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Actuarial Issues Involved in Evaluating a Guaranteed Standard Benefit Package Under Health Care Reform

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The American Academy of Actuaries is a national organization formed in 1965 to bring together into a single entity actuaries of all specialties within the United States. In addition to setting qualification standards and standards of actuarial practice, a major purpose of the Academy is to act as the public information organization for the profession. Academy committees regularly prepare testimony for Congress, provide information to congressional staff and senior federal policy makers, comment on proposed federal regulations, and work closely with state officials on issues related to insurance.

This monograph provides an analysis of the actuarial issues critical to the design of a guaranteed benefit package. The Academy's 10-member Guaranteed Standard Benefit Package Work Group prepared this monograph. Collectively, the work group has over 150 total years of experience in the design and pricing of health insurance plans.

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Introduction

A set of standardized, uniform benefit packages is a necessary element of any comprehensive national health care reform proposal that is based on the managed competition model. They are packages of health insurance coverage mandated by the federal government and are intended to control cost, facilitate comparison among plans, and ensure a minimum level of coverage. A package consists of a list of health care services required to be covered, along with limitations on reimbursement such as copayments, maximum reimbursement, and exclusion of coverage for certain procedures. Another key element of a package is the type and extent of managed care that is included.

This monograph addresses the actuarial issues involved in evaluating the design of guaranteed standard benefit packages, with a particular focus on the packages outlined in the Clinton Administration's proposal of 1993. This proposal describes three benefit packages: (1) a low cost-sharing plan with per-service copayments, (2) a high cost-sharing plan with an annual deductible, and (3) a combination plan to be used with a network of providers whose services are covered at the low cost-sharing level while services from out-of-network providers are covered at the high cost-sharing level.

We have not addressed issues of cost estimation or health plan pricing except insofar as they directly relate to benefit design. Those issues, along with other issues related to health care reform, are addressed in monographs prepared by other work groups of the American Academy of Actuaries.

Some of the questions addressed in this monograph are the following:

- What are the advantages and limitations of a defined package?
- What are the components of a package of medical benefits?
- What are the pros and cons of some possible variations in those components?
- What other issues do actuaries consider in designing a package of medical benefits?

This monograph does not directly answer public policy questions—the critical social choices that elected officials invariably have to make concerning what to provide, who will pay, and how to balance the needs of different groups. The value of the actuarial profession's contribution to the health care debate lies in our objective expertise and our ability to articulate the technical means of achieving public policy objectives.

It is our intention to offer technical suggestions that will enable policy makers to design a health care package that provides incentives to use health care wisely. The benefit package should be designed to encourage the efficient delivery of necessary medical care and to discourage inefficiency and unnecessary care. At the same time, administrative burdens should be as light as possible on providers and consumers of medical care, so that their time can be spent on health improvement instead of administrative work.

Advantages and Limitations of a Guaranteed Standard Benefit Package

There are several advantages to requiring every health plan to offer a set of guaranteed, standardized health care packages. First is the security of continuous and uniform coverage upon change of employment or residence. Second, a uniform federal package of benefits assists in the evaluation of each plan's enrolled population for health risk factors, which are used to develop risk adjustment factors. Third, standardization eliminates the need for 50 states to make separate decisions on benefit design and enables states to integrate health care reform more effectively with neighboring states. Fourth, it makes choice simpler and easier for the individuals and employers, because there are only a few standard packages, and they will not change very frequently.

There are also some limitations to using guaranteed standard benefit packages. If very specific, they are likely to generate intense controversy and debate over which benefits and providers will be covered. If more vague, they will be open to different interpretations by different health plans, which could lead to benefit differentiation, antiselection, and increased total cost of providing coverage.

A switch to guaranteed benefit packages will take away most of the choice of coverage that is available today in the individual and group health insurance markets. Individuals and groups who currently have chosen plans with

high deductibles or limited benefits for a reduced premium would be likely to see a significant increase in their premium rate as their coverage is increased.

Uniform benefits will also put an end to experimentation with different levels of coverage, which in turn will prevent the development of cost-saving or quality-enhancing changes in the benefits. Much of the reduction in cost as a result of advances in managed health care would not have been possible if a uniform benefit design had been mandated 20 years ago.

Also, the process of benefit design will become part of a national political process, with the resulting loss of speed and flexibility in updating the design.

Analysis of Benefit Package Components

The monograph reviews the design of each component of a standard benefit package. Subsections include a description of the most common current coverage levels; and a review of managed care provisions, cost sharing provisions, preventive care, hospital benefits, physician benefits, prescription drugs, and mental health benefits.

Current Coverage Levels

One important aspect of a transition to guaranteed benefit packages is the degree of change that people will experience when switching from their current package to the mandated one. This is extremely difficult to assess, given the myriad combinations of benefit offerings, covered services, reimbursement arrangements, and provider networks available in the group and individual health insurance marketplaces today.

Currently, cost sharing in health plans ranges from almost none (usually in very large employer groups) to plans with high cost-sharing elements, which are prevalent in the small group and individual markets. There is substantial variation by geographic region. Health maintenance organizations (HMOs) have penetrated many metropolitan markets, whereas fee-for-service (FFS) plans are still the leading coverage available in rural areas.

Any standard benefit package will serve to limit or exclude what is currently available to some today. However, in general, the package defined by the Clinton Administration's proposal would increase the amount of coverage (and its cost) for small groups and individuals.

Managed Care Provisions

Managed care includes any of a wide variety of health insurance practices of insurance carriers and HMOs that influence the cost and quality of health care services, including large case management, preadmission certification, preventive services, utilization review, and incentives to receive medical care from specified providers. This section deals with the three major established mechanisms to deliver managed care: HMOs, preferred provider organizations (PPOs) and point-of-service (POS) plans, enumerating their key features and commenting on aspects of the Clinton Administration's proposal that differ from the most common currently available benefit packages. This is a brief and simplistic overview of a very complex set of systems, in which the lines separating HMOs, PPOs, and POS plans are often blurred.

In terms of level of integration of the delivery of health care, HMOs vary from highly restrictive staff models to less restrictive network or individual practice association (IPA) models. Many HMOs finance care on a prepaid basis transferring a substantial amount of financial risk to providers. Most HMO plans offer coverage that is similar to the lower cost-sharing benefit plan included in the Administration's proposal, often with even less cost-sharing. In general, HMO plans do not cover out-of-network care except for emergencies. Given the historical ability of these HMOs to deliver lower cost-sharing plans at competitive prices, we believe that the availability of a pure HMO plan, without out-of-network benefits (except emergency services), should be a key element of a set of guaranteed standard benefit packages under health care reform.

PPOs generally consist of a selectively contracted network of physicians and hospitals that accept a discounted payment. Covered individuals choose between in-network and out-of-network care, with reduced benefits for out-of-network care. The typical PPO contracts with a larger proportion of available physicians than an HMO. PPOs typically manage care by a combination of utilization management, pre-authorization requirements, claims review processes and case management activities administered by the health insurer.

The typical PPO benefit package is similar in design to the combination package in the Clinton Administration's proposal, but both the in-network and the out-of-network cost sharing is usually at a higher level. For in-network

care deductibles, coinsurance and stop loss are part of the coverage. The out-of-network benefits have higher coinsurance, higher stop loss, and frequently higher deductibles than the in-network plan, which encourages subscribers to use network providers.

As currently designed, the Clinton Administration's proposal does not offer a standard benefit package similar to ones offered by most PPOs. We recommend that the combination plan be modified to allow much higher cost sharing for both in- and out-of-network coverage.

POS plans are the most recently developed type of managed care plan. POS plans are typically organized around an existing HMO network. The typical POS plan resembles the combination package in the Administration's proposal, although the out-of-network cost sharing is frequently at a higher level. The POS plan offers the managed care cost reduction of an HMO with the availability of out-of-network care, at a reduced coverage level.

POS plans are complicated plans to design and administer because of the need to manage and balance both in-network and out-of-network services and costs. Out-of-network benefits can add from 5% to 25% or more to the cost of the HMO plan, depending on the cost-sharing provisions, the provider fee schedules, and the utilization controls that apply to in-network and out-of-network care. Utilization controls on out-of-network care are likely to be far less effective than those on in-network care. We recommend that another package be permitted, with generous coverage for in-network services and higher cost-sharing for out-of-network services.

Cost-Sharing Provisions

Under most guaranteed standard benefit packages, individuals will share in the cost of their health care by paying a portion of the cost of the care they receive as well as a portion of the premium. The most common cost-sharing features are deductibles, coinsurance, and copayments.

The choice between higher and lower cost-sharing options will be influenced by health status as well as financial considerations. Healthy subscribers will choose the option with lower premiums, in general. Less healthy subscribers will tend to choose the option that covers their personal physician. Risk adjustment can partially, but not entirely, eliminate the effect of this potential antiselection.

Selection against either the higher or lower cost-sharing package could lead to very high premiums for some benefit packages, under a premium spiral. A premium spiral can occur as a result of the cumulative effect of antiselection leading to higher claim costs and premiums, which would cause more antiselection.

Under the Administration's proposal, deductibles, copayments, out-of-pocket limits and premium caps will be indexed by the Consumer Price Index (CPI) plus a specified amount in each year.

These limits have an effect on the cost of the package, in a way that is described as "leveraging." Since historically the medical CPI has been much higher than the general CPI, premiums allowed under the premium caps may become inadequate for some health plans unless they can obtain significant cost reductions. Because of the effect of leveraging on the value of cost-sharing elements, the inadequacy in premium caps may become even greater than the difference between health care cost increases and the above limits.

Mental Health Benefits

This section addresses actuarial issues of mental health coverage in a guaranteed benefit package. For a more detailed discussion and conclusions of these issues, see the monograph prepared by the Academy's Mental Health Work Group.

The significant actuarial issues of mental health benefit design can be divided into the following categories: (1) levels of coverage, (2) cost impact of different benefit designs, and (3) level of detail in the description.

One challenge in designing managed mental health benefits, just as in other types of benefits, is balancing consumer choice with the cost savings of limited provider networks. Although our society favors free choice of doctors by patients, and free choice of providers to join managed care organizations or to practice independently, from an actuarial point of view the greatest cost savings come in an environment that limits those choices.

Another challenge in designing mental health benefits is evaluating the social costs of limiting coverage. Although actuaries do not include this cost in their premium projections, the following areas of social cost must be considered in evaluating the benefit limitations and cost sharing for mental health services in a guaranteed benefit package:

- Lost productivity from those who forgo treatment;
- Antisocial acts by those who forgo treatment;
- Increased cost of treating physical symptoms related to untreated mental illness;
- Increased use of other social benefits, such as welfare and law enforcement; and
- Pain, suffering, and even death resulting from lack of treatment.

The concept of trading benefits is part of the "continuum of care" concept, which may lead to more flexible and appropriate care, but could result in unnecessary utilization of care. Substitution of benefits has in some cases resulted in reduced cost and appropriate treatment and significant shifting from inpatient settings to outpatient settings (in combination with advances in medical treatment of mental illness, particularly in drug therapy). However, substitution of benefits must be effectively managed and monitored by an appropriate professional in charge of treating the patient to be cost effective and medically effective.

One general issue of a standard benefit package is the level of detail that is prescribed. If a package is not described in detail in the enabling legislation, the power to determine the details must be delegated to a board or commission, to the states, or to the health care plans. Some issues that are particularly important when defining a mental health benefit in detail are described below.

Since treatment plans can vary widely, it is important that definitions are worded clearly, leaving little to interpretation. For example, a "visit" should be stated in units of time, such as 30 minutes.

The benefit package should not be so detailed and inflexible that it prevents discovery and implementation of advances in the treatment of mental illness.

Acute inpatient treatment facilities must be defined, and perhaps licensed, separately from custodial care and short-term residential care facilities. On-site visits may be needed to determine which license to grant to each facility. Intensive nonresidential treatment must be defined and distinguished from outpatient psychotherapy. Without consistency in these definitions, the total cost of providing benefits in the package could be much more difficult to evaluate.

Group therapy could have a lower copayment in order to reduce premium cost while providing effective care. However, the decision on type of therapy should still be made by a qualified provider in consultation with the patient. Substance abuse services should be defined and distinguished from other mental health services. From an actuarial cost standpoint, although there are many people who suffer from substance abuse in combination with other mental illnesses, enough differences occur to justify segregating the benefit limitations that apply to substance abuse.

Conclusions

Designing a guaranteed standard benefit package within a limited health care budget is not an easy task. The ultimate design will depend upon the ability to balance the desire to provide affordable coverage to all with the reality of limited funding. Limited funding may require limiting health coverage, in order to help answer the key questions facing policy makers: (1) What coverage can we provide? (2) To whom can we provide it? (3) Who is willing to pay for it?

The type of managed care that is used is a key consideration in the benefit design. The levels of coverage in the package interact with the delivery system, and unintended consequences could result if the two are not carefully coordinated. In some systems, such as HMOs, PPOs, and POSs, choice of physician or hospital may be limited to those associated with the health plan, but the benefits may be as good or better than those provided by a traditional FFS system for the same cost. The different levels of cost sharing for in-network treatment versus out-of-network treatment in a PPO or POS plan are critical to the success of the benefit package. Cost control is achieved through discounts or other payment arrangements with the network providers, such as capitated reimbursement, and through controls on utilization of services. State Medicaid programs and the federal Medicare program are experimenting more and more frequently with providing coverage through HMOs.

It is also important to plan for periodic updates. The benefit package must be able to evolve, because the means of providing high-quality health care in the most cost-effective manner are still evolving.

If the American public is not willing to pay the cost of a benefit package as rich as the Clinton Administration's proposal, a leaner, lower premium package with basic safety-net coverage is an initial alternative. It is easier and less risky to enrich lean benefits after cost-saving goals have been achieved than to reduce rich benefits if the cost-saving goals are not being achieved.

INTRODUCTION

A set of standardized, uniform benefit packages is a necessary element of any comprehensive national health care reform proposal that is based on the managed competition model. They are packages of health insurance coverage mandated by the federal government and are intended to control cost, facilitate comparison among plans, and ensure a minimum level of coverage. A package consists of a list of health care services required to be covered, along with limitations on reimbursement such as copayments, maximum reimbursement, and exclusion of coverage for certain procedures. Another key element of a package is the type and extent of managed care that is included.

This monograph addresses the actuarial issues involved in evaluating the design of guaranteed standard benefit packages, with a particular focus on the benefit packages outlined in the Clinton Administration's proposal of 1993. This proposal describes three packages: (1) a low cost-sharing plan with per-service copayments, (2) a high cost-sharing plan with an annual deductible, and (3) a combination plan to be used with a network of providers whose services are covered at the low cost-sharing level while services from out-of-network providers are covered at the high cost-sharing level. Other major health care reform proposals at the federal level require that a guaranteed standard benefit package be provided, but most do not specify the package; instead they suggest forming a commission or board to set the guaranteed standard benefit package.

We have not addressed issues of cost estimation or health plan pricing except insofar as they directly relate to benefit design. Those issues, along with other issues related to health care reform, are addressed in papers prepared by other work groups of the American Academy of Actuaries.

Some of the questions addressed in this monograph are the following:

- What are the advantages and limitations of a defined package?
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- What other issues do actuaries consider in designing a package of medical benefits?

This monograph does not directly answer public policy questions—the critical social choices that elected officials invariably have to make concerning what to provide, who will pay, and how to balance the needs of different groups. The value of the actuarial profession's contribution to the health care debate lies in our objective expertise and our ability to articulate the technical means of achieving public policy objectives.

It is our intention to offer technical suggestions that will enable policy makers to design a health care package that provides incentives to use health care wisely. The package should be designed to encourage the efficient delivery of necessary medical care and to discourage inefficiency and unnecessary care. At the same time, administrative burdens should be as light as possible on providers and consumers of medical care, so that their time can be spent on health improvement instead of paperwork.

ADVANTAGES AND LIMITATIONS OF A GUARANTEED STANDARD BENEFIT PACKAGE

Under the Clinton Administration's proposal, every health plan must offer a set of guaranteed comprehensive health care packages.

There are several advantages to this approach. First is the security of continuous and uniform coverage upon change of employment or residence. This approach eliminates the change of health benefits as an issue in a worker's loss or change of employment and provides portability across state lines.

Second, a uniform federal package of benefits assists in the evaluation of each plan's enrolled population for health risk factors, which are used to develop risk adjustment factors. After risk adjustment, it also provides a benchmark by which to measure cost containment effectiveness and administrative efficiencies among health plans within a region, among regions, and among states. Third, standardization eliminates the need for 50 states to make separate decisions on benefit design and enables states to integrate health care reform more effectively with neighboring states. Fourth, it makes choice simpler and easier for the individuals and employers, because there are only a few standard packages, and they will not change very frequently.

Finally, standard benefits may reduce administrative costs for employers, because of standardized benefits design. Also, some functions, such as medical benefit communication and negotiation, will be assumed by health alliances in the Clinton Administration's proposal, although the cost for this will be included in the premiums.

There are also some limitations to using guaranteed standard benefit packages. If very specific, they are likely to generate intense controversy and debate over which benefits and providers will be covered. If more vague, they will be open to different interpretations by different health plans, which could lead to benefit differentiation, antiselection, and increased total cost of providing health care coverage.

A switch to guaranteed standard benefit packages will take away most of the choice of coverage that is available today in the individual and group health insurance markets. Individuals and groups who currently have chosen plans with high deductibles or limited benefits for a reduced premium would be likely to see a significant increase in their premium rate as their coverage is increased.

Uniform benefits will also put an end to experimentation with different levels of coverage, which in turn will prevent the development of cost-saving or quality-enhancing changes in the benefits. Much of the reduction in cost as a result of advances in managed health care would not have been possible if a uniform benefit design had been mandated 20 years ago.

Also, the process of benefit design will become part of a national political process, with the resulting loss of speed and flexibility in updating the design.

ANALYSIS OF BENEFIT PACKAGE COMPONENTS

Current Coverage Levels

One important aspect of a transition to guaranteed benefit packages is the degree of change that people will experience when switching from their current package to the mandated one. This is extremely difficult to assess, given the myriad combinations of benefit offerings, covered services, reimbursement arrangements, and provider networks available in the group and individual health insurance marketplaces today.

Currently, cost sharing in health plans ranges from almost none (usually in very large employer groups) to plans with high cost-sharing elements which are prevalent in the small group and individual markets. There is substantial variation by geographic region. Health maintenance organizations (HMOs) have penetrated many metropolitan markets, whereas fee-for-service (FFS) plans are still the leading coverage available in rural areas.

Any standard benefit package will serve to limit or exclude what is currently available to some today. Many large employer groups currently dictate not only the benefit design and network configurations they desire, they also tailor the services and/or conditions they cover for their employees. However, in general, the benefit package defined by the Clinton Administration's proposal would increase the amount of coverage (and its cost) for small groups and individuals.

Clinical Preventive Services

Some or all of these services are standard offerings for HMO plans, whereas they are often not covered in full under non-HMO plans.

A benefit package of preventive services has recently become a popular optional benefit for group and individual coverage, resulting from the current emphasis on wellness and a healthy lifestyle. One of the selling points for covering these services is the claimed savings in health care costs. There is little experience data available to demonstrate such "savings" in the absence of managed care, whereas some empirical evidence points to a perhaps short-term increase in premium cost to cover many of these services. The social benefits of such coverage are difficult to evaluate quantitatively.

Mental Health and Substance Abuse

Coverage for psychiatric conditions is available in most group health plans, but is less prevalent in individual insurance. Coverage is usually limited to a specified number of days per year for inpatient services, with an annual dollar limit for outpatient services. Insurance companies and self-funded employers have added such limits, in the absence of strong utilization review and case management programs, to control utilization.

The Academy's Mental Health Work Group has addressed mental health issues in another monograph.

Outpatient Prescription Drugs

Coverage of prescription drugs is a standard offering in most health plans today. There are usually separate copayments for brand name and generic drugs, with the dollar difference in the copays substantial enough to encourage use of less costly generic drugs. Some plans require even higher copays when filling prescriptions with brand name drugs that have generic equivalents.

Dental/Health Education Classes

Dental coverage is sometimes offered to medium and large groups, either in conjunction with medical coverage or without. Dental coverage is a less frequent offering for smaller groups, and is usually offered only in conjunction with medical coverage. Due to the high cost of medical coverage, dental coverage is sometimes viewed as a luxury, particularly for smaller groups. Because of the high predictability of claims on the part of the insured, dental coverage is rarely, if ever, offered in individual policies. Providing dental coverage will substantially increase the cost of a benefit package.

Dental benefits usually have annual visit limits for oral exams, X-rays, etc., which do not appear in the Administration's proposal for coverage of children. In addition, orthodontia usually has annual and/or lifetime dollar limits, since orthodontics in some cases is considered cosmetic rather than medically necessary.

Health education classes are rarely, if ever, covered in today's market.

Investigational Treatments

Investigational treatments are not usually covered by health insurers or HMOs. Coverage for these services under the Clinton Administration's proposal is at the discretion of the health plan, as described in Section 1128 of the legislation, meaning that there will be variations on the "standard" benefits package. Discretionary coverage could open up a plan to antiselection. Also, coverage of such treatments could generate additional medical costs from complications, if the treatments are not safe or efficacious.

We suggest consideration of a uniform national definition of investigative and experimental treatment, perhaps as part of a detailed study of medical necessity.

Other Services

Coverage for hospital and physician services is universally included in health plans today. The deductible and coinsurance percentages in the Clinton Administration's proposal are consistent with current offerings.

Managed Care Provisions

Managed care includes any of a wide variety of health insurance practices of insurance carriers and HMOs that influence the cost and quality of health care services, including large case management, preadmission certification, preventive services, utilization review, and incentives to receive medical care from specified providers. Managed care encompasses a wide spectrum of practices. At one end of the spectrum are open access FFS health insurance plans that incorporate moderate utilization and cost controls. At the other end are staff model HMOs, which influence utilization and cost through closed provider panels and the use of physician gatekeepers. This section deals with the three major established mechanisms to deliver managed care: HMOs, preferred provider organizations (PPOs), and point of service plans (POS), enumerating their key features and commenting on aspects of the Clinton Administration's proposal that differ from the most common currently available benefit packages. This is a brief and simplistic overview of a very complex set of systems, in which the lines separating HMOs, PPOs, and POS plans are often blurred.

Health Maintenance Organizations

Historically, HMOs are the oldest mechanism to deliver managed health care, with a well-known example being Kaiser-Permanente Health Plan, founded in California in 1943. HMOs currently provide coverage to 47 million people, according to the Marion Merrell Dow Managed Care Digest (updated edition).

In terms of level of integration of the delivery of health care, HMOs vary from highly restrictive staff models to less restrictive network or individual practice association (IPA) models. HMOs generally manage care through relatively small panels of physicians, supported by systems that support cost-efficient care and eliminate redundant services. Many HMOs finance care on a prepaid basis, transferring a substantial amount of financial risk to the providers. Management of care in HMOs is generally driven by the physicians in the HMO, with less reliance on utilization review and other management activities than found in PPO or traditional FFS plans. Most HMO plans offer coverage that is similar to the in-network coverage in the lower cost-sharing benefit plan included in the Administration's proposal, often with even less cost sharing. HMOs often offer these plans to large groups in competition with FFS plans that have coverage similar to the higher cost-sharing plans in the Administration's proposal. HMOs sometimes deliver a greater scope of coverage at a lower cost than FFS or PPO plans.

Although HMOs are generally considered by actuaries to be effective at reducing cost for medical coverage, the difficulty of measuring the amount of antiselection (the degree to which healthier people have a tendency to choose one plan over another) makes it difficult to evaluate the true relative cost of plans in a multiple-choice situation.

In general, HMO plans do not cover out-of-network care except for emergencies. Including out-of-network benefits in an HMO plan turns it into a POS plan, which is explained further below.

Given the historical ability of these HMOs to deliver lower cost-sharing plans at competitive prices, we believe that the availability of a pure HMO plan, without out-of-network benefits (except emergency services), should be a key element of guaranteed benefit packages under health care reform.

Preferred Provider Organizations

PPOs originated in the early 1980s, and generally consist of a selectively contracted network of physicians and hospitals that accept a discounted payment on a fee-for-service basis. Covered individuals choose between in-network and out-of-network care, with reduced benefits for out-of-network care. The typical PPO contracts with a larger proportion of available physicians than an HMO. PPOs currently provide coverage to 58 million people, according to the Marion Merrell Dow Managed Care Digest (updated edition). PPOs typically manage care by a combination of utilization management, pre-authorization requirements, claims review processes, and case management activities administered by the health insurer. These same managed care techniques are often applied to traditional FFS plans. The application of the managed care techniques by health insurers frequently results in criticism from health care providers. However, these procedures, together with selected contracting, provide more affordable health care plans and are more cost effective than traditional FFS plans.

The typical PPO benefit package is similar in design to the combination package in the Clinton Administration's proposal, but both the in-network and the out-of-network cost sharing is usually at a higher level. For in-network care deductibles, coinsurance and stop loss are part of the coverage. The out-of-network benefits have higher coinsurance, higher stop loss, and frequently higher deductibles than the in-network plan, which encourages subscribers to use network providers.

As currently designed, the Clinton Administration's proposal does not offer a benefit package similar to the most common PPO plans currently available.

We recommend that the Clinton Administration's combination plan be modified to allow much higher cost sharing for both in- and out-of-network coverage.

Point-of-Service Plans

POS plans are the most recently developed type of managed care plan. They became widely available in the market around 1989. POS plans are typically organized around an existing HMO network. They currently provide coverage for 6.8 million people, according to the Marion Merrell Dow Managed Care Digest (updated edition).

The typical POS plan resembles the combination package in the Clinton Administration's proposal, although the out-of-network cost-sharing is frequently at a higher level. The POS plan offers the managed care cost reduction of an HMO with the availability of out-of-network care at a reduced coverage level. We recommend that another package be permitted, with generous coverage for in-network services, and higher cost-sharing for out-of-network services.

Combination plans are complicated plans to design and administer because of the need to manage and balance both in-network and out-of-network services and costs. Potential conflicts exist regarding management of care by a subscriber's in-network personal physician when care is rendered by an out-of-network physician. Adjusting the level of out-of-network benefits limits these problems. Out-of-network benefits can add from 5% to 25% or more to the cost of the HMO plan, depending on the cost-sharing provisions, the provider fee schedules, and the utilization controls that apply to in-network and out-of-network care. Utilization controls on out-of-network care are likely to be far less effective than those on in-network care. Requiring coverage for care from providers that are not affiliated with the HMO also increases administrative costs for the plan.

The current Clinton Administration proposal has raised the issue of the level of out-of-network benefits available in all three managed care plans. Out-of-network benefit levels need to vary by type of managed care plan to ensure that they do not add unacceptable costs. This is a significant issue that should be reexamined, and strong consideration should be given to providing greater flexibility to health plans on this issue.

Conclusions

As stated above, we believe that the availability of a pure HMO plan, without out-of-network benefits (except emergency services), should be a key element of guaranteed benefit packages under health care reform.

We also recommend that the Clinton Administration's combination plan be modified to allow higher cost sharing for both in- and out-of-network coverage. We also recommend that another package be permitted, with generous coverage for in-network services, and higher cost sharing for out-of-network services.

The level of out-of-network benefits is a significant issue that should be re-examined, and strong consideration should be given to providing greater flexibility to health plans on this issue.

Cost-Sharing Provisions

Under most guaranteed standard benefit packages, individuals will share in the cost of their health care by paying a portion of the cost of the care they receive as well as a portion of the premium. The most common cost-sharing features are deductibles, coinsurance, and copayments.

In addition to paying the deductibles, coinsurance, and copayments under their benefit plan, individuals must pay a share of the premium for that plan. An employee's share of the premium is the premium for the plan chosen less the employer's contribution. Under the Clinton Administration's proposal, the employer contributes 80% of the weighted average premium for the higher cost-sharing standard benefit package offered by the regional alliance health plans (RAHPs), weighted by relative enrollment among RAHPs.

The choice between higher and lower cost-sharing options will be influenced by health status as well as financial considerations. If the lower cost-sharing option has lower premiums and if the network for the lower cost-sharing plan is extremely restrictive, then it is likely to attract a healthier pool of subscribers. However, if the premium (or the employee portion) for the lower cost-sharing package is much higher, the reverse effect is likely. Risk adjustment can partially, but not entirely, eliminate the effect of this potential antiselection.

Selection against either the higher or lower cost-sharing package could lead to very high premiums for some packages, under a premium spiral. A premium spiral can occur as a result of the cumulative effect of antiselection leading to higher claim costs and premiums, which would cause more antiselection.

Under the Clinton Administration's proposal, deductibles, copayments, out-of-pocket limits, and premium caps will be indexed by the Consumer Price Index (CPI) plus: 1.5% in 1996, 1.0% in 1997, 0.5% in 1998, and 0.0% in 1999.

These limits have an effect on the cost of the health plan, in a way that is described as "leveraging." If the rate of increase in medical costs is equal to or lower than these limits, then the cost of the plan will increase at a rate equal to or lower than the limits. However, if medical costs increase faster than the limits, then the value of the cost-sharing elements will lag behind the value of the benefits, accelerating the cost increase to the health plan.

Since historically the medical CPI has been much higher than the general CPI, premium caps may become inadequate for some health plans unless significant cost reductions can be obtained and sustained. Because of the effect of leveraging on the value of cost-sharing elements, the inadequacy in premium caps may become even greater than the difference between health care cost increases and the above limits.

Note that cutting back the standard benefit package will not necessarily provide a solution if costs cannot be contained. The indexing factor for the premium cap is also adjusted for changes in benefits. However, this approach may be helpful in reducing utilization, especially if a particular category of benefits is driving the overall cost increases in the plan (for example, mental health or prescription drugs).

Under the Clinton Administration's proposal, employees will pay their deductibles, coinsurance, and copayments with after-tax dollars because of the elimination of health flexible spending accounts (cafeteria plans). This should make employees more responsive to health care costs and produce additional tax revenue to fund subsidies. This change in tax treatment will also increase out-of-pocket costs, all other things being equal.

Preventive Care

Coverage for preventive services is generally intended to encourage healthy lifestyles and to facilitate early detection of illness or disease. Many FFS plans exclude coverage of preventive services or provide coverage subject to the annual deductible and coinsurance amounts. In contrast, HMOs often include coverage at 100% or at low copayment levels to encourage use of services.

In anticipation of the positive effects associated with providing coverage for certain preventive services, several states have mandated coverage of these benefits.

Plan Design

Covered services in a preventive benefit package typically include prenatal visits, well-baby and well-child visits, adult and child routine physical examinations, mammography screening, and immunizations. To reduce costs, there may be a relatively low maximum on reimbursement for certain services in a calendar year.

Additional categories that may be included under a preventive benefit package include:

- Education on preventing disease and injury covering:
  —the risk of overdose of nonprescription medicines,
  —the risk of mixing alcohol and medicines, and
  —healthy lifestyles (i.e., exercise, diet, smoking cessation, avoiding drug and alcohol abuse, weight control, use of seat belts, and blood pressure monitoring);
- Health risk appraisal or health hazard appraisal to identify risk factors and help prevent illness and injury; and
- Employer-provided on-site fitness center.

Effectiveness

The effectiveness of specific preventive benefit programs is difficult to measure. It will take many years to determine the advantages of most of these preventive services.

Generally, preventive care coverage is intended to accomplish two objectives:

- Saving dollars through early detection and treatment of illnesses, and
- Improving the population's health status.

The results of preventive programs occur over an extended time period. There is very little experience data available with which to measure the results, and it is difficult to separate results achieved through preventive benefit coverage from results that may have been obtained through societal and behavioral changes.

There is no doubt that early detection of disease may help deter the onset of serious illness through education and treatment. In addition, coverage of preventive services can also have positive effects on areas other than medical expense costs, such as rates of absenteeism and employee productivity. However, the cost associated with providing coverage for these benefits generally ranges between 2% and 5% of premium, depending on the underlying coverage levels. Additionally, an overall improvement in the health of the population will lead to increased life expectancy, which will presumably have the advantage of a longer, more productive life, but which could result in greater medical costs or accrual of the same costs over an extended time period.

Excess utilization can result from 100% coverage of any benefit that can be patient- or provider- initiated. This can be discouraged to some extent through consumer education and by the provider sharing in the financial risk.

Administration's Proposal

Under each of the basic package designs, the Administration's proposal requires first dollar coverage for clinical preventive services with some limitations. Coverage is required for adult periodic medical examinations (once every three years for individuals aged 20 to 39, once every two years for individuals aged 40 to 65, and annually for individuals aged 65 or more), prenatal care, well-baby and well-child care, pap/pelvic examinations, mammograms, and targeted immunizations and screening tests for high-risk individuals. In addition, prevention and diagnosis of dental disease is provided initially only for children under the age of 18.

Hospital Benefits

Inpatient and outpatient hospital benefits are required components of most health insurance today. Included in inpatient hospital benefits are hospital room and board, as well as operating room facilities, hospital staff services, testing, and other ancillaries. Included in outpatient hospital benefits are emergency room services, ambulatory care, outpatient surgery facilities, radiology and pathology services, and testing performed outside a physician's office. According to "Current Trends in Health Care Costs and Utilization" (Mutual of Omaha's Group Actuarial Annual Report), hospital benefits can account for 40% to 55% of typical benefit package costs, mainly driven by the high cost of each hospital stay. Because hospital benefits are such a large percentage of health care costs, minimizing the cost of a benefit package that includes hospital benefits requires carefully designing a program with specific procedures for controlling hospital costs and utilization and hospital reimbursement mechanisms that encourage efficient delivery of hospital services.

Plan Design

There are a variety of plan designs for hospital benefit coverage, including monitoring procedures, such as utilization review programs, for controlling inpatient hospital admissions and lengths of stay. Utilization review programs can include pre-authorization before hospital admission, concurrent review of the number of authorized days, and/or retrospective review to deny excessive days or to authorize emergency hospital admission. Typically, there are penalties for not complying with a plan's utilization review requirements. Individual case management for catastrophic conditions, such as liver transplants and head injuries, can be especially effective in controlling costs and utilization. Use of outpatient hospital facilities is sometimes monitored by an outpatient precertification utilization review program, but this type of program is less common. Many of the current pre-authorization and utilization review procedures will not be needed under a more intensive managed care environment. The removal of these procedures will save significant administrative expenses for both the providers and the plan administrators.

Hospital benefit cost sharing varies by type of plan. Many conventional fee-for-service plans require a 20% copayment after payment of the comprehensive annual plan deductible (commonly between $100 and $300), which can lead to significant out-of-pocket costs for an individual who has an inpatient hospital stay. This type of plan usually includes an out-of-pocket limit to provide a patient with protection in case of a catastrophic illness. Many PPO and POS plans provide 90% to 100% coverage for a hospital stay as long as a network hospital provider is used, but the patient pays a high deductible and possibly 20%, 30%, or 40% coinsurance if he/she uses a non-network hospital. HMO plans typically provide 100% coverage for inpatient hospital stays, although some HMO plans require a separate per admission deductible, which may range from $100 to $500. Outpatient hospital care, such as outpatient surgery, emergency room, and ambulatory care, is typically covered the same as inpatient treatment care in FFS and PPO plans, although use of outpatient rather than inpatient facilities is sometimes encouraged by waiving deductibles and coinsurance. Outpatient hospital care in HMO plans (and also in some FFS plans) is typically covered at 100% after a copayment. Also, nonemergency use of the emergency room sometimes requires a penalty copayment. Other cost-sharing provisions for hospital benefits exist and generally require a higher degree of cost sharing by the patient.

The Medicare diagnosis related group (DRG) reimbursement system represents a far-reaching effort to contain hospital costs. This system reimburses hospitals a specific dollar amount (adjusted by geographic and intensity factors) based on the type of inpatient hospital stay. All hospital stays are classified by a DRG, and levels of reimbursement are determined annually. As with any simplified system, there is a risk of offering providers an incentive not to care for the sickest patients in each category. Some health insurance plans for non-Medicare beneficiaries have been designed to pay for inpatient hospital care only up to a specified percentage of the DRG limit.

Utilization

Many health plans have already made significant progress in reducing the number and length of hospital stays. Not all hospital stays can be avoided, although many more could be prevented by long-term practice of a healthy lifestyle and appropriate use of new procedures. For this reason, plan design features such as cost sharing (at least at the current typical levels) may have a limited impact on the use of hospital services. Negotiating favorable hospital reimbursement rates and including hospital utilization controls can significantly contain a health plan's hospital expenditures.

A key driver of hospital utilization is the physician, since most hospital admissions are controlled by the patient's physician. Because health care costs have risen faster than the general rate of inflation, physicians have been encouraged by utilization review programs or more directly through risk-sharing arrangements to make more cost conscious choices regarding the need to hospitalize their patients. Depending on the degree of influence the health plan has over the physician, wide variances in hospital days per 1,000 enrollees per year can be experienced. For example, the 1992 average inpatient hospital utilization for non-Medicare enrollees in PPOs was 330 days per 1,000 enrollees and for staff model HMOs was 291 days per 1,000, according to the 1993 Marion Merrell Dow Managed Care Digests (PPO and HMO editions). We do not have any way to determine the causes of this difference, which may be due to differences in medical treatment or differences in the health of the enrolled population.

Administration's Proposal

Two of the three plan design options in the Clinton Administration's proposal contain hospital coverage similar to the benefits described above that are commonly offered today.

The lower cost-sharing package provides 100% coverage for inpatient hospital services and requires a $10 copayment for most outpatient hospital services. To receive these benefits, all services must be provided in a network hospital. Currently, the proposal appears to require plans offering the lower cost-sharing package to offer an out-of-network alternative, although as much as 40% cost sharing might be required.

The higher cost-sharing package provides 80% coverage at any hospital, subject to satisfaction of an individual annual deductible of $200. The third plan design is a combination of the lower cost-sharing benefit for in-network care and the higher cost-sharing benefit for out-of-network care.

All plan alternatives include utilization review provisions, with penalties left as a decision for each health plan.

The combination plan in the Clinton Administration's proposal may not contain enough of a cost-sharing difference to encourage patients to use in-network care. Typical PPO plans today may have a generous in-network benefit, such as 100% or 90% coverage, but the out-of-network benefit is evolving toward a lower level of coverage, such as 60% to 70%. Although plans with 100% in-network and 80% out-of-network benefits still exist, there is a trend toward increasing cost-sharing differentials.

Also, the benefit levels of all three package options are on the generous side of the range of current benefits. If cost sharing is limited, hospital reimbursement rates will need to be reduced, and utilization review procedures and penalties will also need to be well defined in order to contain the hospital component of health care costs. The alternative, requiring a high level of cost sharing, such as 50% for hospital services or a limit on the number of inpatient days covered, would lower significantly the cost of the benefits package. However, it would have a negative impact in that more people would not be able to afford their share. Also, this could potentially lead to an increase in the level of uncompensated care provided by hospitals.

Conclusions

We consider the hospital benefits outlined in the Clinton Administration's proposal to be generous and typical of benefits provided under most group health insurance plans today. However, the cost will be high unless significant means of containing hospital costs are effective.

Some factors that affect the cost of hospital services are related less to plan design than to the ability of hospitals to become more efficient or to change the way they operate. Managing the cost of hospital services in some geographic areas will depend on the ability of a managed competition system to reduce the number of excess hospital beds and to redefine the types of covered services offered by some hospitals. For example, tertiary care may be most efficiently provided regionally rather than locally.

Under the Administration's proposal, it is assumed that hospital efficiencies will be achieved by encouraging health plans to reduce cost in a managed competition environment. Employer and government pressures to contain costs, health reform efforts in many states, and the prospect of national health reform have already forced many hospital providers to become more efficient or to close down.

Physician Benefits

Physician benefits generally include coverage for routine office visits (such as visits to a general practitioner or to an obstetrician/gynecologist) and the services of specialists such as surgeons and anesthesiologists in a hospital or office setting. Physician benefits can account for 20% to 40% of typical benefit package costs. Physician coverage is a critical component of a guaranteed standard benefits package, not only as an essential health care service but also for the key role that physicians play in the provision of all other health care services.

Plan Design

There are a variety of plan designs for physician benefit coverage. Generally, physician benefits are subject to a $5 to $15 copayment per office visit or are covered at 80% or 90% subject to satisfaction of an annual deductible. There is a trend in some HMO plans toward higher copayments of $20 or 50% of an office visit. It is common for HMOs and some PPOs to require that the primary care physician (a general practitioner, family practice physician or internist) serve as a gatekeeper to monitor all other health services received by a patient. Separate obstetrician/gynecologist and pediatrician gatekeeper physicians are also commonly allowed. Most of these plans require that the patient receive authorization from his or her primary care physician to be covered for any other health care services including prescription drugs, laboratory tests, visits to a specialist, and hospital admissions. Some plans exclude or limit services of specific types of specialties such as chiropractors and mental health providers. The Medicare program has recently developed a resource based relative value scale (RBRVS), which attempts to impose an objective evaluation of the appropriate payment for each procedure. Some insurance companies have started to model physician coverage after the Medicare program and cover benefits only up to the amount specified by the current RBRVS schedule or a multiple of the schedule.

Utilization

Utilization for physician benefits is typically described in the number of visits per 1,000 enrollees per year. Copayments for office visits have been shown to affect utilization, especially for low-income individuals. Small copayments for office visits, instead of requiring satisfaction of a deductible before coverage, may encourage overutilization; on the other hand, small copayments may result in the appropriate level of utilization of physician services, thereby preventing serious medical conditions from developing and ultimately saving costs. Costs for other benefits, such as prescription drugs, may increase because small copayments may encourage more frequent office visits.

Administration's Proposal

A key to the success of the lower cost-sharing package will be to involve the physician in managing care. Two of the three plan design options in the Clinton Administration's proposal contain physician coverage similar to the commonly offered benefits described above.

The lower cost-sharing package provides 100% coverage for office visits after a $10 copayment. In order to receive these benefits, all services must be provided by a network provider. Currently, the Administration's proposal appears to require health plans offering the lower cost-sharing package to offer an out-of-network alternative, although as much as 40% cost sharing might be required.

The higher cost-sharing plan provides 80% coverage for any physician, subject to satisfaction of the individual annual deductible of $200. The third package is a combination of the lower cost-sharing benefit for in-network physicians and the higher cost-sharing benefit for out-of-network physicians.

The Clinton Administration's proposal allows states to change the definition of health professionals whose services are covered. This may reduce health coverage costs if states allow health professionals other than licensed physicians, such as nurse practitioners, to perform more of the health care services. HMOs and some PPOs use primary care physician gatekeepers to monitor utilization of all health plan services and supplies. The use of a gatekeeper appears to be an effective way to control health plan costs and utilization, at least until practice guidelines are more widely available to plans.

Conclusions

We consider the physician benefits outlined in the Clinton Administration's proposal to be generous and typical of benefits provided under most health insurance plans today. We think that this level of benefits can be provided, but it is critical, at least initially, that the gatekeeper have incentives to control utilization and that penalties for not using the gatekeeper physicians be significant. In particular, we believe that the out-of-network benefits on the combination plan should have higher cost-sharing provisions than those in the high cost-sharing plan, and that the required alternative plan offered with the low cost-sharing plan should contain even higher out-of-network cost-sharing provisions.

Prescription Drugs

Prescription drug benefits are part of nearly every health insurance plan in the United States. The benefits of treating a wide variety of medical conditions with prescription drugs are well known. At the same time, a drug benefit design that allows for unlimited access to prescriptions at little or no cost to the patient can have adverse side effects on the overall cost of the plan.

Plan Design

There are many prescription drug plans now in use in the United States. At one end of the spectrum are the FFS plans that treat drugs as any other medical expense and generally treat all pharmacies equally. All patient costs must exceed the plan deductible before any benefits are paid. Benefits are paid subject to co-insurance up to the annual out-of-pocket maximum, after which all expenses are paid in full.

The use of prescription drug card programs is at the opposite end of the spectrum. These programs have become very common in both HMOs and FFS plans. With a drug card, a patient can obtain a supply of a drug, usually after paying a copayment or coinsurance, and may also take advantage of discounts negotiated between the pharmacy and the insurer or prescription drug service. Many of the drug card plans also encourage use of generic drugs by charging a lower copayment than for brand name drugs. Use of generic drugs can be encouraged through substantial dollar differentials between the brand name and generic copayments. Some plans require even higher copayments when obtaining brand name drugs that have generic equivalents, and some plans have introduced utilization review programs specifically for prescription drugs.

Utilization

Prescription drug expenses account for 7% to 15% of total health care costs for the population under age 65. There is lower utilization of prescription drugs in rural areas. Higher utilization often occurs with rich benefit plans in which access is easy through a drug card and little or no copayment is required. Prescription drug utilization may

also be higher in plans that encourage, through plan design, physician office visits. For several reasons, prescription drug costs may increase faster than health care costs as a whole. One such reason is the increasing acceptance of drug therapies to treat a growing number of chronic health conditions. As new products enter the market and receive government approval, the associated research and development costs are transferred to the health care financing system.

Administration's Proposal

There are three basic designs for prescription drug coverage in the Clinton Administration's benefit packages. The first is a flat $5 copayment per prescription, which is found in the in-network portion of both the low cost-sharing package and the combination package. The second design is a simple coinsurance payment, used in the out-of-network part of the low cost-sharing package. The percentage payment in this package has not been determined, but is expected to be at least 20%. The third design is used in the high cost-sharing package and the out-of-network portion of the combination package and consists of a separate deductible of $250 per individual per year, followed (presumably) by 20% coinsurance up to the annual out-of-pocket expense limit.

The copayment approach would appear to fit with the concept of low cost sharing, but greater cost savings could be achieved, as described in the conclusions section below. The prescription drug deductible and coinsurance in the high cost-sharing plan may be quite effective at curbing overutilization.

As discussed under PPOs and POS plans in the Managed Care Provisions section above, the level of cost sharing for out-of-network care is a significant issue that should be addressed.

Conclusions

The low cost-sharing plan should vary the prescription drug copayment to favor generic equivalents and ensure that the cost to the patient of the out-of-network benefit is always greater than that of the in-network benefit. Such a package design, with a $5 copayment or higher for generic drugs and $10 or higher for brand name drugs in-network, plus 40% coinsurance for out-of-network utilization, would significantly reduce unnecessary utilization and direct the necessary utilization to lower-cost in-network providers.

Mental Health Benefits

This section addresses actuarial issues of mental health coverage in a guaranteed benefit package. For a more detailed discussion and conclusions of these issues, see the monograph prepared by the Academy's Mental Health Work Group.

The significant actuarial issues of mental health benefit design can be divided into the following categories: (1) levels of coverage, (2) cost impact of different benefit designs, and (3) level of detail in the description.

Levels of Coverage

Mental Health Benefits under Managed Care. One challenge in designing managed mental health benefits, just as in other types of benefits, is balancing consumer choice with the cost savings of limited provider networks. Although our society favors free choice of doctors by patients and free choice of providers to join managed care organizations or practice independently, from an actuarial point of view the greatest cost savings come in an environment that limits those choices. The Administration's proposal recommends requiring a fee-for-service option in every HMO plan, but that greater level of choice may result in greater cost. On the other hand, that greater cost may be a good value if consumer choice is the driving force in the high quality of medical care in the United States, because of the incentive it gives to providers to compete for patients with high-quality care.

Another challenge in designing mental health benefits is evaluating the social costs of limiting coverage. Although actuaries do not include this cost in their premium projections, the following areas of social cost must be considered in evaluating the benefit limitations and cost sharing for mental health services in a guaranteed benefit package:

- Lost productivity from those who forgo treatment;
- Antisocial acts by those who forgo treatment;
- Increased cost of treating physical symptoms caused by untreated mental illness;
- Increased use of other social benefits, such as welfare and law enforcement; and
- Pain, suffering, and even death resulting from lack of treatment.

One concern that arises when designing a mental health benefit package within a managed care setting is the need to prevent "gaming" of the system by health plans. For example, plans might reduce the number and types of mental health care providers to discourage enrollment and utilization by those who need treatment. Coverage of detoxification services for substance abuse is one such area of concern. Many insurance plans and self-insured employers limit the number of detoxification treatments covered in an employee's lifetime, while some mental health advocates argue for unlimited coverage. In an actuarial analysis of a guaranteed benefit package, it is difficult to argue that removing coverage for detoxification services would be successful in either reducing the number of needed treatments or in shifting the cost from society to the patient. In fact, the cost to society could easily be expected to increase if care is postponed. Methods of reducing this cost include programs to prevent progression of the addiction to such a late stage or on outcomes research to guide physicians in determining the most effective treatment programs for different populations of substance abusers.

Responsibility for Treatment of Persons with Severe Mental Illnesses. Currently, most of the cost of treating the severely mentally ill is borne by states and paid for from their general revenues. Moving these persons into health plans at the community premium rate and charging for the inpatient care at retail per diem rates could increase this cost dramatically. Also, providing a detailed list of covered services could provide incentive for increased (perhaps unnecessary) utilization by the severely mentally ill. Any estimate of the increased cost would be subjective in nature, due to the lack of experience with this environment.

Impact of Copayments and Benefit Limits. Cost-sharing elements, such as copayments, deductibles, coinsurance, and benefit limits can hold down utilization and cost significantly by encouraging patient responsibility in evaluating the usefulness of treatment. This is important because medical necessity is difficult to determine in mental health treatment.

The use of copayments can be effective for the above purposes, however, only if it is not possible for providers to waive them. Benefit limits will be effective only to the extent that they encourage efficiency in taking advantage of care. Limits will actually increase the cost if they generate a perception of "entitlement" to the specified amount of treatment.

One risk associated with copayments and benefit limits is the possible underutilization of care that could result when individuals are unwilling or unable to pay the copayment or when inappropriate discharges or termination of treatment occur when maximum benefits are reached. As explained in the previous section, the undertreatment of mental illness can result in significant social costs.

Benefit Trading or Substitution. The concept of trading benefits is part of the "continuum of care" concept, which may lead to more flexible and appropriate care, but could result in unnecessary utilization of care. Substitution of benefits has in some cases resulted in reduced cost and appropriate treatment and significant shifting from inpatient settings to outpatient settings (in combination with advances in medical treatment of mental illness, particularly in drug therapy). However, substitution of benefits must be effectively managed and monitored by the physician in charge of treating the patient to be cost effective and medically effective. A form of case management that relies on a review of treatment by medical professionals such as registered nurses has been used by some insurers in an attempt to achieve patient advocacy and cost efficiency while ensuring appropriate care. Substitution of benefits, whether allowed by the package or provided on a case-by-case basis, is one of the key tools used by these case managers.

Social costs and savings should be evaluated separately from program costs and savings. Actuarial experience and formulas can be used to evaluate program costs, while social costs require more subjective judgment to evaluate.

Cost Impact

Uncertainty in Projecting Future Cost. There is a wide range of reasonable predictions for the future cost of any health care program. Mental health coverage is particularly sensitive to external variables, such as social perceptions, levels of employment, epidemics, and even the weather. The amount of mental health treatment also can vary dramatically as a result of internal effects such as antiselection and induced demand.

Shifting the Utilization Risk to Providers. Methods of reimbursement that shift the risk of higher utilization to the provider include capitations for outpatient care and per diems for inpatient care. Although these methods do provide an incentive for providers to control cost, they also provide incentives for providers to avoid caring for sicker patients.

Philanthropy and Care by Relatives. Although there are no actuarial data available to quantify increased cost if relatives and philanthropic institutions that provide care to the mentally ill cease to do so, it is likely that the direct cost to health plans will increase.

Level of Detail

One general issue of a guaranteed benefit package is the level of detail that is prescribed. If a package is not described in detail in the enabling legislation, the power to determine the details must be delegated to a board or commission, to the states, or to the health care plans. Some issues that are particularly important when defining a mental health benefit in detail are described below.

Since treatment plans can vary widely, it is important that definitions are worded clearly, leaving little to misinterpretation. For example, a visit should be stated in units of time, such as 30 minutes.

The package should not be so detailed and inflexible that it prevents discovery and implementation of advances in the treatment of mental illness.

Case management can have a significant impact on the cost of providing mental health services. Case management can be specified in detail in the plan design or it can be left up to each health plan. Although there are differences in the types of case management provided by state agencies and by insurance companies, both types address the need for ensuring effective care.

Acute inpatient treatment facilities must be defined, and perhaps licensed, separately from custodial care and short-term residential care facilities. On-site visits may be needed to determine which license to grant to each facility. Intensive nonresidential treatment must be defined and distinguished from outpatient psychotherapy. Without consistency in these definitions, the total cost of providing benefits in the package could be much more difficult to evaluate.

Group therapy could have a lower copayment in order to reduce premium cost while providing effective care. However, the decision on type of therapy should still be made by a qualified provider in consultation with the patient. Substance abuse services should be defined and distinguished from other mental health services. From an actuarial cost standpoint, although there are many people who suffer from substance abuse in combination with other mental illnesses, enough differences occur to justify segregating the benefit limitations that apply to substance abuse.

The determination of medical necessity for mental health treatment can be subjective. Covering necessary treatment while excluding unnecessary treatment is a significant challenge to the designer of a guaranteed benefit plan. One solution is to provide differing levels of benefits for both outpatient and inpatient coverage based on specific diagnoses and severity of the illness. Choosing which diagnoses to include will be subject to debate.

CONCLUSIONS

Designing a guaranteed standard benefit package within a limited health care budget is not an easy task. The ultimate design will depend upon the ability to balance the desire to provide affordable coverage to all with the reality of limited funding. Limited funding may require limiting health coverage, while trying to benefit the greatest number of people. For example, a benefit package could include generous preventive care coverage, but contain physician and hospital benefits that are more restrictive than would typically be found in most health plans today.

The key questions facing policy makers in this limited environment are the following: (1) What coverage can we provide? (2) To whom can we provide it? (3) Who is willing to pay for it?

The level of benefits that can be provided in a guaranteed benefits package with limited funding is partly dependent upon the type of managed care that is used. The plan may be an HMO, PPO, POS, or FFS. In these plans, choice of physician or hospital provider may be limited to those providers that are in the HMO or PPO network, but the cost of the plan can be controlled through provider discounts or other payment arrangements with the network providers (for example, capitation). A more generous benefit package may be possible for the same cost in an HMO than in an FFS plan, if the cost and utilization of health services is controlled. The trend in state Medicaid programs and in the federal government's Medicare program is to experiment with providing the benefits wherever possible through HMOs.

It is also important to plan for periodic updates. The benefit package must be able to evolve, because the means of providing high-quality health care in the most cost-effective manner are still evolving.

If the American public is not willing to pay the cost of a benefit package as rich as the Clinton Administration's proposal, a leaner, lower premium package with basic safety-net coverage is an initial alternative. It is easier and less risky to enrich lean benefits after cost-saving goals have been achieved than to reduce rich benefits if the cost-saving goals are not being achieved.

GLOSSARY

Antiselection
The tendency of individuals to choose insurance plans that will produce the greatest financial advantage to themselves. (See Risk Classification).

Capitation
Reimbursement of a health care provider based on a flat dollar amount per eligible insured per month, instead of on a fee-for-service basis.

Copayment
A dollar amount per health care service paid by the patient under a health insurance plan.

Co-insurance
A percentage of the cost of a health care service, paid by the patient under a health insurance plan.

Cost Sharing
Policy provisions that require insureds to pay, through copayments, deductibles, and co-insurance, a portion of their health care expenses.

Deductible
A dollar amount toward health care expenses paid by the patient under a health insurance plan.

Fee-for-Service Plan (FFS)
A health care insurance plan that reimburses providers based on their fees for each service.

Health Maintenance Organization (HMO)
An organization that provides for a wide range of comprehensive health care services for enrolled members at a fixed periodic payment. See HMO — Staff Model, HMO — Group Model, and HMO — IPA Model.

HMO — Staff Model
An HMO that provides medical care from physicians who are salaried employees of the HMO.

HMO — Group Model
An HMO that provides medical care from physicians who are members of group practices that contract with the HMO.

HMO — IPA Model
An HMO that provides medical care from physicians who are individual or group practitioners contracting with the HMO.

Health Risk Adjustment
See Risk Adjustment.

Health Risk Assessment
See Risk Assessment.

Induced Demand
The increase in utilization of a health care service that is associated with an increase in health insurance coverage for the service.

Large Case Management
System of patient assessment, planning, treatment, referral and follow-up to ensure provision of coordinated medical services. Also includes coordination of payment and reimbursement.

Managed Care
Any of a wide variety of health insurance practices of insurance carriers and HMOs that influence the cost and quality of health care services. See Large Case Management, Preadmission Certification, and Utilization Review.

Managed Care Network
A system that integrates the financing and delivery of appropriate health care services to covered individuals by means of: (1) arrangements with selected providers to furnish a comprehensive set of health care services to members; (2) explicit criteria for the selection of health care providers; (3) formal programs for ongoing quality assurance and utilization review; and (4) significant financial incentives for members to use providers and procedures associated with the plan.

Morbidity
Incidence and duration of ill health and disability.

Out-of-Pocket Expense
Those medical expenses that an insured must pay that are not covered under the insurance contract.

Out-of-Pocket Limit
See Stop Loss.

Point-of-Service Plan (POS)
A health care plan that provides different benefits when the patient uses a provider outside the HMO network. The choice between an HMO provider and a non-HMO provider is made at the point at which service is received.

Preadmission Certification
A health care plan's review of the medical appropriateness of a planned hospital admission. (See Utilization Review).

Preferred Provider Organization (PPO)
A group of health care providers (which may include physicians and hospitals) that contracts with a plan administrator or sponsor to provide certain health care services, usually at a discounted rate.

Preventive Services
Health care services, such as well-baby visits, immunizations, mammograms and physical exams, that are intended to help the patient prevent illness.

Risk Adjustment
A financial transfer based upon risk assessment and implemented through reinsurance pooling or other methods.

Risk Assessment
After establishing a health risk model and underlying categories of risks, an assessment done to establish relative risk weights for each category.

Risk Classification
The process of grouping risks with similar risk characteristics so that differences in expected costs may be appropriately recognized.

Standard Benefit Package
A package of health insurance coverage mandated by a governmental body.

Stop Loss
A limit on the out-of-pocket expense that must be paid by an insured in a year.

Utilization
Patterns of frequency usage for a single medical service or type of service (for example, hospital care, prescription drugs, or physician visits). Use is expressed in rates per unit of covered population for a given period, such as number of annual admissions to hospitals per 1,000 covered persons over age 65.

Utilization Review
Program designed to reduce unnecessary hospital admissions and to control the length of stay for inpatients through the use of preliminary evaluations, concurrent inpatient evaluations, or discharge preplanning.

APPENDIX A: ACTUARIAL ISSUES AFFECTING BENEFIT PACKAGE DESIGN

Health actuaries working at insurance companies and HMOs have encountered certain effects of the interaction of human behavior with packages of health care coverage. In this appendix, we describe three of the effects that have a major impact on package design.

Antiselection

Antiselection is the effect of consumers choosing the best alternative for themselves in a range of possible health coverage plans. Universal coverage will eliminate the effect of antiselection on the *total* health care system, but we still expect to see the effect of antiselection on individual health plans. Healthier enrollees choose the lower premium plans even with restrictive networks of physicians, while sicker people tend to stay with a plan that covers their personal physician. Another way antiselection can affect the market is if health plans "game the system" by providing fewer providers for certain services in their networks, thereby encouraging high utilizers to choose or switch to a different plan.

The effect of antiselection can be increased or reduced by other aspects of health care reform. For example, antiselection is increased when employers contribute a constant dollar amount for all plans, thereby widening the apparent premium differentials seen by employees. It is also increased when a choice of packages with different networks of providers and premium levels is available.

Antiselection can be decreased by bringing the premiums of different plans closer together, for example, by using high out-of-network cost sharing or common provider fee schedules. The use of some form of risk adjustment also decreases risk selection. Risk adjustment is a method for redistributing premium dollars among health plans based on the expected cost of treating the enrolled population in each plan. Further discussion of risk adjustment appears in the American Academy of Actuaries' *Monograph Number One: Health Risk Assessment and Health Risk Adjustment—Crucial Elements in Effective Health Care Reform*, (May, 1993).

Induced Demand

Induced demand is the tendency of providers and patients to use more treatment if greater coverage is provided. It is not the role of actuaries to judge whether the additional treatment is medically necessary. We can only report that more medical care is generally provided when more third-party payment is available.

Although many illnesses have well-defined diagnoses, others are more subjective in nature. Some guaranteed standard benefit packages try to distinguish medically necessary health treatment from treatment that is helpful but not essential. For example, Minnesota's MinnesotaCare subsidized health plan for low-income residents, which was created as part of the 1992 Health Right legislation, provides coverage for mental illness based on a specific list of ICD-9 medical diagnosis codes (International Classification of Diseases, 9th Revision).

Intensive utilization review or other managed care techniques can be used to limit the amount of increased utilization in a greater coverage package.

Provider Issues

There are several provisions in the Administration's proposal that could lead to reduced costs due to incentives to change the way health care is delivered. First, states will need to define who is covered as a licensed professional. There may be a shift in responsibility from primary care physicians to other defined licensed professionals such as nurse practitioners, which could result in decreased costs. Second, there may be an increase in the demand for primary care physicians. In addition, primary care physicians may be encouraged to perform certain services that they currently refer to specialists.

Loss of Control of Reimbursement Levels

Providers may lose some control of reimbursement levels because they will need to negotiate with health plans. There will be changes in the way providers are reimbursed; providers will accept more risk and may move from fee-for-service reimbursement to capitation with incentives or straight salary. Also, providers will continue to consolidate through formation of provider networks, consolidation of physician practices, continued hospital and hospital/physician mergers.

Since much of the provider's income will come from arrangements negotiated with managed care plans, the providers will have an incentive to score high on the managed care plan's quality measures and patient satisfaction measures. There will also be incentives to practice medicine in a cost-effective manner.

Under Section 6011 of the Clinton Administration's proposal, if price controls lead to an alliance requiring a health plan to reduce rates, in some circumstances the health plan can reduce payments to providers—a condition that could threaten the financial solvency of the provider.

APPENDIX B: SUMMARY OF THE ADMINISTRATION'S GUARANTEED STANDARD BENEFIT PACKAGE

Note: The combination plan in the administration's proposal is the low cost-sharing for in-network services and the high cost-sharing for the out-of-network services.

Chart here

Chart, continued

Chart, continued

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