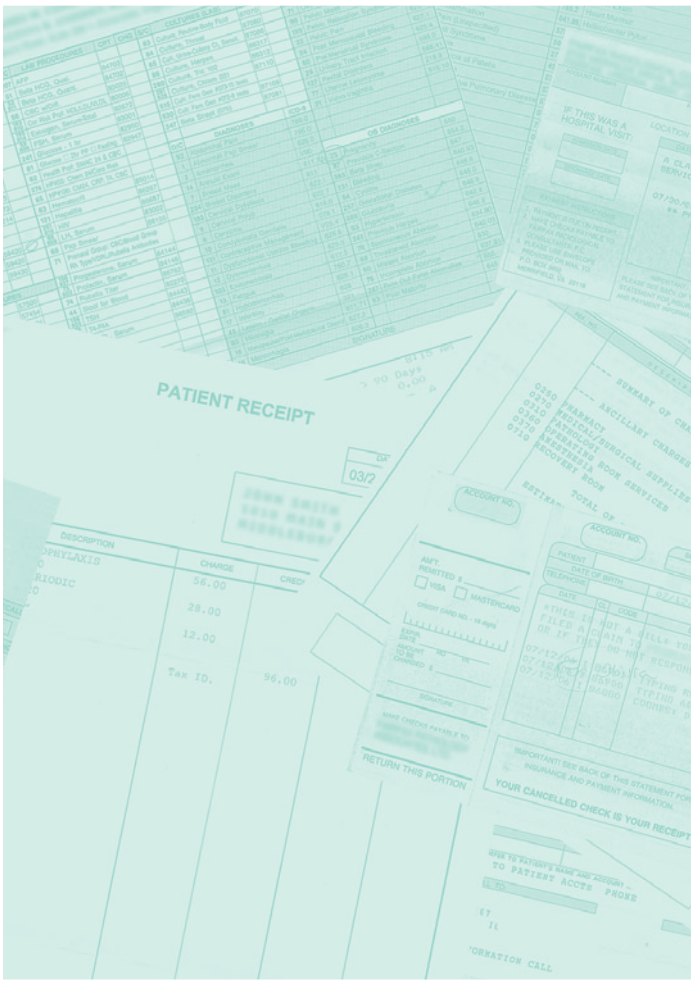
THE HENRY J. KAISER FAMILY FOUNDATION

MATERNITY CARE AND CONSUMER-DRIVEN HEALTH PLANS



JUNE 2007

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

BACKGROUND

With approximately 4 million births in the United States each year,[1] pregnancy and childbirth-related conditions are the leading causes for hospital stays and account for almost 25 percent of U.S. hospitalizations.[2] The cost of having a baby can easily reach thousands of dollars, making insurance coverage critical for pregnant women. Predicting the cost of even a routine, planned pregnancy, however, can be difficult. Estimates of the cost of maternity-related care vary widely, as costs can be affected by many factors.

A family's out-of-pocket costs for maternity care depends on clinical factors as well as whether the woman has health insurance, the type of coverage, and how, if at all, her health insurance covers maternity care. With the development of a relatively new type of health insurance policy, consumer-driven health plans (CDHPs), the variation in costs that families face is likely to increase. Over the past few years, these policies have been marketed to individuals and employers as a more affordable insurance product that has lower premiums and may help to control health care costs.

Compared to traditional health plans, CDHPs have certain defining features, including more financial responsibility for patients for the cost of their medical care, particularly through higher deductible levels. Qualified CDHPs may be combined with tax-free savings accounts—Health Reimbursement Arrangements (HRAs) or Health Savings Accounts (HSAs)—to cover patients' out-of-pocket medical expenses. Contributions to these accounts can be made until the tax filing deadline for that year, even after health expenses have been incurred. The tax benefits from these accounts, combined with slightly lower premiums than traditional health plans and reductions in unnecessary health care utilization, are intended to make CDHPs lower in cost than more traditional plans.

To evaluate the level of insurance protection that CDHPs provide, this study examines CDHPs' coverage of maternity care, one of the most common and costly medical interventions that women of reproductive age will experience. This study discusses the costs of maternity care, the features of private health insurance affecting maternity coverage, and the issues raised by the development of CDHPs. Coverage, however, is only one part of the cost equation. Costs can vary dramatically depending on a patient's specific medical condition and pregnancy outcomes. Therefore, this analysis provides estimates of maternity care costs under three different clinical scenarios—an uncomplicated vaginal delivery, an uncomplicated Cesarean (C-section) delivery, and a pregnancy with considerable complications—and compares the level of coverage offered by one traditional insurer and 12 CDHPs in the group and individual markets.

METHODS

Cost estimates for each of these scenarios were generated by compiling a list of medical services recommended for pregnancy related care and summing the average costs for these services from a sample of health plan claims. Services typically provided for prenatal care, vaginal delivery, C-section delivery, and gestational diabetes were based on professional practice guidelines developed by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP).[3] Researchers calculated median costs for these services using a sample of claims from 106 women covered under the Maryland Health Insurance Plan (MHIP), a state high-risk pool whose provider payment levels are thought to be consistent with those of other commercial insurers in Maryland.[4,5] These costs were then used to estimate total costs for the three clinical scenarios: 1) uncomplicated pregnancy and vaginal delivery, 2) uncomplicated C-section delivery, and 3) a complicated pregnancy with gestational diabetes, pre-term labor, and C-section delivery. In addition to clinical differences, these scenarios present some other different circumstances, such as pregnancy spanning over one or two plan years and anesthesia administered by an out-of-network provider, reflecting other dimensions of variability in pregnancies and the limited predictability of maternity care.

The features of 12 different types of CDHPs from the Federal Employees Health Benefits Program (FEHBP), the small group, and individual markets were compared to a policy that is more like "traditional" health insurance (Appendix 1). The cost estimates derived from the MHIP analysis were used to determine which costs were and were not covered by each of the plans and what share of total costs the insurance policy reimbursed (Appendices 2–4). Each insurance policy contract was analyzed to determine covered benefits for maternity care and related services and the level of coverage provided, including cost sharing requirements, under the three clinical scenarios.

PLAN FEATURES

For the sake of brevity, the main body of the report presents a detailed analysis of four CDHPs as well as a traditional plan and their coverage for maternity care. Of the four CDHPs chosen, all cover maternity care and three are HSA-qualified. In plans that have HSAs, the enrolled person could use funds in an HSA to offset the costs that the plan did not reimburse. The major features of these five plans are summarized in Table A-1, and the characteristics for all 12 plans analyzed can be found in Appendix 1.

TABLE A-1.

Key Features of Selected Consumer-Driven Health Plans that Cover Maternity Care

	Traditional Plan	Consumer-Driven Health Plans			
Plan Features	**Plan A**	**Plan B**	**Plan H**	**Plan E**	**Plan K**
Market	FEHBP	FEHBP	Small Group	Small Group	Individual
HSA-qualified?	No	Yes	Yes	Yes	No
Cost Sharing (In-Network)					
Annual Deductible (individual/family)	$250/$500	$1,500/$3,000	$2,250/$4,500	$3,500/$7,000	$5,000/$10,000
Co-insurance and Co-pays	10% obstetric, hospital; 15% imaging, anesthesia, $0 for designated lab, $20 office visit (no deductible)	None for maternity care	10% co-insurance	$35/office visit	30% co-insurance
Annual OOP Maximum (individual/family)	$4,000 (per policy)	$4,000/$8,000	$5,000/$10,000	$4,000/$7,500	$7,500/$15,000
Includes Deductible?	No	Yes	Yes	Yes	Yes
Includes Co-pays?	No—n/a to prescription drugs	n/a	Yes	Yes	Yes
Cost Sharing (Out-of-Network)					
Annual Deductible (individual/family)	$300/$600	Same as in-network	Same as in-network	$3,500/$7,000	$5,000/$10,000
Co-insurance and Co-pays	30% co-insurance, $100 co-pay/ hospital admission + 30% co-insurance	30% co-insurance	30% co-insurance	50% co-insurance (+ balance billing)	50% co-insurance Hosp all amounts over $650/day
Annual OOP Maximum (individual/family)	$6,000 (per policy)	None	$10,000/$20,000	$4,000/$7,500	$7,500/$15,000
Includes Deductible?	No		Yes	Yes	Yes

KEY FINDINGS

Table A-2 compares the extent of coverage for the three scenarios under four of the CDHPs studied (Plans B, H, E, and K) to a traditional health insurance policy (Plan A). Scenario 1 aims to present a best-case scenario, with an uncomplicated pregnancy and uncomplicated vaginal delivery. In scenario 2, total costs increase primarily because of C-section delivery and a longer hospital stay as a result. Scenario 3 is the most expensive scenario due to pre-term labor and a long hospital stay during pregnancy. It is important to note that these scenarios are theoretical constructions designed to provide cost estimates to enable the comparison of potential out-of-pocket spending under different plans.

Scenario 1: It is assumed that the mother has family coverage when the pregnancy begins, the pregnancy begins and ends within a single plan year, and all care is received from in-network hospitals, doctors, and other providers. The uncomplicated pregnancy ends in vaginal delivery and the mother and baby stay in the hospital for two days. This pregnancy was estimated to result in $9,660 in allowable charges.

Under the traditional policy, out-of-pocket costs would total $1,455, or about 15 percent of allowed charges. For HSA-qualified CDHPs, out-of-pocket costs are higher because of their higher annual deductibles. The woman's cost liability can reach $3,000 to $7,000, or 31 percent to 73 percent of total allowed charges. In the case of the plan K, the individual plan that covered maternity care, the family was liable for $7,884 or 82 percent of costs.

Scenario 2: It is assumed that the mother has family coverage when pregnancy begins, and that her pregnancy spans two plan years, with routine prenatal care taking place under the first plan year but labor and delivery (C-section with three-day hospital stay) occurring the following year. The mother is assumed to seek all care within the plan network with the exception of anesthesia care during delivery (the anesthesiologist on call when she delivers is out-of-network) so balance billing costs may apply. Allowable charges for this pregnancy were estimated to be $12,453.

Under this scenario, family cost sharing increases somewhat due to balance billing by the out-of-network anesthesiologist. More significantly, family cost sharing increases under all plans because prenatal care in year one is subject to a separate annual deductible. First year costs to the family are somewhat lower under the traditional insurance policy because the mother's prenatal care is subject to the lower, embedded deductible for an individual. Under HSA-qualified CDHPs, however, the full family deductible must be satisfied in both years before claims are reimbursed. Family out-of-pocket expenses were $2,244 in the traditional policy and ranged from $3,545 to $9,818 in the CDHPs.

Scenario 3: In this scenario, it is assumed that the mother has family coverage at the outset of the pregnancy and her pregnancy spans two plan years, but this time medical complications arise. The mother develops gestational diabetes, which adds to her prenatal care costs. She also experiences pre-term labor and requires hospitalization during the first plan year. The pre-term labor hospitalization is assumed to cost $75,000. The baby is delivered by C-section just after the second plan year begins and requires several weeks in neonatal intensive care, assumed to cost another $200,000. All care is assumed to be received in-network under this scenario, and total allowed charges are $287,453.

Out-of-pocket costs are even higher under this scenario because maximum cost sharing limits are reached in two consecutive plan years. Under the traditional policy, the family's cost sharing exposure reaches $8,770, or about 3 percent of the total, catastrophic expense. The family's share of costs is lowest ($6,000) under one of the CDHPs, Plan B, because no cost sharing applies to maternity or other inpatient care after the deductible is met under this plan. By contrast, under CDHPs E, H, and K, the OOP maximums are much higher. Total spending for the family would be $14,000 to $21,194 under these plans, or 5 to 7 percent of total costs.

TABLE A-2.

Out-of-Pocket Expenses for Maternity Care Under Three Different Scenarios

	Insurer and Policy Features				
	Plan A Traditional Policy FEHBP	**Plan B FEHBP CDHP**	**Plan H Small Group CDHP**	**Plan E Small Group CDHP**	**Plan K Individual Market CDHP**
Plan Characteristics	$250/$500 deductible; 10% co-insurance for obstetric, hospital; 15% imaging, anesthesia; nothing for preferred lab; $20 (no deduct) office; OOP $4,000 (per policy) only for co-insurance	$1,500/$3,000 deductible; no additional co-insurance for maternity; $4,000/ $8,000 OOP; HSA-qualified	$2,250/$4,500 deductible (in network); 10% co-insurance to OOP of $5,000/$10,000 (in network); HSA-qualified	$3,500/$7,000 deductible; no co-insurance; $4,000/$7,500 OOP; HSA-qualified	$5,000/$10,000; 30% co-insurance post-deductible until OOP max reached; OOP: $7,500/$15,000; not HSA-qualified
Clinical Scenario and Estimated Total Cost	**Family Out-of-Pocket Costs***				
Scenario 1 Uncomplicated Pregnancy, Vaginal Delivery **$9,660**	**$1,455** (15%)	**$3,000** (31%)	**$5,016** (52%)	**$7,000** (73%)	**$7,884** (82%)
Scenario 2 Uncomplicated Pregnancy, C-section Delivery **$12,453**	**$2,244** (18%)	**$3,545** (29%)	**$5,929** (48%)	**$7,688** (62%)	**$9,818** (79%)
Scenario 3 Pregnancy with Gestational Diabetes, Pre-term Labor, C-section Delivery **$287,453**	**$8,770** (3%)	**$6,000** (2%)	**$20,000** (7%)	**$14,000** (5%)	**$21,194** (7%)

*Families with tax-exempt HSA funds can apply account balances to these costs

CONCLUSIONS

Pregnant women could face exposure to high out-of-pocket costs under CDHPs, particularly when complications arise.

While many CDHPs cover maternity care services, there is tremendous variation in the deductibles, cost sharing requirements, and out-of-pocket maximums between various CDHPs. This analysis finds that women and families could be left with thousands of dollars of expenses from maternity care even with an uncomplicated birth, resulting from the high deductibles and cost sharing requirements in these plans.

Funds in an HSA may not be sufficient to cover the out-of-pocket costs resulting from pregnancy, particularly in the event of complications, leaving families with significant medical bills to pay. Even for families who had used their HSA to save for such an event, cost sharing for maternity care could drain an HSA, leaving little in reserve for other health care expenses.

In this analysis, out-of-pocket costs for the best-case pregnancy scenario in CDHPs range from $3,000 to $7,000, which could take several years for a person to accumulate in an HSA. Previous research has found that about two-thirds of those with HSAs receive employer contributions to their accounts, and on average, employers contribute approximately $1,600, which falls short of maternity care cost liability under most of the plans analyzed. Furthermore, funds in an HSA may also be needed to pay for services not covered by the CDHP, such as dental, vision, or mental health care. The high costs of pregnancy alone could potentially exhaust a family's HSA, leaving little or no funds for other health care expenses.

Prenatal care is generally subject to the deductible in CDHPs, unlike other preventive services, such as well-child care or mammography.

CDHPs often exempt preventive services from the deductible or co-payments. In all of the plans that were examined, however, prenatal care services were not considered to be preventive services. High cost sharing could pose a disincentive for some women to obtain prenatal care services.

Transparency remains a challenge, as health plan policies are complex, and the details of coverage are often not explicit.

Transparency in health care costs is a cornerstone of the consumer-driven health care model, as it is expected that beneficiaries should have enough information to plan for health care expenses and set aside sufficient funds in an HSA to cover out-of-pocket costs. The details of a plan's coverage for specific services are not always apparent, making it very difficult to estimate spending accurately. Investigating the details of plan coverage for unpredictable health care needs, such as pregnancy complications, is even harder for consumers.

Coverage for maternity care in the individual insurance market is extremely limited.

Many plans in the nongroup market do not cover maternity care at all, and pregnancy can be grounds for denial of an application for coverage in medically underwritten policies. For CDHPs in the nongroup market that do cover maternity care though, out-of-pocket spending may be very high due to high deductibles and cost sharing as well as coverage exclusions for certain services.

INTRODUCTION

Childbirth is the leading reason for hospitalization in the U.S. Approximately 4 million births occur annually in United States[6] and three-fourths of American women become mothers during their lifetimes.[7] Pregnancy and childbirth are also a leading source of health care spending. In 2002, pregnancy and childbirth-related conditions accounted for almost 25 percent of U.S. hospitalizations.[8] Having a baby can be expensive, with medical costs easily reaching $10,000 or more. These costs depend on many factors, including whether the baby is delivered vaginally or by C-section and whether complications of pregnancy arise. While most pregnancies progress normally, an estimated one-third of pregnancies have some complications requiring additional medical attention.[9]

In fact, complications of pregnancy can add significantly to the cost of care, with the most expensive involving preterm labor and premature delivery.[10] According to one study, the cost of hospitalization to prevent or delay pre-term labor in 2001 was almost $1.9 billion, averaging over $75,000 per case, with an average hospital length of stay of almost 25 days.[11]

A family's out-of-pocket cost for maternity care depends on clinical factors as well as whether the woman has health insurance, the type of coverage, and how, if at all, the health insurance covers maternity care. Except in a few states that require the sale of standardized health insurance policies, covered benefits, cost sharing, and other health insurance policy terms vary enormously. Policy features will affect the overall level of cost sharing for maternity care that families might expect under any health plan.

With the development of a relatively new type of health insurance policy, called consumer-driven health plans or CDHPs, the variation in costs that families face is likely to increase, with women and families facing higher deductible costs than ever before. Over the past few years, these policies have been heavily marketed to individuals and employers as a more affordable insurance product that may help to control health care costs.

To evaluate the level of insurance protection CDHPs provide against the cost of maternity care, one of the most common and costly medical interventions that women of reproductive age will experience, this analysis provides estimates of likely maternity care costs families will face using real CDHP policies sold in the group and individual markets. To gauge different types of costs families may experience, we examine costs under three different clinical scenarios: uncomplicated vaginal delivery, C-section delivery, and one with considerable complications of pregnancy.

HOW DOES HEALTH INSURANCE COVER PREGNANCY?

For most women, pregnancy is routine and uncomplicated. Widely accepted guidelines have been published for maternity and perinatal care—including monthly prenatal care visits, standard laboratory tests to detect complications and congenital abnormalities, and ultrasound to monitor the development of the fetus. [12]

Despite the widespread agreement on the content of care, health insurance policies can vary dramatically in their coverage of maternity care and the protection they offer against out-of-pocket costs. Consumers trying to budget for their out-of-pocket medical needs must make an effort to understand how their insurance coverage works, and even then, may face challenges.

Most health insurance provides at least some coverage for maternity benefits. By federal law, all group health plans sponsored by employers with 15 or more employees must cover maternity care similarly to other medical care services.[13] In the individual health insurance market, however, maternity coverage is far less common.[14] Some carriers offer maternity benefits as an amendment (or rider) to individual policies for a separate premium, although waiting periods (for example, one or two years) often apply before maternity benefits take effect and the cost of maternity riders in some cases can almost double the policy premium in individual policies.[15]

Visible health plan features

When health insurance includes maternity benefits, other policy features must also be examined to determine the level of protection offered. The details in any health insurance policy are important. Certain provisions can have a key impact on out-of-pocket costs for maternity care, and in any health insurance policy there are a number of "gray areas" that can make it difficult to know how coverage works.

Cost Sharing—In plans that cover maternity care, the level of cost sharing required by the patient is one key determinant of likely out-of-pocket costs. Some plans exempt certain preventive care, such as well-baby visits, from any cost sharing, but for most covered services at least some cost sharing typically applies. Pregnancy and related care are not typically considered to be a preventive service that is exempted from the deductible and cost sharing. Most plans have several cost sharing features (Figure 1).

The annual deductible is the amount of covered charges the consumer must pay before reimbursement will begin under the policy. In some policies, separate deductibles may apply for different types of services, such as hospital care.

Once the deductible is met for a year, co-insurance often applies, requiring the consumer to pay a portion (e.g., 20 percent) of the costs for covered services. Instead of or in addition to co-insurance, the policy may require co-payments—a flat dollar amount the consumer pays for each covered service. For example, a policy might require a co-payment of $20 for office visits.

FIGURE 1

Cost Sharing Features In Health Insurance

Annual deductible—The amount of loss or expense that must be incurred by a health plan beneficiary before an insurer will assume any liability for all or part of the remaining cost of covered services.

Co-insurance—A percentage of covered costs that a health plan beneficiary must pay.

Co-payments—A fixed amount of money paid by a health plan beneficiary at the time of service.

Out-of-pocket maximum (OOP)—A capped amount of spending for which consumers are liable. This amount typically only includes the expenses that the plan covers. Payments for uncovered services are excluded.

Based on "Glossary of Terms Commonly Used in Health Care," Academy Health, 2004.

Insurance policies usually cap the consumer's annual cost sharing liability with an out-of-pocket (OOP) maximum. Once reached, the plan pays for 100 percent of the allowable charges for covered care. However, depending on the policy, not all cost sharing may be limited by the annual out-of-pocket maximum. For example, expenses subject to the deductible may or may not be counted toward the OOP maximum. Co-insurance expenses usually are limited by the OOP maximum.

Provider networks—Many health insurance plans contract with networks of doctors, hospitals, labs, and other providers to accept negotiated fees for care they provide to plan enrollees. Coverage under the plan may be restricted only to care received from these network providers or, higher cost sharing may apply for care received from providers who are "out-of-network." In particular, expenses for care received out-of-network might not be limited by the OOP maximum or might have a separate and higher OOP maximum. Patients may also be liable for balance billing costs for out-of-network care. Balance billing costs usually are not covered or limited by the OOP maximum. Pregnant women who make an effort to select in-network providers may still inadvertently receive some care from out-of-network providers despite their best effort—e.g., the anesthesiologist on call when she delivers may not be in-network, even though her obstetrician and hospital were in-network providers.

Other benefit limits or exclusions—Finally, policies may impose other exclusions or limits on covered benefits. For example, some policies studied for this report specifically excluded coverage for PKU formula,[16] while others restricted coverage for treatment of congenital or genetic birth defects (such as cleft palate).

Challenges to transparency

One of the greatest challenges to transparency may lie in the sheer number of ways in which policies can vary. Consumers cannot assume two products called "health insurance" will cover the same benefits, impose the same cost sharing, require the same authorization procedures, use comparable provider networks, or have other similar rules or protections (Figure 2).

FIGURE 2

Sample Policy Language on How In-network Care Will be Covered (emphasis in the original)

"In determining whether or how much of a covered charge is allowable, we will consider the following factors:

1. the most appropriate procedures and medical service codes according to the Physician's Current Procedural Terminology or the Health Care Financing Administration (HCFA) standards that were current during the time the services or supplies were provided;
2. the actual charges;
3. specialty training, work value factors, practice costs, regional geographic factors and/or inflation factors (including but not limited to any state or national resources based relative value system);
4. the *negotiated rate* with the *physician,* facility or supplier;
5. the amount charged for the same or comparable services or supplies in the same region or in similar geographic regions …; or
6. consideration of new procedures, services or supplies in comparison to commonly used procedures, services or supplies."

As a result of this language, a patient who receives care from an in-network provider under this plan may be responsible for more than 20% of fee the plan brochure describes.

Policies reviewed for this study were highly variable. Some policies offered by the same insurer in the same market nonetheless had significantly different rules, such as the type of expenses that would be counted toward the annual deductible or out-of-pocket maximum. One contract reviewed included language stating the insurer would not necessarily abide by fee schedules it negotiated with network providers, thereby potentially exposing patients to significant and unpredictable out-of-pocket costs for in-network care. The summary brochure did not include this information; only by reading the entire contract would consumers find out about it.

The level of complexity and variation that can exist across health insurance policies was underscored by a statement on the cover page of another policy, typed in bold and capital letters, **"THIS AGREEMENT SHOULD BE READ AND RE-READ IN ITS ENTIRETY."**[17]

Vague or confusing terminology—Most consumers don't read their health insurance contracts carefully, but even if they did, these legal documents are complex and difficult to understand even for the most sophisticated health consumer. Some key terms may be vague or undefined, such as the definition of "complications of pregnancy." Other contract language may be ambiguous—for example, policies may leave it to insurer discretion to define medical necessity on a case-by-case basis. Contracts may reference rules that limit coverage—e.g. formularies that limit coverage for prescription drugs, or fee schedules that limit coverage for medical services—that nonetheless are proprietary and so inaccessible to policyholders.

Family coverage status—For working couples, the first pregnancy may begin with the wife covered as an individual under her own job-based policy. Usually there is an opportunity to convert to family coverage when the baby is born.[18] Because cost sharing requirements for family-level coverage are typically twice that for single coverage, it is important to know when family coverage takes effect. However, this may not be easy to do. Industry experts interviewed said typically family coverage becomes effective on the date it is elected by the mother and the higher level of cost sharing also applies for all claims as of that date. In some plans, however, the effective date of family coverage is retroactive to the baby's birth date. In others, the effective date of family coverage is the first day of the month after family coverage is elected.

Several of the contracts examined specified a window of time (30 to 60 days) after the birth of a baby during which parents can elect to add a newborn to their policy, but did not clearly state when newborn coverage would take effect. None of the contracts studied specified whether the higher family deductible, once it takes effect, applies to delivery charges. These differences have the potential to directly affect the amount of out-of-pocket costs families will incur following a delivery.

Complications of pregnancy—Some policies that exclude maternity care, such as most individual policies, will nonetheless cover complications of pregnancy. However, because there is no standard definition of what constitutes complications of pregnancy, it is difficult to know in advance what expenses might be covered as complications. The policy contract may specify what complications of pregnancy will be covered, or this decision may be left to the discretion of health plan medical directors on a case-by-case basis (Figure 3). State laws also typically do not include specific language about this issue. As a result, it may not be possible for consumers to know in advance what services they might be responsible for should they have pregnancy complications when their policy does not cover maternity care.

Infant claims resulting from complications of pregnancy are much more likely to be covered. To reduce the incidence of uncompensated care for newborns, all states require health insurers to cover newborn infants under the mother's policy for at least 30 days, and longer if the mother elects to add the baby to her policy. In addition, federal law requires employer-sponsored health plans to permit the enrollment of newborns within 30 days of birth so long as dependent coverage is offered by an employer. Therefore, neonatal care beyond 30 days would typically be covered for the dependent infant under most health insurance policies.[19]

FIGURE 3

Understanding When Complications of Pregnancy are Covered by Health Insurance

Some health plans that do not cover routine maternity care will nonetheless cover complications of pregnancy. However, the definition of what constitutes a complication is often unclear and can vary. For instance, one plan defined complications with a great degree of specificity including:

> "… spontaneous miscarriage; ectopic pregnancy, spontaneous premature delivery of nonviable fetus; non-elective C-section; preeclampsia and eclampsia; gestational diabetes; hyperemesis gravidarum; and medical conditions whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy such as: acute pyelonephritis, renal failure, diabetes, cardiac decompensation, malignancy, chronic hypertension, and phlebitis …"

Complications under this policy do not include,

> "elective abortion, morning sickness, nausea and vomiting, headaches, cramping, edema, and other similar conditions."

In another policy, by contrast, contract language was general and non-specific:

> "… expenses incurred for services related to complications of pregnancy at the point the complication occurs …"

According to health plan medical directors interviewed for this project, coverage decisions about complications of pregnancy may rest on clinical circumstances or judgments about what constitutes a complication. For example, atypical weight gain during pregnancy might be considered a complication or a "pre-complication," with additional medical monitoring and follow up care covered, or it might not. The timing of a complication with respect to hospital discharge can also matter. Some relatively common complications of pregnancy include wound infection (following C-section delivery) or development of blood clots. One plan official said these complications might be covered if they developed after hospital discharge and resulted in a new hospital admission for the mother; however, if these complications developed during the mother's initial hospital stay for delivery, treatment would probably be excluded along with other non-covered maternity care.[1]

With respect to gestational diabetes, when insurance plan contract language did not specify coverage of this complication, it was not clear whether additional medical services required for pregnant women with this condition would be covered. Plan officials interviewed indicated coverage decisions would be subject to plan review. For example, one medical director said test strips and monitors used to manage diabetes would likely be covered for the pregnant woman as they would be for any other enrollee, but more intensive obstetrical care, including added physician visits and imaging, probably would not be covered.

A more significant issue relates to pre-term delivery. Several industry experts described a general decision rule that pregnancy complications could encompass any care outside of what would be provided for normal prenatal care and delivery of a live baby. However, different opinions were offered on whether pre-term delivery would be covered as a complication. Medical directors interviewed for this paper indicated decisions to cover treatment for pre-term labor are made on a case-by-case basis. One medical director who had worked for more than one insurer said some insurers might recognize pre-term labor as a complication and pay for hospital days leading up to the day of delivery, while others might refuse to cover a hospital stay of any length that ended in delivery because "labor and delivery" charges would be excluded. Another health plan official thought hospital charges for the mother in pre-term labor would be covered as a complication, but any additional standby pediatrician, neonatologist, or anesthesiologist care brought in for the high-risk delivery probably would be considered part of "labor and delivery" and so excluded.

Life uncertainties

Finally, nobody can predict with certainty how a pregnancy will proceed or what unforeseen medical needs may arise. Even the timing of pregnancy can be uncertain. Most health insurance contracts are for a term of one year, and cost sharing requirements start over at the beginning of each year. Nine-month pregnancies, therefore, tend to span two contract years and so may be subject to two annual deductibles and OOP maximums. Some health insurance contracts credit expenses in the final quarter of one contract year toward the following year's deductible or out-of-pocket maximum. However, this carryover of prior year expenses to a subsequent year's deductible may not be allowed under some CDHPs.

WHAT ARE CONSUMER-DRIVEN HEALTH PLANS?

In response to the high cost of health insurance and in the wake of consumer backlash against managed care, insurers have developed new products called consumer-driven health plans (CDHPs).[20] Compared to traditional health plans, CDHPs have certain defining features, including more financial responsibility for patients for the cost of their medical care. The rationale assumes that patients who are required to pay a greater share of medical care costs will become more cost conscious, avoid unnecessary services, and demand lower cost care options from their providers. Some CDHPs also seek to empower patients with information about the cost and quality of providers to enable more prudent health spending choices while promoting quality of care.

In addition, qualified CDHPs may be combined with tax-free savings accounts—Health Reimbursement Arrangements (HRAs) or Health Savings Accounts (HSAs) to help patients finance out-of-pocket medical expenses. Different rules apply for tax-qualified HRAs and HSAs and the CDHPs that can accompany them. This paper includes an examination of IRS-qualified high-deductible health plans (HDHPs)—a type of CDHP—that qualify for HSAs.[21]

Potential advantages

A key advantage of CDHPs is that premiums for such policies tend to be lower than traditional insurance products. According to one report, premiums for traditional health insurance plans are, on average, 24 percent higher for single coverage and 31 percent higher for family coverage compared to CDHPs.[22] For job-based health coverage, premium cost savings under CDHPs can be shared by employers and employees; on average, employers pick up 85 percent of the premium expenses for covered workers and 75 percent for family coverage.[23]

HSAs are savings accounts established by individuals to pay for their out-of-pocket health care expenses. HSA contributions can be made by employers and workers. Contributions and earnings are tax-free, as are fund withdrawals used to pay for qualified medical expenses not reimbursed by the health plan. Unused account balances belong to the policyholder and can be carried forward indefinitely. Under IRS rules for 2006, the maximum annual HSA contribution (whether made by an individual or her employer) is the lesser of 100 percent of the qualified CDHP annual deductible or $2,700 for a single person and $5,450 for a family. These amounts are indexed for inflation. Beginning in tax year 2007, people may simply contribute and deduct up to the statutory maximum level.[24] Tax-free contributions to HSAs must be made before April 1 of the following plan year, and can be made before or after expenses are incurred. Employers are not required to contribute to their employees' HSAs, but a 2006 survey of employers found two-thirds of employees with HSAs received employer contributions to their accounts, averaging approximately $1,600.[25]

Proponents claim that HSAs are intended to convey a sense of ownership of health care spending, reinforcing consumer incentives to save for future medical expenses with a savings account and share in the financial rewards of prudent health care use. Some proponents hail CDHPs as the health plan design of the future, promising enhanced consumer choice and responsibility with better control over health care costs as a result. Proponents have also argued such policies are preferable to managed care plans because they favor consumer decision-making over gatekeepers, referrals, and other insurer utilization controls. Marketing of CDHPs has targeted a range of consumers, including families who plan to have children.[26] Lower premiums are one feature emphasized in marketing. Advocates of CDHPs and HSAs also emphasize these plans promote patient choice and control over medical care.[27]

Potential disadvantages

Opponents of CDHPs argue that these policies shift risk to consumers, potentially burdening patients with high out-of-pocket health care costs. They also question whether consumers have—or will have in the future—adequate information resources to make cost effective and medically appropriate care decisions that CDHPs demand.

Consumers contemplating CDHP coverage for maternity care can anticipate similar challenges to those in traditional health plans. Needed benefits may not be covered and insurance rules may not be easy to understand from vague and complicated contract language. In addition, however, certain features unique to CDHPs—and especially HSA-qualified CDHPs—may affect the level of coverage for maternity care in ways not found in other health insurance policies.

Under IRS rules, the minimum annual deductible for covered services under HSA-qualified CDHPs in 2006 is $1,050 per person and $2,100 for family coverage. These amounts are indexed to inflation in future years. No benefits can be reimbursed until the annual deductible has been satisfied. An exception is made for preventive care services, including well-baby visits and immunizations, which some HSA-qualified plans exempt from the annual deductible.[28] Pregnancy-related services, however, are not typically considered "preventive care" and are not exempted from the deductible.

For HSA-qualified CDHPs, IRS rules also prohibit embedded per-person deductibles. This means that the entire family deductible must be met before care for any family member can be reimbursed in a year. This is a departure from traditional plans, under which pregnant women only have to satisfy the per-person deductible before their claims can be reimbursed. For women who begin pregnancy covered as an individual and switch to family coverage after the baby is born, this feature of CDHPs may prove particularly problematic because claims for services incurred after family coverage takes effect cannot be paid until the higher family deductible is satisfied. CDHPs that are not HSA-qualified may have higher or lower deductibles and may allow for embedded per-person deductibles similar to other health insurance policies.

IRS rules also state the annual OOP maximum on cost sharing for in-network care under HSA-qualified plans is $5,250 for single coverage and $10,500 for a family policy. However, the federal maximum OOP standard only applies to cost sharing for covered services, and certain financial penalties need not be limited by the OOP maximum. Plans are also allowed to have higher OOP levels for non-network providers. Depending on plan features, therefore, it may take several years to save enough funds to cover the out-of-pocket costs needed to pay for maternity care. These rules do not apply to CDHPs that are not HSA-qualified.

Carryover of prior year expenses to a subsequent year's deductible may be problematic for HSA-qualified plans. Some qualified policies allow for carryover for claims incurred in the month preceding the new plan year.

While there has been a lot of discussion about growth in CDHPs, enrollment in such plans remains relatively low. Just under 3 million workers, or about 2 percent of those with employer-sponsored insurance, are enrolled in high deductible health plans, evenly split between HSA-qualified plans and plans with HRAs.[29]

WHAT DOES A TYPICAL PREGNANCY COST?

Any examination of the cost of maternity care must take into account billing and payment practices involving three parties: the provider of health care services (hospital, physician, laboratory, etc.), the patient who receives services, and the patient's health plan, which might be provided under an insurance policy or from a self-insured employer. [30]

Estimates of the costs of pregnancy vary considerably. To identify the services typically provided during pregnancy and their associated costs, professional practice guidelines for perinatal care developed by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP)[31] were used to construct illustrative pregnancy scenarios ending in vaginal and C-section delivery. Specific services and tests that are part of typical prenatal care, delivery, and postpartum care of the mother and child were enumerated, along with their billing codes.[32]

The next step involved finding charges for each maternity care service. Fee schedules that insurers use to pay for services are proprietary and closely guarded. Instead, this analysis relies on a sample of claims for maternity care services for 106 women covered under one state high-risk pool, the Maryland Health Insurance Plan (MHIP).[33] MHIP fee schedules for most providers are approximately 20 percent higher than those paid by Medicare. The MHIP payment level is thought to be generally consistent with that of other commercial insurers in Maryland.[34] To estimate the cost of maternity care, median charges (those billed to and paid by MHIP) for each maternity care service were matched to each service and then summed. Researchers generated cost estimates for prenatal care, vaginal delivery, C-section delivery, and gestational diabetes care.

The most common model of health care financing is to reimburse providers for each service they perform, including diagnostic tests, office visits, and any other medically necessary care or service. Obstetric care is an exception to this fee-for-service billing method. Most health insurance plans require costs of obstetric care after an initial consultation to be billed as part of one global fee encompassing prenatal care, delivery, and postpartum care.[35] The obstetrician's global fee is billed to the health plan shortly after delivery. The global fee, however, does not usually include laboratory tests, ultrasound, or other ancillary services included in routine prenatal care. These services are typically billed separately when they are provided by laboratories, radiologists, and other providers. In addition, some costs associated with complications of pregnancy are not part of the global fee and may be billed prior to or significantly after delivery.

Providers bill for services using a standard coding system developed by the American Medical Association, called the Common Procedure Terminology (CPT). For example, CPT code 59400 represents a bundle of obstetrical services: prenatal care associated with the pregnancy, the vaginal delivery, and a single postpartum visit.

Usually, insurers will recognize a lesser amount (the "allowed charge") for a service than the provider bills (the "billed charge"). In plans with provider networks, doctors and hospitals will contract to accept the plan's allowed charge as payment in full. If a patient receives care outside of the network, she may also owe the difference between billed and allowed charges.

The difference between allowed charges and those billed by providers in network can be significant. This analysis compares billed and allowed charges for maternity care and related services under the Maryland Health Insurance Plan (MHIP), a state high-risk pool whose provider payments are set to be comparable to those by private health insurers in Maryland. For example, a common laboratory test performed in pregnancy is an obstetrics panel, a combination of many assays bundled under one charge. The median charge by laboratories for this test was $275, but the median allowed by MHIP was $50. In general, the greatest discrepancy between billed and allowed charges observed among MHIP claims was for laboratory services (Figure 4). On average, the ratio of billed to allowed laboratory charges was 4.8 to 1. For charges by obstetricians, the ratio of billed to allowed charges under MHIP was 1.6 to 1. For charges by non-Maryland hospitals (not subject to the state rate setting system), the ratio of billed to allowed charges under MHIP was 1.44 to 1.

FIGURE 4

Ratio Of Billed to Allowed Charges for Types of Maternity Care Services Under the Maryland Health Insurance Plan

Service type	Billed to allowed charges
Hospital*	1.44 to 1
Obstetrician	1.6 to 1
Lab	4.8 to 1

*DC and VA hospitals only, not subject to Maryland hospital rate setting system.

The billed charges are usually only relevant to consumers when they use services rendered by providers that are not participating in the plan network. In such cases, patients may have to pay the difference between the billed charge and the allowed charge on top of a co-insurance or co-payment. When they use in-network providers, the allowed charge is usually utilized, and no balance billing is allowed.

Applying data on MHIP median billed and allowed charges to a typical, model pregnancy, we observed the cost of prenatal care ranged from approximately $500 to $1,500, based on approved and billed charges, respectively (Table 1).

TABLE 1.

Non-Physician Billed and Allowed Charges Associated with Prenatal Care in an Uncomplicated Pregnancy Derived From a Sample of MHIP Enrollees

CPT Code	Description	MHIP Median Billed	MHIP Median Allowed
99214	Initial Office Visit	$122.50	$95.00
84702	hCG	$98.58	$20.84
80055	Obstetric panel	$274.91	$49.65
86701	HIV	$95.97	$12.51
76801	Ultrasound	$246.48	$163.26
76817	Ultrasound	$264.00	$108.73
82947	Glucose; quantitative	$30.19	$5.31
82950	Glucose; post glucose dose	$29.74	$6.82
82105	Alpha Fetoprotein	$108.53	$23.50
85025	Blood count	$35.20	$10.99
85025	Blood count	$35.20	$10.99
86592	Syphilis test; qualitative	$30.43	$6.06
86850	Antibody screen, RBC	$41.63	$17.43
87340	Hepatitis B surface antigen (HBsAg)	$73.63	$14.40
	Total Prenatal Care	**$1,486.99**	**$545.49**

Adding labor and delivery costs for a normal vaginal delivery, the range of costs (based on approved and billed charges) was approximately $10,000 to $15,000. For C-section deliveries, the cost range was higher—about $12,500 to almost $19,000 (Table 2).

TABLE 2.

Billed and Allowed Charges Associated with Delivery Derived From a Sample of MHIP Enrollees

CPT Code	Charges for Normal Vaginal Delivery	MHIP Median Billed	MHIP Median Allowed
59400	Routine obstetric care	$3,140.50	$2,007.21
54150	Circumcision	$250.00	$250.00
01967	Neuraxial labor analgesia/anesthesia	$1,078.00	$935.00
	Hospital Charges* (mother)	$5,830.77	$4,049.14
	Hospital Charges* (baby)	$2,697.49	$1,873.26
	Delivery Charges for Vaginal Delivery	$12,996.76	$9,114.61
	Prenatal Care	$1,486.99	$545.49
	Total (Vaginal Delivery + Prenatal)	**$14,483.75**	**$9,660.10**
	Charges for C-section Delivery		
59510	C-section	$3,700.00	$2,256.57
54150	Circumcision	$250.00	$250.00
01967	Neuraxial labor analgesia/anesthesia	$1,078.00	$935.00
	Hospital Charges* (mother)	$8,335.32	$5,788.42
	Hospital Charges* (baby)	$3,856.17	$2,677.89
	Delivery Charges for C-section	$17,219.49	$11,907.88
	Prenatal Care	$1,486.99	$545.49
	Total (C-section Delivery + Prenatal)	**$18,706.48**	**$12,453.37**

*Hospital charges in Maryland are regulated under a unique, statewide system so that billed and approved charges are the same; therefore, in the MHIP claims file, billed charges equaled allowed charges for most hospitals. However, the MHIP claims file also included charges from DC and Virginia hospitals that were, on average, 44 percent higher than the approved amount. For purposes of this estimate, billed hospital charges are assumed to be 44 percent higher than allowed charges. The 44 percent discrepancy assumed in this estimate is lower than that found in other studies of hospital billed and allowed charges, which have exceeded 100 percent.[36]

Finally, this analysis used MHIP data on charges for lab tests and specialist consults to estimate added prenatal care costs associated with gestational diabetes. We relied on publicly available price data on test strips and home monitoring devices because these were not included with the MHIP claims file. Using these data, we estimate gestational diabetes can add about $2,000 to $4,000 to the cost of pregnancy, based on approved vs. billed charges (Table 3).

TABLE 3.

Supplemental Billed and Allowed Charges Associated with Gestational Diabetes Mellitus Derived From a Sample of MHIP Enrollees

CPT code	Care and Supplies Related to Gestational Diabetes	MHIP Median Billed	MHIP Median Allowed
82950	Glucose; post glucose dose (includes glucose)	$30	$7
82962	Glucose home monitoring (glucose monitor and 500 strips)*	$473	$473
59025	Non Stress Test x7	$1,400	$392
76817	Ultrasound, AFI x3	$792	$326
	Insulin, 2x 10mL vials*	$157	$157
82950	Glucose; post glucose dose (includes glucose)	$30	$7
99436	Neonatology Standby/Consult	$126	$125
99245	Maternal Fetal Consult	$426	$258
99244	Maternal Fetal Consult	$234	$207
	Additional charges for gestational diabetes	**$3,666**	**$1,951**

*Prices for glucose monitor, test strips, and insulin obtained from www.drugstore.com, not MHIP.

Cost estimates constructed using MHIP data appear to be consistent with other publicly available maternity care cost estimates. For example, Blue Cross Blue Shield of North Carolina reports average billed charges arising from an uncomplicated vaginal delivery totaled $8,505. Average charges for C-section delivery with no complications were $13,746.[37] A cost calculator for Aetna estimates total charges for an uncomplicated vaginal delivery at $19,969.[38] Subimo, an Internet-based consumer health care information resource, estimates the average cost of providing health care to a pregnant woman at $9,674 for all types of deliveries.[39]

Recent analysis by Thomson Healthcare of maternity claims under large employer health plans found average billed charges for maternity care in 2004 were approximately $14,000 for vaginal delivery and $21,000 for C-section delivery. Average allowed charges for these two pregnancy types, respectively, were $7,700 and $10,900.[40]

HOW DOES MATERNITY COVERAGE UNDER CDHPs COMPARE TO TRADITIONAL INSURANCE?

This analysis compares coverage for maternity care and related services under CDHPs and traditional health plans for three scenarios that present different clinical circumstances (i.e. vaginal vs. C-section delivery, routine vs. complications) and other factors (i.e. pregnancy within one plan year vs. spanning two plan years).

To undertake this analysis, the features of 12 different private sector CDHPs from the small group and individual health insurance markets and the Federal Employees Health Benefits Program (FEHBP) were compared to a policy that is more like "traditional" health insurance (Appendix 1). Researchers worked with insurance agents in California, Maryland, and North Carolina to obtain copies of insurance contracts for policies sold in the individual and small group markets in those states. In addition, industry contacts provided several "specimen" policies sold by commercial insurers in multiple states. Also examined were several policy options available to federal government employees under the FEHBP.

Researchers relied on advice of insurance agents to identify policies sold by insurers with significant market share, as well as by insurers that are industry leaders in the development of CDHP products. Each insurance policy contract was analyzed to determine covered benefits for maternity care and related services and the level of coverage provided, including cost sharing requirements under three different clinical scenarios. Estimated maternity care charges derived from the MHIP analysis were used to determine what share of costs each insurance policy would reimburse. This information was augmented by interviews with insurance company executives including several medical directors.

It should be noted that only one of the four individual policies studied actually covered maternity care (Plan K). This policy had a $5,000 individual deductible and a $10,000 family deductible and was not HSA-qualified. As discussed earlier, individual plans do not typically cover maternity care. In some cases, consumers can purchase a rider, but that option is not always available. These plans may or may not explicitly state whether they will cover complications of pregnancy.

For sake of discussion, each scenario compares four of the CDHPs studied (Plans B, E, H, and K) to a traditional health insurance policy (Plan A). Three of the CDHPs chosen are HSA-qualified and all cover maternity care. Of the four, Plan B offers the most coverage, Plan K is the least comprehensive, and Plans E and H are in between. The characteristics and estimated out-of-pocket costs for all of the plans analyzed can be found in Appendices 1–4.

Table 4 shows key plan features of a traditional employer-sponsored plan (Plan A) and four high deductible CDHPs (identified as Plans, B, E, H and K). Plan A, the traditional policy, is not intended to represent other traditional policies, given the broad variation in health insurance policies discussed above. However, it does appear to be generally comparable to health insurance coverage that is provided by large employers.[41] The annual deductible for Plan A is $250/person and $500/family, with co-insurance of 10 to 15 percent depending on type of service (except for lab services at designated providers.) Office visits are subject to a $20 co-payment without any other cost sharing. The annual OOP maximum under Plan A is $4,000 per year for all covered charges, whether incurred by an individual or family. This feature differs from most traditional employer-sponsored insurance where there is typically a different OOP maximum for individuals and families. It should be noted that premium costs for traditional plans tend to be higher than those charged for high-deductible health plans like the ones analyzed in this report. The KFF/HRET survey found that workers contribute an average of $2,973/year in premium payments for family coverage in traditional plans and $2,115/year in CDHPs that are HSA-qualified.[42]

TABLE 4.

Key Features of Selected Consumer-Driven Health Plans that Cover Maternity Care

	Traditional Plan	Consumer-Driven Health Plans			
Plan Features	**Plan A**	**Plan B**	**Plan H**	**Plan E**	**Plan K**
Market	FEHBP	FEHBP	Small Group	Small Group	Individual
HSA-qualified?	No	Yes	Yes	Yes	No
Cost Sharing (In-Network)					
Annual Deductible (individual/family)	$250/$500	$1,500/$3,000	$2,250/$4,500	$3,500/$7,000	$5,000/$10,000
Co-insurance and Co-pays	10% obstetric, hospital; 15% imaging, anesthesia, $0 for designated lab, $20 office visit (no deductible)	None for maternity care	10% co-insurance	$35/office visit	30% co-insurance
Annual OOP Maximum (individual/family)	$4,000 (per policy)	$4,000/$8,000	$5,000/$10,000	$4,000/$7,500	$7,500/$15,000
Includes Deductible?	No	Yes	Yes	Yes	Yes
Includes Co-pays?	No—n/a to prescription drugs	n/a	Yes	Yes	Yes
Cost Sharing (Out-of-Network)					
Annual Deductible (individual/family)	$300/$600	Same as in-network	Same as in-network	$3,500/$7,000	$5,000/$10,000
Co-insurance and Co-pays	30% co-insurance, $100 co-pay/hospital admission + 30% co-insurance	30% co-insurance	30% co-insurance	50% co-insurance (+ balance billing)	50% co-insurance Hosp all amounts over $650/day
Annual OOP Maximum (individual/family)	$6,000 (per policy)	None	$10,000/$20,000	$4,000/$7,500	$7,500/$15,000
Includes Deductible?	No		Yes	Yes	Yes

Under the four CDHPs, annual deductibles range from $3,000 to $10,000. Annual OOP maximums for in-network cost sharing range from $7,500 to $15,000 for family coverage. However, notably under Plan B, after the annual deductible is satisfied no other cost sharing applies for maternity care services or inpatient care. In other words, the maximum out-of-pocket costs families could face for maternity care under this plan is the $3,000 annual family deductible (Table 4).

Within each scenario, assumptions about the cost of routine maternity care are based on billed and allowed charges observed in the MHIP claims file. Assumed costs of a more complicated pregnancy rely on outside studies of the cost of such care. For purposes of comparison, under each of these scenarios, the mother is assumed to have family coverage throughout the pregnancy, as half of individuals with employer-sponsored coverage are covered as dependents. This assumes that family-level cost sharing applies. Women who were covered as individuals may have lower out-of-pocket costs.

It is important to note that these scenarios are theoretical constructions designed to provide cost estimates. The services provided under these scenarios are likely to vary on a case-by-case basis, but these scenarios provide a baseline to compare potential out-of-pocket spending under different plans. Furthermore, the cost estimates do not account for the HSA balances that individuals may have accumulated through their own or their employer's contributions to offset their expenses. For some of these scenarios, women could have accumulated enough funds in their HSAs to cover all the out-of-pocket expenses. It is worth noting that two-thirds of workers with an HSA receive contributions to the HSA from their employer.[43] However, in many cases, it may take more than one tax year to accumulate sufficient funds to cover out-of-pocket costs, depending on the level of cost sharing imposed by the CDHP. In the case that the cost of the pregnancy consumes all of the savings accrued in the HSA, women are potentially exposed for other non-pregnancy related costs, should they arise. A recent survey found that of those employees with HSAs who received employer contributions to their accounts, the average contribution was $1,600.[44]

Scenario 1

The first is a best-case scenario with the lowest overall costs and least potential financial liability for the patient. Under this scenario, pregnancy is assumed to begin and end within a single plan year. All care is received from in-network hospitals, doctors, and other providers. The uncomplicated pregnancy ends in vaginal delivery, and the mother stays in the hospital for two days. Billed charges for this care are assumed to be $14,484. All health plans are assumed to use the same fee schedules, which would recognize allowed charges of $9,660.

Under the traditional policy, out-of-pocket costs would total $1,455, or about 15 percent of allowed charges. For HSA-qualified CDHPs, out-of-pocket costs are higher because of their higher annual deductibles. The woman's cost liability can reach $3,000 to $7,000, or 31 percent to 73 percent of total allowed charges, if CDHPs apply family-level cost sharing to labor and delivery charges (Table 5). In the case of plan K, the individual plan that covered maternity care, the family was liable for $7,884 or 82 percent of costs.

Among other plans studied for this report, out-of-pocket cost exposure could be even higher when maternity benefits were not covered, and patients could be liable for balance billing charges (Appendix 2).

TABLE 5.

Out-of-Pocket Expenses for an Uncomplicated Pregnancy With Vaginal Delivery

Pregnancy confined to one plan year, all care provided in-network; family coverage from outset

Total Allowed Charges = $9,660	
Insurer	**Out-of-Pocket Expenses* (percent of allowed charges)**
Traditional Policy—Plan A	$1,455 (15%)
FEHBP CDHP—Plan B	$3,000 (31%)
Small Group CDHP—Plan H	$5,016 (52%)
Small Group CDHP—Plan E	$7,000 (73%)
Individual CDHP—Plan K	$7,884 (82%)

*Families with tax-exempt HSA funds can apply account balances to these costs.

Scenario 2

This scenario may also be likely for many families. Under this scenario, the mother is assumed to have family coverage when pregnancy begins, and her pregnancy is assumed to span two plan years, with routine prenatal care taking place under the first plan year but labor and delivery occurring the following year. The mother is assumed to seek all care within the plan network with the exception of anesthesia care during delivery (the anesthesiologist on call when she delivers

is out-of-network) so some balance billing costs may apply. In addition, this scenario assumes a normal pregnancy with a C-section delivery and a three-day hospital stay, but no other medical complications. In 2004, 29 percent of all births in the U.S. were by C-section.[45]

Under this scenario, family cost sharing increases somewhat due to balance billing by the anesthesiologist. More significantly, family cost sharing increases under all plans because prenatal care in year one is subject to a separate annual deductible. First-year costs to the family are somewhat lower under the traditional insurance policy because the mother's prenatal care is subject to the lower, embedded deductible for an individual. Under HSA-qualified CDHPs, however, the full family deductible must be satisfied in both years before claims are reimbursed (Table 6). Out-of-pocket expenses under the CDHPs ranged from $3,545 in the FEHBP plan to $9,818 in the individual plan because of the application of two calendar-year deductibles.

TABLE 6.

Out-of-Pocket Expenses for an Uncomplicated Pregnancy with C-section

Spans 2 plan years, anesthesia care out-of-network with balance billing; family coverage from outset

Total Allowed Charges = $12,453	
Insurer	**Out-of-Pocket Expenses* (percent of allowed charges)**
Traditional Policy—Plan A	$2,244 (18%)
FEHBP CDHP—Plan B	$3,545 (29%)
Small Group CDHP—Plan H	$5,929 (48%)
Small Group CDHP—Plan E	$7,688 (62%)
Individual CDHP—Plan K	$9,818 (79%)

*Families with tax-exempt HSA funds can apply account balances to these costs.

Scenario 3

The third pregnancy scenario is least likely to occur, but involves the worst case, with the highest expense. As such, it illustrates the importance of catastrophic health insurance coverage for maternity care. Under this scenario, the mother is also assumed to have family coverage at the outset of the pregnancy and her pregnancy is assumed to span two plan years, but this time

medical complications arise. The mother develops gestational diabetes, which adds to her prenatal care costs. She also experiences pre-term labor and requires hospitalization during the first plan year. The pre-term labor hospitalization is assumed to cost $75,000. The baby is delivered by C-section just after the second plan year begins and requires several weeks in neonatal intensive care, assumed to cost another $200,000. All care is assumed to be received in-network under this scenario, and total allowed charges are $287,453. Although this is the worst-case scenario, it is not altogether uncommon.[46] For example, gestational diabetes affects 3 to 6 percent of pregnancies in the U.S., or approximately 135,000 women annually.[47] About 12 percent of babies are born prematurely due to complications such as multiple births, infection, or serious medical conditions such as preeclampsia.[48] Almost 8 percent of babies are born low birth weight.[49]

Out-of-pocket costs are even higher under this scenario because maximum cost sharing limits are reached in two consecutive plan years. Under the traditional policy, the family's cost sharing exposure is $8,770, or about 3 percent of the total, catastrophic expense. The family's share of costs is lower under one of the CDHPs, Plan B, because no cost sharing applies to maternity or other inpatient care after the deductible under this plan. By contrast, under CDHPs E, H, and K, OOP maximums are much higher. Total spending for the family would be $14,000, $20,000, or $21,194 under these plans, or 5 to 7 percent of total costs (Table 7).

TABLE 7.

Out-of-Pocket Expenses For a Pregnancy With Complications and C-section Delivery

Spans 2 plan years, prenatal care and $75,000 hospitalization to stop pre-term labor in year 1; C-section delivery, and $200,000 NICU hospitalization in year 2; family coverage from outset, all care in-network

Total Allowed Charges = $287,453	
Insurer	**Out-of-Pocket Expenses* (percent of allowed charges)**
Traditional Policy—Plan A	$8,770 (3%)
FEHBP CDHP—Plan B	$6,000 (2%)
Small Group CDHP—Plan H	$20,000 (7%)
Small Group CDHP—Plan E	$14,000 (5%)
Individual CDHP—Plan K	$21,194 (7%)

*Families with tax-exempt HSA funds can apply account balances to these costs.

CDHP INFORMATION RESOURCES TO SUPPORT CONSUMER DECISION-MAKING

One of the features of CDHPs that proponents praise is the potential they have for allowing consumers to make more informed decisions about their health care choices, often using Web-based informational tools. The researchers were not able to assess the availability or content of information resources under the 12 CDHPs studied because their Web-based resources are restricted to plan enrollees. As a result, it is not possible to say for certain whether enrollees under any of these plans might be better able to, for example, select more skilled providers possibly able to reduce the risk of complications or more cost-effective providers possibly able to further reduce the cost of maternity care.

Other studies of CDHPs have found such information support is limited at best. One study that surveyed more than 1,000 CDHP enrollees, employer purchasers, providers, and plan officials found that plans have invested significantly in information support resources. Nevertheless,

> "Given consumers' increased financial stake and decision-making responsibility … in consumer-directed plans, respondents often … expressed frustration that, in their opinion, the availability of adequate support has lagged behind the demands these products place on consumers."[50]

Health plan officials interviewed acknowledged that development of meaningful consumer information support resources is challenging for many reasons. The science of measuring the quality and cost effectiveness of care is still developing. Medical directors cited lack of reliable data linking outcomes to cost and suggested it may take many years and substantial investment in research to obtain such data. One director also noted disincentives for health insurers to invest heavily in this area for two reasons: First, enrollee turnover can make it harder for insurers to capture future cost savings that may arise from changing current consumer behavior. Second, to the extent real-time savings can be realized, under high-deductible health plans these may accrue to the consumer, not the health plan.[51]

Finally, in many cases, uncertainty about out-of-pocket cost liability for maternity care would also likely be a problem for consumers in traditional plans. Uncertainty about future medical needs, difficulties seeking care in-network, and ambiguity in insurance policy contract language are challenges facing many consumers and are not unique to CDHPs. Higher cost sharing liability under CDHPs only amplifies the consequences of uncertain cost liability.

CONCLUSION

This study finds that families can expect substantial financial liability for the cost of maternity care under CDHPs, although for any given plan, anticipating out-of-pocket cost liability is difficult to predict even in the best of circumstances. Unanticipated medical complications, timing over a calendar year, and network participation of providers all make a tremendous difference in costs and are not easy to control or predict even for the savviest health care consumers.

Understanding the details and exact policies of any health insurance plan can be difficult, but CDHPs can make this more onerous because one of the underlying premises in these arrangements is that consumers take more responsibility for anticipating how much health care they will consume and the related costs. To estimate likely out-of-pocket costs, consumers first would need to be able to predict their future medical needs. This is difficult even for planned health events like pregnancy with well-established care guidelines. It is much harder for other expensive health conditions that are less predictable and involve a broader range of potential medical care needs.

Even if consumers could accurately forecast health care needs for the coming year, however, lack of transparency in contract language makes it hard to know what expenses a plan will reimburse. In addition, enormous variation in the details of what different health insurance policies cover and how they work can frustrate even diligent consumers from investigating and understanding what health plans cover. On top of this, many health needs and expenses cross into more than one plan year, making it even more complicated to project future spending. Health insurance can be exceedingly complicated. This is a problem for traditional policies as well as new CDHPs.

However, high cost sharing under CDHPs magnifies the financial impact on consumers. In CDHPs that cover maternity benefits, high deductibles shift a significant share of the cost of care to families. Although this study was not able to estimate the tax savings that families would experience by putting funds in an HSA (even after costs have been incurred), it did find that families would have to pay thousands of dollars in out-of-pocket costs for routine maternity care under many of the CDHPs studied. For modest income families, the tax benefits would be lower and the financial burden of the costs quite high. Under some plans, families would have to pay more than half of all covered costs. It is possible that even under the most diligent savings arrangements that the amount of funds accrued in an HSA may fall short of covering the needs families will have in paying for out-of-pocket maternity costs. A pregnancy can easily wipe out several years of savings and leave families exposed to future costs for other health needs.

In all of the CDHPs that were studied, prenatal care was not considered to be a preventive service and was not exempt from cost sharing the way some other covered preventive services sometimes were. Instead, it was covered as a medical expense.

If policymakers want to encourage prudent consumer decision making in health care through insurance policy design, a first step could be to require insurers to write contracts clearly in language understandable to consumers. Because many people do not read their insurance contracts or even fully understand what they mean, consumer-friendly brochures, marketing materials, and other summaries could also be developed to include a variety of medical care scenarios illustrating how coverage works and what consumer financial liability might be.

In addition, greater standardization of health plans could go far to eliminate many of the variations that can limit coverage and drastically affect consumer out-of-pocket costs. Given low rates of health literacy in the general population,[52] it may not be practical to expect consumers to understand and compare so many, often hidden, health plan features and complex rules. Overwhelmed by complexity, consumers are more likely to focus on recognizable plan features (such as deductibles) and make assumptions about their insurance protections without regard to other important factors (such as what expenses count toward deductibles.)

While this study was not able to evaluate the informational materials provided by plans to help consumers evaluate options and make informed choices, other research shows that this feature of CDHPs may prove the most challenging. Maintaining accurate and current information about providers and choices is a difficult undertaking in a rapidly changing health care environment, where providers routinely shift in and out of networks and where quality information is difficult to obtain and interpret.

The scenarios developed in this study find that women who are enrolled in CDHPs are likely to face sizable out-of-pocket costs and may not have the funds accrued in their HSAs to offset these costs. Complications, even those as common as a C-section delivery, can drive up costs to levels that are unaffordable for most moderate income families. Even the most predictable events can cause unanticipated financial hardship for new families with coverage through CDHPs.

ENDNOTES

1 Martin, J., et. al., "Births Final Data for 2001," *National Vital Statistics Reports,* December 18, 2002.

2 Agency for Healthcare Research and Quality, "Hospitalization in the United States, 2002: HCUP Fact Book No. 6." Health Care Cost and Utilization Project. Available online at: www.ahrq.gov/data/hcup/factbk6/factbk6.pdf.

3 American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care 5th ed. 2002.

4 Claims data provided by MHIP were stripped of patient-identifying information.

5 Communication with Richard Popper, MHIP Executive Director. In addition, MHIP payments to hospitals are subject to a state rate-setting system that applies to all payers; consequently, billed and allowed charges for Maryland hospitals are the same. However, when MHIP enrollees receive hospital care out of state (in Virginia or the District of Columbia) there are substantial differences between hospital billed charges and allowed charges.

6 Martin, J., et. al., "Births Final Data for 2001," *National Vital Statistics Reports,* December 18, 2002.

7 Keefe, C. "Overview of Maternity Care in the U.S.," Citizens for Midwifery, available online at: www.cfmidwifery.org.

8 Agency for Healthcare Research and Quality. "Hospitalization in the United States, 2002: HCUP Fact Book No. 6." Health Care Cost and Utilization Project. Available online at: www.ahrq.gov/data/hcup/factbk6/factbk6.pdf

9 Coventry Health Care. "The Importance of Prenatal Care." Available online at: www.chcde.com/framesetdef.asp?Community=Member

10 John, E., K. Nelson, S. Cliver, et al. "Cost of neonatal care according to gestational age at birth and survival status," *American Journal of Obstetrics and Gynecology*, 182(1):170-175, January 2000.

11 Agency for Healthcare Research and Quality. "Care of Women in U.S. Hospitals, 2000: HCUP Fact Book No. 3." Available online at: www.ahrq.gov/data/hcup/factbk3/factbk3.pdf.

12 American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care 5th ed. 2002.

13 The Pregnancy Discrimination Act requires health plans sponsored by employers with at least 15 workers to cover pregnancy similarly to other benefits for short term disabilities.

14 Gabel, J., K. Dhont, H. Whitmore, et.al. "Individual Insurance: How Much Financial Protection Does It Provide?" *Health Affairs* Web Exclusive, April 17, 2002.

15 For example, consider premiums quoted on ehealthinsurance.com for individual policies sold in Charlotte, North Carolina (zip code 28201). One large insurer, Humana, quotes a standard rate of $210.19/month for a 30-year-old woman for a base policy ($1,000 deductible, 80/20 to $2,000 OOP). A maternity rider is available for an additional $222.33/month for 60/40 coverage after separate $500 maternity deductible in network; 40/60 coverage after separate $1,000 maternity deductible out-of-network. Information downloaded from www.ehealthinsurance.com on November 1, 2006. This policy was not included in the report's analysis.

16 Infants with phenylketonuria (PKU) lack an enzyme needed to metabolize phenylalanine, an amino acid needed for normal growth and development. This condition is treated by feeding infants special formula that is free of phenylalanine.

17 Page 3 WP-COC-Direct Access-2/2004 IDX # 2224 CHWP 2224 WellPath Select Inc., Certificate of Coverage. This policy was not included in the report's analysis.

18 Federal law requires employer-sponsored health plans to provide a special enrollment opportunity following the birth of a baby, during which conversion to family coverage can be elected. All states have laws requiring insurers to cover newborn infants for the first month and to permit newborns to be added to policies that offer family coverage.

19 Federal law does not require employers to offer dependent coverage. However, when it is offered, the law requires plans to offer an opportunity to parents to enroll their newborn in the plan.

20 Sometimes these policies are also referred to as consumer-directed health plans or consumer-driven health care.

21 A person with a qualified high-deductible health plan (HDHP) may open an HSA. Not all CDHPs qualify. However, there are other tax preferred accounts. For instance, Health Reimbursement Arrangements (HRAs) are a second type of tax preferred account that can be combined with qualified CDHPs. HRAs are outside the focus of this report. For more information about the difference between HRAs and HSAs, see "Health Savings Accounts: Issues and Implementation Decisions for States," State Coverage Initiatives, September 2004, Vol V, No. 3. See also IRS Health Savings Accounts at www.irs.gov/publications/p969/ar02.html.

22 U.S. Government Accountability Office. "Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans," GAO-06-798, August 2006.

23 Kaiser Family Foundation (KFF) and Health Research and Educational Trust (HRET). 2006 Annual Employer Health Benefits Survey. Available online at: www.kff.org.

24 Public Law 109-432 Signed December 20, 2006.

25 KFF and HRET, 2006.

26 See Kulak, D. "Health Savings Account (HSA) Useful for Women in Childbearing Years?" available at www.healthinsurance-help.com/savings-account.html (2/6/2006). The author notes that the patient will "be paying the first $1,000, $2,500, or $5,000 (depending on the deductible), because the total cost will be that plus more. But after the deductible is satisfied, the insurance will kick in and pay for the rest of the cost." The author goes on to say that an optional maternity rider must be purchased for pregnancy coverage. Although it is accurate that in some states it is possible to purchase an optional maternity rider, that is not the case in every state. And even when available, the price for maternity riders can be more than the monthly premium for the health insurance policy, making it prohibitively expensive. Maternity riders typically do not provide any coverage for at least the first year of the policy. Additionally, with respect to policies that cover maternity, the policies we examined continued to require patients to pay co-payments and co-insurance after the deductible was satisfied. An article by the Women's HealthPlan Network, LLC called "Health Insurance for Pregnancy and Maternity Care" available at www.herhealthplan.com/healthcare/maternity-insurance.php (2/6/06) also discusses how HDHPs and HSAs can save families money.

27 Cannon, M. "Health Savings Accounts: Making the Healthcare System Work for Women." Independent Women's Forum, March 18, 2004.

28 Internal Revenue Service. "Administrative, Procedural and Miscellaneous, Health Savings Accounts, M-Additional Q&As" Notice 2004-50 (Revised and Corrected August 9, 2004)."

29 KFF and HRET, 2006.

30 In this paper, the term "cost" refers to the cost of care faced by the patient or her insurer, not the input cost of providing services.

31 American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care 5th ed. 2002.

32 Providers bill for services using a standard coding system developed by the American Medical Association, called the Common Procedure Terminology (CPT). For example, CPT code 59400 represents a bundle of obstetrical services: prenatal care associated with the pregnancy, the vaginal delivery, and a single postpartum visit.

33 Claims data provided by MHIP were stripped of patient-identifying information.

34 Communication with Richard Popper, MHIP Executive Director. In addition, MHIP payments to hospitals are subject to a state rate-setting system that applies to all payers; consequently, billed and allowed charges for Maryland hospitals are the same. However, when MHIP enrollees receive hospital care out of state (in Virginia or the District of Columbia) there are substantial differences between hospital billed charges and allowed charges.

35 American Academy of Family Physicians. "Obstetric Care." Available online at: www.aafp.org/online/en/home/practicemgt/codingresources/codingob/overview.html.

36 See, for example, testimony of Gerard Anderson (citing hospital billed-to-paid charge differences of 3:1) and Mark Rukavina (citing average hospital markups of 135 to 300 percent) at hearing of the House Energy and Commerce Committee on Hospital Billing and Collections Practices, June 24, 2004. Available online at: http://energycommerce.house.gov.

37 BlueCross BlueShield of North Carolina. "Healthcare Cost Estimator." Available online at http://www.bcbsnc.com/apps/cost-estimator/report.do?type=inpatient&sub=14, viewed July 14, 2006.

38 Aetna Insurance. "Plan For Your Health." Available online at: www.planforyourhealth.com/, viewed July 14, 2006.

39 BlueCross BlueShield of Minnesota. "Health Cost Calculator." Available online at: www1.subimo.com/ca/app/bcbsmngrp/CoverageAdvisor, viewed July 14, 2006.

40 Thomson Healthcare, "The Healthcare Costs of Having a Baby." 2007.

41 KFF and HRET, 2006.

42 KFF and HRET, 2006.

43 KFF and HRET, 2006.

44 KFF and HRET, 2006.

45 National Center for Health Statistics. "2004 Preliminary Birth Data: Maternal and Infant Health." Available online at www.cdc.gov/nchs/products/pubs/pubd/hestats/highlights/2004prebirth.htm.

46 Coventry Health Care. "The Importance of Prenatal Care." Available online at: www.chcde.com/framesetdef.asp?Community=Member.

47 Jovanovic, L; Pettitt, D. "Gestational Diabetes Mellitus." *JAMA,* 286: 2516-2518, 2001.

48 Moore, M. "Preterm Birth: A Continuing Challenge," *Journal of Perinatal Education*, 11(4): 37-40, Fall 2002.

49 Moore, M., ibid.

50 Regopoulos, L., J.B. Christianson, G. Claxton, et al. "Consumer Directed Health Insurance Products: Local-Market Perspectives," *Health Affairs,* 25(3), May/June 2006.

51 On August 22, 2006, President Bush issued an Executive Order directing federal agencies to compile and analyze available data on health care quality, cost, and cost effectiveness. Of note, the Executive Order specified this effort does not authorize any additional federal resources or spending. Available online at: www.whitehouse.gov/news/releases/2006/08/20060822-2.html.

52 The Institute of Medicine has estimated that 120 million Americans are considered "health illiterate." See Institute of Medicine of the National Academies. "Health Literacy: A Prescription to End Confusion." Report Brief. April 2004.

MATERNITY CARE AND CONSUMER-DRIVEN HEALTH PLANS

APPENDICES

APPENDIX TABLE 1

Summary of Key Features of 12 Consumer-Driven Health Plans

	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
Plan Features						
Market	FEHBP	FEHBP	FEHBP	Small Group	Small Group	Small Group
HSA-qualified?	Yes	Yes	No	Yes	No	No
Covered Benefits						
Maternity Care	Yes	Yes	Yes	Yes	Yes	Yes, if elected by employer
Complications of Pregnancy	Yes	Yes	Yes	Yes	Yes	Yes
In-Network Cost Sharing						
Annual Deductible (individual/family)	$1,500/$3,000	$2,500/$5,000	$1,000/$2,000 (no embedded deductible)	$3,500/$7,000	$2,000/$4,000	$1,000/$2,000 (no embedded deductible)
Co-insurance and Co-payments	None for maternity care, inpatient care	10% co-insurance	15% co-insurance	$35/office visit	$20/$35 visit, no co-insurance	$20/visit pre-deductible, 20% co-insurance hosp/lab/x-ray
Annual OOP Max (individual/family)	$4,000/$8,000	$4,000/$8,000	$3,000/$6,000	$4,000/$7,500	None	$3,000/$6,000 (no embedded deductible)
Includes Deductible?	Yes	Yes	Yes	Yes	N/A	No
Includes Co-payments?	N/A	Yes	Yes	Yes	N/A	No
Out-of-Network Cost Sharing						
Annual Deductible (individual/family)	Same as in-network	Same as in-network	Same as in-network	Same as in-network	$4,000/$8,000	$2,000/$4,000
Co-insurance and Co-payments	30% co-insurance (none for inpatient anesthesia)	30% co-insurance	40% co-insurance	50% co-insurance (+ balance billing)	40% co-insurance	$20-$40/visit post-deductible, 50% co-insurance
Annual OOP Max (individual/family)	None	$5,000/$10,000	$4,000/$8,000	$4,000/$7,500	$4,000/$8,000	$7,500/$15,000
Includes Deductible?	N/A	Yes	Yes	Yes	No	No
Other Costs Not Limited by OOP Max	None	Precertification penalties	Rx co-pays, precertification penalties, etc	Certain expenses for non-participating providers	None	None

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APPENDIX TABLE 1 (CONT.)

Summary of Key Features of 12 Consumer-Driven Health Plans

	Plan H	Plan I	Plan J	Plan K	Plan L	Plan M
Plan Features						
Market	Small Group	Small Group	Individual	Individual	Individual	Individual
HSA-qualified?	Yes	Yes	Yes	No	Yes	No
Covered Benefits						
Maternity Care	Yes	Yes	No	Yes	No	No
Complications of Pregnancy	Yes	Yes	Yes	Yes	No	No
In-Network Cost Sharing						
Annual Deductible (individual/family)	$2,250/$4,500	$2,750/$5,500	$2,600/$5,150	$5,000/$10,000	$3,500/$7,000	$3,500/$7,000
Co-insurance and Co-payments	10% co-insurance	$20-$30/visit, 20% co-insurance for in/outpatient	None post-deductible	30% co-insurance	N/A for maternity costs—none after deductible; $500 hospital	N/A for maternity costs—none after deductible; $500 hospital (N/A toward deductible)
Annual OOP Max (individual/family)	$5,000/$10,000	$5,000/$10,000	$2,600/$5,150	$7,500/$15,000	$5,000/$10,000	None
Includes Deductible?	Yes	Yes	Yes	Yes	Yes	N/A
Includes Co-payments?	Yes	Yes	Yes	Yes	Yes	N/A
Out-of-Network Cost Sharing						
Annual Deductible (individual/family)	Same as in-network	$5,500 /$11,000	$5,200/$10,300	Same as in-network	Same as in-network	Same as in-network
Co-insurance and Co-payments	30% co-insurance	$20-$30/visit plus 20% co-insurance; 35% co-insurance for inpatient	30% co-insurance	50% co-insurance Hospital all amounts over $650/day	N/A for maternity costs	N/A for maternity costs
Annual OOP Max (individual/family)	$10,000/$20,000	$10,000/$20,000	$11,200/person	$7,500/$15,000	None	$10,000/person
Includes Deductible?	Yes	Yes	Yes	Yes		Yes
Other Costs Not Limited by OOP Max	Some hospital related fees	None	None	Brand-name drug deductible	None	Certain expenses for non-participating providers

APPENDIX TABLE 2

Out-of-Pocket Expenses for Maternity Care Under Twelve Consumer-Driven Health Plans

Scenario 1: Normal pregnancy, no complications, vaginal delivery, pregnancy confined to one plan year, all care in-network, family coverage

Total Allowed Charges = $9,660

Insurer/Policy Features	Out-of-Pocket Expenses (% allowed charges not covered by plan)
FEHBP—Consumer-Driven Health Plans	
Plan B Maternity covered; $1,500/$3,000 deductible; no additional co-insurance for maternity; OOP max: $4,000/$8,000; HSA-qualified	**$3,000** (31%) $3,000 family deductible; no other cost sharing
Plan C Maternity covered; $2,500/$5,000 deductible; 10% co-insurance; OOP max: $4,000/$8,000; HSA-qualified	**$5,466** (57%) $5,000 family deductible + $466 co-insurance (10% other medical of $4,660)
Plan D Maternity covered; $1,000/$2,000 deductible; 15% co-insurance; OOP max: $3,000/$6,000; not HSA-qualified	**$3,149** (33%) $2,000 family deductible + $1,149 co-insurance (15% other medical of $7,660)
Small Group—Consumer-Driven Health Plans	
Plan E Maternity covered; $3,500/$7,000 deductible; no co-insurance; OOP max: $4,000/$7,500; HSA-qualified	**$7,000** (73%) $7,000 family deductible; no other cost sharing
Plan F Maternity covered; $2,000/$4,000 deductible*; $20/$35 co-pay; no co-insurance; OOP max: no limit; not HSA-qualified	**$2,020** (21%) **to $4,020** (42%) $2,000 embedded deductible + $20 co-pay; no other cost sharing or $4,000 family deductible + $20 co-pay; no other cost sharing
Plan G Maternity covered if elected by employer; $1,000/$2,000 deductible; $20 co-pay/visit pre-deductible, 20% co-insurance; OOP max: $3,000/$6,000 (excludes deductibles and co-pays); plan contract allows for balance billing in-network if plan pays less than negotiated rate; not HSA-qualified	**$3,533 + unknown balance billing** $2,000 family deductible + $20 co-pay + $1,513 co-insurance (20% other medical of $7,565) + ? balance billing all services
Plan H Maternity covered; $2,250/$4,500 deductible (in-network); 10% co-insurance to OOP max of $5,000/$10,000 (in-network); HSA-qualified	**$5,016** (52%) $4,500 family deductible + $516 co-insurance (10% other medical of $5,160)
Plan I Maternity covered; $2,750/$5,500 deductible; $20 co-pay; 20% co-insurance for in/outpatient; OOP max: $5,000/$10,000; HSA-qualified	**$6,333** (66%) $5,500 family deductible + $20 co-pay + $1,823 co-insurance (20% other medical of $4,065)

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APPENDIX TABLE 2 (CONT.)

Out-of-Pocket Expenses for Maternity Care Under Twelve Consumer-Driven Health Plans

Scenario 1: Normal pregnancy, no complications, vaginal delivery, pregnancy confined to one plan year, all care in-network, family coverage

Total Allowed Charges = $9,660

Insurer/Policy Features	Out-of-Pocket Expenses (% allowed charges not covered by plan)
Individual Market—Consumer-Driven Health Plans	
Plan J Maternity not covered; $2,600/$5,150 deductible; no co-pays and no co-insurance post-deductible (n/a to maternity); OOP max: $2,600/$5,150; HSA-qualified	**$14,484** (100%+)^ $14,484 for *billed charges*
Plan K Maternity covered; $5,000/$10,000; 30% co-insurance post-deductible until OOP max reached; OOP max: $7,500/$15,000; not HSA-qualified	**$7,884** (82%) $5,000 embedded deductible for mom + $761 (30% co-insurance of $2,537) + $2,123 baby
Plan L Maternity not covered; $3,500/$7,000 deductible; co-pays and co-insurance n/a for maternity costs (none after deductible), $500 for hospital; OOP max: $5,000/$10,000; HSA-qualified	**$14,484** (100%+)^ $14,484 for *billed charges*
Plan M Maternity not covered; $3,500/$7,000 deductible; co-pays and co-insurance n/a for maternity costs (none after deductible), $500 for hospital; OOP max: no limit; not HSA-qualified	**$14,484** (100%+)^ $14,484 for *billed charges*

Note: For plans that are HSA-qualified, actual out-of-pocket spending may vary depending on the amount of money contributed to an individual's HSA.

Assumptions: In plans with different co-pays for primary care physicians and specialists, we assumed the lower co-payment would apply for two reasons: 1. in many states, network plans are required to allow a woman to designate her OB/GYN as a primary care physician and 2. some policies explicitly treat OB/GYN as "non-specialist" for purposes of determining a co-payment for office visits. We also assumed that a co-payment is only charged for the first visit with an obstetrician.

Claims are assumed to be processed in the order services are listed.

*Some policies (not those that were HSA-qualified) were not clear on whether an insurer would pay benefits once one person under family coverage met the individual deductible or whether the entire deductible had to be satisfied before any benefits were paid under family coverage. Additionally, some policies were not clear whether the maximum out-of-pocket protection would apply once one person under family coverage reached the individual maximum or whether the family maximum had to be reached.

^Percentages could exceed 100% because maternity care is not covered under the plan and the woman could be required to pay "billed charges," which exceed "allowed charges" that are typically paid by plans that cover maternity care.

APPENDIX TABLE 3

Out-of-Pocket Expenses for Maternity Care Under Twelve Consumer-Driven Health Plans

Scenario 2: Normal pregnancy, C-section delivery, spans 2 plan years, anesthesia care out-of-network with balance billing, family coverage

Total Allowed Charges = $12,453

Insurer/Policy Features	Out-of-Pocket Expenses (% allowed charges not covered by plan)
FEHBP—Consumer-Driven Health Plans	
Plan B Maternity covered; $1,500/$3,000 deductible; no additional co-insurance for maternity; non-network anesthesia covered in full; OOP max: $4,000/$8,000; HSA-qualified	**$3,545** (29%) Year 1 = $545 prenatal care subject to family deductible Year 2 = $3,000 family deductible for C-section delivery
Plan C Maternity covered; $2,500/$5,000 deductible; 10% co-insurance; OOP max: $4,000/$8,000; HSA-qualified	**$6,379** (51%) Year 1 = $545 prenatal care subject to family deductible Year 2 = $5,000 family deductible + $691 co-insurance (10% other medical of $6,908) + $143 balance billing for anesthesia
Plan D Maternity covered; $1,000/$2,000 deductible; 15% co-insurance; OOP max: $3,000/$6,000; not HSA-qualified	**$4,174** (33%) Year 1 = $545 prenatal care subject to family deductible Year 2 = $2,000 family deductible + $1,486 (15% other medical of $9,908) + $143 balance billing for anesthesia
Small Group—Consumer-Driven Health Plans	
Plan E Maternity covered; $3,500/$7,000 deductible; no co-insurance; OOP max: $4,000/$7,500; HSA-qualified	**$7,688** (68%) Year 1 = $545 prenatal care subject to family deductible Year 2 = $7,000 family deductible for C-section delivery + $143 balance billing for anesthesia
Plan F Maternity covered; $2,000/$4,000 deductible*; $20/$35 co-pay; no co-insurance; OOP max: no limit; not HSA-qualified	**$4,613** (37%) Year 1 = $20 co-pay + $450 prenatal care subject to family deductible Year 2 = $4,000 family deductible + $143 balance billing for anesthesia
Plan G Maternity covered if elected by employer; $1,000/$2,000 deductible; $20 co-pay/visit pre-deductible, 20% co-insurance; OOP max: $3,000/$6,000 (excludes deductibles and co-pays); plan contract allows for balance billing in-network if plan pays less than negotiated rate; not HSA-qualified	**$4,451 + unknown balance billing** Year 1 = $20 co-pay + $450 prenatal care subject to embedded deductible + ? balance billing all services Year 2 = $2,000 family deductible + $1,981 (20% other medical of $9,907) + ? balance billing all services
Plan H Maternity covered; $2,250/$4,500 deductible (in-network); 10% co-insurance to OOP max of $5,000/$10,000 (in-network); HSA-qualified	**$5,929** (48%) Year 1 = $545 prenatal care subject to family deductible Year 2 = $4,500 family deductible for C-section delivery + $741 co-insurance (10% other medical of $7,408) + $143 balance billing for anesthesia

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APPENDIX TABLE 3 (CONT.)

Out-of-Pocket Expenses for Maternity Care Under Twelve Consumer-Driven Health Plans

Scenario 2: Normal pregnancy, C-section delivery, spans 2 plan years, anesthesia care out-of-network with balance billing, family coverage

Total Allowed Charges = $12,453

Insurer/Policy Features	Out-of-Pocket Expenses (% allowed charges not covered by plan)
Plan I Maternity covered; $2,750/$5,500 deductible; $20 co-pay; 20% co-insurance for in/outpatient; OOP max: $5,000/$10,000; HSA-qualified	**$7,469** (60%) Year 1 = $545 prenatal care subject to family deductible Year 2 = $5,500 family deductible for C-section delivery + $1,281 (20% other medical of $6,405) + $143 balance billing for anesthesia
Individual Market—Consumer-Driven Health Plans	
Plan J Maternity not covered; complications covered; $5,150 deductible; no co-pays and no co-insurance post-deductible (n/a to maternity); OOP max: $2,600/$5,150; HSA-qualified	**$18,706** (100%+)^ Year 1 = $1,487 prenatal care *billed charges* Year 2 = $17,219 for C-section delivery *billed charges*
Plan K Maternity covered; $5,000/$10,000 deductible; 30% co-insurance post-deductible until OOP max reached; OOP max: $7,500/$15,000; not HSA-qualified	**$9,818** (79%) Year 1 = $545 prenatal care subject to embedded deductible Year 2 = $5,000 embedded deductible + $1,194 (30% other medical) + $2,928 baby, + balance billing for anesthesia
Plan L Maternity not covered; complications not covered; $3,500/$7,000 deductible; co-pays and co-insurance n/a for maternity costs (none after deductible), $500 for hospital; OOP max: $5,000/$10,000; HSA-qualified	**$18,706** (100%+)^ Year 1 = $1,487 prenatal care *billed charges* Year 2 = $17,219 for C-section delivery *billed charges*
Plan M Maternity not covered; complications not covered; $3,500/$7,000 deductible; co-pays and co-insurance n/a for maternity costs (none after deductible), $500 for hospital (doesn't count toward deductible); OOP max: No limit; not HSA-qualified	**$18,706** (100%+)^ Year 1 = $1,487 prenatal care *billed charges* Year 2 = $17,219 for C-section delivery *billed charges*

Note: For plans that are HSA-qualified, actual out-of-pocket spending may vary depending on the amount of money contributed to an individual's HSA.

Assumptions: In plans with different co-pays for primary care physicians and specialists, we assumed the lower co-payment would apply for two reasons: 1. in many states, network plans are required to allow a woman to designate her OB/GYN as a primary care physician and 2. some policies explicitly treat OB/GYN as "non-specialist" for purposes of determining a co-payment for office visits. We also assumed that a co-payment is only charged for the first visit with an obstetrician.

Claims are assumed to be processed in the order services are listed.

*Some policies (not those that were HSA-qualified) were not clear on whether an insurer would pay benefits once one person under family coverage met the individual deductible or whether the entire deductible had to be satisfied before any benefits were paid under family coverage. Additionally, some policies were not clear whether the maximum out-of-pocket protection would apply once one person under family coverage reached the individual maximum or whether the family maximum had to be reached.

^Percentages could exceed 100% because maternity care is not covered under the plan and the woman could be required to pay "billed charges," which exceed "allowed charges" that are typically paid by plans that cover maternity care.

APPENDIX TABLE 4

Out-of-Pocket Expenses for Maternity Care Under Twelve Consumer-Driven Health Plans

Scenario 3: Complicated pregnancy, spans 2 plan years, prenatal care and $75,000 hospitalization to stop pre-term labor in year 1, C-section delivery and $200,000 NICU hospitalization in year 2, all care in-network, family coverage

Total Allowed Charges = $287,453

Insurer/Policy Features	Out-of-Pocket Expenses (% allowed charges not covered by plan)
FEHBP—Consumer-Driven Health Plans	
Plan B Maternity covered; $1,500/$3,000 deductible; no additional co-insurance for maternity; OOP max: $4,000/$8,000; HSA-qualified	**$6,000** (2%) Year 1 = $3,000 family deductible for prenatal care and pre-term labor hospitalization Year 2 = $3,000 family deductible for C-section delivery
Plan C Maternity covered; $2,500/$5,000 deductible; 10% co-insurance; OOP max: $4,000/$8,000; HSA-qualified	**$16,000** (6%) Year 1 = $5,000 family deductible for prenatal care and pre-term labor hospitalization + 10% co-insurance to OOP max = $8,000 Year 2 = $5,000 family deductible for C-section delivery + 10% co-insurance to OOP max = $8,000
Plan D Maternity covered; $1,000/$2,000 deductible; 15% co-insurance; OOP max: $3,000/$6,000; not HSA-qualified	**$12,000** (4%) Year 1 = $2,000 family deductible for prenatal care and pre-term labor hospitalization + 15% co-insurance capped at OOP max = $6,000 Year 2 = $2,000 family deductible for C-section delivery + 15% co-insurance capped at OOP max = $6,000
Small Group—Consumer-Driven Health Plans	
Plan E Maternity covered; $3,500/$7,000 deductible; no co-insurance; OOP max: $4,000/$7,500; HSA-qualified	**$14,000** (5%) Year 1 = $7,000 family deductible for prenatal care + pre-term labor hospital stay Year 2 = $7,000 family deductible for C-section delivery + NICU
Plan F Maternity covered; $2,000/$4,000 deductible*; $20/$35 co-pay; no co-insurance; OOP max: no limit; not HSA-qualified	**$6,000** (2%) to **$8,000** (3%) Year 1 = $2,000 embedded* deductible for prenatal care + pre-term labor hospital stay ($4,000 if not embedded) Year 2 = $4,000 family deductible for C-section delivery + NICU
Plan G Maternity covered if elected by employer; $1,000/$2,000 deductible; $20 co-pay/visit pre-deductible, 20% co-insurance; OOP max: $3,000/$6,000 (excludes deductibles and co-pays); plan contract allows for balance billing in-network if plan pays less than negotiated rate; not HSA-qualified	**$16,020 + unknown balance billing** Year 1 = $2,000 family deductible + $20 office visit + 20% hospital until OOP max of $6,000 = $8,020+ balance billing Year 2 = $2,000 family deductible + 20% hospital until OOP max of $6,000 = $8,000+ balance billing
Plan H Maternity covered; $2,250/$4,500 deductible (in-network); 10% co-insurance to OOP max of $5,000/$10,000 (in-network); HSA-qualified	**$20,000** (7%) Year 1 = deductible for prenatal care + pre-term labor hospital stay + 10% co-insurance to OOP max of $10,000 Year 2 = deductible for C-section delivery + 10% co-insurance for remaining medical + NICU to OOP max of $10,000

Continued on next page

APPENDIX TABLE 4 (CONT.)

Out-of-Pocket Expenses for Maternity Care Under Twelve Consumer-Driven Health Plans

Scenario 3: Complicated pregnancy, spans 2 plan years, prenatal care and $75,000 hospitalization to stop pre-term labor in year 1, C-section delivery and $200,000 NICU hospitalization in year 2, all care in-network, family coverage

Total Allowed Charges = $287,453

Insurer/Policy Features	Out-of-Pocket Expenses (% allowed charges not covered by plan)
Plan I Maternity covered; $2,750/$5,500 deductible; $20 co-pay; 20% co-insurance for in/outpatient; OOP max: $5,000/$10,000; HSA-qualified	**$20,000** (7%) Year 1 = $5,500 family deductible for prenatal care and pre-term labor hospitalization + $20 co-pay + 20% co-insurance capped at OOP max = $10,000 Year 2 = $5,500 family deductible for C-section delivery + 20% co-insurance capped at OOP max = $10,000
Individual Market—Consumer-Driven Health Plans	
Plan J Maternity not covered; complications covered; $2,600/$5,150 deductible; no co-pays and no co-insurance post-deductible (n/a to maternity); OOP max: $2,600/$5,150; HSA-qualified	**$24,900** (8%) Year 1 = *billed charges* for prenatal care $1,487+ $5,150 family deductible for pre-term labor hospitalization (considered a complication) up to OOP max of $5,150 = $6,637 Year 2 = C-section delivery *billed charges* $13,113 + $5,150 family deductible for NICU = $18,263
Plan K Maternity covered; $5,000/$10,000 deductible; 30% co-insurance post-deductible until OOP max reached; OOP max: $7,500/$15,000; not HSA-qualified	**$21,194** (7%) Year 1 mother = $7,500 OOP Year 2 mother = $5,000 embedded deductible + 30% co-insurance = $6,194 Year 2 baby = $7,500 OOP
Plan L Maternity not covered; complications not covered; $3,500/$7,000 deductible; co-pays and co-insurance n/a for maternity costs (none after deductible), $500 for hospital; OOP max: $5,000/$10,000; HSA-qualified	**$99,600** (35%) Year 1 = $1,487 prenatal care *billed charges* and hospitalization $75,000 (billed charges unavailable—used approved charges for hospital) = $76,487 Year 2 = C-section delivery *billed charges* $13,113 + $10,000 for NICU = $23,113
Plan M Maternity not covered; complications not covered; $3,500/$7,000 deductible; co-pays and co-insurance n/a for maternity costs (none after deductible), $500 for hospital (doesn't count toward deductible); OOP max: No limit; not HSA-qualified	**$97,100** (34%) Year 1 = $1,487 prenatal care and hospitalization $75,000 (billed charges unavailable—used approved charges for hospital) = $76,487 Year 2 = C-section delivery *billed charges* $13,113 + $7,000 family deductible and $500 co-pay for NICU = $20,613

Note: For plans that are HSA-qualified, actual out-of-pocket spending may vary depending on the amount of money contributed to an individual's HSA.

Assumptions: In plans with different co-pays for primary care physicians and specialists, we assumed the lower co-payment would apply for two reasons: 1. in many states, network plans are required to allow a woman to designate her OB/GYN as a primary care physician and 2. some policies explicitly treat OB/GYN as "non-specialist" for purposes of determining a co-payment for office visits. We also assumed that a co-payment is only charged for the first visit with an obstetrician.

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