Silver 3000 Preferred
43	Regence BlueShield	Small Group	Regence EmployeeChoice Platinum 250 Preferred
44	Regence BlueShield	Small Group	Regence EmployeeChoice Gold 2000 Preferred
45	UnitedHealthcare Insurance Company	Small Group	CVAQ Choice Plus
46	UnitedHealthcare Insurance Company	Small Group	CVAR Choice Plus
47	UnitedHealthcare Insurance Company	Small Group	CVAT Choice Plus
48	UnitedHealthcare Of Washington, Inc.	Small Group	Navigate CVAH
49	UnitedHealthcare Of Washington, Inc.	Small Group	Navigate CVAE
50	Aetna Life Insurance Company	Large Group	PENINSULA TRUCK LINES, INC.
51	Aetna Life Insurance Company	Large Group	98POINT6 TECHNOLOGIES INC
52	Aetna Life Insurance Company	Large Group	Payscale, Inc. - Negotiated Form Filing

	Carrier Name	Source of Health Benefits	Plan Name
53	Cigna Health and Life Insurance Company	Large Group	OAP1 - HDPF Open Access Plus CN004-3343891
54	Cigna Health and Life Insurance Company	Large Group	Local Plus - OAP1R CN087 (204 to 206) - 3339768
55	Cigna Health and Life Insurance Company	Large Group	Local Plus - OAP1R CN086 108F/108E(110F) - 3339768
56	Kaiser Foundation Health Plan of the Northwest	Large Group	Northwest Carpenters Health
57	Kaiser Foundation Health Plan of the Northwest	Large Group	SEIU Healthcare NW HB Trust
58	Kaiser Foundation Health Plan of the Northwest	Large Group	Clark County
59	Kaiser Foundation Health Plan of Washington	Large Group	Large Group HMO
60	Kaiser Foundation Health Plan of Washington Options, Inc.	Large Group	PPO Elect
61	Kaiser Foundation Health Plan of Washington Options, Inc.	Large Group	POS Options
62	Premera Blue Cross	Large Group	WXPXB923
63	Premera Blue Cross	Large Group	WXPXA874
64	Premera Blue Cross	Large Group	WXPXB810
65	Regence BlueShield	Large Group	WMW50208
66	Regence BlueShield	Large Group	WMW50248
67	Regence BlueShield	Large Group	WMW50212
68	UnitedHealthcare Of Washington, Inc.	Large Group	Choice Plus: BNDB
69	UnitedHealthcare Of Washington, Inc.	Large Group	Nexus: CO7A
70	UnitedHealthcare Of Washington, Inc.	Large Group	CL-5R
71	Kaiser Foundation Health Plan of Washington	Public Employee	PEBB Value Plan
72	Kaiser Foundation Health Plan of Washington	Public Employee	PEBB Classic Plan
73	Kaiser Foundation Health Plan of Washington	Public Employee	PEBB HMO Sound Choice
74	Kaiser Foundation Health Plan of Washington	Public Employee	SEBB HMO Sound Choice
75	Kaiser Foundation Health Plan of Washington	Public Employee	SEBB HMO Core
76	Kaiser Foundation Health Plan of Washington Options, Inc.	Public Employee	SEBB PPO Summit
77	Regence BlueShield	Public Employee	2023 SEBB UMP Achieve 2 plan
78	Regence BlueShield	Public Employee	2023 PEBB UMP Classic medical plan

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