MODELING MEDICARE+CHOICE STANDARDIZED BENEFIT PACKAGES IN LOCAL MARKETS

FINAL REPORT

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I. INTRODUCTION

Introduction

The Balanced Budget Act of 1997 (BBA-97) established the Medicare+Choice (M+C) program in large part to expand the health plan options available to Medicare beneficiaries and to encourage them to more actively consider their choices. Many believed that the types of managed care choices available to beneficiaries should be comparable to those offered in the commercial sector. Supporters of expanded choice also hoped it would lead to a more privatized and market-based Medicare program.

Since establishment of the M+C program, however, questions have been raised about the appropriateness of expanding choices for beneficiaries. Recent studies indicate considerable confusion among beneficiaries regarding the wide range of benefits and cost-sharing requirements of M+C plans.[1] The detail and complexity of benefit packages makes it difficult to estimate anticipated out-of-pocket expenses for alternative plans. Recent M+C plan withdrawals, increased cost sharing, reduced coverage of prescription drugs, increased benefit package complexity, and disruptions in provider networks have added to the difficulty of comparison shopping on the basis of cost.[2] Some have called for standardization of at least some portion of M+C benefit package features as one option for helping to restore informed choice to the Medicare program.[3]

In support of an increased market-based Medicare program, BBA-97 also established a new basis for the Centers for Medicare & Medicaid Services (CMS) to test competitive pricing for M+C Organizations (M+COs). The statute directed the Department of Health and Human Services to design and implement four competitive pricing demonstrations. The demonstrations' goal was to encourage Medicare to move away from a fee-for-service based payment method for M+COs to one relying more on a "market-based" payment rate. A Competitive Pricing Advisory Committee appointed for the demonstrations recommended that all participating health plans submit bids on a standard benefit package to help the government assess bids across plans and provide beneficiaries with comparative information on managed care alternatives.[4] Although implementation of the Medicare Competitive Pricing Demonstration was ultimately delayed in 1999, CMS has an ongoing interest in examining market-based rate setting strategies as an alternative to its current M+CO payment methodology.

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[1] Dallek, G. and C. Edwards. *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages.* Prepared by the Center for Health Services Research and Policy, The George Washington University Medical Center, for The Commonwealth Fund, October 2001.

[2] Stuber, J., G. Dallek, C. Edwards, K. Maloy, and B. Biles. *Executive Summary: Instability and Inequity in Medicare+Choice: The Impact on Medicare Beneficiaries.* The Commonwealth Fund, January 2002.

[3] Stuber, et al., 2002; Fox, P.D., R. Snyder, G. Dallek, and T. Rice., "Should Medicare HMO Benefits Be Standardized?" *Health Affairs*, July/August 1999.

[4] *Design Report of the Competitive Pricing Advisory Committee* (revised), January 6, 1999.

Purpose of Report

As an initial step in exploring the topic of M+C benefit package standardization, CMS contracted with BearingPoint (and its partner HayGroup) to design a limited number of model core benefit packages. The standardized core package(s) might serve as the plans that could be offered to Medicare beneficiaries in an M+CO's service area. CMS directed that the proposed core packages were to include mandatory Medicare-covered services and beneficiary cost-sharing standards for these services. They were also to include some non-Medicare covered benefits (e.g., coverage of routine physicals with no beneficiary out-of-pocket charges) and associated beneficiary cost-sharing standards. This report also proposes a set of standardized "add-on" or rider benefit options that M+COs could choose to add to the core package(s). Alternatively, the riders might be offered on a "cafeteria-like plan" basis to beneficiaries, allowing consumers to choose supplemental benefits. The set of core packages plus rider options, while standardizing M+C benefit plans to a degree, also preserves some plan flexibility for M+COs and beneficiaries to respond to local market conditions and preferences.

Specifically, for this project, CMS asked BearingPoint to:

- Examine and document the current range of M+CO benefit package offerings in a representative set of local Medicare markets. The documentation should encompass additional, mandatory, and optional supplemental benefits (including point-of-service options) to determine their prevalence, scope of coverage, and potential for inclusion in model core and rider packages.
- Summarize public and private sector experiences with developing defined benefit packages for employees or beneficiaries.
- Propose M+C standardized core and rider benefit packages, based on current M+CO offerings, market characteristics, and consumer demand.
- Estimate the value of the packages, beneficiary out-of-pocket liabilities, and Medicare expenditures for the proposed model core benefit packages and riders.

Summary of Data and Methods

As a first step in developing a set of model standardized benefit packages, we collected information on standardization experiences from a range of public and private entities, including information about the Federal Employees Health Benefit Program (FEHBP), private and state health insurance purchasing cooperatives, standardized Medigap policies, the California Public Employees' Retirement System (CalPERS), and the State of Oregon's 1991 proposal to change the method for determining its Medicaid-covered benefits. Findings from a series of key informant interviews and a focused literature review are summarized in sections II and III of the report. The primary purpose of this section of the report is to describe alternative methods and criteria that might be used for constructing a standardized benefit package for M+COs.

The second step of the project involved characterizing and analyzing current M+CO benefit packages. The primary basis for the design of the proposed model core benefit package and riders are the range of M+CO plan offerings in 2001 and 2002. Details on the data and methodology for constructing model packages are provided in Appendix B and section IV of the report. In summary, we took the following steps:

1. Characterize the full range of benefit packages offered by a sample of M+COs in 2001 and 2002, including Medicare-covered and non-covered ("enhanced") benefits.

   We examined M+CO benefit packages for 2001 and 2002 to balance the decline in M+C plan generosity since 1999 with the increased availability of more complete and accurate information on the range of plan designs available from CMS's Plan Benefit Package (PBP) data system for 2001. Medicare Compare for 1999 and 2000, used to document M+C plan benefit design in other studies, sometimes has incomplete, missing, or ambiguous benefit and patient cost-sharing information, and does not provide good information on optional benefits.[5] These problems are particularly prevalent for vision, dental, and hearing benefits, which are important to this project. The new PBP system captures more detailed and complete information on all plan benefits, including supplemental and "high option" benefits, such as the point-of-service option.

2. To also balance the needs of this project, we focused the review of benefit package designs in Medicare markets with a greater number of M+COs and competition, higher M+C payment rates, and recent market stability.[6] These are the markets that were most likely to still offer fairly generous M+C benefit packages with low cost-sharing and premium requirements in 2001 and 2002.

3. We next selected a subset of 22 counties that had M+COs operating in them in 2001, based on the number of M+COs available in a county.[7] Other selection criteria included regional diversity, and diversity with respect to M+C payment rates, county Medicare beneficiary enrollment in M+COs, and M+CO withdrawal from the county in the previous two years. There were 69 M+COs operating in the 22 counties in 2001 (M+CO/county pairs), offering a total of 96 plans. In 2002, only 55 M+CO/county pairs were in operation in the same 22 counties, offering a total of 73 plans.

[5] This information is based on E. Peppe and G. Trapnell, *Trends in Benefits Offered by Medicare+Choice MCOs, 1999-2001, Volume II: Appendices.* Prepared by the Actuarial Research Corporation for the Centers for Medicare and Medicaid Services, December 19, 2001; and discussion with Carlos Zarabozo, CMS, on February 22, 2002.

[6] Another reason for focusing the project on a limited number of markets is to ensure that the scope of the project is manageable within the timeframe and project budget. Examining all plans offered in all Medicare markets in the U.S. in 2001 would involve documenting approximately 800 different plans.

[7] We selected five counties from Metropolitan Statistical Areas (MSAs) across the United States that had a high number of M+COs operating in them (5 or more M+COs) in 2001; 7 counties, that may or may not be included in an MSA, with moderate M+CO operations (2 to 5 M+COs); and 10 counties that had only one M+CO operating in them in 2001.

4. We created a series of analytic files containing plan benefit information for all M+COs operating in the selected counties in 2001 and 2002. The files included details on all Medicare-covered and enhanced benefits offered by the 96 plans, beneficiary cost-sharing structures and amounts, and premiums. We included additional, mandatory, and optional supplement benefits/plans (including "high option" POS plans). We also constructed a similar set of files of "basic" plan offerings only (see Appendix B for how we defined a basic plan) for the M+COs in the 22 counties. These files included details for 68 plans.

5. We constructed a matrix of benefits and beneficiary cost-sharing arrangements for all benefit packages offered within the selected counties, separately for 2001 and 2002. (The matrices for 2001 are provided in Appendix C).

6. Finally, we examined whether a benefit was covered as an additional, mandatory, or optional benefit; whether or not it was included in the M+CO's "basic" benefit package; whether the supplemental notes provided in the 2001 PBP files suggested modifications to the model core packages or riders; whether there were significant changes in coverage of benefits or beneficiary liability in 2002; and whether recommendations from our key informant interviews and focused literature review suggested changes to the model core and rider benefit designs.

The third step of the project consisted of bringing together results from the literature review, key informant interviews, and M+CO benefit packages review for 2001 and 2002 to construct the set of model core benefit packages and riders. This step is summarized in section IV of the report, and the model core packages and riders are described in section V.

As the fourth step in this project, HayGroup provided actuarial values of the model core and rider benefit packages in terms of expected total costs and beneficiary out-of-pocket liabilities. The methodology for valuing the packages are described in detail in Appendix E and their results are discussed in section VI of the report.

II. BACKGROUND ON BENEFIT DESIGN STANDARDIZATION

Medigap Plans

The Medigap experience has often been suggested as a basis for examining the feasibility and desirability of establishing a standardized benefits package requirement for M+COs. Similar to the M+C program today, Medicare beneficiaries in the 1980s were confronted with a wide array and number of private individual Medicare supplemental insurance ("Medigap") policies, causing difficulty in comparison shopping. The abundance of Medigap options was coupled with a decade of bad practices and abuses, including the marketing of policies that duplicated coverage and had overlapping benefits.[8] In response, Congress passed the 1990 OBRA Medigap

[8] McCormack, L.A., P.D. Fox, T. Rice, and M.L. Graham, "Medigap Reform Legislation of 1990: Have the Objectives Been Met?" *Health Care Financing Review*, 18(1):157, September 1996.

reform legislation. The goals of the legislation included simplifying Medigap choices to facilitate plan comparisons, while still providing a range of consumer choice; promoting competition and market stability; and helping to address adverse selection problems in Medigap markets.[9]

Based on the 1990 legislation, beginning July 1992, the only policies that can be sold as Medicare supplements are a set of specified benefit packages, identified as A-J. All packages cover a core set of health benefits (Plan A), with different bundles of non-Medicare covered benefits included in plans B-J. Plan A is least comprehensive and Plan J is most comprehensive. All carriers selling Medigap policies are required to offer A, but can choose to sell any or all packages B-J.

The method for constructing the benefit packages was rare in that it gave a private body – the National Association of Insurance Commissioners (NAIC) – an opportunity to formulate the number and structure of the benefit packages to be offered.[10] By directing the NAIC to design the standardized plans, decision-making authority was shifted from Congress and the executive branch to an outside body. This shift in decision-making power was purposeful: conventional decision-making procedures under which Congress would have specified the benefit package was felt to almost guarantee the involvement of various lobbying groups representing varied special interests. Some believed that a decision-making process susceptible to special interests may not result in the appropriate decisions or balance among benefits.[11]

Congress gave NAIC nine months to formulate as many as 10 standard policies. (Had it failed, CMS would have assumed this role.) Congress did not give instructions regarding the content of the policies or the process for developing them other than to require balanced representation of the insurance industry, consumer groups, and Medicare beneficiaries.[12] NAIC established an advisory working group comprising six insurance and six consumer representatives, which became the focal point for designing the policies. The process, dependent on consensus building, technical work of the NAIC staff, and compromise, is widely regarded as having worked well.[13]

NAIC had to balance concerns about providing consumers with sufficient choice and the need to simplify and streamline the Medigap market. In the end, NAIC developed 10 plans. At the time, some consumer representatives felt that, given the growing number of other options available to Medicare beneficiaries, 10 was too many. Many of those who originally favored fewer plans now believe that the number should not be changed in order to avoid confusion among beneficiaries, who have grown accustomed to and knowledgeable about the current choice set.[14]

Benefits in the 10 standardized packages focused on coverage of beneficiary cost-sharing amounts for Medicare-covered services. However, the benefits that aroused the greatest

[9] Op cit.
[10] Op cit.
[11] Key Informant Interviews.
[12] McCormack, et al., 1996.
[13] Fox, et al., 1999.
[14] McCormack, et al., 1996

controversy within the NAIC task force were ones not covered by Medicare: outpatient prescription drugs, preventive care, and at-home recovery. Prescription drug coverage was the most controversial topic in the NAIC deliberations, centering on the issues of moral hazard and adverse selection. Ultimately, drug coverage was included in 3 of the 10 plans. Moral hazard was addressed by setting a high deductible and coinsurance rate for drug benefits in all three plans. The possibility of adverse selection was less easily solved. As a result, many insurers even today do not market Medigap plans with drug coverage.[15]

Consumer advocates who participated in the NAIC process favored the inclusion of preventive benefits to educate beneficiaries about the value of prevention. Conversely, industry representatives thought that insurance should focus on catastrophic and unexpected events. The final compromise – coverage of almost all preventive services combined with a $120 limit in Plans E and J – apparently failed to satisfy either side.[16]

At-home recovery, also controversial, was included in Plans D and G. The benefit is broader than services covered by Medicare, and the inclusion and exact wording of the benefit were fiercely debated. Consumer advocacy groups tried to expand upon the Medicare home health benefit while insurers fought for stricter medical necessity guidelines and tighter provider participation restrictions than were ultimately adopted.[17]

Lessons from Medigap Standardization

Although there are substantial differences between the pre-Medigap standardization environment and the M+CO environment of today, there are some lessons from the Medigap experience that may be applicable to M+CO standardization. Most instructive perhaps, the Medigap plan options were determined by a non-political body that included strong consumer and industry input. This resulted in a compromise between the two groups among the plans adopted. A perceived failure of the process, however, was the lack of an on-going systematic process to review and update Medigap benefit designs. Several of our key informants felt that the plans have become outdated, with little to no flexibility for States or insurance companies to update them to meet changing consumer preferences and insurance markets.[18]

The number of Medigap plans offered, while limited to 10, still provides a variety of choices to consumers. Our key informants generally felt that the 10 plans work well for consumers, with some exceptions. Research suggests that consumers have an easier time understanding which post-standardization Medigap policies offer the most value for their money than before reform.[19] Also, consumers have spent more money on Medigap policies after standardization, partly because they are purchasing coverage with greater benefits.[20] Finally, some studies suggest that

[15] Fox, P.D., T. Rice and L. Alecxih, "Medigap Regulation: Lessons for Health Care Reform," *Journal of Health Politics, Policy, and Law*, 20(1), Spring 1995.
[16] Op cit.
[17] Op cit.
[18] Key Informant Interviews.
[19] McCormack, et al., 1996.
[20] Op cit.

the fact that consumers gravitate toward so few plans (primarily C and F) suggests that the elimination of the hundreds of different Medigap packages that existed prior to OBRA 1990 has not been detrimental to consumer choice.[21]

The inclusion of the at-home recovery benefit is informative in that it reflected the NAIC's need to try to satisfy all parties. Its inclusion was a partial victory to consumers because Medigap policies can cover home care, but industry representatives were relieved to see limits placed on the daily and annual payout, as well as restriction of the benefit to patients recovering from acute care illnesses. However, some studies indicate that this benefit has resulted in consumer confusion, as it may appear to pay for comprehensive home care, including homemaker service. In addition, there is concern that the benefit discourages some individuals from purchasing long-term care insurance. One lesson for potential M+CO standardization is that the benefit package should be easily understood and should not create the illusion of being more extensive than it is.[22]

The distribution of policies sold under the 1990 reform legislation is also instructive. Analysis of the purchasing patterns of Medigap policies reveals that most enrollees want coverage that is more extensive than a minimum bare bones package. Medigap Plan A accounts for only 7 percent of sales. Plan F, which provides more coverage than Plan A, is purchased most frequently. The second most popular is Plan C, which covers everything in Plan F except for physician excess charges. Preventive services do not appear to be in great demand, as reflected in the low proportion (about 1 percent) of persons electing Plan E in recent years. In addition, at-home recovery generates little consumer interest, as shown by recent sales of Plans D and G, which together represent less than 7 percent of sales. Finally, only about one in seven enrollees purchase prescription drug coverage through Plans H, I, and J.[23]

Important differences between the Medigap and M+CO markets suggest that the Medigap experience may not be the most appropriate example for M+CO standardization:[24]

- The M+CO market is less mature than the Medigap market when it was standardized, which had a history dating back to the implementation of Medicare in 1966.

  Several key informants suggested that the M+CO market may be mature enough to withstand standardizing at least some benefits, such as prescription drugs and consumer copayments for Medicare-covered services, but are not sure whether the market is mature enough to standardize all benefits. While there was key informant consensus that drug benefits would be the most difficult to standardize, there was also general consensus that benefit standardization, if done, should focus on benefits that consumers are most interested in but have the most difficulty in comparing across

[21] Op cit.
[22] McCormack, et al., 1996; Fox, et al., 1995.
[23] Op cit.
[24] List of differences cited are based on: P. Fox, R. Snyder, G. Dallek, and T. Rice. *Should Medicare HMO Benefits be Standardized?* Prepared for The Commonwealth Fund, February 1999; and Key Informant Interviews.

health plans. Prescription drugs fit this category well (although not all key informants were in favor of standardizing a drug benefit – a couple thought the "marketplace" should be allowed to search for the best ways to provide drug benefits).

Some key informants also argued that benefit structures that have the potential to substantially harm a select group of beneficiaries, e.g., high copayments for certain conditions such as cancer therapies, should be standardized to prevent such harm.

However, key informants also noted that before standardizing any benefit, it should be clear that standardization is the best way to address the problems that consumers now face. These include choosing a health plan that best fits their health care needs, managing their out-of-pocket costs, and having access to prescription drug coverage.

- Key informants uniformly believe that benefits covered under Medigap plans are relatively easier to standardize than M+C benefit packages because Medigap coverage only addresses non-Medicare-covered services.
- M+COs' benefit and premium levels display greater geographic variation than Medigap policies did prior to standardization, primarily due to differences in county-based M+CO payment levels according to several key informants.
- Consumers select Medigap policies primarily on the basis of premiums and benefits offered under each plan (and perhaps company reputation). In contrast, enrolling in an M+CO is a larger commitment that also requires accepting the health plan's delivery system. M+COs differ in important ways with respect to their network composition, utilization controls (PCP gatekeepers or prior authorization policies, for example), processes for determining medical necessity, ease of access to specialty care, drug formulary composition, and quality assurance mechanisms. Additionally, M+COs tailor provider negotiations and payment structures to local market conditions. None of these components easily lends itself to standardization. While these managed care components would not need to be standardized even if the benefits package were, a couple of key informants argued that benefit standardization alone would address at most a minor part of the difficulties with consumer health plan choice. They suggested that differences in the underlying structure of M+COs influence consumer demand, and also lead to consumer confusion, as much as differences in the benefit packages themselves.
- According to several key informants, M+CO and Medigap regulations differ with regard to open enrollment, pre-existing conditions, and premium-setting practices. M+COs are already more tightly regulated than Medigap plans were before and after Medigap standardization.
- State experiences with standardizing Medigap plans prior to passage of national legislation provided a framework for federal Medigap standardization. This experimentation in States and private markets is largely missing in M+C markets.

Federal Employees Health Benefit Plan

The Federal Employees Health Benefit Plan (FEHBP), which provides health care coverage for federal workers and their dependents, has also been suggested as a model for M+CO benefit package standardization (as well as a potential model for restructuring the entire Medicare program). The FEHBP is considered to have relatively high quality of plan information, low out-of-pocket costs, a wide range of acceptable benefit packages, and high beneficiary satisfaction compared with other public and private health insurance programs.[25]

FEHBP currently offers over 200 different health plans through their contracts with HMOs, PPOs, FFS plans, and other plan types. Health plan applications for participation in the FEHBP are open annually. After a three-month evaluation by the Office of Personnel Management (OPM), successful applicants are notified and coverage begins on January 1 of the following year. Evaluation of applicants is based on limited minimum criteria, such as licensing, reasonable benefits coverage, offering of group rates, a sufficient provider network, and meeting various requirements for financial solvency. OPM generally allows new HMOs to join without any barrier, but by law and regulation generally prohibits new fee-for-service competitors. For the most part, each participating plan must take any eligible employee without regard to pre-existing conditions.[26]

There is no prescribed minimum benefit package for FEHBP plans (5 USC 8904(a) requires that plans "include benefits both for costs associated with care in a general hospital and for other health services of a catastrophic nature").[27] OPM from time to time specifies particular benefit changes it wants from all plans, but individual plan benefit changes are negotiated annually with OPM. For example, OPM is currently moving plans in the direction of greater equity in medical and mental health benefits. In general, however, the participating HMOs or other organizations themselves develop their benefit packages. Except for changes mandated by OPM, changes are usually expected to be budget neutral, with the cost for a new benefit offset by a reduction in some other benefit.[28]

In 1999, all FEHBP plans were more generous than original Medicare. All had lower inpatient deductibles (or none), provided a limit on out-of-pocket spending, and included some coverage for outpatient prescription drugs. Plans with a PPO option usually imposed lower coinsurance than Medicare's 20 percent for physician and ambulatory services. There is significant variation among plan benefit packages, with different levels of cost-sharing, annual out-of-pocket limits, and coverage of ancillary services such as prescription drugs and dental and vision care.[29]

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[25] Caplan, C. F. and L.A. Foley. *Structuring Health Care Benefits: A Comparison of Medicare and the FEHBP.* AARP Public Policy Institute, May 2000; Francis, W. *The Political Economy of the Federal Employees Health Benefits Program.* Prepared as an American Enterprise Institute Conference Paper for "Health Care Expenditure Controls: Political and Economic Issues," April 15, 1993.
[26] Op cit.
[27] Merlis, Mark. *Medicare Restructuring: The FEHBP Model.* Prepared by the Institute for Health Policy Solutions for the Henry J. Kaiser Family Foundation, February 1999.
[28] Op cit.
[29] Op cit.

The federal contribution for FEHBP, unlike that for Medicare, is not set before participating plans establish their benefits and premium rates. Instead the contribution is set on the basis of the plans' rate quotations. Through 1998, the government contribution was tied to the prices of five plans: Blue Cross/Blue Shield, the two largest employee organization plans, and the two largest HMOs. Beginning in 1999, the maximum government contribution is the lesser of 1) 75 percent of the premium for the plan selected or 2) 72 percent of the average premium, weighted by enrollment, of all participating plans. Thus, even if a plan's premium is so low that the maximum government contribution would cover all of it, the enrollee must still pay 25 percent.[30]

Lessons from FEHBP

Restructuring Medicare and/or M+CO plan offerings along the lines of the FEHBP would re-shape many aspects of the Medicare and M+C programs, including premium rules, eligibility rules, and benefit packages. The FEHBP may have valuable lessons if there is support for reforming the Medicare program into a premium support system like the FEHBP. However, because FEHBP does not require a standardized benefit package for participating plans, it has few lessons for standardizing M+C plans per se.

- FEHBP statute lists broad "types" of benefits that plans "may" cover, suggesting that plans cover hospital care, surgery, ambulatory care, and obstetrics;
- OPM sets minimal plan standards for FEHBP participating plans (e.g., minimum catastrophic guarantees on out-of-pocket costs; coverage for services of clinical psychologists, clinical social workers, nurse-midwives, and nurse practitioners through self-referral);
- OPM does not explicitly regulate plan member cost-sharing;
- OPM discourages confusing coverage limitations.

An important aspect of the FEHBP experience, however, is that all participating plans are required to explain their benefits using 1) the same standard format, and 2) the same "plain English" vocabulary based on common definitions of benefits.

In addition to not providing a particularly good model for benefit standardization, several of our key informants also argue that the experience of the FEHBP is not a good model in general for reforming the Medicare or the M+C programs. FEHBP, as well as private employers, offer a health plan to their employees as part of a comprehensive benefits package (including salary, life insurance benefits, retiree benefits, etc.). In contrast, the M+C program is regulatory in nature and a "stand-alone" benefit; other benefits cannot be adjusted to compensate for an increase or decrease in the benefit package, making the M+C program uniquely different from the others.

[30] Op cit.

Oregon's Medicaid Proposal[31]

In 1991, the State of Oregon proposed implementing a demonstration program that would change the State's existing Medicaid program in three fundamental ways: 1) expand coverage to include all persons with incomes up to 100 percent of the Federal poverty level; 2) enroll all covered persons in some form of managed care; and 3) determine acute and primary health care benefits according to a ranked, prioritized list of services, with actual benefits dependent on the level of program funding. Oregon's main intent in funding a prioritized list of health services was to use existing Medicaid funds to expand program coverage to more people, while still providing necessary and preventive services to all current Medicaid recipients. Oregon's method for determining its Medicaid benefit package provides an alternative that may provide lessons for M+CO plan standardization efforts.

Briefly, Oregon's proposed methodology for determining which benefits its Medicaid program would pay for consisted of developing a prioritized list of health services in which selected health conditions and their treatments were listed by importance from highest to lowest. The State legislature would then determine its budget for the program, and a line would be drawn where projected program costs equal the budgeted amount. All conditions and treatments at or above the line would be covered; conditions and treatments below the line would not be covered. (Necessary diagnostic services were intended to be covered regardless of the condition and were not included on the prioritized list. The prioritized list of services was limited to primary and acute health care services.) Oregon has a two-year budget cycle and the intent was that the State legislature would vote biennially on the threshold (i.e., the benefit package). If the Medicaid program should suffer a budget shortfall, the program would not drop people from the program or reduce provider payments. Instead, the State would either allocate additional funds to the program or reduce covered services as necessary, with the lowest-ranked services being eliminated first.

Oregon's Governor appointed a Health Services Commision (HSC) made up of health care providers and consumers to "prepare a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served (Senate Bill [SB] 27, 1991)." The HSC spent approximately two years working through six steps to establish their Medicaid benefits package. The building blocks of HSC's prioritized list were "condition-treatment (CT) pairs." CT pairs linked a medical condition (e.g., appendicitis) with one or more therapies used to treat it (e.g., appendectomy or a broader "treatment" such as any medical therapy used to treat the condition). Some conditions appeared more than once on the list, paired with different treatments.

Rather than using a cost-effectiveness approach to rank services as HSC initially considered (although the OTA report does not explain why), the list was ultimately developed through the following process: 1) Each CT pair was assigned to one of 17 general service categories (e.g.,

[31] Information in this section is derived from: U.S. Congress, Office of Technology Assessment, *Evaluation of the Oregon Medicaid Proposal*, OTA-H-531. Washington, DC: U.S. Government Printing Office, May 1992.

maternity services, services for acute conditions for which treatment prevents death). The HSC then ranked the categories using a group consensus method intended to reflect community health care values as expressed at a series of public hearings and meetings. 2) Within each category, CT pairs were ranked according to their "net benefit," intended to indicate the average improvement in quality of life associated with treatment for the specified condition. To derive this net benefit measure, the HSC used data from a health care providers' assessments of treatment outcomes (furnished by provider groups in the State), and Oregonians' opinions about being in various states of health as elicited through a telephone survey. 3) The HSC undertook a line-by-line review of the preliminary ranked list and used its judgment to move selected individual CT pairs up or down the list. 4) The final list was sent to an actuarial firm, which estimated the cost of providing services at various thresholds on the list. The State legislature then decided which benefits to fund for inclusion in the initial Medicaid benefits package based on the Medicaid budget. Additional details about each step of the process are provided below.

Step 1: Creating Condition-Treatment Pairs

The CT pairs were created by 50 volunteer groups of healthcare providers representing most licensed practitioners in the State. The providers coupled disease and procedure codes to initially create 1,600 CT pairs.[32] The HSC then collapsed these into broader pairs based on more general treatment and diagnostic groups, reducing the list to 709. The chart below displays examples of CT pairs.

Condition	Treatment
Open Wounds	Repair
Acute Myocardial Infarction	Medical Therapy
Congenital Hydronephrosis	Nephrectomy/Repair

Step 2: Calculating the Cost-Benefit of Each CT Pair

HSC next intended to conduct a cost-benefit analysis for each of the 709 CT pairs, developing a measure of quality of life improvement for a "typical patient" for each CT pair compared to the cost of treatment. The HSC wanted its definition of quality of life to be backed by verifiable, evidence-based outcomes information, as well as by societal health values. To accomplish this, the HSC planned to apply the algorithm, C/(NB X D), where,

- C = Treatment-associated costs
- NB = Expected net benefit of treatment (i.e, patient's expected change in quality of life with treatment)
- D = Duration of treatment benefit in years.

[32] The OTA report does not describe the criteria or process used for creating the initial 1,600 CT pairs but does state that virtually all conditions were accounted for in the prioritization process.

For each CT pair, the HSC gathered information regarding the expected net benefit of treatment, the duration of treatment benefit, and treatment-associated costs. These three pieces of information were initially components of a cost-effectiveness formula used to rank CT pairs on a preliminary list. The initial attempt to rank CT pairs according to cost-effectiveness was abandoned (the OTA report provided no explanation for this) and only one component of the initial formula, the expected net benefit of treatment (NB), was important to the final ranking methodology.

To determine clinical opinions about outcomes, the HSC asked the same 50 volunteer provider groups that originally created the CT pairs to estimate the probability of clinical outcomes for each CT pair under two different scenarios: one under the assumption that treatment was provided and the other that treatment was not provided. For each CT pair, the groups were asked to estimate the probability in five years of a patient being in one of the following clinical health states (both with treatment and without treatment):

- Death
- Morbidity state 1
- Morbidity state 2
- Morbidity state 3
- Perfect Health

Providers described the morbidity states using six functional limitations and 23 symptoms. Provider groups did not employ any common or standardized methodology for estimating probabilities.

To elicit judgments from the public about the value of these outcomes, the HSC randomly surveyed 1,001 Oregonians by telephone. They asked consumers about the health states described above (i.e., the six functional limitations and 23 symptoms). Consumer value statements and priorities were captured by asking consumers to imagine themselves permanently affected by the health states and to rate each health state on a scale from 0 ("as bad as death") to 100 ("good health").

Net benefits for each CT pair were calculated using a complicated weighting formula that took into account differences in "expected quality of life values," based on the above two information collection strategies, for patients with and without treatment. In essence, a treatment's net benefit was designed to reflect both clinicians' best estimates of treatment effects and consumers' perceptions of the desirability of experiencing those effects.

Step 3: Ranking Categories of Services

The HSC was interested in creating a benefit package that included basic benefits in several service areas, not only those with the highest net benefit ratings. Therefore, instead of ranking the CT pairs from 1 through 709 based on the net benefit caculations, it first created 17

categories of services, thus preventing the possibility of entire types of services from dominating the benefit package.

Over a period of five months, the HSC held public hearings for the purpose of determining the types of services or service categories that were most important to providers, health care advocates, and the public. They heard from approximately 275 people over the course of 12 hearings. State legislation required that they hear from specific advocacy groups and that they solicit input from others. The following chart estimates the frequency of specific groups of people who testified at the hearings.

Group Testifying	Number of Representatives
Health Care Providers & Administrators	92
Consumers (many as advocates)	125
Formal Advocates for Various Constituencies	50

The service categories most frequently mentioned by consumers and professionals included preventive health care, mental health care, prenatal care, family planning, dental care, chemical dependency, primary care, and care for chronic non-acute conditions. To confirm the findings at the hearings and further explore both the exclusivity of service categories and their importance to the public, the HSC held 47 additional community meetings throughout the State. The HSC then ranked the 17 health service categories according to community health care values using a group concensus method (i.e., a modified Delphi method).

Step 4: Categorizing CT Pairs

At this step of the prioritization process, the HSC had 17 ranked service categories and 709 CT pairs, each assigned a net benefit value. The HSC placed each of the 709 CT pairs within one (and only one) of the 17 service categories, based on service-specific and expected health outcomes information. Nearly one-half of the service categories were service-specific and defined by the treatment portion of the CT pair. The other one-half required some amount of judgment on the part of the HSC.

Step 5: Ranking CT Pairs Within Categories

Because the service categories themselves were already ranked, instead of ranking CT pairs from 1 to 709, HSC only had to rank them within each of the service categories. The net benefit value for each CT pair was used to accomplish this.

Step 6: Reviewing CT Pairs Line-by-Line

The final step that the HSC took to prioritize CT pairs was a line-by-line review of the appropriateness of the CT pairs for both their rank and their service category. In this final review,

the HSC used professional judgment, its interpretation of community values, cost-benefit ratios, and cost alone to alter the order of CT pairs on the list.

The final list was sent to an actuarial firm, which estimated the cost of providing services at various thresholds on the list. The Oregon State legislature decided to fund an initial benefits package consisting of all services included in CT pairs 1 through 587. The HSC was charged with continually reviewing health outcomes and effectiveness data and to reissue a revised list every two years when the legislature meets. Technical amendments to the list could be made in the interim, for example, to add new medical technologies to the list.

Lessons from Oregon's Medicaid Proposal

Perhaps one of the most important features of Oregon's process of developing its benefits package is its incorporation of consumer and societal values, as well as professional opinions, in determining which health services should be covered. Its process involved providers, consumers, and consumer advocates in Oregon in a public discussion of the relative value of different kinds of health care services. The commission established to determine and oversee this process had ample opportunity to hear from the professional and lay communities about what they considered important in a benefit package. According to the OTA report, although not ultimately an important determinant of CT pair list placement, HSC's effort to measure public health state preferences was an important conceptual aspect of the priorization process. It is likely that any national attempt to standardize a benefit package would require extensive consumer, consumer advocate, and provider input to gain political acceptance and Oregon's process provides one model for doing so. However, it is also likely that a national model might need to be very different from Oregon's, which was limited to one State with a relatively small population.

The OTA report provides a detailed critique of the prioritization process that is not duplicated here. In summary, however, OTA concluded that much of the methodology – while trying to incorporate several scientifically-based methods – was ultimately rooted in subjective processes. Even after the creation and use of algorithms and statistical calculations intended to assimilate qualitative data with quantifiable results, the final prioritized list was largely guided by the collaborative decisions of the HSC and not the rigorous calculations. A contribution of Oregon's extensive efforts in its demonstration is that the HSC deemed that – at least at the time of their efforts – outcomes and cost-effectiveness data were inadequate for use as the primary building-blocks of a ranking system for many health services. More and better information on the outcomes of more health services would improve its usefulness, but it seems unlikely that such information will ever be sufficiently comprehensive to enable all health care services to be objectively ranked.

Another instructive feature of the Oregon process is that it established an on-going commission (the HSC) charged with continually reviewing health outcomes and effectiveness data to incorporate new medical technologies, other types of services (i.e., mental health), and new cost-effectiveness and efficacy research information into an updated list. The permanent HSC could

also address initial errors in the list, as well as incorporate changing political and societal values and priorities on an on-going basis.[33]

California Public Employees' Retirement System[34]

CMS requested that we gather information about the California Public Employees' Retirement System's (CalPERS) initial health benefit package standardization process. CalPERS currently offers a set of standardized health plans to, and negotiates health premiums, for many public employers in California, acting as a purchasing cooperative for most State agencies and hundreds of city and local public and non-profit agencies that include school districts and universities. The Public Employees' Medical and Hospital Care Act authorizes the CalPERS Board to enter into contracts with health care plans and to operate self-funded health plans. CalPERS offers HMOs in most parts of the State and two self-funded preferred provider organizations (PPOs) statewide.[35] CalPERS also administers enrollment for three plans that are available only to members of State-based police organizations.

CalPERS offers several standard health care benefit packages for non-Medicare employees. These include a basic HMO plan that consists of thirteen required medical benefits, including inpatient care, physician office visits and prescription drug coverage, all with the same scope of coverage and required copayments. HMO benefit packages must also include an outpatient emergency benefit, outpatient mental health benefit, and substance abuse coverage, which may vary by number of visits and copayments within certain ranges. Four optional benefits may be offered within certain coverage and copayment parameters.[36] More than three-quarters of CalPERS enrollees are in HMOs.[37] In addition, CalPERS offers the PPO basic plan (PERSCare), which includes the basic benefit package but has higher employee cost-sharing. PERS Choice is another PPO benefit package that has more limited coverage than PERSCare. Additionally, CalPERS offers an HMO Medicare plan that acts as a supplement to either Original Medicare or Medicare managed care plans, as well as supplemental PERSCare and PERS Choice plans to Medicare beneficiaries.[38]

CalPERS negotiates with each HMO and PPO and sets premiums for which the organizations will provide the basic and supplemental plan services. During an annual open enrollment period, employees and retirees have the option of selecting any HMO in their service area at the

[33] In December 2002, Blue Shield of California announced a plan that supports universal health insurance coverage for all Californians. A key feature of this plan was the development of an essential benefits package designed by medical professions to describe the minimum coverage level that would be required for all individual and employer-sponsored plans. The Essential Benefits Package process was a modification and expansion of the Oregon process. The *Blue Shield of California Foundation Report: Essential Health Benefits* is provided as an attachment in Appendix F of this report.

[34] Most of the information in this section, unless otherwise noted, was collected during a telephone interview on August 19, 2003, with Tom Elkin, head of the CalPERS Health Benefits Program from 1990 to 1995.

[35] *Understanding CalPERS: An Overview of the California Public Employees' Retirement System*, PERS-PUB-36, October 2002.

[36] *Health Benefit Summary*, California Public Employees' Retirement System, HBD-110, August 2002.

[37] *Understanding CalPERS*, October 2002.

[38] *Health Benefit Summary*, August 2002.

premium CalPERS has negotiated. If the employee or retiree is a member of an employee association with an approved plan, they may enroll in the association's plan. Employees and retirees may also select one of the self-funded PPOs (PERSCare or PERS Choice). Premiums for these plans are generally higher than for the HMOs, and enrollees pay a percentage of the cost in return for greater control over the direction of their medical care.[39]

When CalPERS initially began administering health plans for its members, it offered one basic benefit package consisting of outpatient and inpatient benefits. Participating health plans, however, were allowed to add benefits, change copayment amounts, and make other changes to their benefit packages. By 1990, there were in reality 22 benefit designs and 22 premiums. Health plan choices for CalPERS enrollees were complex and it was difficult for the CalPERS management team to understand how premiums were calculated in order to negotiate prices with the plans. Higher premiums were not always tied to a richer benefit package. In 1993, CalPERS chose to standardize its benefit package and employee cost-sharing. This decision was made to simplify health plan selection, provide a more comprehensive and uniform scope of benefits, reduce costs to beneficiaries, reduce administrative costs, and significantly improve CalPERS' ability to negotiate competitive premiums.

CalPERS and other stakeholders welcomed the concept of standardizing the benefit packages, but it proved challenging. To begin the standardization process, CalPERS staff reviewed each contracted health plan's Evidence of Coverage (EoC) to identify particular benefits that seemed odd or exceptional. This review was a lengthy and arduous process (taking "hundreds of hours" of staff time), in part to understand why plans had adopted certain rules. Benefit designs, coverage limits, and copayments varied across health plans. For example, nine different copayments for physician visits existed among the 22 plans. Plans also varied according to included and excluded services. For example, oxygen was not covered consistently; it was sometimes covered for primary and not secondary coverage, for various types of equipment, for some and not other family members, and under varying circumstances. The CalPERS team had been completely unaware of such nuances prior to the standardization process.

The CalPERS management team's next step was to discuss the exceptional benefits with health plans over a six-month period to determine whether or not to include the benefits in a standardized package. The team emphasized that the goal of standardization, however, was not to reduce benefits. The team then worked extensively with each health plan to identify the "best" standard definition for each benefit covered, and requested plan feedback on the definition ultimately selected. To achieve benefit design standardization, eight plans had to reduce their copayments for outpatient prescription drugs and physician services, four plans expanded substance abuse coverage, nine expanded skilled nursing facility coverage, and nine added hospice care.

In the end, the standardization process consisted of a staff review of all of the various benefit packages offered by the 22 plans to render them consistent in terms of language and content.

[39] *Understanding CalPERS*, October 2002.

Although there had been initial consideration of incorporating "evidence-based" or cost-effectiveness research into the standardization process, the management team found that the literature was not extensive enough to support this goal. Additionally, measurement in terms of benefits or consumer satisfaction was not conducted prior to or after standardization.

In July 1992, the CalPERS board – consisting of 13 lay members from various California constituencies – approved the final benefit package and plans were asked to price benefits for calendar year 1993. Plans were required to price a package consisting of about 30 elements on a per member per month basis based on current and projected costs. The negotiation process allowed the team to meet privately with each plan, examine its prices carefully in comparison with other health plans, ask questions and determine the reason, if any, for price differentials. Negotiations were only conducted with existing plans due to the number that already contracted with CalPERS. All 22 existing plans bid on the standardized package and obtained contracts with CalPERS.

Subsequent to the initial standardization process, there has been a marked reduction in the number of health plans that contract with CalPERS due in part to plan withdrawal and market consolidation and CalPERS' desire to reduce the number of participating plans. As of 2003, there are only two contracted plans, Blue Cross Blue Shield and Kaiser Permanente. Additionally, health plans have been allowed to add small benefits to the basic benefit packages if the benefit was deemed to be in the consumers' interest. Health services such as acupuncture have been added and some variation in benefits and copays now exists.

Lessons from CalPERS

According to Tom Elkin, head of the CalPERS Health Benefits Program from 1990 to 1995, the standardization of health benefit packages and benefit definitions achieved its intended goal of allowing the CalPERS management team to more effectively negotiate health premiums with participating plans and to reduce growth in these premiums, at least in the short run. He also felt standardization made health plan comparison much simpler for consumers.

The initial standardization process was aided by the large number of health plans interested in contracting with CalPERS during the early 1990s. This provided CalPERS with a great deal of leverage and bargaining power at that time. Since then, variations in the basic packages and the low number of participating plans has resulted in less room for negotiation and created a shift in the balance of power away from CalPERS and back to the health plans, according to Mr. Elkin.

Another important feature of the standardization process was the CalPERS board's sole power to approve the final benefit definitions and benefit package design without oversight from either the executive or legislative branch of State government. According to Mr. Elkin, the process would have been much more complicated and time-consuming, and may not even have occurred, had State government played a role in approving the plans.

Similar to the Oregon Medicaid benefit design process, best judgment and subjective methods were used to determine which health benefits would be included in CalPERS' covered benefit package. The CalPERS management team did not review or conduct any cost-effective studies. Instead, it reviewed the benefits and packages currently available from California's participating managed care plans (although the standardized plans were not based on regional differences), rather than creating benefit definitions or designs "from scratch." The CalPERS team started with a comprehensive benefit design and fine-tuned it at the margins based on what the team felt was "fair to the consumer." Also, similar to Oregon and the FEHBP, CalPERS established an on-going process to review participating plan's offerings and to update standardized benefit packages on an annual basis.

III. ISSUES IN STANDARDIZING M+CO BENEFIT PACKAGE

This section of the report reviews arguments in favor of and against M+CO benefit package standardization as obtained from key informants and a limited review of the literature directly relevant to M+CO health plan standardization. This section also reviews alternatives to full M+CO health plan standardization and describes the principles for standardization suggested by our key informants.

Advantages of Standardization

One of the most frequent arguments in favor of M+CO health plan standardization is ease of plan comparison for beneficiaries. Greater plan comparison has the potential to enhance price competition through improved ability to compare beneficiary costs and benefits across health plans; focus prospective enrollees on delivery system differences; and enhance competition based on quality rather than favorable risk selection.

Strong evidence exists suggesting that M+CO beneficiaries' understanding of their extra benefits is uneven. This confusion can stem from a variety of sources:[40]

- Variation in M+CO marketing materials with respect to the wording and description of services.

  For example, a benefit covered without a cost-sharing requirement might be described by one plan as being "covered in full" and by another as having "no charge." The quality of the benefit and cost information on Medicare Compare has improved markedly since CMS first began providing this data in 1998 and requiring comparable information be provided by plans for at least some benefits through a Summary of Benefits document since 1999. However, remaining differences in wording and presentation, and the lack of some detailed

[40] Fox, et al., July/August 1999; Dallek and Edwards, 2001; Barents Group, LLC. *Analysis of Benefits Offered by Medicare HMOs, 1999: Complexities and Implications*. Prepared for The Henry J. Kaiser Family Foundation, September 1999; Office of Inspector General, Department of Health and Human Services. *Medicare+Choice HMO Extra Benefits: Beneficiary Perspectives*. February 2000 OEI-02-99-00030; Stevens, B., and C. Young, "Impact of Market Volatility on Medicare Beneficiaries," *Operational Insights*, No. 1, May 2001; Key Informant Interviews.

information (e.g., information on which drugs are on plan formularies or how plans calculate costs that count toward their prescription drug limits) still make it difficult for prospective M+CO enrollees to locate, understand, and compare information on extra benefit coverage and cost sharing requirements.

- Confusing benefit design.

  Not only are there numerous differences among plans' individual benefits, but multiple combinations of features are often offered by the same M+CO through alternative health plan options or among M+COs in a given market area. The greatest difficulty consumers face is in comparing benefits that Medicare does not cover, such as prescription drugs, dental care, hearing tests and aids, and vision care. The point-of-service option, offered by some M+COs, also complicates plan comparisons. The recent increasing imposition of different cost-sharing requirements by some M+COs on a host of Medicare-covered and certain supplement benefits that traditionally were very comparable among plans adds to plan complexity. These include costs associated with "large-ticket benefits" such as hospital and nursing home care.[41]

- Health plans sometimes failing to list all of the benefits offered in their marketing materials, including some Medicare benefits that plans are required to cover.

  A 1999 study of marketing materials disseminated by six large HMOs in Los Angeles County, California, and Cook County, Illinois, found that some marketing materials did not specify that the health plan covered physical therapy or occupational therapy or pap smears, colorectal cancer screenings, or other preventive services.[42] Consumers, however, can now find this information on Medicare Compare if they are aware of the website of Medicare toll-free line to access this information.

Another common argument for health plan standardization would be to enhance the government's ability to promote price and quality competition if a competitive bidding process for Medicare health plans were implemented. Finally, some argue standardization has the potential to reduce biased selection between M+COs and Original Medicare and/or among M+COs, particularly if some standard level of prescription drug coverage is included in all standardized plans allowed to be offered. Inclusion of drugs in all standardized packages reduces the potential for M+COs to gain from favorable risk selection.[43]

Disadvantages of Standardization

Medicare health plans frequently argue that standardization would reduce their ability to introduce innovations in their benefit package design 1) across market areas, inhibiting their ability to respond to geographic variation in market conditions, county-based Medicare payment

[41] Dallek and Edwards, 2001. (They also provide other examples: In 2001, some plans in both Tampa and Cleveland increased (their study areas) – or imposed for the first time – copays for a number of benefits, including physician visits, ambulatory surgery, rehabilitation services, durable medical equipment, and diagnostic lab and X-ray services.

[42] Fox, et al., July/August 1999.

[43] Fox, et al., February 1999.

amounts, and consumer preferences, and 2) over time to respond to changes in the Medicare program itself.[44] Standardizing M+C plans might make M+CO costs and benefits more apparent to Medicare beneficiaries, but it might also stifle the ability of M+COs to innovate. Reducing health plans' ability to respond to consumer preferences may reduce overall social welfare by mandating packages that are more generous than consumers want, either requiring them to pay for benefits they do not value, prohibiting plans from offering some benefits that consumers would value, or pricing some consumers out of the market.[45] Medigap insurers, for instance, currently cannot offer a more limited drug benefit at a lower price, which some argue might attract a number of beneficiaries. While potential social welfare reduction was also an objection to standardizing Medigap policies, the level of M+CO experimentation in designing benefits for the Medicare population is greater than it was in the years preceding the OBRA 1990 reforms. Also, it is expected that this period of creativity will continue as M+COs respond to changes in the BBA-97.[46]

Academic researchers contend that the previous argument is most cogent when consumers have enough information about competing health plans to make well-informed choices among plans in a competitive market. In the current environment of beneficiary confusion, it is not clear that social welfare-enhancement from allowing plan flexibility and innovation outweighs the reduction in social welfare that stems from beneficiaries being too confused to choose a plan that best meets their health care needs.

Although risk selection is common to all health insurance products, there is concern that M+CO benefit standardization would lead to a worsening of adverse or favorable selection problems between M+COs and the Original Medicare plan and among M+COs. According to one key informant, CMS has a responsibility to ensure that any standardized benefit package it adopts does not discriminate against sicker beneficiaries. With fewer benefit designs to choose from, beneficiaries with particular risk characteristics would tend to aggregate in certain plans, driving up average costs in plans with poor risk populations and driving down costs in plans with good risk populations. Guaranteed issue, bundling of benefits,[47] and community pricing are all ways to help combat, but not eliminate, this problem.

Some have also expressed concerns that standardization would shift the process of benefit package design from the marketplace to the political or administrative arena, making the process vulnerable to special interests.[48] In any setting, consensus decision making is difficult, with often

[44] Fox, et al., February 1999; Dallek and Edwards, 2001; Key Informant Interviews.
[45] Finkelstein, A. *Minimum Standards and Insurance Regulation: Evidence from the Medigap Market.* National Bureau of Economic Research, Working Paper 8917, May 2002; Key Informant Interviews.
[46] Fox, et al., February 1999.
[47] For example, a rider option for prescription drug coverage only is not likely to be a viable product due to adverse selection, but it may become viable if bundled with benefits that healthier, lower cost, beneficiaries value. The standardized Medigap plans B-J packaged more than one additional benefit in a plan to reduce adverse selection. For instance, if a consumer wants to purchase outpatient prescription drug coverage under Plans H, I, or J, they must also purchase other supplemental benefits such as foreign travel emergency coverage, at-home recovery benefits, or preventive care benefits.
[48] Fox, et al., July/August 1999; Key Informant Interviews.

the "lowest common denominators" being the only elements that the group can agree on. The political process is perhaps most difficult, requiring all entities to buy in to any final decisions. Even based on scientific risk/benefit analysis, in the end the coverage for benefit categories and new technology is usually a judgment.

An additional concern specific to M+CO plan standardization was noted above in the Medigap discussion. Beneficiary choice of an M+CO plan involves choosing the type of health care delivery system as well as a package of benefits and associated premium, with some arguing that the former choice is perhaps more important to consumers than the latter choice. Some contend that standardizing benefits would solve at most a minor problem.[49]

Finally, there was considerable agreement among the key informants that the current volatility of M+C markets and the M+C program make standardization of benefit packages a very poor idea at this time. Some suggested that, in the context of adequate program funding, standardization might make sense, particularly if coupled with a competitive bid pricing model. Health plans argue that in order to survive in this volatile market, however, they need the flexibility to re-design benefit packages as local market conditions demand. Standardization at this time would only make the program more unstable and exacerbate the trend in declining M+C program participation and beneficiary enrollment.

Standardization Principles

The literature review and key informant interviews provide numerous constructive principles for designing a standardized benefit package for M+COs. Some principles, as follow, clearly conflict with others. These principles also illustrate the current lack of consensus among health services researchers, health plan administrators, trade organizations, industry representatives, and consumer advocates about the best approach and design of a standardized M+C benefit package, if this were to occur.

- Suggested approaches for designing M+CO standardized plans include:
  - Cover most benefits in core benefit packages, and cover only a few benefits through rider options.
  - Construct a minimum core benefit package that includes all Medicare-covered benefits, plus a minimal number of enhanced benefits, particularly those that a high proportion of M+COs cover now, such as routine physicals, routine hearing exams, world-wide emergency and urgent care, and additional inpatient hospital days above those covered by Medicare. Offer one or two additional benefit packages that are more generous.
  - If rider options are made available, design options only for outpatient prescription drug benefits and dental benefits, with perhaps two designs for drug benefits and one for dental. This approach, coupled with either a generous or minimal core benefit

[49] Fox, et al., February 1999.

package, would balance standardization goals with plan flexibility and choice, and would reduce, but not eliminate, adverse selection problems.

- ◊ Develop two reference plans for a competitive bidding model: A low option for which competitive bidding would establish the reference premium, and a high option that beneficiaries could choose by paying the difference in the reference premium and the premium for the high option package. The low reference plan would include a minimum set of benefits, low copayments (e.g., $100 per day for inpatient hospital stays), and small deductibles based on current M+CO plan designs. The low reference plan might be structured so that low-income beneficiaries could afford it, but beneficiary out-of-pocket costs should not be completely eliminated in order to maintain some incentives to control utilization. The high reference plan would include very limited beneficiary out-of-pocket liabilities and prescription drug coverage.[50]
- ◊ Some key informants suggested that copayments and deductibles be standardized, while benefits and premiums be varied among alternative packages. Others suggested the opposite – that several packages with standardized benefits be constructed, but vary copayments, deductibles, and coinsurance levels among them. The latter argue that this type of benefit design makes it easier for beneficiaries to compare plans and, if differences in beneficiary out-of-pocket liabilities are large enough among plans, the differences will help beneficiaries choose among alternatives.

- ♦ Suggested approaches for designing a standardized drug benefit include:
  - ◊ Offer a small drug benefit with low premiums that most beneficiaries can afford. This design would cover the majority of drug costs for a majority of beneficiaries. However, it will not cover a large portion of drug costs for beneficiaries in poor health, who are likely to be most in need of a drug benefit.
  - ◊ Offer a catastrophic drug benefit.[51] This design will meet the needs of those most likely to need a drug benefit, but will be more costly than the first option. However, if everyone is required to purchase the benefit, individual costs will be lower.[52]

[50] The Buyers Health Care Action Group (BHCAG) has adopted a system somewhat similar to this option, where participating employees are offered a common set of benefits which they can purchase from a choice of 25 "care systems" under contract to BHCAG (for example, a pediatric care system, a diabetic care system). BHCAG contracts directly with health care providers called care systems, which are a provider-established networks of primary care physicians, specialists, and hospitals. Each care system is responsible for determining access protocols, cost and benefits covered. BHCAG pays each system a capitation rate that is risk-adjusted at the end of the year based on comparison of a target level of services and actual service delivery. BHCAG also adjusts payments according to quality and consumer satisfaction indicators. Participating employers pay for the lowest cost system, with consumers being able to "buy-up" to a higher cost system. Each family member selects a system; the family is charged for the highest cost choice. BHCAG's goal is to have each care system specialize, although this has not yet occurred, with care systems mainly competing on price and access. The first iteration of the common benefit package adopted by BHCAG in 1992 occurred after five years of discussion. Since then, the package is reviewed on an on-going basis and changed according to participating employers' requests and group consensus.

[51] According to a key informant, Wisconsin, for example, requires catastrophic drug coverage under all Medigap-type plans offered in their state, which is offered at relatively low cost.

- ◊ Combine the first and second options by covering the first $2,000 of drug costs through the federal government, combined with "good" deductibles and coinsurance features to control beneficiary spending. Federal coverage would permit negotiated discounts from drug retailers; currently, M+COs separately negotiate drug buying, so most have little purchasing power individually to obtain discounted prices. This option would, of course, require additional expenditures for the Medicare program.

- Several possible (sometimes conflicting) criteria for developing standardized benefits packages were suggested in the literature and key informant interviews:
  - ◊ Base the design of a standardized benefit package on prevailing options in the M+C marketplace. Current options are apt to accurately reflect the tradeoff between costs and benefits as determined by consumer preferences, given prevailing M+C payment rates.
  - ◊ Base the design of a standardized benefit package on what consumers are actually purchasing in the M+C marketplace, rather than on a "conceptual discussion" of what others think is more appropriate for consumers or on the types of current plans being supplied by M+COs.[53] Some plan benefits may not provide value to beneficiaries.
  - ◊ Design the benefit package to provide incentives for consumers and providers to use services efficiently, including use of appropriate care settings (e.g., provide incentives to use urgent or emergency care only when appropriate). This might be accomplished through coinsurance or deductibles, which provide better incentives for cost control than copayments.
  - ◊ Employ cost/benefit, cost-effectiveness, net cost, and/or effectiveness analysis to select which benefits to cover under a standardized benefits package. However, this is often prohibitively costly to do, particularly if applied to the entire package of benefits/services. This might be a good method, however, for determining if new technologies should be covered under an existing benefit package.
  - ◊ Equity versus efficiency is another criterion to consider when choosing which benefits to cover under a standardized benefits package. For example, if it is determined that all Medicare beneficiaries should have equal access to prescription drug coverage, then a standardized drug benefit that is included in a core benefit package would be appropriate. CMS has a responsibility to make sure that any standardized benefit package does not discriminate against sicker beneficiaries.

[52] The Medicare Catastrophic Coverage Act of 1988 took a somewhat similar approach. However, because beneficiaries themselves bore the entire cost of the new coverage, that legislation essentially taxed beneficiaries who already had catastrophic drug coverage through retiree health benefits. Fewer beneficiaries now have such coverage so this may not be as controversial today as it was then, or a different financing scheme could be used that would overcome this problem (based on conversation with a key informant).

[53] Several studies have examined beneficiary preferences for benefits (see, for example, Office of Inspector General, February 2000).

- ◊ Base the benefit design on answers to the following questions: Which benefits/services and plan features are most important to consumers? What are the current problems faced by beneficiaries, how significant are the problems, and how likely is benefit standardization likely to resolve them? In the same line of reasoning, some argue that current M+CO plans are not equitable, being designed to attract good risks, leading to biased selection problems that should be addressed through representative group consensus, with input from consumers, regulators, and industry.
- ◊ Benefit design should include bundling of benefits that are apt to lead to adverse selection (such as outpatient prescription drugs) with those likely to mitigate adverse selection (such as health club benefits, foreign travel emergency coverage, at-home recovery benefits, or vision and dental benefits).
- ◊ Base benefit design on public policy objectives. These objectives may at times supersede individual consumer preferences because public policy may have goals to rebalance an acute care delivery system to favor primary care and services for the chronically ill; encourage access and use of prevention services as a public health measure; and/or include a broad range of services in the basic plan to assure adequate financial protection for all plan beneficiaries.

  While these public policy objectives may be desirable, the consequences resulting from intervening in individual consumer preferences must be considered. First, even if those benefits desirable on a public policy basis are offered to the public, consumers may not purchase them. For example, the 10 standardized Medigap policies make coverage of certain services available that reflect more closely what health planners favor rather than what consumers are willing to purchase.[54] Consumers exhibit little demand for policies that cover preventive, home health, or prescription drug coverage at the price that insurance companies are currently willing to offer them. Second, inducing consumers to buy benefits that they would not necessarily seek for themselves may result in higher costs. Finally, if public policy justifies covering services that are not in high demand, logically they should be incorporated into the minimum benefit package and not left to individual consumer choice.

  Of course, there is still the issue of who should pay for benefits included in a standardized benefit package based on public policy objectives. There would need to be considerable debate over whether individual consumers, current or former employers, or the government should pay for services that consumers would not necessarily voluntarily purchase.

  Additionally, if the standardized package is determined through a political process, one key informant suggested that a "Supreme Court of Benefits Design" be appointed for life terms. The Court would have authority to address continual updates to the benefit packages, and depoliticize the process.

[54] Discussion with Key Informant.

◊ Any benefit standardization should balance consumer and managed care plan needs (e.g., access to specialized services when needed versus financial sustainability), with consensus required by consumers, regulators, and the managed care industry to ensure that the solution is both technically and politically feasible.

Alternatives to Full Standardization

Several alternatives to full M+CO plan standardization have been suggested in the literature and by our key informants:[55]

1) Standardize M+CO marketing materials and presentation of benefits.

   For any set of standardized benefits offered, it is important that they are not expressed differently or marketed differently if the benefits are the same. And, if benefits do differ among plans, the differences should be clearly visible to consumers. CMS has pursued this goal for M+C plans in the last couple of years by requiring them to produce a standardized "Summary of Benefits" document for beneficiaries and through its "Personal Plan Finder" and Medicare Compare website. While the Summary of Benefits does not list every service covered or every limitation or exclusion, it requires plans to use common language/definitions to define benefits and beneficiary cost-sharing, as well as a common presentation format to help beneficiaries compare important benefits across M+CO plans and between the M+CO's plan and the Original Medicare plan.

2) Place parameters around some benefits and/or beneficiary cost-sharing liabilities within which health plans must stay when defining their benefit packages.

3) Standardize only within major categories of benefits.

   This might involve standardizing such features as copayments for Medicare-covered services and prescription drugs. Consumer advocates key informants also said benefits whose actual value they doubted, such as "discounted" dental or vision services. Within these constraints, plans could combine Medicare-covered services and enhanced benefits as desired.

4) Establish a minimum benefit package.

   Plans might be required, for example, to provide all Medicare-covered benefits, plus a minimum set of enhanced benefits. Plans would then be free to add benefits to any package they sell. However, the experience with the minimum benefits for Medigap policies that were mandated prior to the OBRA 1990 reforms is that they did little to reduce beneficiaries' confusion, since nearly all Medigap plans exceeded the minimums. This would likely also

[55] Fox, et al., July/August 1999; Fox, et al., February 1999; Key Informant Interviews.

happen, in very disparate ways, in the M+C market under minimum benefit standardization requirements.[56]

5) Implement a core-plus-rider approach.

This approach might entail setting a minimum level of Medicare-covered benefits and beneficiary cost-sharing, plus some enhanced benefits, and allowing a series of riders with standardized supplemental benefits to be sold individually. Such an approach would permit beneficiaries to tailor their benefit package to their needs, and M+COs to tailor benefit packages to local market conditions. Fox, et al., (1999) suggested that the core plan might involve high copayments, but beneficiaries would be able to purchase separate riders for lower copayments for physician services, for hospital and other institutional services, and for prescription drugs.

Although the core and rider approach helps preserve consumer choice, the number of combinations of core plus rider options can easily add up to hundreds of different plan options, defeating the purpose of standardization by providing too many choices to consumers. A balance between flexibility and choice would be needed.

This approach also has strong potential for adverse selection, particularly for the prescription drug rider. Risk averse beneficiaries may become priced out of the market because the product's price is driven up due to heavy selection by those who need the rider the most. Medigap was structured in part to reduce (but does not eliminate) this problem. First, to address adverse selection issues, more than one additional benefit is bundled together in each alternative B-J. This approach helps to "average out" risk. For example, Medigap Plan J includes a prescription drug benefit that is likely to attract less healthy and more costly beneficiaries, but this benefit is bundled with others, such as preventive care benefits, designed to attract more healthy and less costly beneficiaries.

6) Several key informants suggested that M+C benefit package standardization only makes sense in the context of reforming the entire Medicare program (Original Fee-for-Service Medicare together with the M+C program) and the Medigap market.

IV. SUMMARY OF 2001 M+CO BENEFIT PACKAGES AND DESIGN

Benefit packages offered by the M+COs operating in the 22 selected counties in 2001, with the exception of outpatient prescription drug benefits, are presented in detail in Table C-1 in Appendix C. Because of their complexity, drug benefits offered in 2001 (and 2002) are summarized separately in Appendix Table C-2. The summaries include frequencies of enhanced benefits provided by plans, the percentage of plans charging deductibles, copayments, or coinsurance, along with average dollar amounts, as well as this information for maximum

[56] Fox, et al., February 1999.

enrollee out-of-pocket costs, maximum plan benefits, and prior authorization requirements. The table is divided into Medicare-covered services, accompanied by a summary of enhanced benefits offered under these service categories, and non-Medicare covered services.

Table 1 summarizes the enhanced benefits provided by M+COs in the 22 selected counties in 2001 and 2002 for both Medicare-covered and non-Medicare-covered benefits.

TABLE 1. ENHANCED BENEFITS, 2001 and 2002

	2001		2002
MEDICARE-COVERED BENEFITS	**# of Plans that offer benefit**	**% of Plans**	**% of Plans**
Inpatient Hospital			
Additional IP days for an unlimited number of days	Most	90%	98%
Room upgrades	Few	4%	0%
Inpatient Hospital Psychiatric			
Additional IP days (half unlimited, half limited)	Few	9%	8%
Skilled Nursing Facility			
No prior hospital stay (non-Med covered stay)	Most	81%	85%
Additional SNF days	Few	2%	0%
30-day discharge from hospital prior to SNF admission	Few	16%	NA
Comprehensive Outpatient Rehabilitation Facility (CORF)	Enhanced benefits not applicable		
Emergency/Urgent Care			
World-wide EC	Most	93%	92%
World-wide UC	Most	87%	88%
Partial Hospitalization	Enhanced benefits not applicable		
Home Health			
Homemaker services	Few	2%	0%
Custodial Care	Few	3%	0%
Respite Care	Few	8%	3%
Primary Care Physicians	Enhanced benefits not applicable		
Independent Occupational Therapy Services	Enhanced benefits not applicable		

TABLE 1. ENHANCED BENEFITS, 2001 and 2002 (continued)			
	2001		2002
MEDICARE-COVERED BENEFITS	# of Plans that offer benefit	% of Plans	% of Plans
Physician Specialist (excl. Psychiatric Services)	Enhanced benefits not applicable		
Mental Health Specialty Services (Non-Physician)	Enhanced benefits not applicable		
Podiatry Services - Med-coverage only for certain medical conditions Routine foot care	About Half	48%	47%
Other Health Care Professional Services	Enhanced benefits not applicable		
Psychiatric Services	Enhanced benefits not applicable		
Physical Therapy and Speech-Language Pathology Services	Enhanced benefits not applicable		
Clinical/Diagnostic/Therapeutic Radiological Lab Services Outpatient Clinical Authorization	Enhanced benefits not applicable		
Clinical/Diagnostic/Therapeutic Radiological Lab Services Outpatient X-Rays	Enhanced benefits not applicable		
Outpatient Hospital Services	Enhanced benefits not applicable		
Ambulatory Surgery Centers	Enhanced benefits not applicable		
Outpatient Substance Abuse Services	Enhanced benefits not applicable		
Cardiac Rehabilitation Services	Enhanced benefits not applicable		
Ambulance Services	Enhanced benefits not applicable		
Durable Medical Equipment/Medical Supplies	Enhanced benefits not applicable		
Renal Dialysis	Enhanced benefits not applicable		
Outpatient Blood 3-pint deductible waived	Most - About Half	75%	66%
Immunizations Additional immunizations	About Half - Few	41%	32%

TABLE 1. ENHANCED BENEFITS, 2001 and 2002 (continued)			
	2001		2002
MEDICARE-COVERED BENEFITS	# of Plans that offer benefit	% of Plans	% of Plans
Pap/Pelvic Screening Addtl pap/pelvic exams (most common 1 addtl/yr)	About Half	44%	52%
Prostate Cancer Screening Addtl prostate exams (1 addtl/yr)	Few	6%	1%
Colorectal Screening Addtl colorectal exams (1 addtl/yr)	Few	13%	10%
Bone Mass Measurement	Enhanced benefits not applicable		
Mammography Screening Addtl mamogram exams (1 addtl/yr)	Few	3%	3%
Diabetes Monitoring	Enhanced benefits not applicable		

TABLE 1. ENHANCED BENEFITS, 2001 and 2002 (Continued)			
	2001		2002
NON-MEDICARE-COVERED BENEFITS	# of Plans that offer benefit	% of Plans	% of Plans
Transportation Services (Trips)	Few	17%	12%
Chiropractic Services (Routine Care)	Few	21%	14%
Acupuncture (Treatments)	Few	9%	4%
Other Services Other 1 (transplants, adult day care, outpatient injectables, diaphragms) Other 2 (dental silver, optional dental personal medical emergency)	Few Few	36% 20%	34% 15%
Health Education/Wellness Programs	About Half	55%	50%
Routine Physical Exams	Most	100%	99%
Outpatient Prescription Drugs	About Half	68%	70%

TABLE 1. ENHANCED BENEFITS, 2001 and 2002 (Continued)			
	2001		2002
NON-MEDICARE-COVERED BENEFITS	# of Plans that offer benefit	% of Plans	% of Plans
Dental Services (Preventive)	About Half	52%	47%
Dental Services (Comprehensive)	Few	34%	19%
Vision Care (Routine Eye Exams)	Most	92%	81%
Vision Care (Eye Wear)	About Half	66%	60%
Hearing Services			
Routine Hearing Exams	Most	84%	74%
Fitting/Evaluation for Hearing Aid	Few	22%	30%
Hearing Services (Hearing Aids)	About Half	52%	48%
Visitor/Travel Services	Few	29%	19%
Point-of-Service Option	Few	7%	12%

In designing the core packages and rider options, we examined whether a benefit was covered as an additional, mandatory, or optional benefit; whether or not it was included in the M+CO's "basic" benefit package; whether the supplemental notes provided in the 2001 PBP files suggested modifications; whether there were significant changes in coverage of the benefit or beneficiary liability in 2002; and whether recommendations from our key informant interviews suggested changes to the 2001 benefit designs. These additional considerations affected the designs of the three core packages as follows:

- Overall, almost all enhanced benefits that plans offered in 2001 were included in their packages as either additional benefits (the most common arrangement) or as mandatory benefits (meaning that an additional premium was charged for these additional benefits). In only a few instances (for routine chiropractic services, acupuncture treatments, and both preventive and comprehensive dental services) were the benefits optional in 15 to 30 percent of the plans. The optional benefits were either included in the most generous core benefit package (chiropractic care) or not at all (acupuncture) because of the percentage of plans offering these services, or in a rider option (dental services). Because only 7 of the 96 plans offered a point-of-service (POS) option as (3 as an additional, 3 as a mandatory, and 1 as an

optional benefit), and because the POS option only included a very limited number of services (most frequently inpatient hospital coverage (5/7 plans), a POS benefit is not included in any of the core packages.[57]

- The 96 plans offered by the 69 M+CO/county pairs that were examined to create the initial set of core benefit packages and riders had varying levels of benefits generosity. Therefore, we created a file consisting of only "basic" plans – one for each M+CO/county pair. We did this mainly to help design Core Benefit Package #1, which represents the most basic of the three model plans.

  We then examined the same benefit design variables for the resulting 69 basic plans as we had for the 96 plans. In almost all cases, there was little difference that prompted changing the structures of the three core benefit packages. Basic plans were slightly less likely to offer some of the enhanced benefits (i.e., 1 to 2 percentage points lower); slightly more likely to charge a copay; the minimum copay for basic plans was more likely to be higher than for all plans (about $5), although maximums and modes were equivalent; and basic plans were slightly more likely to limit the number of visits for selected enhanced benefits, but again ranges and modes did not differ from the 96 plans in total. We changed Core Package #1 to reflect the few differences as follows:

  - ◊ Because per day SNF copays were on average higher for the basic plans than for all plans, we changed the copay from $75 to $100 per day for days 1-100 in Core Package #1 and for days 21-100 in Core Package #2.
  - ◊ A higher percentage of basic plans (52 percent) compared to all plans (34 percent) charged a copay for partial hospitalization services, with a higher copay mode of $20 rather than $15, so we changed Core Packages #1 and #2 to reflect this.
  - ◊ Basic plans also had a $5 copay mode for clinical/diagnostic/therapeutic lab services, compared with a higher mode for all plans, but basic plans had a higher outpatient hospital copay mode of $20 instead of $15 for all plans, so these changes were made to Core Packages #1 and #2.

- Notes included in the PBP files typically clarified that the beneficiary liability provided in the PBP file is only applicable when the services are delivered by in-network providers, clarified that benefits are covered in full after copayment is made, identified the particular gatekeeper for certain benefits (e.g., prior authorization from a mental health, rather than a PCP,

[57] Enhanced benefits not covered under any of the three standardized core packages because less than 10 percent of the 96 plans covered them in 2001 include: Room Upgrades for Inpatient Hospital Services; Additional Inpatient Hospital Psychiatric Days; Additional SNF Days; Additional Home Health Services (homemaker services, custodial care, respite care); Additional Prostate Screenings; Additional Mammograms; Acupuncture Treatments (generally covered as a form of anesthesia in connection with covered surgery); and Miscellaneous "Other Services" (e.g., adult day care, personal medical emergency response system, group exercise classes, weight watchers classes, immediate care facility coverage, diaphragms, registered dietitian consultation, and home assessment and adaptation services).

gatekeeper for partial hospitalization services), defined the benefit in more specific terms (e.g., terms under which occupational, physical, and speech therapy are covered), or provided general terms for excluded benefits.

However, the notes did indicate the need for two minor changes. The benefit design for the following sets of services in Core Packages #1 (and #2 where relevant) were modified: copays for outpatient clinical/diagnostic/therapeutic radiological lab services, and for immunizations and preventive screenings, are in addition to a separate office copay for an associated physician office visit; we added a note to the low option vision supplies rider stating that there are no beneficiary charges for one set of glasses following cataract surgery.

- We next examined the same benefit design variables as we had in 2001 for the 73 plans still offered by the M+COs remaining in the selected 22 counties in 2002.[58]
  - For almost all of the enhanced benefits included in the table above, the percentage of plans covering them in 2002 declined from 2001. However, the declines were not enough to change the benefits design in any of the three core packages, except for the benefit that waives the three-pint blood deductible (which fell from 75 percent of plans providing this benefit in 2001 to 66 percent in 2002) and coverage of additional immunizations (which fell from 41 percent providing this benefit in 2001 to 32 percent in 2002). Because the blood deductible is covered by Medigap Plan A, we chose to keep this coverage in Core Benefit Package #1 (as well as the other core packages, which build on it); because Core Benefit Package #2 does not cover many more enhanced benefits than #1, we chose to keep additional immunization coverage in this model package (and in Core Package #3, which builds on #2).
  - Another general trend from 2001 to 2002 was an increase in the percentage of plans that required a copay for almost all benefits, as well as an average $5 increase in copays for all benefit categories. We did not reflect this in the core benefit packages but an update to 2002 prices would reflect this increase.
  - There was a general shift between 2001 and 2002 from enhanced benefits being offered as additional benefits (no additional premium required) to being offered as mandatory, or sometimes optional, benefits (both of which require an additional beneficiary premium). This did not affect the core benefit package designs, but would affect the premiums charged for each of the model core packages.
  - There was a slight increase in the percentage of plans (1 to 2 percentage points) that charged a service-specific deductible for some of the benefit categories, but the overall percentage of plans charging a deductible in 2002 was still extremely small. This did not affect the core benefit package designs.
  - There was a slight increase in the percentage of plans (2 to 4 percentage points) that charged a service-specific coinsurance for some of the benefit categories, but the overall

[58] We did not examine the benefit packages for new 2002 entrants in those counties.

percentage of plans charging a coinsurance in 2002 was still extremely small. This did not affect the core benefit package designs.

◊ There was a slight increase in the percentage of plans (1 to 2 percentage points) that had a service-specific maximum plan benefit, but, again, this percentage was still very small. This did not affect the core benefit package designs.

V. MODEL STANDARDIZED BENEFIT PACKAGES

This section presents three model core benefit packages and a set of rider options for M+COs that draw on the above focused literature review and key informant interviews. The core packages also draw extensively from M+CO benefits and beneficiary liabilities prevalent in 2001 for the 96 sample M+CO plans. This was done under the assumption that recent M+CO benefit plan offerings, in part, reflect the range of consumer demand. (Benefit plan offerings also reflect supply conditions, such as M+CO payment levels, health services and administrative costs, strength of market competition, etc.) The core-plus-rider approach was adopted in this initial step of proposing model standardized benefit package options to CMS based on CMS requests and on recommendations from several key informants.

The approach also closely mirrors that adopted by the Medicare Competitive Pricing Demonstration in its early design phase.[59] Both a "statutory minimum package" of required Medicare Part A and B services and an "augmented minimum package" that would contain certain preventive services and eliminate most deductibles, were rejected as candidates for a core benefit package for HMO bids. In the opinion of experts, few beneficiaries would want to enroll in these plans, so few HMOs would want to bid on them. The consensus within CMS was that each HMO should bid on a core package comprised of the statutory minimum and "standard enhancements." The standard enhancements were described as the standard benefit supplements commonly offered by HMOs in the local demonstration city. CMS believed this approach would result in a standardized core benefit package that was accepted by both beneficiaries and HMOs. This is the approach taken in this report.

In the early design phase of the demonstration, CMS also considered how to treat additional benefit enhancements that HMOs might wish to offer, weighing beneficiaries' and CMS's ability to compare prices across plans, adverse selection issues, mandating of "inefficient" supplementary benefits, and allowance for plan innovation. In the end, CMS chose to permit demonstration HMOs to offer supplementary packages at their discretion, but required that all optional supplemental packages could only be sold in conjunction with the core benefit package. The approach in this report follows the demonstration approach in that optional supplemental packages ("riders") would be required to be sold in combination with one of the core benefit packages, but deviates from the demonstration approach in proposing a model standardized set of riders that could be offered.

[59] *Design Report: Medicare Competitive Pricing Demonstration*, authors unknown, August 12, 1996, obtained from the Centers for Medicare & Medicaid Services.

The model standardized core packages proposed in this section of the report are not specific to any geographic area, but they do differ in generosity of benefits so that M+COs located in rural and/or low M+C payment areas can choose to offer the least generous core benefit package, while M+COs in urban and/or high payment areas can choose to offer either of the two more generous core benefit packages. All three packages also have different copayment structures, as well as other differences (e.g., virtually no plan charges a deductible for either Medicare-covered or non-Medicare-covered benefits and very few have coinsurance charges, but some plans do have a service-specific maximum plan benefit for some enhanced benefits).

As a final note, the core benefit packages and riders only standardize the benefits that M+COs are required to cover when offering the benefit package, as well as beneficiary out-of-pocket liabilities. They do not attempt to standardize M+CO delivery systems, including network composition, processes for determining medical necessity, referral or prior authorization systems for specialty care, drug formulary composition, or other aspects of operation such as 24-hour medical advice access or quality assurance mechanisms.

All three core packages exclude selected rider benefits. In the next section of this paper, we propose two options each for four types of enhanced rider benefits (dental preventive and comprehensive services, vision supplies, hearing supplies, and outpatient prescription drugs). Rider options differ in generosity and copayment amounts. The combination of the three core packages and eight rider options offers a large degree of standardization of benefit packages, yet still allows for considerable flexibility by permitting M+COs to choose from among 240 possible combinations of core and rider options to construct benefit packages that can be tailored to their market area and Medicare population.

Model Core Benefit Packages

Table 2 below compares selected benefit design features among the three model core benefit packages. The details of the core packages are included in Appendix D.

Table 2. Summary of Core Benefit Package Provisions

	Core #1	Core #2	Core #3
Plan-wide Deductible	None	None	None
Plan-wide Max OOP	None	None	$3,500/yr
IP Hospital Deductible	$500/yr	None	None
IP Hospital Copay	None	$100/stay	None
IP Hospital Max OOP	None	$300/yr	None
IP Psych Deductible	$500/yr	None	None
IP Psych Copay	None	$100/stay	None
IP Psych Max OOP	None	$300/yr	None
SNF Deductible	None	None	None
SNF Copay (100 days limit; for Medicare-covered stays only)	$100/day for days 1-100	$100/day for days 21-100	None
SNF Max OOP	None	None	None
OP Hospital Copay	$20	$20	None

Table 2. Summary of Core Benefit Package Provisions (continued)			
	Core #1	**Core #2**	**Core #3**
Primary Care Physician Copay	$10	$10	$10
Physician Specialist (exc. psychiatric) Copay	$10	$10	$10
Mental Health Copays	$10-$20/indiv-group	$10-$20/indiv-group	$10-$20/indiv-group
Clinical/Diagnostic/Therapeutic Radiological Lab (inc. outpatient X-Rays) Copays (in addition to $10 office visit copay)	$5	$5	None
Partial Hospitalization Copay	$20	$20	$15
Home Health Copay	None	None	None
Physical Therapy/Speech-Language Pathology Copay	$10	$10	$10
Ambulance Copay	$50	$50	None
Durable Medical Equipment Copay	$10	None	None
Medical Supplies Copay	$10	None	None
Renal Dialysis Copay (in- and out-of-area)	$15	None	None
Immunizations/Screenings (in addition to $10 office visit copay)	Charge of $5 to $15	None	None
World-Wide Emergency and Urgent Care Copays	$50 (waived on hospital admission)	$50 (waived on hospital admission)	$50 (waived on hospital admission)
Addtl. Physical per year Copay	$10	$10	$10
Addtl. Eye Exam per year Copay	$10	$10	$10
Addtl. Hearing Test per year Copay	$10	$10	$10
Addtl. Pap/Pelvic Exam per year Copays	N/A	$0 Pap/$15 Pelvic	$0 Pap/$15 Pelvic
Addtl. Immunizations Copays (but no sep. office visit cost share)	N/A	$10	$10
Routine Foot Care Copay/4 visits per year	N/A	$10	$10
SNF coverage after >30 days IP discharge (up to 365 days) Copay	N/A	N/A	None
Addtl. Colorectal Screening per year Copay	N/A	N/A	None
Transportation Services Copay (40 Trips per year to a plan-approved location/round-trip coverage)	N/A	N/A	None
Routine Chiropractic Care Copay (12 visits per year)	N/A	N/A	$10
Other Services	N/A	N/A	$500/year max. benefit
Visitor/Travel Services	N/A	N/A	$2,500/ year max. benefit

Core Benefit Package #1

This is a somewhat "basic" package that covers all Medicare-covered services plus selected enhanced benefits from Table 1 above. An enhanced benefit is included in this package if approximately 75 percent or more ("most") health plans covered it in 2001.

Beneficiary cost sharing is more extensive than in the other two core packages. According to several key informants, substantive differences in beneficiary out-of-pocket costs are a good way to preserve benefit standardization and plan comparison while still creating meaningful differences among benefit packages. Higher cost sharing also reduces plan premiums, increasing the affordability of this proposed "basic" M+CO plan.

The primary form of beneficiary cost sharing in core package #1 is based on the most prevalent form plans used in 2001. Very few plans had deductibles or coinsurance charges, while a substantial number relied on copayments to control costs and utilization for almost all service categories. In no case did a plan charge both a service-specific deductible and a coinsurance or copay for the service. While several plans had service-specific maximum enrollee out-of-pocket costs for some services, they also were few and are incorporated into Core Package #3 – the most generous package. The copayment amount for each service category in this core package is based on the copay mode for the 96 plans, and is included for each service category if at least one plan charged a copay for the service. It has no maximum plan benefit or enrollee out-of-pocket cost limits.[60]

In the 96 plans, nearly all types of Medicare-covered services required prior authorization from a PCP or by an organizational review in 2001, and nearly all plans required prior authorization before enhanced benefits were covered, with the exception of some preventive services (immunizations, some preventive screenings or tests, routine physicals, acupuncture treatments, "other" miscellaneous covered services, dental, vision, or hearing services, and health and education/wellness programs). Therefore, we assume that the copayment amounts apply only when the required prior authorization or referral is obtained (otherwise, the beneficiary must pay the full cost of the service). That is, the copayment structure does not include reduced copayments for referred/authorized services and higher copayments for non-referred/non-authorized services.

Although few of the 96 plans used plan deductibles (overall or for specific service categories), our key informants suggested that varying deductibles rather than copayments to modify beneficiary liabilities is more transparent to individuals, allowing them to more readily detect differences among packages and calculate anticipated out-of-pocket costs. We were told that M+COs use copays more often than deductibles mainly because of administrative simplicity

[60] An option for Core Benefit Package #1 would be to equalize all "Part B" service category copayments at $10. MedPAC (2002) suggested this as a way to improve beneficiaries' financial protection from high medical costs, especially those with chronic conditions, as well as to minimize financial incentives to choose one type of outpatient site over another.

(providers collect the copays, requiring less paperwork for the beneficiary and insurance company). Therefore, Core Package #1 includes inpatient hospital deductibles, with the amount based on plan mode. The deductibles also make package #1 more comparable to Medigap Plan A, although it is certainly more generous with respect to the coverage of enhanced benefits and has no "Part B" deductibles.[61]

Core Benefit Package #2

This is a more generous package than #1, including all of the first core package's benefits as well as enhanced benefits from Table 1 above that were covered by "about half" of plans in 2001. It also has no service-specific plan deductibles, making it somewhat comparable to Medigap Plan C (with more enhanced benefits, however).

The package does impose copayments for inpatient hospital and SNF benefits based on the benefit designs of several M+C plans in 2001. Beneficiary liability is limited, though, for inpatient hospital services, through maximum enrollee out-of-pocket costs. Copayments on other services would be charged only if at least 20 percent of the health plans charged a copay for these services in 2001 (the 20 percent applies only to those plans that offered the enhanced benefit in 2001).[62]

Core Benefit Package #3

This is the most generous core package that M+COs would be allowed to offer. It includes all of the second package's benefits plus benefits covered by "few" (but at least 10 percent) of the health plans in Table 1.

This package has more limited beneficiary liabilities, primarily through a maximum enrollee out-of-pocket cost that is applicable to all services in the benefit package (equal to the mode for the 8 percent of plans without a POS option that had a maximum in 2001). It also includes copays only for those services for which at least 50 percent of plans offering the benefit charged a copay in 2001.

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[61] In an earlier version of the core benefit packages, an overall plan deductible of $872 was applied to Core Package #1. MedPAC has recently suggested combining Medicare Part A and Part B deductibles into a single annual deductible as a way of better encouraging appropriate use of services while still providing beneficiaries with financial protection from high out-of-pocket costs (Medicare Payment Advisory Commission (MedPAC). *Report to the Congress: Assessing Medicare Benefits*. June 2002). MedPAC notes that a single deductible would be less confusing to beneficiaries than the current system of separate deductibles and would be more consistent with private sector benefit design. However, this change also substantially changes the distribution of charges among beneficiaries as relatively few have an inpatient stay ("Part A", while a relatively large number have an ambulatory visit ("Part B"). Because the overall plan deductible made Core Package #1 caused the valuation of annual plan benefits to be lower than under the Original Medicare plan, we instead used service-specific deductibles based on the actual benefit design of several M+CO plans in 2001.

[62] This is also a change from an earlier version of the core benefit packages, in which copays would have been charged in Core Package #2 for services for which at least 50 percent of plans charged a copay in 2001. The 50 percent rule caused Core Package #2 to be too generous compared with Core Package #1 and fairly close in valuation to Core Package #3.

Model Rider Options

Criteria for the benefit design for "low" and "high" options for dental, vision supplies, and hearing supplies benefit categories are essentially the same as for the core packages. The low option includes those enhanced benefits that about one-half of the plans covered in 2001, with dollar limits, copayments, and maximum plan benefits based on the mode for plans that included beneficiary out-of-pocket charges for these benefits. The high option includes those enhanced benefits that few, but at least 10 percent, of the plans covered, with beneficiary liabilities based on the experience of the majority of plans. Criteria for the benefit design for the prescription drug rider are discussed below.

Dental Services

The main differences between the low and high options for dental benefits are higher copayments for the lower option, and lack of coverage for "comprehensive" dental services. Only "preventive" dental services would be covered in the low option.

Table 3. Dental Rider Benefit Packages

	Low Option	High Option
Preventive Services	Oral exams, limited to 2 visits per year, with a $10 copay per visit	Oral exams, limited to 2 visits per year, no copay
Prophylaxis (cleaning) Services	Limited to 2 visits per year, with a $10 copay per visit	Limited to 2 visits per year, no copay
Dental X-rays	Limited to 1 visit per year, with a $10 copay per visit	Limited to 1 visit per year, no copay
Fluoride Treatments	None	Limited to 2 visits per year, no copay
Prosthodontics/other oral/maxillofacial surgery/other services (unlimited services)	None	$20 min copay and $390 max copay per service
Emergency Services	None	$10 max copay per service
Diagnostic Services	None	$15 max copay per service
Restorative Services	None	$30 max copay per service
Endodontics/periodontics/extractions	None	$20 min and $363 max copay per service
Maximum Out-of-Pocket	None	None

Vision Services

The main differences between the low and high option for vision benefits consists of higher copayments for eyeglasses in the low option, and more limited periodicity of benefit coverage.

Table 4. Vision Rider Benefit Packages		
	Low Option	**High Option**
Eyeglasses (lenses and frames)	Limited to 1 set every year, with a $20 copay[63]	Limited to 1 set per 6 months, no copay
Contact lenses	None	Limited to 1 set per year, no copay
Maximum Plan Benefit	$100 every 2 years	$100 per year
Maximum Out-of-Pocket	None	None

Hearing Services

The main differences between the low and high options for hearing benefits consist of more limited periodicity of benefit coverage and a maximum plan benefit in the low option (and no battery replacement coverage).

Table 5. Hearing Rider Benefit Packages		
	Low Option	**High Option**
Fitting/Evaluation for Hearing Aids	Limited to 1 evaluation every 3 years, with a $10 copay	Unlimited, no copay
Hearing Aid Replacement	1 inner ear hearing aid every 3 years, with no copay; or 1 outer ear hearing aid every 3 years, with no copay; or 1 over-the-ear hearing aid every 3 years, with no copay	1 inner ear hearing aid unlimited, with 15% paid for by beneficiary; or 1 outer ear hearing aid unlimited, with 15% paid for by beneficiary; or 1 over-the-ear hearing aid unlimited, with 15% paid for by beneficiary
Hearing Aid Replacement Batteries	None	Unlimited, no copay
Maximum Plan Benefit	$500 every 3 years	None
Maximum Out-of-Pocket	None	None

Outpatient Prescription Drugs

As recommended by a 1998 advisory working group, funded by the Robert Wood Johnson Foundation, that examined standardization of Medicare HMO benefits, the standardization of prescription drug benefits in the low and high option riders are limited to a few structural features: copayment structure; time period for applying maximum benefit limit; method for counting benefit payments for determining when benefit limits have been reached; and maximum supply of prescription drugs allowed before a new copayment is charged.[64] The standards for these features were determined by examining the 68 percent of the 96 plans in 2001 and the 70 percent of the 73 health plans in 2002 that offered an outpatient drug benefit, and MPR's

[63] Member pays nothing for one set of eyeglasses following each cataract surgery.
[64] Fox, et al., July/August 1999.

analysis of prescription drug benefits for basic plans in 2001 and 2002 based on Medicare Compare.[65] The benefit covers both formulary and non-formulary drugs (i.e., only a two-tiered structure allowed) due to the most common design for the plans examined in 2001 and 2002.

The low and high options, however, also incorporate suggestions from key informants, mainly the inclusion of a deductible for the low option, which is set equal to the deductible charged under Medigap Plans H, I, and J – the three plans that have a prescription drug benefit – and an out-of-pocket limit for the high option.

The low option is designed to offer most beneficiaries a small drug benefit, but it would not provide protection against very high drug spending. The high option is designed to be a more generous benefit, as well as to offer catastrophic prescription drug coverage.

Table 6. Prescription Drugs Rider Benefit Packages

	Low Option	High Option
Annual Deductible[66]	None	None
Designated Retail or HMO Pharmacy (30-day supply) Copays (formulary or non-formulary)	Generic: $20 Brand-name: $35	Generic: $10 Brand-name: $20
Mail Order (90-day supply) Copays (formulary or non-formulary)	Generic: $40 Brand-name: $70	Generic: $20 Brand-name: $40
Annual Drug Cap*	$1,000	None
Maximum Out-of-Pocket	None	$1,500[67] (excludes premiums)

*This is a single "combination" cap that applies to formulary and non-formulary drugs and to generic and brand-name drugs, is based on "discounted percent of published national average wholesale price," and is less the copayment amounts for both generic and brand-name drugs.

VI. VALUATION OF MODEL STANDARDIZED BENEFIT PLANS

The HayGroup evaluated the estimated relative cost of the benefits packages to the plan and to the participant. The valuation is based on using HayGroup's Medicare Benefit Value

[65] Achman and Gold, 2002.
[66] Only one plan in 2001 and no plans in 2002 charged a deductible for prescription drugs.
[67] In 2001 and 2002, no M+C plan included in this study had a maximum enrollee out-of-pocket cost for prescription drugs with which to set an amount for the high option. In a recent Rand study, the authors define "catastrophic" expenditures as more than $2,000 out-of-pocket spending (Goldman, D.P., G.F. Joyce, and J. Malkin, "The Costs of a Medicare Prescription Drug Benefit," Topics in Economic Analysis & Policy, 2(1), Article 3). In consultation with CMS, we chose the $1,500 option as a reasonable limit on out-of-pocket spending for the high option. The $1,500 maximum out-of-pocket would have only a slight cost to the plan because few beneficiaries would have total copayments that exceed $1,500 under the other parameters of the high option package. If, for example, all of the purchases were for brand-name drugs, the beneficiary would have to have 75 retail prescriptions to exceed the $1,500 out-of-pocket maximum in a year. It is improbable that many beneficiaries would reach the $2,000 limit based on prescription drug expenditures alone.

Comparison (MedicareBVC) model. A detailed description of their methodology is included in Appendix E.

Core Benefit Packages

Table 7 below shows the estimated annual cost for plan benefits and the amount paid by the participant as out-of-pocket expenditures, as well as the total paid by the plan and the participant. The annual plan cost is the relative value of the benefits paid by the plan. The calculation assumes that the demographic characteristics of the beneficiaries covered by the plan would be the same as those for all participants covered by Medicare. Out-of-pocket payments include those for prescription drugs, dental, and all other medical expenses, assuming the beneficiary does not have a rider covering these enhanced benefits. The table, however, does not include out-of-pocket expenses for long-term care.

Table 7. Estimated Annual Plan and Participant Costs for Core Packages, per Medicare+Choice Participant

	Benefit Package Plan Design			
	Medicare	**Core #1**	**Core #2**	**Core #3**
Annual Plan's Cost for Plan Benefits	**$6,068**	**$6,539**	**$6,772**	**$7,087**
Beneficiary Out-of-Pocket Costs (other than for long-term care):				
Prescription Drugs (A)*	$1,202	$1,211	$1,212	$1,217
Dental (B)*	$86	$86	$86	$87
Other (C) **	$787	$647	$599	$502
Total Amount Paid by the Beneficiary (A+B+C)	**$2,075**	**$1,944**	**$1,897**	**$1,806**
Amount Paid by Plan and Beneficiary	**$8,143**	**$8,483**	**$8,669**	**$8,893**

* The estimated expenditures for prescription drugs and dental care are based on current levels of beneficiary coverage for these benefits.

** "Other" includes deductibles and copayments for Medicare-covered and non-covered services detailed in the model core packages, taking into account maximum out-of-pocket limits and maximum plan benefits for selected services, plus costs for vision, hearing, and dental services that could be covered under the rider options.

In Table 7, "induced demand" causes the health plan's (and total) health expenditures to rise when out-of-pocket expenses decline. Economic theory proposes that, as the price of a service or product declines, more of the service or product will usually be demanded; empirical studies of health care demand have supported the theory. Thus, Core Packages #2 and #3, which have lower copayments, deductibles, or maximum out-of-pocket limits than Core Package #1, reduce the "price" of health services to enrolled beneficiaries, motivating them to demand more health services than they would otherwise want to purchase under Core Package #1 ("induced demand").

The Medicare BVC model determines the induced demand on all out-of-pocket expenses in combination. Therefore, a reduction in out-of-pocket expenditures for covered services, such as physician office visits, will increase the expenditures for non-covered services, such as prescription drug costs. As a result, the non-covered expenses increase as the value of the core

benefits package increases. For example, the prescription drug out-of-pocket expenditures increase from $1,211 for Core Package #1 to $1,217 for Core Package #3 because Core Package #3 has lower beneficiary cost sharing for many benefits.

Rider Options

BearingPoint specified the design for eight riders that could be added to the basic plan as specified in Tables 3 through 6 above. HayGroup evaluated the cost of the riders assuming that each one would be added to Core Package #2. The resulting costs of the riders is shown in Table 8 below. The annual rider costs are the amounts that the beneficiary or Medicare would pay to the insurance company or health plan to purchase the benefit described in the table (i.e., the "premium"). That is, the cost does not include copayments or amounts not covered by the plan. For example, for the low prescription drug option, the rider's estimated cost does not include the $20/$35 copayments or the cost of prescription drugs after the $1,000 drug cap has been met.

Table 8. Estimated Annual Total Rider Costs Per Medicare Beneficiary (Total Plan and Beneficiary Costs)

Rider	Cost
High Dental	$166
Low Dental	$59
High Hearing	$51
Low Hearing	$6
High Vision	$55
Low Vision	$15
High Prescription Drug	$1,769
Low Prescription Drug	$678

Collapsed Rider Options

Even with limiting health plan offerings to three core benefit packages and four riders (with two options each), there would still be 240 combinations of core and riders that health plans could make available to beneficiaries. Some might argue that this represents too many confusing choices for beneficiaries. An alternative is to "collapse" rider options so there are fewer possible combinations. M+COs who wanted to offer rider options could only offer certain combinations of riders. This might also help to reduce the potential for adverse selection, particularly if drug riders were combined with one or more of the other rider benefits.

One possible criterion for rider options would be to base allowable offerings on combinations of the rider benefits currently offered by M+COs. Frequencies of rider benefits offered by all 96 M+CO plans and the 69 M+CO basic plans in 2001 suggest the following combinations of riders might be allowed:

- If only one benefit is offered, it could be drug benefits OR hearing benefits OR vision benefits (about 5 plans offered only one of these benefits).

- If only two benefits are offered, the rider could consist of a combination of drug & vision benefits OR hearing & vision benefits (12 percent offered the first combination; 4 percent offered the second combination; both would build on the above riders allowed).
- If only three benefits are offered, it could be drugs, hearing & vision benefits (7 percent of plans offered this combination; it is most prevalent among plans that offered only three of the rider benefits).
- If only four benefits are offered, it could be drugs, vision & preventive and comprehensive dental benefits, OR drugs, hearing, vision and preventive dental benefits (about 12 percent of plans offered one or the other combination).
- All five supplemental benefits could be offered (16 percent of basic and of all health plans offered all five enhanced benefits).