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GUARANTEED STANDARD BENEFIT PACKAGES UNDER HEALTH CARE REFORM

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Actuarial and benefit design issues of various health care reform proposals will be identified. An update on task force activities will be presented. The relative "richness" of benefits will be discussed. Key benefit components such as mental illness coverages will be featured.

MS. JULIA T. PHILIPS: We will talk about standard benefits under health care reform. I would like to give some background about why the five of us are being represented as experts on standard benefits under health care reform. Then I will turn it over to the four people here to talk about different sections of the issues.

The American Academy of Actuaries decided in early 1993 that it would be helpful to the health care reform debate to prepare some issue papers, also called monographs, on topics that actuaries, in general, are experts on, or at least are more expert than most people. As part of that process, I chaired a work group that prepared a monograph on standard benefits and health care reform. Two other papers were also prepared last year, one on risk adjustment and another on community rating. That process was quite successful and did not manage to completely burn out volunteers, so it decided to repeat it in 1994 with 17 work groups instead of 3. We were members of a work group that prepared a monograph, "Actuarial Issues Involved in Evaluating a Guaranteed Standard Benefit Package Under Health Care Reform." The monographs are available from the Academy.

John Saari is with Blue Shield of California. He will talk about managed-care provisions in the standard benefit package. Cindy Lewis is with Blue Cross of Massachusetts, and she will talk about cost-sharing provisions. Bryan Miller is with Blue Cross and Blue Shield of Kansas City and will talk about preventive care. Sheree Swanson is with Coopers & Lybrand, and she will talk about the mental health care provisions.

MR. JOHN SAARI: I'm going to deal with the managed health care aspects of the Clinton proposal. Four types of managed care plans exist. Health maintenance organizations vary in terms of their organization from fairly wide-open individual practice associations (IPAs) to staff models where the providers and hospitals are basically employed by the plan. These types of plans are fairly old. They've been around at least since the 1940s. They are characterized by very rich benefit plans and by fairly narrow provider networks, with a lot of risk sharing—a lot of alignment of the economic incentives of the plan and the providers.

Preferred provider organizations have been around since the 1980s, at least familiarly, and they've been by far the most popular of managed-care-type organizations.

They're discounted, fee-for-service-type plans with fairly broad networks, with about 50% of the hospital beds and maybe as much as 60% or 70% of the physicians.

A point-of-service (POS) plan is sort of a hybrid that brings in an HMO core with a sort of PPO outside. PPO plans are a relatively new type of plan and are a response in the marketplace to the need for choice. Choice is one of those consumer and marketplace needs that seems to be fairly important. It is certainly a big component of many compromises in the Clinton plan.

Other plans include certain exclusive provider organization (EPO)-type arrangements, some direct contracting between providers and large groups, and a few large groups that employ physicians.

When I was in San Diego at the 1993 spring meeting, somebody bright and young said, "There's going to be health care reform, and it's going to take in everybody. How many people are in HMOs?" Somebody answered that the number was about 40 million. He wondered how you got the other 210 million in, given the capacity restraints in an organized medical system. HMO enrollment in 1992 was 47 million, PPO enrollment was 58 million, and point-of-service enrollment at that time was 7 million. That means 112 million were in the managed-care-type systems. Then there's the rest of the population. Part of the remaining 146 million, 33 million, were on Medicare. The Medicare number does take the Medicare risk people and put them in the HMO, so this is the Medicare fee-for-service. About 10% in 1992 on Medicare were on Medicare risk and 90% were in the fee-for-service program. That's changing fairly rapidly.

Medicaid had 36 million, including managed-care Medicaid (about 4 million people who are mainly in HMOs). By the end of 1994 or 1995, about half of people on Medicaid will probably be in HMOs. As near as I can tell, practically every state is moving its Medicaid population into some kind of HMO arrangement.

The 37 million uninsured would really profit from health care reform. That leaves the 40 million persons who have fee-for-service indemnity coverage only. There's a lot of dual coverage in the United States right now. Probably twice or close to twice as many of the 40 million people have indemnity insurance and managed-care coverage, either through a spouse or through some other kind of arrangement, such as buying it on their own.

There are three types of plans under President Clinton's standard benefit package: a high cost-sharing, a low cost-sharing, and a combination plan. These are their labels. I think that people who are familiar with benefit plans in the private market right now would be a little hard-pressed to call the high cost-sharing plan a high cost-sharing plan. It's very broad in benefit scope. It's a $200-deductible indemnity-type major medical comprehensive plan. It basically doesn't exist in California. So it's a strange plan. The low-cost-sharing plan has an HMO core for the in-network benefits, but it has a lot of out-of-network benefits. That's one of the issues that we as a group had with the standard benefit plans. In the current Clinton proposal, there are many out-of-network benefits. The combination plan is probably the only plan in the proposal that's sort of like something that exists in the market right now. It is fairly close to a point-of-service plan.

You need to pay attention to the breadth of coverage and the amount of out-of-network benefits. I'm going to do a little comparing and contrasting. The low cost-sharing plan, which is supposedly aligned with a health maintenance organization, has the same out-of-network and in-network benefits, except the out-of-network benefits have a 20% or higher cost sharing.

There really is no benefit plan that corresponds to a usual PPO plan, at least that I'm familiar with. A usual PPO plan has a benefit design that's similar to a comprehensive major medical design for in-network benefits, with considerably greater cost sharing on out-of-network benefits. The cost-sharing components are tied to the types of contracts that are in the networks. Often they're way below what billed charges are, and they're capped for a member who goes outside the network. That's a typical design. There doesn't seem to be anything in the material I've read on the Clinton plan that is very clear about the fee schedule or out-of-network benefits. There's a considerable potential for quite a bit of extra cost because of these out-of-network expenses.

The point-of-service plans that I'm familiar with are frequently designed with out-of-network benefits that have more than 20% cost sharing. Oftentimes benefits, particularly the preventative ones, are not available out of network. They are only available in network. That doesn't seem to be an aspect of the Clinton plan either. So in our document that we presented, we made many suggestions to the Clinton people. "Why don't you have standard benefit plans that are more reflective of the kinds of benefit plans that exist in the market today?"

There is a little bit of hope. These are some examples of existing plans that work in the market today, that have features of managed care, managed competition, and generally deliver a fairly good product. First is the California Public Employees' Retirement System. This is a plan for about one million people in the state of California. It has moved to standard HMO benefits, which is a common feature of managed competition, so all the plans have the same benefits. The Federal Employee Health Benefit Plan is the employee benefit plan for the federal government. It has an uncountable number of options, which are not standard; they are all over the place. But it, too, has worked reasonably well and has a driver of cost sharing and contribution. The Health Insurance Plan of California is an interesting example, because it is likely to be a first step in health care reform, if I'm reading the papers correctly. This plan came out of the reform for small-group coverage in the state of California. This plan also has standard benefits, a high/low option, a PPO, an HMO, and it has been tremendously successful in its first two years in terms of delivering more affordable cost and putting a lot of pressure on the market to keep costs down. It has had as much as 13% rate reductions from year 1 to year 2 in the Los Angeles area, which makes up most of California.

Medicaid isn't going to be on managed competition, but there evidently will be plans if the state is large enough. There will be a choice for Medicaid recipients, but it looks like everything will be in the HMO. Medicare risk is more similar to the large-employer option, where you can pick the Medicare fee-for-service or you can go to Medicare risk, which is generally an HMO with broader benefits, usually including prescription drugs.

I don't know how general health care coalitions are, and I don't know how successful they are, but it seems now that many large employers are getting together and standardizing their benefit plans across the companies. As a result, we will move away from having a Chevron plan, a Pacific Gas & Electric plan, and a Bank of America plan. Instead there will be a coalition plan. This will particularly be the case on the HMO side. This is a standard feature of the managed competition.

So let me summarize a little bit. The Clinton plan has three benefit plans. Three types of managed-care plans exist. However, there is very little correspondence between the three plans from the Clinton plan and the three plans or the three types of networks that exist currently in the market. The biggest difference, at least from my point of view, is the level of out-of-network benefits. So when you think of the cost implications, one of the characterizations that has been made of the Clinton plan is that it is a single payer in disguise. Actually, about the only way it would work would be with a lot of governmental authority on all of those out-of-network benefits and out-of-network payments. Otherwise, the cost implications would make health care reform unaffordable.

MS. PHILIPS: Cindy Lewis will now talk about cost sharing. I would like to comment on one thing that John Saari said. We really had a problem with terminology, which has not become established. In the Clinton proposal, a health plan is more or less equivalent to a carrier. But I could construct a sentence that would say, "In the Clinton plan, a health plan provides a plan of benefits." It drove us crazy, so that's why we use "package" to refer to the benefits (including cost sharing) that would be provided to an individual.

MS. LUCINDA (CINDY) M. LEWIS: I'm going to discuss cost sharing under the standard benefit package. I'm going to start by defining cost sharing and reviewing what the different cost-sharing provisions are under the Clinton plan. Then I will discuss the implications of cost sharing and some influences on cost sharing that are included in the Clinton proposal. Finally, I will summarize some controversial issues related to cost sharing that are prevalent today.

The most obvious form of cost sharing, of course, is cost-sharing schedules that are in the plans. We're most familiar with deductibles, coinsurance, and copayments under the HMO-type model. Also fairly obvious are premium obligations. One form of cost sharing is the portion of the premium an individual is required to pay. There are going to be different percentages for different income levels and so forth.

One form of cost sharing that is not quite as obvious is limited benefits or benefit exclusions. When you exclude a benefit from the benefit package, or if you have very high copayments associated with it, or you limit the amount of visits or the amount of dollars that can be paid out for that particular benefit, you can effectively be requiring up to 100% cost sharing for that benefit. So it's a hidden form of cost sharing.

Table 1 summarizes the different cost-sharing schedules under the Clinton proposal. This is just a brief summary of a much more detailed chart that we have included in the monograph. As John said, there are three basic options under the Clinton proposal. All really have relatively modest cost-sharing provisions. To accommodate

all income levels, the cost-sharing schedules have been geared to the lower income levels. The lower cost-sharing schedule has copayments similar to an HMO model. The big difference from a pure HMO is that one must offer out-of-network benefits and must require at least 20% coinsurance on those out-of-network benefits.

TABLE 1
CLINTON PLAN
COST-SHARING SCHEDULES

	Lower Cost-Sharing Schedule	Higher Cost-Sharing Schedule	
	Copayment	Deductible	Coinsurance
MEDICAL	None	None	None
Preventative	None	None	None
Prenatal	$25/visit	$200/individual	20%
Emergency room	$10/visit	$400/family	20%
Office visits	$10/visit	Per year	20%
Vision	$10/visit	Per year	20%
Pregnancy-related Services	$25/visit	Per year	50%
Outpatient psych	None	Per year	20%
Home health care	None	Per year	20%
Hospice			
Diagnostic, X-Ray,	None	Per year	20%
Laboratory (DXL)	None	1 day of treatment/episode	20%
Inpatient	$5/prescription	$250/individual/year	20%
Prescription drugs			
DENTAL	None	None	None
Preventative/diagnostic	$10/visit	$50/individual/year	20%
Restorative	$20/visit	$50/individual/year	40%
Orthodontic (limited)			
OUT-OF-POCKET LIMIT	$1,500/individual $3,000/family	$1,500/individual $3,000/family	

The second option is called the higher cost-sharing schedule. That's really a typical fee-for-service plan. The third option is the combination plan, which has the lower cost-sharing schedules for in-network benefits and the higher cost-sharing schedules for out-of-network benefits.

The second form of cost sharing is premium obligations. Under the Clinton plan, employers are required to pay 80% of the weighted-average premium for plans offered by the regional health alliance. That dollar amount then serves as an offset to whatever the premium is for the particular plan in the alliance that an individual chooses to purchase. So the individual's share can actually be less than 20% of the cost of the plan that he or she has chosen, if that plan has a lower-than-average premium. So the idea here is to encourage people to enroll in the lower-cost plan.

The third form of cost sharing that I mentioned is the limited or excluded benefits. The package proposed in the Clinton plan limits the periodicity of benefits in some cases; for instance, for immunizations and mammograms. There are age limits on some preventative services as well, such as dental. Certain dental services are provided only for children. The benefits excluded are really the typical benefits that

are excluded from many plans in the market today. All in all, I would say that the benefit exclusions and limitations are fairly minimal. This is consistent with the lower cost-sharing schedules as well. This whole approach is geared toward making the plan affordable to the majority of the population.

The implications of cost sharing are affordability and adequacy, which kind of tie together based on the things we've just been discussing. The plan can be unaffordable to purchase because the premium is too high for someone to pay. In addition, the care can be unaffordable if the cost-sharing schedule is too high or the benefits are too limited. If the cost-sharing schedule is unaffordable, or the benefits are too restrictive, then the coverage is effectively inadequate for a person. Lower-income people will be weighing the choice between lower premiums and lower cost-sharing schedules. Unfortunately, all else being equal, the plans with higher cost-sharing schedules will have lower premiums and vice versa. Effective managed care in plans with lower cost-sharing schedules can help narrow the difference in premiums. But as John mentioned, with the way the plans are now designed, there really isn't a strict HMO model where the care can be effectively managed.

Another implication of cost sharing is adverse selection. Having universal coverage will eliminate adverse selection on the entire health care system, but it won't eliminate adverse selection among the different plans that are offered through an alliance. Health status as well as financial considerations will influence the choice that a person makes between a higher and lower cost-sharing plan. Higher utilizers will tend to choose the lower cost-sharing schedule, which will drive premiums for those plans higher unless utilization can be effectively managed. Healthier subscribers will tend to choose lower-premium plans. The results of this are that adverse selection will create a premium spiral. There are some provisions that can help to modify that a bit, but left unchecked this is what would happen.

Induced demand is another area that cost sharing can affect. There is a tendency to use more treatment if greater coverage is provided. More medical care is generally provided when more third-party payments are available. The fear, of course, is that bringing more people into the system is going to create significant induced demand.

Cost-sharing schedules and benefit limitations can help to avoid unnecessary care and encourage most cost-effective care. In an unmanaged-care environment, cost-sharing schedules are really necessary to avoid overutilization. They're less necessary in a managed-care environment where financial incentives to encourage providers to control unnecessary utilization are in place, but they are still effective. Today we are seeing that HMOs with $6 copayments are starting to index cost-sharing schedules as they get eroded by inflation. Also, cost sharing can help keep individuals aware of the cost of services and encourage them to participate in cost-effective health care decisions.

There are some things that are proposed in the Clinton plan that will help modify some of the cost-sharing provisions to avoid some of the negative impacts they might have. First, there are some subsidies to make the premium obligations more affordable for low-income individuals and small employers. The cost-sharing schedules for the lower-income individuals are being reduced if sufficient low-cost plans aren't available for them to enroll in. For instance, Aid to Families with Dependent

Children (AFDC) and supplemental security income (SSI) recipients will only pay 20% of the lower cost-sharing-plan copayment, if there isn't a low-option plan for them to enroll in. And for those whose incomes are under 150% of the poverty level, copayments will be reduced to the levels of the lower cost-sharing plan in the alliance.

A major issue being discussed is the limitation on premium obligations. They're eliminated or capped at about 3.9% of income for low-income individuals. But the issue receiving a lot of public attention is the employer cap. The Clinton plan caps premium share at 7.9% of payroll. For small employers (under 75 employees) with a fairly low average wage per employee, the premium obligations can be capped at as little as 3.5% of payroll.

Another influence on cost sharing is risk adjustment. This can help the adverse selection problem and the premium spiral that I discussed earlier. This is a mechanism to transfer payments among the health plans in the alliance to compensate them for the differences in their risk pools. If properly designed, risk adjustment can eliminate the differentials in premiums that result from adverse selection among the plans.

There are also premium caps in the Clinton plan. Each regional alliance will have a per-capita premium target, and that's going to limit the total payments they can make to health plans in the alliance. This limits cost sharing by limiting the levels of premiums that can be charged. But the fear is that, as health plans get lower and lower premiums and have to manage to a lower budget, there may be a reduction in the quality of care if they're not able to achieve enough savings through administrative efficiencies.

There's some indexing in the Clinton plan on the deductibles, the copayments, the out-of-pocket limits, and the premium cap. The index is the CPI plus a factor that starts at 1.5%, but it is being phased out to 0% by the year 2,000. We all know that historically medical CPI has been higher than CPI, and so the problem is that to the extent that the indexing doesn't really keep up with inflation, the leveraging effect of these copayments is going to make the premiums increase even faster than they would otherwise.

Cutting back the benefit package to make the premium cap adequate won't work, because there will be adjustments to the premium caps for changes in the benefit packages. But if one particular category of benefits is driving the cost, for instance, drugs, cutting back that benefit could be an effective way to manage within the premium cap and the indexing.

In the end, the desire to provide affordable comprehensive coverage to all must be balanced with the reality of limited funding. Therefore, the elements of cost sharing are at the heart of the health care debate. Right now I think the two most controversial issues related to cost sharing are the employer mandate and benefit exclusions or limitations. Benefit exclusions or limitations would control overall costs by phasing in universal coverage. These issues are at the heart of the debate right now; that is, whether the employer mandate should be eliminated or cut back or whether the benefits should be cut back. We have suggested in our paper that perhaps given the richness of the plans that are in the Clinton plan right now, there is some room to

offer a leaner plan initially and phase into the richer benefits as savings in the system are actually realized.

MS. PHILIPS: Bryan Miller now will talk about preventive care.

MR. BRYAN F. MILLER: Actually I have two topics to cover. I will discuss both preventive care and prescription drugs. First we'll look at preventive care. The first thing we should look at regarding preventive care is how common this care is in the market today. I will recite some numbers from a 1990 HIAA study of preventive care. For example, in indemnity plans, 39% of the enrollees had some form of coverage for well-child care, and 30% had some form of coverage for routine adult exams. In a PPO plan those numbers improved to 58% and 49%. As you can probably expect, in an HMO plan you're getting nearly full coverage for these forms of preventive care: 97% for well-child care and 95% for routine adult exams. I then took the numbers that John Saari provided you earlier on HMOs, point-of-service plans, and preferred provider plans and came out with an approximate proportion of our population that has some form of coverage for these preventive care benefits. For these two benefits anyway, it's a little under half (48% and 42%, respectively). In its report, the HIAA did mention that such things as mammograms, pap tests, and immunizations were covered at somewhat higher proportions than these. But the important point to see from this is that any standard benefit package that includes full coverage of these benefits is obviously going to be an improvement for many people. If you also take into consideration the amount of cost sharing in indemnity and PPO plans and take them to a full-cost basis with no cost sharing by the patient, that's even more of an increase in benefits.

We've already heard about the topic of induced demand, which would suggest to you that the use rates for these benefits would certainly go up. Let's look at some of the kinds of care that the health proposals are considering as preventive care. The Clinton plan follows this design fairly closely.

This is a report from what's called the U.S. Preventive Task Force, which is sponsored by the U.S. Public Health Service. A periodic health exam is recommended. As Cindy stated, it's mentioned in the Clinton plan as a relatively routine schedule by age of what services you are allowed to receive. Included is a physical examination, which includes height and weight check and medical history, and a series of immunizations. The latter are mainly for children, but included are pneumococcal and influenza vaccines for the elderly. A full range of prenatal, pap/pelvic and mammogram exams are included as are laboratory tests. Under risk-specific services are any special immunizations and screening tests for individuals who are identified as high-risk patients. Risk assessment and health-guidance services include diet counseling, injury prevention, oral health, drug, alcohol, tobacco, and sex counseling. This information was included in a May 1993 report by the Division of Health and Human Services. As I said, I think this report played quite a large role in the benefit design of the Clinton plan. It was also supported by a number of studies, which pointed out the value of preventive care and early detection of certain conditions in reducing health insurance rates. But it's probably a little difficult to say how direct an impact these preventive-care measures have had on public health as a total, when you consider such things as improvements in hygiene and sanitation. The direct effects of many of these procedures are quite difficult to show.

Let's look at what that same paper estimated the cost to be for a full range of preventive care at no cost to the patient. Its estimates in 1992 dollars were $62 per year for children, $84 for adult females, and $52 for adult males. You can read into those figures whatever you'd like. Again, they represent no cost sharing, so that's a full value for every service that's provided. The claim was that this would add less than 3% to health-plan premiums.

Table 2 shows what the major health care proposals are proposing in the way of preventive care. The first plan is a single-payer or Canadian-style plan. You are probably familiar with the Clinton plan. The Cooper plan is one that was popular for quite a while. But with the way things are happening, it's hard to know from day to day which one is on top. All three of those plans basically guarantee a full range of preventive care, and they do not involve any cost sharing on the part of the patient. So there's quite a bit of consistency there. Two of the three plans also include a full range of preventive services for Medicare patients. The Clinton plan is not quite clear on that issue. We've already talked about the complexity in these bills, so we can't be too sure what is included and what is excluded. In summary, I think it's clear that those who are designing these plans think that preventive-care benefits should be part of any package, and with little or no cost sharing. So that's likely what we're going to see from any bill that eventually gets passed.

TABLE 2
PREVENTATIVE CARE IN U.S. PROPOSALS

	Wellstone-McDermott	**Clinton**	**Cooper-Brown**
Full range of preventative care?	Yes	Yes	Yes
Cost-sharing?	None	None	None
Includes Medicare?	Yes	Not stated	Yes
Who sets benefit levels?	National Health Board	National Health Board	Health Care Standards Commission

Let's move on briefly to prescription drugs. As you may be aware, there is quite a wide range of benefits out there, starting with the typical indemnity plan with which many of you are familiar. Here, any drug benefits are included within the overall health-plan deductible and coinsurance limits. There have been a number of variations in the coverage of outpatient prescription drugs. Many plans have a separate drug deductible, which they think is most effective at controlling costs or having a maximum benefit on drugs. Drug cards certainly have become popular, either through a copayment or through percentage charges. Another more recent variation, which is popular with many carriers and certainly with our plan, is splitting the dollar or percentage copayments for generic equivalents versus brand-name drugs. We have found that to be relatively effective at reducing name-brand usage.

Now we'll look at some of the recent trends in prescription-drug plans. The average copayment that companies have designed for their prescription drug plans has

increased, and I know our plan sells virtually nothing less than $5. We frequently have copayments at $10 or higher, and even variations in which the copayment may be only $5 or $8 but we also require the patient to pay an additional 20% of the remaining cost. The split copayment idea is certainly a popular one among insurance plans. However, it was not so popular among those who designed the Clinton packages, as you're going to soon see.

Let's look at a couple of other issues relating to prescription drugs and health care plans. The indemnity approach that traditionally was the most popular approach to prescription drugs had some advantages that are probably only beginning to be realized now. People were not satisfying their deductibles, and there was frequently no incentive to submit all their drug claims. As many companies went to prescription-drug-card programs in the 1980s, I think they found that utilization rates nearly doubled. I think a lot of that is due to the fact that people just simply weren't submitting all those claims. They knew they weren't going to reach their plan deductible for that year. So on the stand-alone or prepaid plans, family utilization rates grew remarkably high. We were hard-pressed to explain it, because the drug prices were not changing that much. Instead, it was the utilization rate that was changing.

My third point, that drugs are proxy for other forms of care, can probably best be illustrated by a quote from Dr. Carl F. Meyers at a 1989 Society meeting. He said, "What happens is you have an unhappy patient when you do not write a prescription for him. You can explain for ten minutes what a virus is and how a virus is not helped by an antibiotic. And the patient is still unhappy after that ten minutes. On the other hand, it takes two minutes to write a prescription and tell a patient how to use it. The patient does not pay for the prescription because the third-party payer does, and the patient is happy." I think that, regardless of what kind of prescription drug program eventually comes out of Congress, that situation will probably still exist. Certainly the pharmaceutical companies can have an impact on overall usage rates and generic substitution rates. Through advertisements and distribution of free samples to physicians, a number of providers become comfortable with a certain brand and are not as likely to prescribe a generic equivalent.

Now let's look briefly at the same three proposals I mentioned earlier and what they're doing with prescription drugs (Table 3). Two of the three, the single-payer option and the Clinton plan, are really proposing a full range of prescription drugs, with very few exclusions. The Cooper plan stated that the basic benefit package did not have to cover all prescription drugs. It did say, however, that for individuals below the poverty line, there would be additional coverage, in case the basic benefit package did not cover everything. I think the interesting thing about cost sharing is that the single-payer plan did not require any cost sharing for drugs. In fact, the only cost sharing in the entire plan was for long-term care. So that would certainly be a significant change. And again, the induced demand effect might really have a significant impact on drug utilization under such a plan. There are three drug benefit options in the Clinton plan, which we'll soon see. The Cooper plan, without being specific, does mention that there would be cost sharing. The same two plans that talk about a full range of prescription drugs also would include prescription drugs in Medicare, so that would certainly be an addition to the current Medicare benefit. In

each of the proposed systems, a board or commission is set up to periodically review the benefits that are being offered and make any changes.

TABLE 3
PRESCRIPTION DRUGS—U.S. PROPOSALS

	Wellstone-McDermott	Clinton	Cooper-Brown
Full range of prescription drugs?	Yes	Yes	No
Cost-sharing?	None	Yes—3 plan options	Yes
Includes Medicare?	Yes	Yes	No
Who sets benefit levels?	National Health Board	National Health Board	Health Care Standards Commission

Let's see a little more detail on the Clinton plan (Table 4). The low cost-sharing plan includes a $5 copayment for each prescription inside the network. As John mentioned, the coinsurance out of network is not specific, but we believe it will be at least 20%. Our recommendation is that it be higher than that, because at a drug charge of $25, you can see that the benefits are the same in and out of network, and that's certainly not the kind of utilization pattern we hope to see. The high cost-sharing plan features a separate drug deductible: $250 per person per year. Beyond that there will be 80% reimbursement for drugs over the $250 deductible. In the combination plan, the in-network benefit is the same as the in-network benefit under the low cost-sharing plan, in that a $5 prescription copayment is required. The out-of-network benefit mirrors the high cost-sharing plan, with the deductible and 20% coinsurance thereafter. What you don't see in Table 4, obviously, is any generic/name-brand substitution differences. So one of our major concerns with the drug plan designs offered is that name-brand drugs are likely to fare rather well, if the patient is going to pay the same amount for either.

MS. PHILIPS: Sheree Swanson will talk about the mental health care provisions in standard benefit packages.

MS. SHEREE SWANSON: I am not going to spend a lot of time talking about the specific provisions of the Clinton plan. Instead I would like to spend the time discussing the issues that are unique to mental health and substance-abuse benefits. I did want to point out some changes to the Clinton plan summary located at the back of our monograph. The described mental health and substance abuse benefits were the benefits that were included in the original 1,300-page document issued in September 1993. The plan was officially announced in December and there were some changes made to the benefits between September and December. In particular, the coinsurance for psychotherapy visits in the high cost-sharing plan increased from 20% to 50% and the low cost-sharing plan, copayments increased from $10 to $25. These changes would be effective until the year 2001. Some of the cost-sharing provisions

were also increased for substance abuse benefits. At this time, we do not know if there will be a standard benefit package defined in any ultimate legislation that is passed. We do know that few Senate committees have begun working on proposals that include less detailed references to the benefits packages. For example, the Senate Finance Committee markup specifies that mental illness coverage will have parity with services for other medical conditions. The Senate Labor and Human Resources Committee write-ups also suggest that they would provide a level of benefits that is more in parity with the physical health benefits covered.

TABLE 4
PRESCRIPTION DRUG BENEFITS
IN THE HEALTH SECURITY ACT

	Deductible	Copayment	Coinsurance
Low cost-sharing In-network Out-of-network		$5 per prescription	 20%
High cost-sharing	$250 per person		20%
Combination In-network Out-of-network	 $250 per person	$5 per prescription	 20%

We briefly addressed the issues of mental health and substance abuse benefits in our monograph. A separate American Academy of Actuaries work group was also formed to specifically address the topic of mental health benefits. The work group issued its monograph in May 1994. The monograph contains a more in-depth discussion of the issues, as well as a section on cost estimates.

There are four questions that I will address to attempt to highlight the important issues related to mental health and substance abuse benefits. The first question is, what is unique about mental health benefits? We all know that mental health benefits have a sort of stigma attached to them. It is much easier to say that you are going to go to the hospital for a knee operation than it is to admit that you are going into the hospital because you are suffering from schizophrenia.

There are also other issues that are unique to mental health benefits. One issue involves the social costs, which are more difficult to measure than the cost of the benefits provided. We as actuaries will price out a package of mental health benefits, but there are some things that do not get included in that price. For example, a recent study completed at MIT showed that there was a $43.7 billion annual cost in the United States associated with mental depression, including treatment costs and a measurement of the loss in labor productivity. Other social costs included the cost of law enforcement and other social programs unrelated to health care that result when people with mental health conditions do not receive the treatment they need. In addition, the level of treatment for mental health and substance abuse conditions can have an impact on the physical health benefit costs. There has been a lot of research done on this, and some studies have shown that if you spend more money to provide the appropriate level of treatment for mental health and substance abuse conditions,

the costs of physical health benefits may be reduced. We actually recognized the impact on the costs of physical health benefits of improving mental health benefits coverage in our work for the state of Oregon. Based on our review of the research, we found that for every additional $1 spent on substance abuse and chemical dependency treatment, a range of $1 to 11 could be saved on the physical health side. Similarly, we found that for every additional $1 spent on mental health benefits, anywhere from $0 to $20 could be saved on physical benefits. The assumptions we used were at the lower end of those ranges.

Another unique attribute of mental health benefits coverage is the difficulty in determining medical necessity. This may be truer for some mental health services more than others. It is more difficult to measure whether a person can be "cured" after 10 or 15 psychotherapy sessions, or whether he or she will only be "cured" after 50 or 100 more sessions.

The final unique issue that I will mention relates to the fact that right now the country's infrastructure includes public institutions that take care of the severely mentally ill. These institutions are currently separate from the rest of the health care system and are funded through general revenues. The issue is whether they should be incorporated into a program of universal coverage. The Clinton plan addresses the issue by specifying that a study would have to be done to determine how to incorporate these public institutions into the system.

The second question that I would like to address is—what factors should be considered in determining the level of benefits to be guaranteed? Cindy talked a little bit about induced demand. I guess that is the big issue with whether you provide benefits that are in parity with the medical benefits commonly provided now (80% or higher coinsurance protection), or if you provide mental health benefits that are more in line with today's commercial plans (closer to a 50% level of coinsurance). Are we going to have greater costs if we increase coinsurance to 80% or higher without any additional changes to the system, such as a stricter level of managed care? Well, yes we are. Is this necessarily bad? No. There are probably many people out there who argue that they are not getting the level of mental health coverage they need, so those people might have a better opportunity to receive the appropriate benefits coverage. However, as Cindy said, providing a richer benefit package tends to make people utilize more services. It is likely that, to some extent, services that are not needed would be more utilized.

I want to mention the importance of cost sharing in a mental health and substance abuse benefit design. The experience has been that in the absence of appropriate managed care, cost sharing is needed to keep costs in line. The question is, how much choice are people willing to give up in order to receive more benefits? One item in particular, related to how mental health benefits are designed, is that they often have a limit, such as 30 visits per year. There is an issue of whether someone will think that because the limit is 30 visits per year, they should use all 30 visits, as opposed to maybe using only 10, if that is all they really needed. By "impact of limits," I am including limits in the number of treatments, such as lifetime treatments, and in the case of detox benefits, the number of days in a residential facility and the limits on number of office visits. But is there a better way of defining the benefits

that would not require the incorporation of specific limits (that may not be appropriate in every case) into the benefit design?

A separate factor related to the level of benefits is designing the benefits to avoid abuse by people whom the benefit was not intended for.

For example, the Clinton plan provisions include some benefits that may go outside of what would be medically necessary, by providing benefits within a family setting. There are questions as to whether those are mostly benefits that the people who are chronically mentally ill would benefit from, but in actually specifying such benefits within a package, others may utilize the services inappropriately. This problem can be corrected by including a more specific definition of when and to whom the benefit applies.

The third question is, should mental health benefits be standardized? The big issue here is that many large employers have carved their mental health and substance abuse benefits packages out of their health plans and are separately providing a special managed-care carve-out plan for these benefits. They are then able to provide much richer benefits, in terms of lower copayments, very cost effectively. So should a standardized plan be strictly defined for all carriers, or should you have more flexibility, so that more benefits could be provided under a more managed type of environment?

My final question is—how should the benefits be defined? Again, this gets into a couple of areas where there are a few things that are a little bit different for mental health benefits than for physical health benefits. The level of detail is very important, and it is on the physical health side too. You have to choose between creating a plan that is easily abused because the plan benefits are not specifically defined and making the benefits description so specific that you do not encourage innovation. If the benefits are not well defined, and people think they were denied benefits when they should have received them, they may be more likely to litigate.

Substitution of benefits is the specific type of feature used more and more with mental health and substance abuse benefits, and it is used to encourage people in in-patient hospital treatment into something such as a residential treatment. For example, substitution of benefits allows for two days in a residential facility for every one day of benefit that you might have in an inpatient facility.

Case management has been one of the main ways that the carve-out mental health packages have been able to keep costs low or provide a richer benefit for a lower cost. The case manager plays a very significant role in making sure that the treatment is provided in the most cost-effective manner. The case manager actually has the authority to approve treatment in a lower-cost environment, and that has proved to be very effective in keeping costs down. As an aside, this type of case management is not defined in the Clinton plan. In fact, case management is defined as it currently works for Medicaid recipients, which is more of an outreach effort to make sure that patients get the appropriate access to services.

A final point—the Clinton plan has mental health and substance abuse benefits described together, although some of the cost-sharing provisions are separated. The

issue is, are these two types of benefits different enough that they should be defined separately? It raises a bigger question of how the benefits that can be provided should be defined in the package. One solution is to define the benefits at a detailed enough level so that you have a different treatment for every diagnosis-related group (DRG) code. This would be one way to provide the most appropriate treatment for the specific condition, although it would require far more detail than is now normally specified in benefit plan descriptions.

MR. JEFFREY L. SMITH: Sheree, I have a question on the mental health substance abuse information. I did some work in Ohio with a work group, and looking at that component of a standardized or basic health benefit plan, one of the things that we looked at (and I'm sure it was between the introduction and the December time frame, as it related to the Clinton benefit program) was published information that mental health/substance abuse was 19% of the program cost. At least I think that's what I read. And in some of the work that our group did, we came up with cost estimates that ranged in a fairly rigorous managed-care setting, from 5%–6% up to more moderate or fairly limited managed care at about 10%. I know there was some criticism or second thinking of whether the whole benefit cost was put together at an adequate level, but have you had any subsequent thinking about what proportion of either the cost or a premium equivalency would be consumed by the mental health substance abuse portion of the benefits program?

MS. SWANSON: We didn't study cost issues for this monograph. However, the Academy's work group on mental health included cost estimates. I believe the factor of 10% was used as their estimate of the percentage of total cost for mental health and substance abuse benefits. Historically, that's close to the percentage of total cost for typical mental health substance abuse benefits coverage that is provided today.

MS. LEWIS: I would like to point out that there's a very wide range of cost estimates in that paper, so there's no one number to allow you to say this is the rule of thumb. There really is a broad range, depending both on the delivery system and how you do the estimate.

MR. ALAN W. FINKELSTEIN: What does the Clinton health plan say about major organ transplants? Is this considered a medical necessity in all cases? Or is it based on some sort of outcome, whether a therapy has in fact been proven to be effective? The reason I ask is because I'm from the Philadelphia area where the story about the Lakeberg twins has received a lot of attention. The ultimate outcome has been that more than $1 million was spent to help prolong the baby's life 10 or 11 months. I don't think that that's a very effective way of allocating our resources.
MR. MILLER: I assume the medical-necessity definition would probably override there. But there isn't any specific reference to different coverage levels for transplants as opposed to other procedures.

MS. PHILIPS: I think that question does bring up a good example of something that I've noticed as this process has gone on. You might think that having a detailed standard benefit package would resolve some of the controversial issues. No. Having something down on paper merely adds fuel to the fire. There are several such issues, as far as what should be covered and what care is really necessary. Various other issues really have not been fully addressed, let alone resolved.

MS. SWANSON: Julia, we have mentioned several examples of plans in existence today that have standard packages. I would like to add a comment on Oregon's plan for its covered Medicaid population. Oregon went through a tremendous process to develop its standard plan based upon a prioritized list of services, detailing covered services by diagnosis and treatment pairs. All health services were prioritized by the Health Services Commission and the benefits covered by the plan depend upon how many of the prioritized services can be funded by the allocation of the state legislature. An example of some of the decisions that were made is the value of providing organ transplants to people aged 80 or to people who have a very low probability of surviving. This is a case in which a very specific set of benefits is defined under the standard plan.

MS. KAREN BENDER: John, you referred to certain standard plans already in California. How does the proposed plan compare with those other standard plans that are available in California? Is it richer? Is it more limited? I'm not familiar with those other plans.

MR. SAARI: How does the Clinton plan, as outlined, compare with some of the standard plans like the plan in California? Basically, the Clinton plan is about as broad in scope as the HMO plans that are covered under those standard plans, but the level of cost sharing, and in terms of specific limitations, is less in the Clinton plan than in the plans on the market today. So the Clinton plan in terms of breadth of coverage is much broader than some of the richest plans that I'm familiar with in the commercial market.

MR. HARRY L. SUTTON, JR.: I missed the very beginning, but you talked about three levels of plans. According to Clinton, an HMO must offer a POS. My question is, can the HMO give a choice of being locked into a closed panel, as well as a POS, so the enrollees can have a choice? Can they get a lower price for a closed panel versus a POS?

MS. LEWIS: Well, it's not clear. The National Health Board has the ability to set the coinsurance in the out-of-network up to 100%. It has to be at least 20%; it has some authority. The wording is very bad, it's in double and triple negatives, so you must do a lot more math to figure out what the positive sense of the wording is, and it is a real concern. It seems fairly clear that there is no typical HMO plan offered under the Clinton proposal, and it's something that we specifically mention in our monograph. We suggest that they should allow that.

MS. PHILIPS: I'd like to add to that. Just from the perspective of having been to Washington a couple of times and having had some discussions, there does seem to be a general agreement in Washington that a closed-panel HMO without out-of-network benefits is offered in the Clinton plan. But as John says, from the wording in the law and from the uncertainty of how this would be implemented after it became law, I think that it's an issue that would be well kept in the forefront. I know that in our group, although we had different opinions on various issues, we were in general agreement that a traditional HMO plan has been effective at managing care and that to wipe that out under health care reform does not seem like a good idea.

MR. SUTTON: I raised that question partly in relation to mental health services. In HMOs that we reinsure with a POS plan, as much as 90% of the mental health is out of network because the people want to use their own physicians or psychiatrists. It varies a lot from plan to plan, but even the managed-care plans admit on occasion that they're very good at managing mental health. So the leakage could be immense in a POS plan on the mental health benefit.

I have one other reaction to the study that Sheree talked about. I have looked at many studies on whether mental health treatment reduces medical services. The problem is, in the studies that I've seen, the medical services all occur prior to the discovery that the person has a mental health problem. And it's true. Once the person gets treatment the medical services go down. The question is, how early do you intervene to block the medical utilization before the person gets there? Many studies were run with HMOs, and even just visiting a doctor removed a mental health problem and lowered the medical use, even when there was practically no intervention.

MS. SWANSON: I know that in coming up with some of the assumptions we used for Oregon, we took into account that for chemical dependency there would be a timing issue.

MS. LEWIS: I'd just like to add one more comment on the issue of the out-of-network benefits for the HMO. There is a provision that for the out-of-network option, the plan can charge a higher premium. So it is possible that people could elect to restrict themselves to the network model only. But it sounds like the plan has to always allow for that option.

MR. DAVID P. MAMUSCIA: There has been a tremendous amount of pressure on my organization for our major customers to control drug costs. We spend a lot of time on all kinds of innovative plans. Bryan, I was surprised that there aren't any stipulations in the proposals to have different forms of cost sharing or copayments for generic-versus-brand-name drugs. I know we've spent time developing plans and copayments, and have even spent time with providers. I think I'm really making a statement more than asking a question. I hope that someone can advise people designing a plan that may affect us someday to make changes to the drug program.

John, do your plans with the California groups have examples of managed competition? Maybe that's not a fair question. Do they have drug provisions that urge people to use generic substitution to hold down cost?

MR. SAARI: The typical drug plan nowadays has different copayment amounts for generic-versus-brand-name drugs. Yes, we do that. I thought everybody does it.

MR. GREGG E. LITTLEFIELD: My question has two parts. First, what about some of the alternative medicine treatments (acupuncture, some of the things like herbs and so on)? Second, what consideration have they given to the fact that this process might be manipulated by a special interest group, so that you're getting fairly exotic coverage included in a standard benefit package at a greater cost? What are we doing to prevent this process from being manipulated by special interest groups so it doesn't get overloaded in years to come?

MR. MILLER: In terms of alternate providers, I think the bill mentions that services must be provided by either a physician or by another person who is legally authorized to provide such services in the state. So it may get down to a state-by-state issue, whether alternate providers are licensed or not, and whether that care would be covered under the plan.

MR. LITTLEFIELD: What about keeping the process from getting loaded up with a lot of other benefits as time goes on? Did they put anything in place to prevent that?

MR. SAARI: One other potential mechanism of control is the naming of the plans that administer the programs as accountable health plans and what provisions there are for an accountable health plan to choose its network. That's basically how that type of benefit cost is controlled under a typical HMO, which is that the plan itself has enough authority to designate the kinds of providers that are in it. I don't know enough about what affordable health plans will be under the Clinton proposal to know whether that kind of leeway or authority is given to the plan, but there are two ways to handle it. The second way is under the authority of the health plan. If there really is price competition, there will probably be a substantial amount of control over that particular issue by the health plan. That's provided, of course, that it doesn't have all these leaky out-of-network benefits in there that I talked about previously.

MS. SABRINA B. HELTZ: I know abortion has been a hot topic in all of this. Could you just give us a few comments about the current status? How is it covered under these plans? Will it be covered? Could you comment on expected costs?

MS. PHILIPS: The Clinton plan does cover it. President Clinton may be willing to compromise on that one. This is a change from what we were originally saying. I don't know whether the other bills are specific enough, in terms of what they say they're going to cover, to the level of whether they cover abortion. In terms of the cost, it's not high. I don't know if anyone else wants to comment on whether cost would be a significant issue in this. It's mainly a political issue.

MR. MILLER: I think the cost issue would probably rest in favor of covering abortion, in that you might be reducing the number of low-birth-weight babies and premature situations, which tend to get costly. So that side of the argument probably would lean in favor of it. But the political issue will probably overshadow the actuarial one.

MS. SWANSON: I listened to one health-reform presentation by a plan sponsor, and someone predicted that there will be no standard benefit plan, because it would come down to disagreement on the issue of abortion.

MR. SUTTON: I'd like to follow up on the question about alternative providers of health care. For example, the American Dental Association wants full dental coverage to be included in the national health plan. It's a survival issue. I think you're seeing the provider legislation sweeping the states. There will be tremendous lobbying because of the fact that benefits offered outside the basic Clinton benefit plan will not be tax deductible to either the employer or to the individual. Therefore, I think what we have is a tremendous battle for all these providers to be specifically included.

President Clinton has waffled when the question has been raised by chiropractors. "We don't cover providers, we just cover services; whoever is legally licensed to provide it can provide it." But that doesn't work with health plans that can control who's going to participate in the health plan. There's a fear that they're all going to be excluded. I really think this question hasn't satisfactorily come to the forefront yet, because nobody has talked much about the fact that benefits outside might not be tax exempt.

MR. ROBERT M. DUNCAN, JR.: Considering that the Clinton plan and many of its look-alikes have been practically, though not politically, dead for quite some time, I'm wondering, John, do you think that there will ultimately be a bill that has standardized benefit plans as you presented here? Or will people be allowed to develop their own comprehensive plans as we go along? Sheree, were there any constraints involved in the pricing of the benefits? This might be a general question for all, but consider the large number of uninsured people, many of whom probably have catastrophic and high-cost mental illnesses. Were those people built into the cost of this program? Were there any constraints on the morbidity attached to the induced demand and the high-cost people out there who are uninsured for things such as mental illness and any other medical conditions?

MR. SAARI: I don't think anybody knows. I don't choose to make a guess right about what would happen, given that the Clinton plan is likely to be, if not dead, highly amended before it turns into anything.

MS. SWANSON: The cost estimates for the mental health portion are mostly in the mental health paper, not in ours. If you look at some of the assumptions that were made, and if you even just look at the cost for the uninsured, they are three or four times higher. And I think their paper does factor induced demand into the assumptions. There is quite a detailed level of description as to how the work group performed its estimates, so I would suggest you obtain a copy of the paper for further reference.

FROM THE FLOOR: A recent national study, perhaps last year, has been published that shows that the per-capita cost of health care for the Medicaid population is three times greater than the rest of the population. That should be an indicator of an awful lot of induced demand and medical problems that may be underneath that will blow all these pricing assumptions.

MS. SWANSON: I think the estimate for the uninsured, again from the mental health work group's paper, was between $550 and $750 per year versus $165 and $186 for the commercial population.