THE LEADERS' PROJECT
On the State of American Health Care

# Health Insurance Design Choices

## *Issues and Options for Change*



A PROJECT OF THE

BIPARTISAN POLICY CENTER

## Preamble

The Bipartisan Policy Center (BPC) is a public policy advocacy organization founded by former U.S. Senate Majority Leaders Howard Baker, Tom Daschle, Bob Dole, and George Mitchell. Its mission is to develop and promote solutions that can attract the public support and political momentum to achieve real progress. The BPC acts as an incubator for policy efforts that engage top political figures, advocates, academics, and business leaders in the art of principled compromise.

This report is part of a series commissioned by the BPC to advance the substantive work of the Leaders' Project on the State of American Health Care. It is intended to explore policy trade-offs and analyze the major decisions involved in health insurance benefit design, and discuss them in the larger context of health reform. It does not necessarily reflect the views or opinions of the four Leaders or the BPC. Launched in April 2008, The Leaders' Project is crafting a framework to accelerate constructive discussion and implementation of policy solutions to address the delivery, cost, coverage, and financing challenges facing the nation's health system. To accomplish this goal, the four Leaders will host several public policy forums across the country and release a final report with comprehensive policy recommendations on the issues defined in the project's four "pillars" of health care reform. This report and recommendations will be released in early 2009.


## Acknowledgements

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The BPC is honored to have the support of the Robert Wood Johnson Foundation (RWJF). RWJF is working to ensure that all Americans have stable, affordable health care coverage.

Robert Wood Johnson Foundation


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# Health Insurance Design Choices

*Issues and Options for Change*

By

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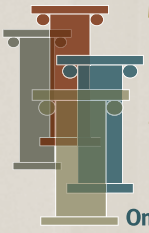

THE LEADERS' PROJECT
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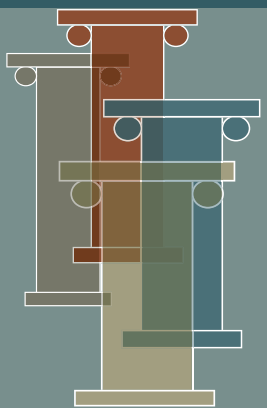
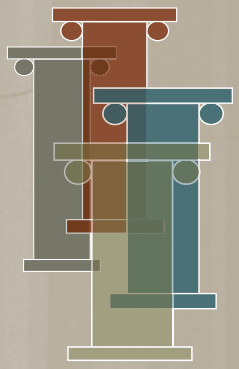


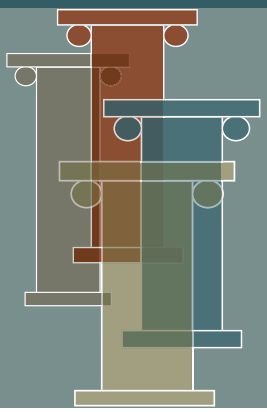


## Four Pillars of Health Care Reform

The Leaders' Project is structured around four "pillars" that, taken together, the Leaders believe represent the foundation of a solid policy needed to achieve quality, affordable health care for all Americans. The four pillars are:

- Preserve and improve quality and value
- Increase the availability and accessibility of affordable coverage options in a reformed insurance market
- Promote the individual's role in health care coverage and cost
- Secure a workable financing mechanism for the nation's health care system

# Executive Summary



Health insurance coverage is an essential tool to achieve the goal of affordable, high-quality, sustainable health care. It enables utilization of health services, drives prices, and provides incentives for high-value care and high-quality providers. It also ensures protection against catastrophic health care costs. For these reasons, reforms that affect the design of health insurance coverage are key elements of the health care reform discussion. Resolving the challenges facing the nation's health system will require the consideration of policies that promote insurance benefit designs that provide adequate financial protection, while producing high-value, high-quality care at the lowest cost. Ensuring that benefit designs stay up-to-date with current medical research and practice standards is another issue that must be addressed, so that health insurance coverage promotes effective, efficient use of health care services over time.

Successful health reform will require a balance between ensuring affordable insurance (for consumers, businesses, and the government), and promoting benefit designs that produce positive medical outcomes. In achieving this balance, benefit design policies must negotiate extending covered services to the point of being overly generous, and thus excessively expensive, with limiting covered services to the point that they put consumers at financial risk. It is important to note, too, that while variation in health benefit design may lead to innovative ways of providing coverage effectively, it can also result in "adverse selection." For example, competing health plans could structure a mix of covered benefits and cost-sharing requirements to try to avoid patients with chronic illnesses or other high costs, rather than to promote high-value care. This could result in inadequate or inefficient coverage for those who need it most.

There are a number of key questions that must be addressed when designing effective health insurance choices:

### *What essential standards for coverage must be met by insurance plans?*

Standards for insurance design could range from minimal requirements (defining in the most basic terms what constitutes health insurance for tax purposes, for example), to broad requirements (such as categories of benefits and minimum actuarial values), to more detailed requirements (mandating coverage of particular services or provider specialties).

### *How should cost-sharing be designed?*

The structure of cost-sharing, which includes deductibles and copayments, is an important factor in health benefit design, as it can encourage or discourage the use of health services or certain health care providers. Cost-sharing requirements also present a variety of issues, and can be incorporated into health reform efforts in a number of ways. For example, one way to improve value is to remove cost sharing from desired care, and impose it on care that does not improve health outcomes. An extension of this concept can be seen in the recent innovation of value-based insurance design. This approach relates copayment levels to the effectiveness of specific services. In doing so, it removes financial barriers to appropriate care, and uses it as a tool to discourage excessive or inappropriate use of care. An alternative to using cost sharing to improve health care value is to give individuals a high-deductible health plan and informational tools, and allow them make the value determination of care themselves.

### *What steps beyond restrictions on health benefit design flexibility can help prevent adverse selection?*

Irrespective of insurance design choices, adverse selection can still occur. Policymakers will likely need to consider such available policy options as risk-adjustment, subsidies for healthy people who cannot afford coverage—or a purchase requirement for healthy people who can—to mitigate its effects.

The question of who should shoulder the responsibility for determining the structure of health benefits and other aspects of insurance design is also important, as such decisions could be made at several levels, including:

- Legislatively-defined benefits
- Partially-defined benefits with some flexibility for insurers
- Delegated-benefit authority
- Market-based benefits determined jointly by insurers and purchasers (which most closely reflects the current system)

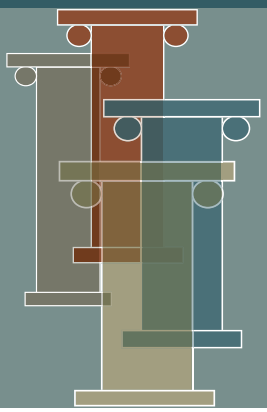
These options are differentiated by who determines the policies that influence covered services, the basis for those decisions, and how likely benefits may both promote high-value care and reflect the most current clinical research and practice methods.

Strategies for setting health benefit design will inevitably need to strike different balances on key trade-offs. For example, standardized benefits, including benefit designs based on expert opinion, can simplify choices for individuals, make health plans accountable for

ensuring specific, important features of coverage, and reduce adverse selection pressures. On the other hand, providing greater flexibility may lead to coverage that better reflects individual preferences and health needs. Likewise, competition in benefit design can promote innovative ways to improve quality and lower costs, but may cause adverse selection. Steps like risk adjustment could reduce that likelihood, as can reinsurance and greater subsidies to purchase health insurance. But these steps would add to federal costs and administrative complexity. An individual mandate also could reduce selection problems by bringing healthy people who currently opt-out of the voluntary health insurance market into the risk pool; but it could also bring in low-income people, who may require financial assistance to purchase coverage. This, too, could have the effect of increasing overall federal costs.

This paper aims to clarify the major decisions involved in health insurance benefit design, and then discuss them in the larger context of health reform.

# Introduction



Health insurance gives individuals access to health care while protecting them against the risk of high costs if they become severely ill or injured. It can make health care more affordable by lowering financial barriers to needed, clinically appropriate care, but it does not neccessarily ensure that patients will use or have access to high-value health care. If poorly structured or under-financed, insurance might not cover the treatments or types of care that individuals need, or it might require individuals to pay a large part of the cost themselves, leading to inadequate access and insufficient financial protection. Conversely, overly-generous insurance might encourage both patients and providers to use more health services than are necessary or clinically advisable. In fact, many argue that overly-generous benefit packages have fueled a rapid expansion of medical technology, some of which adds to costs even when the treatment is more effective and leads to improved outcomes.[1,2] At the same time, rising health costs are making insurance increasingly unaffordable, driving up the rolls of the uninsured and underinsured, and putting these same technological advances beyond the reach of many.[3,4]

Although public attention has focused on how best to increase the number of Americans who have health insurance, an equally important issue is how insurance can be designed so as to promote both better care and better value. That debate raises a number of significant and meaningful questions. Is there an essential standard for coverage? Should that standard include differential copayment structures to provide incentives for appropriate use of care? How should coverage choices be structured, and how can the potential for adverse selection be reduced? What balance should be struck between expert opinion and individual preference, and insurer flexibility and public accountability? And, finally, who should make such decisions? Individually and collectively, these questions can have a substantial impact on the performance of the health system, and, ultimately, the success and sustainability of health reform.[5]

Currently, health benefit design options—and trade-offs—are being debated in the context of rising costs, declining coverage, and a growing sense that our health system does not provide adequate quality of care or value for patients. Yet the United States spent about $2.1 trillion on health care in 2006, an amount that is twice what it was in 1996, and half as much as is projected for 2017.[6] Health costs strain American businesses, which directly finance about one-fourth of health system spending.[7] With insurance premiums on the rise, families are paying more for health care. The average cost of

a family, employer-based insurance policy in 2008 was $12,680, nearly the full-year, full-time earnings of a minimum wage job.[8] Federal and state budgets are under increasing pressure because of the rising cost of health programs. According to the Congressional Budget Office (CBO), rising health care costs represent "the nation's central long-term fiscal challenge … and the single most important factor determining the nation's long-term fiscal condition."[9]

Not surprisingly, the cost problem has contributed to an access problem. The number of non-elderly Americans covered by employer-based health insurance fell from 66 percent to 61 percent between 2000 and 2006.[10] With few affordable alternatives, individuals who lose employer coverage often become uninsured, or enroll in public programs such as Medicaid. In 2007, 46 million Americans, more than 15 percent of the population, were uninsured—up roughly 7 million since 2000.[11] If trends continue, another 7 million will be added to the ranks of the uninsured by 2012.[12] Lacking health insurance puts individuals at risk for not obtaining needed care, leading to decreased workplace productivity, and a greater risk of illness or death, with an economic cost by some estimates of $65 to $135 billion per year.[13,14,15]

*Rising health care costs represent "the nation's central long-term fiscal challenge … and the single most important factor determining the nation's long-term fiscal condition."*

Cost and lack of coverage are not the only problems plaguing our health system. As costs have risen, so have concerns about the quality and value of health care delivered to Americans, whether they have insurance coverage or not. Considerable evidence shows that having Medicare, Medicaid, or private insurance does not guarantee high-quality, efficient care. In fact, one comprehensive study found that effective, evidence-based care is provided only 55 percent of the time.[16] The Institute of Medicine estimated that roughly 100,000 deaths per year result from low-quality care.[17] At the same time, the United States lags behind other nations in the use of error-reducing mechanisms, such as health information technology, which could improve both outcomes and efficiency.[18]

As policymakers debate solutions to these complex and multi-faceted challenges, it is essential that the importance of health benefit design not be overlooked or diminished, because it can address the challenges of cost, access, and quality of care. With roughly 250 million Americans covered by some form of health insurance, plans effectively structure the financial environment in which medical providers operate. Private and public insurers serve as a medical gateway, having paid for 81 percent of health care delivered in 2006.[19] And, finally, decisions affecting how insurance markets determine coverage of services, set cost sharing, and establish pricing can have a powerful impact on the performance of the health system. This is because these structural pillars can affect the use of high-cost care by individuals, the provision of care by physicians and other health professionals, and the use of such care by individuals. For these reasons, careful consideration of the intricacies of health benefit design is an important step toward meaningful health care reform.

## Insurance Design and Why it Matters

Because the need for health care can be both unexpected and costly, health insurance is essential for ensuring that individuals receive necessary services while being protected against high expenses. Like other forms of insurance, health coverage provides a means to spread the financial costs of unexpected, expensive treatments needed by a few people across a wider population. In addition, it offers a way to pre-pay for routine and affordable expenses, which promotes the use of high-value health services such as recommended preventive care. Finally, health insurance provides assistance to individuals with chronic conditions or predictably high expenses for their expected costs.

Insurers design coverage to provide value to the consumer while keeping costs (and insurance premiums) in check. Each health plan contains a legal contract that establishes the medical services covered, includes reasons for benefit exemptions, and sets the cost of premiums, deductibles, and copayments.[20] Plans also contract with a set of health care providers to pay for covered services. These contracts set reimbursement rates, conditions for payments, and, with increasing frequency, standards for quality of care. Some plans provide benefits such as care coordination, health behavior education, and personal health records that affect how coverage is used. Private insurers build into their premiums the cost of administering benefits and managing their use of services, marketing, and, when appropriate, profits. Public insurers function similarly, and typically subsidize the premiums and cost sharing charged to enrollees.

The more generous the coverage and the wider the provider network, the higher the cost of insurance (unless there is an offsetting increase in the costs that enrollees must pay directly). These benefit design features allow insurers to leverage prices and influence utilization of care, both of which affect cost. Private insurers adjust all of these parameters to create insurance products that balance attractive coverage policy, premiums, and protection from excessive financial liability. Public programs such as Medicare and Medicaid also must consider how changes in coverage and benefit design will affect vulnerable beneficiaries and the government's budget.

### *How Coverage Policy Works*

One of the most confusing aspects of both private and public health insurance is coverage policy. A health plan may "cover" a particular treatment, which means that under certain circumstances it will pay part or all of the cost of the service. Although health plans typically cover most major services (including hospital and physician services, diagnostic tests and, often, prescription drugs) not all offered services are covered at all times for all patients. For example, the plan will pay only if the service is "medically necessary" or "necessary and reasonable" for the treatment of a specific patient. Medical necessity typically reflects prevailing standards of good practice in the medical community.[21]

Most plans require that beneficiaries pay a portion of the cost of the service to discourage overuse of health services, and to help keep premiums affordable.[22] These cost-sharing requirements may include a deductible (a fixed amount the consumer must pay each year before any insurance payments are made), or a copayment (a fixed amount or a percentage of the cost of a service that the consumer pays to the provider). Health plans often charge lower cost sharing if the provider is in its network of preferred providers.

Some insurance plans offer price discounts, even when a benefit is not covered. For example, individuals who must pay for a service because their deductible has not yet been met can pay the provider the same rate that the insurer negotiated—a rate that is much lower than an individual purchaser would be able to negotiate or receive. Some plans even extend these discounted rates to services not covered by an individual's plan.

An insurer's decision to cover a specific treatment is based upon scientific information about the effectiveness of intervention, typical practice in the health care community, and a judgment that weighs the potential value of the treatment against its cost—both the financial cost and the risk that the treatment might be ineffective or harmful to the patient. Coverage decisions are often complicated and individualized. While there is a dearth of definitive proof of treatment effectiveness, available evidence must be interpreted based upon the actual patient's condition, symptoms, and medical history. Sometimes, coverage will include requirements that help providers and insurers learn more about the consequences of treatment, such as registry tracking to help understand complication rates. Coverage also may limit use of providers to those who have demonstrated better outcomes. Even with these steps, judgments may differ about the value of a treatment for many patients. This inherent clinical uncertainty contributes to the wide variation in the practice of medicine and, consequently, health spending across different localities.[23]

For this reason, and because health care is intensely personal, an integral part of any health plan is an appeals process that provides the physician or patient with an opportunity to have a coverage determination reconsidered. The appeals process is central to the health care system's protection of medical consumers.[24] It helps ensure access to needed health care, and serves as an external quality control and review mechanism.[25]

Health plans may have additional restrictions on what they will reimburse. For example, private insurers offering coverage in the individual (non-group) market may exclude payment for treating "pre-existing" conditions—health problems that the enrollees had before they purchased insurance. Such exclusions discourage consumers from waiting to buy insurance until after they have been diagnosed with an expensive illness, and protect individuals who are already in the market from large premium spikes. However, people

facing coverage exclusions often have difficulty paying for needed care. The Health Insurance Portability and Accountability Act (HIPAA) limits the extent to which group insurance plans can exclude coverage for pre-existing conditions.[26] Specifically, HIPAA limits exclusions to group health plans based on preexisting conditions to physical or mental conditions that were diagnosed, treated, or for which medical advice was given, within 6 months before the enrollment date. A preexisting condition exclusion is not applicable to individualswho have maintained continuous coverage, which is defined as coverage without a break for more than 63 days in a 12 month period. If a preexisting condition is applicable, however, group health plans may apply an exclusion for up to one year.

Some plans have limits on the "amount, duration, and scope" of coverage. This generally means that coverage has some time or monetary limit. For example, some state Medicaid programs have attempted to reduce program outlays by establishing such limits on the number of covered hospital days. Since there is no concrete rule as to what constitutes a sufficient amount of services to treat an illness, such limits have been challenged regularly in court.[27] Other examples exist in Medicare, which has a lifetime limit on hospital coverage, and some private plans, which cap the annual amount of drug coverage.

*Policymakers, payers, and the public want health insurance to accomplish three specific functions: provide financial peace of mind to families, promote the use of effective care, and encourage greater efficiency in the practice and delivery of medicine.*

***Goals of Health Insurance Design***—Generally, policymakers, payers, and the public want health insurance to accomplish three specific functions: provide financial peace of mind to families, promote the use of effective care, and encourage greater efficiency in the practice and delivery of medicine. This can be achieved only if the insurance promotes high-value care while also providing financial protection. Because these objectives may be in conflict with one another, well-designed insurance programs seek a balance between benefit generosity and the cost of coverage. Likewise, payers must find the appropriate balance between standardized benefit features and individualized, clinical determinations of what should be covered.

***1. Protects Against Financial Catastrophe***—Health insurance spreads the cost of care across a large number of people. Each participant pays an average monthly premium to insurers who use the pooled resources to cover at least a portion of an agreed-upon set of medical benefits.[28] People who need more health services than average face lower total costs than they would if they did not have insurance. That is particularly important for individuals faced with serious illness and high health costs, as they might not be able to afford treatment without insurance.

To receive this financial protection, consumers must be able to pay their health insurance premiums, plus additional out-of-pocket costs that are not covered by insurance. The rising cost of care is making health insurance less affordable for many families, more of whom are going without coverage. Between 2003 and 2007, the number of people in families reporting problems paying medical bills rose by 14 million, accounting for 19.4 percent of population.[29]

***2. Promotes the Use of Effective Care—***The design of insurance benefits can influence consumers' use of health care, and can be used to promote the use of more effective services. For example, individuals are likely to forego some beneficial services if their cost sharing is high. A recent study showed that as little as a $10 copayment can cause significant reductions in the use of mammograms among seniors.[30] The uninsured are more at risk for not receiving recommended preventive care. One study found that the uninsured are 50 percent less likely to undergo disease screenings (such as pap smears, mammograms, and prostate exams).[31]

Although insurance is essential in promoting the use of health care, insurance design can sometimes impede the delivery of efficient care. While there are many factors driving up health costs (including rising obesity rates, increasing rates of chronic disease, and the growth of medical technology), insurance design also has played a significant role. Broad coverage combined with payments that reward the provision of services rather than improvements in patient health status have contributed to the problem of rising costs. Current insurance design ensures that providers will be paid regardless of the value of the care delivered, and coverage insulates consumers from the immediate costs of treatment. It fosters many clinical decisions being made without sound evidence of effectiveness. Indiscriminate, generous coverage allows for the substitution of high-tech—and often high-cost services—for low-cost services that may be equally, if not more effective.[32] It may also create incentives for extra tests and services that may not be necessary, and might not be prescribed or used if patients had to pay for these services out-of-pocket.

Insurers have begun to adjust their coverage and cost-sharing requirements to steer patients toward services perceived as having a high value and away from those whose value may be low. For example, most health plans require their enrollees to pay a standard copayment if they fill a prescription. To improve patient adherence with medical treatment, some insurers and employers have eliminated the medication copayment for some high-risk patients. One such firm, Pitney Bowes, reduced or eliminated copayments for drugs commonly prescribed for diabetes, asthma, and hypertension—chronic diseases that can lead to expensive acute episodes if not managed properly.[33]

Some insurers have used cost sharing (e.g., multi-tiered drug formularies) to steer patients toward more effective and/or lower-cost services. This model is another example of "value-based insurance design", providing more finely tuned financial incentives to promote appropriate use of care.[34] That is, patients experience lower costs and get more of the savings compared to a traditional insurance design because they chose high-value care. This could improve health outcomes for patients, and might help constrain overall system costs.

Payer interest in using benefit design to guide utilization of health care has spurred efforts to provide a more scientific basis for treatment decisions.[35] Comparative effectiveness studies focus on the relative medical benefits and risks of various treatment options, (including surgical, medical, and pharmaceutical approaches) or on alternative strategies for providing care. Cost-effectiveness studies consider the financial costs of the options in their analyses, and for that reason are controversial in policymaking circles.

The widespread application of comparative effectiveness research is constrained by data availability, research methodology, and its validity for a broad range of people, including those with complicated cases or chronic illnesses. Questions have been raised about whether the government, the private sector, or a public-private partnership should drive the research agenda, who ultimately will own the data, and who will pay for what could be a sustained, large-scale undertaking. Concerns also have been raised that insurers might exclude coverage of treatments that could be highly effective for some patients because research suggests that it is not beneficial for the broad population.

Moreover, a significant portion of the wide variation in health spending from region-to-region has been linked to differences in practice styles (such as how intensively specialists, lab tests, and imaging procedures are used in treating disease), rather than the relative effectiveness of specific intensive medical technologies. This variation in practice styles, spending and treatment approaches calls for an even broader research agenda—one that will produce sound clinical evidence that can be applied throughout the health care system, to improve effectiveness and efficiency.

To date, comparative effectiveness research has garnered broad, bipartisan support. A systemic comparison of diagnostic and treatment strategies, as well as the intensity or breadth of use of these strategies within a population, could improve patient outcomes and patient safety, and might also reduce unnecessary health spending.

***3. Influences Provider and Health System Performance—***Another element of health insurance design that affects both provider and consumer behavior is the health plan's structure. A fee-for-service (FFS) plan applies the same coverage and payment rules to all providers and services. A preferred provider organization (PPO) applies the plan's coverage policy only to providers participating in its network, and use of out-of-network providers results in either greater cost sharing or no insurance payment at all. A health maintenance organization (HMO) often covers health care provided only by its own group of providers, also known as a "closed network." These plan designs have a number of implications for health policy, including an interaction with health coverage and cost sharing.

Recently, health plans have begun to experiment with using quality performance as an element of health insurance design. Initiatives such as pay-for-performance are intended to provide insurers with a scientific basis for rewarding providers delivering high quality care, and likewise discourage use of services that do not provide sufficient benefit for the cost. The Institute of Medicine called for a concerted national effort to implement performance-based measures across the health system in 2005.[36] Medicare has tested a variety of payment approaches, including bonus payments to hospitals that report their performance on clinical performance standards, and gain-sharing arrangements that allow hospitals and physicians to share savings resulting from collaborative efforts to improve quality and efficiency.[37] Designed to foster greater accountability among medical providers, these reforms tie insurance payments directly to measurable improvements. Such reforms are also being extended to benefit design, with some insurers offering much lower copays or no copays at all—for high-quality providers. These reforms are likely to continue to evolve as evidence accumulates on their impact improving the value of health care.

## How Health Insurance Design Is Determined Today

Health insurance design in the United States is determined through a complex set of government rules, with regulation of insurance markets historically falling under the purview of the states, and decisions made by the private sector. Virtually every public program and private insurance policy has a different coverage design (see the Appendix for a discussion of health insurance benefit design policies). Private insurance, the predominant mode for coverage in this country, is governed by a mix of market forces (e.g., what employers believe workers want) and regulation (e.g., state benefit mandates and federal consumer protection laws). An employer offering a choice of plans often presents a menu of options with varying benefit structures, cost-sharing requirements, and premiums. Similarly, coverage offered by one insurer could vary significantly across states or employees and could be quite different depending on individual characteristics.

Similar differences exist across public health insurance programs. Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), programs for veterans, active military, Native Americans, and federal employees, among others, each have their own benefit rules. For instance, the coverage and cost sharing for care for a senior with diabetes differs depending on whether she is low income, is enrolled in a private MedicareAdvantage plan, is an active worker or retired, or is a veteran. The lack of a clear and consistent public policy toward health benefits design across public and private insurance, and its subsequent negative consequences on access, quality, and the costs of care, is a primary motivation for health reform.

## Health Insurance Choice and Adverse Selection

A main concern in any health system with a variety of plan choices is the potential for "adverse selection" to occur. Adverse selection is the disproportionate enrollment of predictably high-cost individuals in health benefit designs with relatively generous coverage. In turn, the insurer must charge a higher premium to cover its costs, creating a competitive disadvantage. To avoid adverse selection, insurers modify their design to avoid predictably high-cost enrollees. This could mean scaling back benefits, limiting access to high-cost specialists, and/or implementing marketing or retention policies that dissuade high-risk individuals from enrolling. It could also mean discontinuing coverage altogether. Some of the strategies could limit high-risk individuals' access to needed health care.

Public and private policymakers have tried a number of strategies to mitigate the problems of adverse selection. The most direct is to limit insurance choices. Since restricted choice is the exception rather than the rule in the U.S. system, other strategies limit the extent to which health insurance plans can vary their covered benefits, cost-sharing requirements, and plan structure. Greater uniformity reduces, but does not eliminate the pressure of adverse selection. It provides enrollees with greater certainty about what is covered, but also limits their ability to get coverage that reflects individual insurance preferences. It also restricts insurers' ability to modify coverage designs.

Another approach is to adjust health plan payments to mitigate adverse selection problems. Under such "risk-adjustment" arrangements, plans that attract individuals with chronic diseases or other high-cost conditions get payments that reflect their higher expected costs. Risk adjustment can be done prospectively (e.g., through capitation payment add-ons or subtractions related to the expected cost of a person's care) or retrospectively (e.g., through adjustments to capitation payments based on costs incurred during the enrollment year). These risk-adjustment methods are usually based on the enrollees' characteristics, such as age, gender, and the presence of specific chronic diseases. Payments to the plan reflect the average costs (either projected or actual) of patients with similar characteristics, rather than the specific cost experience of an individual plan. These public payments usually aim to be "budget neutral," meaning that plans with low-cost enrollees help fund the cost of coverage in plans with high-cost enrollees.

Alternatively, the financial risks of adverse selection can be shared between insurers and the government. This is done through subsidies to insurers in the form of reinsurance (which pays for part of the higher operating costs actually incurred by an insurer's high-cost beneficiaries) or risk corridors (which limit the maximum dollar profit or loss that an insurer might actually realize). These "risk-sharing" tools differ from risk adjustment

in that the payments depend to some extent on the actual cost experience of a particular insurer. In contrast, "risk-adjustment" payments depend on the characteristics of the beneficiaries in the plan, not their actual cost experience.

All of these tools have been employed in Medicare's prescription drug benefit. Risk adjustment based on patient characteristics, and partial reinsurance for high-cost individuals remain key elements of Medicare payments. Although, it should be noted that risk corridor payments are being phased down over time, as experience with the costs of drug coverage increases.

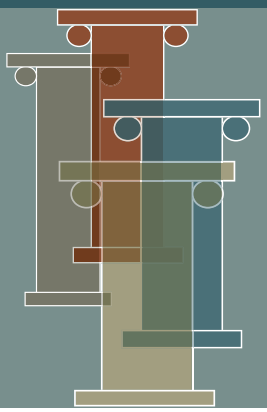
A different approach to managing high-risk people is removing them from broad-based insurance pools altogether and enrolling them in high-risk pools or public programs. This could reduce competitive pressure plans face to avoid higher-cost beneficiaries. States that have created high-risk pools have experienced difficulties financing their operation, forcing many of them to limit enrollment or take other steps to control costs. More evidence is needed on risk pool management, including best practices in stabilizing premiums, managing high-cost enrollees, and providing individuals with the type of benefits they want.

Lastly, providing subsidies to low-income individuals, rather than high-cost individuals, may limit adverse selection. Reducing the price low-cost individuals pay for insurance would increase and broaden the risk pool for health insurance plans. This, in turn, would stabilize premiums and insurance benefit designs, and address concerns about affordability and equity of coverage. It would also, however, add to government costs.

Additionally, the effectiveness of risk-adjustment, reinsurance, and subsidies is limited in a voluntary insurance market where low-risk individuals can self-select out of the system to avoid cross-subsidizing the costs of higher risk individuals. Requiring individuals to have health insurance both expands the size of the risk pool, and facilitates the spreading of risk through tools like community-rated premiums. Methodologies for addressing adverse selection are imperfect, but they are increasingly important for preventing the negative consequences of adverse selection.

In this paper, we primarily focus on explicit benefit design issues, but we also describe how risk-adjustment techniques can reduce the pressures on explicit benefit design, and note that some limits on the range of plan variation, combined with risk-adjusted subsidies, are likely to be part of major health system reform.

# Options for Determining Health Insurance Design



Although differences exist in the details and implementation of health reform, a rough consensus exists on several common features of benefit design. Policymakers across the political spectrum agree that coverage should include catastrophic protection, meaning limits on individuals' out-of-pocket costs (e.g., annual out-of-pocket limits, or limits on cost sharing as a percent of income). Also, it should cover major broad-service categories, including, but not limited to, hospital services, doctor services, and prescription drugs.

There is general agreement that there should be minimums and maximums for the value of benefits supported by public subsidies—although how those thresholds are set is a political and financing decision. For example, more generous benefits generally will be more expensive, requiring larger government subsidies to ensure sustainability. There also is accord on the need, if not the method, to incorporate evidence on the comparative effectiveness of therapies and modes of delivery into benefit determination. The object of such efforts is to encourage better and more efficient care, while avoiding overly prescriptive "cook-book" medicine.

Agreement on these benefit design features quickly disappears, however, when moving from concepts to details. Determining catastrophic coverage limits, the extent of coverage, and size of deductibles, for example, have been the topics of heated debates. Controversy may be inevitable the more granular the policy, and the closer policymakers come to concrete policy decisions. The debate also reflects different beliefs and values about how much or how little health care insurance should cover, and who should bear the cost. Standards for insurance design could range from minimal requirements (defining in the most basic terms what constitutes health insurance for tax purposes) to broad requirements (such as categories of benefits and minimum actuarial values), to more detailed requirements (requiring coverage of particular services or provider specialties). Cost-sharing requirements also could vary, by permitting high deductibles or adjusting copayments to promote the use of specific services by patients who would most benefit from their use.

We discuss four models for determining the degree to which health insurance designs might vary in a reformed system. One approach, used in programs like Medicare, is to set the benefit design through legislation, using existing political system to

incorporate public preferences. A second approach is to set some aspects of benefit policy in legislation, but allow insurers to innovate within limits, as is the case with MedicareAdvantage, and SCHIP. A third approach is to delegate the benefit design standards to some third-party authority, allowing appointed experts or stakeholders to determine the extent to which benefits are standardized. Lastly, benefit design could be left primarily to insurers who would design benefits to attract enrollees in a competitive market place.

In every case, there is a role for both individual choice and rules that limit, to a greater or lesser extent, available plan options. Even with a high degree of standardization, there will be some variation in coverage or cost sharing for specific services; consumers will still have choices to make; and, inevitably there will be a risk of adverse selection. Even with a high degree of variation in plans, there will be rules that define, at least minimally, the range of products sold in the market.

## Legislatively-Defined Benefits

***Description:*** Some proponents of health care reform advocate defining in statute the set of benefits that should be available to all Americans. Under this approach, authorizing legislation would specify the covered services, their amount, duration and scope, and required cost sharing. All enrollees in plans affected by this benefit policy, potentially all Americans, would receive the same set of specific benefits. They would be determined through the ordinary legislative process, starting with congressional hearings and concluding with a presidential bill signing. Implementation and interpretation of some aspects of the law would be done by the Executive Branch, but within strict constraints. Legislative decisions could be informed by an expert organization, similar to the Medicare Payment Advisory Commission that guides Congress's Medicare payment policymaking.

***Examples:*** Medicare is the best-known example of defined benefits set through legislation. The original 1965 legislation set most of the rules for coverage, and Congress has periodically modified them since then. Proposals to expand Medicare as part of health reform typically build on this model. For example, the United States National Health Insurance Act advanced by Physicians for a National Health Program proposes that every American have the option of publicly backed health insurance. This insurance would cover 13 broad categories that constitute a minimum of care and include services from primary care and emergency services, to long-term care, prescription drugs, and mental health services.[38] With respect to prescription drugs, the bill proposes a formulary system to encourage best practices, promote generic alternatives and discourage over-utilization. The act also expressly forbids deductibles or cost sharing, and guarantees coverage of any licensed health care provider.

Another example of a federally defined benefit was President Clinton's Health Security Act in 1993. This legislation guaranteed a comprehensive benefit package similar to those proposed by large employers at the same time, with an added emphasis on preventive services. The act also added a prescription drug benefit through Medicare, and a long-term care program aimed at community and home-based care for the severely disabled. With regard to cost sharing, the act allowed it to vary by plan type (traditional fee-for-service plans, PPOs, and HMOs) and also allowed a "high cost-sharing option" with a $400 deductible (in 1994 dollars), set at 20 percent coinsurance, and limits placed on the amount of out-of-pocket costs.[39]

***Rationale:*** The rationale for defining benefits legislatively is that the needs of individuals are more similar than different: protection against medical risk and promotion of high-value services is less a matter of personal choice than a public obligation. Proponents further argue that the uncertainty involved in health decisions clouds rationality. People do not necessarily have well-defined preferences, leading to some mismatches of needs and benefits. Thus, individuals may be better off—and possibly happier—with a standardized benefits package than one they design themselves. Supporters of this approach also argue that the process for setting health benefits would be the same public policy process that typically is used when significant taxpayer dollars are at stake. And lastly, they argue that it is easier for consumers to do apples-to-apples comparisons of plan offerings on the basis of cost and quality when there are not so many benefit options to choose.

However, legislatively defining benefits has been criticized on both substance and process. Its "one-size-fits-all" approach will not address everyone's needs, and it puts an abstract sense of what should be covered ahead of individual preferences. It could also limit the adaptability of benefit design over time, suggest that our legislative process is not well suited for this type of decision because policymakers may be too willing to add benefits that are based on a political, rather than a policy or clinical, rationale.

## Partially-Defined Benefits with Some Insurer Flexibility

***Description:*** The most common approach to benefit design in health reform proposals is to combine specificity and flexibility. The specificity typically pertains to two aspects of benefits. One is the minimum value of coverage, typically expressed as "actuarial value", is the average amount per person that a health insurance plan pays through benefits for an average population. A number of policies and proposals set a minimum actuarial value for coverage, which is often linked to a "benchmark" benefit package offered by a well-regarded private or public insurance program. In addition, proposals that adopt this approach often specify some services (such as preventive coverage) that must be included in health benefit packages, or a limit on out-of-pocket spending. This provides assurance of

coverage for services that might not otherwise be included if left to individual or insurer choice. Beyond these rules, insurers may set their design benefit options however they wish, and typically may offer benefits exceeding the minimum actuarial value.

***Examples:*** In the past decade, two major policies set benefits using a minimum value with some specified coverage: SCHIP and the Medicare prescription drug benefit. Both include one or more standard benefits packages that may be used for coverage. They also set benchmark levels of actuarial value, prescribe certain cost-sharing limits, and require plans to cover certain types of drugs or services (e.g., well child care in SCHIP). The Healthy Americans Act, sponsored by Senators Ron Wyden (D-Ore.) and Bob Bennett (R-Utah), also adopts this model. Under that proposal, private insurers would be required to offer coverage to everyone without restriction. Coverage would be at least equal to the actuarial value of the standard Blue Cross Blue Shield benefit plan offered to federal employees. Plans would also have to cover preventive benefits. Beyond that, they could vary benefits and cost sharing. Insurers could offer high-deductible plans with a health savings account, with the account deposit counting toward meeting the minimum actuarial value.

President-elect Obama's campaign health proposal also follows this approach. It would create a new public program option with benefits similar to those offered through the Federal Employees Health Benefit Program (FEHBP). The proposal also suggests that this public plan would include coverage of preventive health services with minimal copayments, as well as maternity and mental health care. Private plans that participate in the purchasing pool created in the proposal would have to offer benefits at least as generous as the new public plan.[40]

***Rationale:*** This mix of regulation and market-based benefit design aims to provide minimum protection while allowing some flexibility for benefit design to evolve and innovate without legislative directives. By creating a floor for the actuarial value of the benefits, such proposals aim to ensure their adequacy, effectively preventing gap-ridden coverage by forcing a minimum amount of benefit generosity. At the same time, it trusts that health insurers, rather than policymakers, can design benefits in a way that meets individual and population needs.

Critics of this approach generally focus on whether there is enough regulation or enough insurer flexibility: MedicareAdvantage has been criticized for having too few boundaries for benefit flexibility, and SCHIP has been criticized as being too strict in its benefit standards. Concerns also arise over designing benefits with a mix of specificity, because it could yield unintended consequences like unanticipated benefit gaps, adverse selection, or too few insurers offering benefits in a particular market to allow for choice of plans.

## Delegated-Benefit Decision Authority

***Description:*** A third approach to benefit design uses an appointed board, or other entity, to set benefit standards for the health system. The board might be given the authority to decide what benefits must be covered, and could decide whether benefits should be fully or partially defined. Congress's influence over the authority would be limited to establishing the entity's structure and functions. For example, it could have a single administrator or board, be composed of experts or stakeholders, and be given either purely advisory or aggressive implementation authority. Once Congress has established these rules of operation, the decisions of the entity would largely be autonomous.

***Examples:*** The FEHBP most closely resembles this model at the federal level. Explained in detail in the Appendix, the Office of Personnel Management is bound by few statutory rules, and acts like any other large employer in negotiating health benefits for its employee pool. It is fully integrated into the Executive Branch, which limits its independence relative to other possible models for delegated benefit decision authority. This has meant that on several occasions, including when mental health parity became a priority in the late 1990s, FEHBP required its participating plans to modify their benefits to come into compliance. Similarly, when Congress established high-deductible plans offering health savings accounts, FEHBP encouraged participating insurers to offer such plans.

Another example of delegated benefit decision authority is the Massachusetts Commonwealth Health Insurance Connector Authority. Created in 2006 as part of the state's larger reform efforts, the Connector Authority is a quasi-public entity overseen by a board of 10 appointed members and a chairperson. It facilitates the purchasing of health insurance by creating a statewide insurance market, and sets standards of participation for private insurers offering coverage in the non-group market. The Connector board and the state's commissioner of insurance must approve deductibles and other cost-sharing requirements. However, insurers offering plans with higher levels of cost sharing, and lower premiums than the determined standard, are permitted for 19 to 26 year olds. All plans offered through the Connector Authority must be licensed in Massachusetts, and nonsubsidized plans must cover all benefits mandated by state law. [41]

Others have proposed this model for health reform plans, as well. Proposals from former Sen. Tom Daschle, Dr. Ezekiel Emanuel of the National Institutes of Health, Stanford University economist Dr. Victor Fuchs as well as the Committee on Economic Development, have urged the creation of an independent authority modeled on the Federal Reserve Board to set benefits for all or parts of the U.S. health system.[42,43,44] Members of the authority would have significant expertise, and be appointed to long terms to minimize political influence. Some proposals also include regional boards to solicit stakeholder involvement and disseminate federally-defined insurance standards. Its authority could go beyond that of the Massachusetts Connector, with the standards it sets for benefit design superseding state laws.

***Rationale:*** One rationale for delegating health benefit decisions is that political representation may be less important than technical expertise in making these types of decisions. Individuals tend to want comprehensive coverage, as health care decision making is often clouded by uncertainty, a belief that more is better, and a fear that the wrong decision will have negative, irreversible consequences. Seeking public input on health plan design may be similarly challenged. Those who participate in a democratic process most vigorously are those who have a personal desire to see that treatments for their own particular health problems are covered. This phenomenon is seen in Congress and state legislatures, where coverage requirements may result from the work of a legislator with a friend or family member afflicted by a particular disease. As such, delegating benefit decisions to a group one-step removed from the political process may result in policy that better reflects the existing evidence on what constitutes high-value health care.

Objections to this approach come from both ends of the political spectrum. Liberals worry that such an authority will be unaccountable to the public and make benefit-rationing decisions involving taxpayer dollars behind closed doors. Conservatives worry that such an authority would set new health benefit mandates based on weak evidence, and without real accountability for efficiency, thereby imposing unnecessary costs on the system. Others fear that the authority would inappropriately restrict the use of health care services that could provide value to patients.

## Market-Based Benefits

***Description:*** Several reformers have proposed reducing state regulation of private insurance, arguing that such regulations unnecessarily impose costs on consumers, and limit competition among insurers that could yield more efficient insurance choices for individuals. The 50 sets of state regulations could be simplified by creating uniform federal insurance standards that pre-empt state laws, although there is no guarantee that the burden of federal regulation would be lower than that of state regulation. A more commonly discussed proposal would allow individuals, employers and associations to purchase health insurance from any insurer, regardless of where it is licensed. Insurers would be free to locate their operations in the state that gives them the most flexibility and the least benefit regulation, which could lead to lower premiums for some consumers.

Proposals that promote coverage in the individual market versus the group market also might increase the ability of consumers to select insurance coverage. This allows choices independent of employer and other workers' preferences, and could make individuals more sensitive to cost because individually purchased insurance does not receive the federal tax subsidy. Lastly, some suggest that public programs (including Medicare,

Medicaid, and SCHIP) are too rigid in their design and advocate for new approaches, including premium assistance and account-based plans that could allow greater beneficiary choice of benefits within a fixed level of public funding. These proposals often include other steps to address adverse selection, and promote plans that better meet the needs of all types of beneficiaries, including high-risk individuals (for example, through improved Medicare Special Needs Plans).

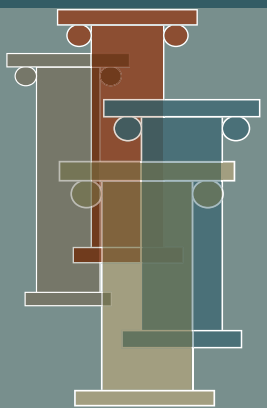
***Examples:*** The Health Care Choice Act sponsored by Rep. John Shadegg (R-Ariz.) would let any insurer licensed in one state sell health insurance in all 50 states.[45] This is intended to promote competition among insurers, in effect creating a national market. Association Health Plans (AHPs), advanced by a number of policymakers, including Sen. Michael Enzi (R-Wyo.), would allow individuals or employers to band together to purchase health insurance that is not subject to state benefit rules. Under Enzi's proposal, AHPs would be required to cover benefits mandated by at least 45 states, but would not have to cover benefits required by fewer states.[46]

A potentially complementary policy to these proposals is creating financial incentives to purchase coverage on the individual market where, unlike public programs and employer coverage, competing insurers determine plan design. In his Fiscal Years 2008 and 2009 budgets, President Bush proposed to repeal the current tax exclusion for employers' contributions to health benefits, and replace it with a standard deduction that could be used for individual-market coverage as well. This new form of subsidy, coupled with limiting benefit regulation, could prove powerful in driving people who seek benefit choices from employer coverage to the individual market. Sen. McCain's campaign health plan adopted virtually all of these ideas: state health plan shopping, AHPs, and a tax policy similar to President Bush's, except that it replaced the exclusion with a new tax credit rather than a standard deduction. The proposal also included federal funding for high-risk pools as a strategy to address adverse selection in a competitive market.

***Rationale:*** The rationale for market-based approaches to benefit design is that, in a well-functioning market, benefit and plan design preferences will be expressed by consumer choices, and met by supplier (in this case, insurer) response. Advocates trust that individuals know best the types of coverage they want to purchase at a given price, especially when empowered with information on plan design and benefits. In turn, insurers would design coverage policies and provider networks to increase enrollment and retention. A market-based approach would facilitate changes in benefit design over time as new evidence or consumer preferences emerge. Supporters also believe that it would avoid benefit decisions being made by government or a delegated authority, that might put the needs of large groups ahead of individual needs.

Criticism of market-based approaches to benefit design stem from the belief that health care and health insurance are inherently complex. Individuals cannot easily know or anticipate their own health care needs, or whether an insurance plan, given the intricacies of benefit design, meets those needs. This puts the power in the hands of the insurers who have an incentive to design benefits that attract lower-cost enrollees. Although risk-adjustment methods can reduce this likelihood, critics argue that benefit standards are needed to ensure access to meaningful coverage for everyone, and encourage competition on the basis of value in providing those benefits, rather than risk avoidance. Permitting interstate sales of insurance would make it extremely challenging for states to exercise their oversight of the insurance market and ensure sufficient consumer protections.

# Major Trade-Offs



Choosing which of these approaches should be used for health insurance design will require consideration of policy and politically related factors. These factors involve societal values and policy mechanics—deciding on goals and how best to achieve them. The optimal combination will likely be forged through negotiation and public debate. The model ultimately selected will likely depend on the balance struck on three key trade-offs: choice of plan design versus adverse selection, expert opinion versus individual preference, and accountability for specific benefits versus flexibility in benefits.

## Choice of Plan Design Versus Adverse Selection

Choice is a powerful concept in American society, often equated with enabling individual opportunity and responsibility. It is a major theme in health policy debates regarding insurance coverage, although its definition varies. For some, choice means deciding between the scope of services covered, the amount of cost sharing imposed, and the level of premiums. Choice proponents argue that individuals best know their needs, and will rationally seek coverage that balances coverage for the needs with price. Moreover, private insurers responding to market demands may be better able to devise efficient health benefits designs than legislators or regulators.

Choice is a priority even among advocates of a fully defined benefit. Individuals may want to select whether to obtain those defined benefits though a closed or open network of providers, as choice of doctor may be a priority. Indeed, some research suggests that people want choice of doctor over choice of health plan design.[47] There has recently been interest in enabling a choice between a public or private health insurance plan, that is, letting individuals, rather than policymakers, decide which organizational type performs best, according to their own criteria.

If implemented poorly, giving people a choice of health insurance designs could lead to adverse selection. People with high health costs might gravitate to health plans with generous coverage for the services they need. They might also seek plans that include high-cost specialists and have an open network. Disproportionate enrollment of people with higher-than-average spending would raise premiums for affected plans. Enrollees with lower-than-average spending might disenroll from the plan because the benefits may no longer be worth the higher premiums. This, in turn, could cause health

insurance plans to constrain their benefits, or drop out of the market altogether, limiting the very choice that policymakers intended to encourage.

As described earlier, a number of policies could limit adverse selection. Risk adjustment, risk sharing, and subsidies for low-income individuals are among the tools for pooling and redistributing resources to partially offset the extra cost to plans that experience disproportionately high-risk enrollment. These tools help make premiums affordable, but they tend to raise public costs. However, subsidies also would be needed to encourage the purchase of insurance if benefits were standardized, particularly if the benefit standard is set at a high level. In either case, individuals will have to decide how much they are willing to pay to expand health coverage, and improve the health care system.

## Prioritizing Expert Opinion Versus Individual Preference

Another significant consideration in any discussion of health reform is the occasional, but inevitable, mismatch between evidence-based best practices and personal preferences. There is widespread agreement that we need better evidence on the relative value of particular health services and care delivery mechanisms. With investment and attention, such information has expanded in recent years, although there is still a vast number of common treatments with little or weak research to back them up. Despite support for the enterprise, disagreement persists on who is the best "user" of such information: providers, patients, or payers. It seems reasonable for scientific evidence to be used to improve provider practice, enrich patient decision making, and guide payment policy and plan design. This is clearly an area that needs greater emphasis in a reformed health system.

Some approaches, such as the use of an expert board, might be better able to apply the available evidence to coverage decisions in a consistent manner. That could help drive value: if information on the most effective and efficient services were backed by a coverage and cost-sharing policy that provides incentives for their use, then the probability of adoption would increase. It might also lessen the political influence of powerful lobbying groups on coverage policy. Medicare has responded to pressure to cover certain expensive treatments (like CT angiography and PET scans for Alzheimer's disease), whose usefulness is not fully known. Standards for publicly backed coverage would rest more squarely on what research suggests works. This could, by some definitions, increase the fairness of such policies, especially if resources are constrained. It also could promote efficiency and quality—if political influences on the process could be kept at bay.

On the other hand, the strength and nature of the evidence may not support it taking such a large role in public health insurance policy. The complexity of human health means that few interventions are 100 percent effective: they work for many, but uncertainty almost always remains. The breadth of existing evidence is narrow,

covering only a small part of the medical care provided today. And, by definition, it does not take into account personal preferences and priorities. People may want certain health services that appear to have a low value or probability of success—for example, unproven therapies that might help a patient with a life-threatening condition. They may object to coverage policies (e.g., financial limits on health coverage of costly life-prolonging care) that impinge upon their values.[48] Evidence is flawed and inherently limited, and an argument can be made that individuals should be part of the decision regarding what their insurance covers.

## Accountability for Specific Benefits Versus Flexibility in Benefits

Because taxpayers will likely provide subsidies for the purchase of health insurance under any reform plan, there is a need for public accountability for how those funds are spent. Whether taxpayer assistance comes in the form of tax credits for private coverage or expanded government health programs, the public has a right to expect that coverage will provide adequate financial protection with access to appropriate care.

A strong public role in benefit design offers predictability and assurances that individuals receive promised coverage. It could reduce the cost of complexity that contributes to the excessive health spending in the U.S. health system compared to peer nations.[49] And, some advocates of "managed competition" suggest that it enables insurers to vie for enrollees based on price and quality rather than their potential cost.

The trade-off is rigidity—a defined or standardized benefit may be less able to meet an individual's specific needs, offering a "one-size-fits-all" approach. It could limit adaptability of health benefits over time, as modifying public standards typically takes longer than a market adjustment. And, it may impede the ability to align benefits with value purchasing. For example, pre-set cost sharing may limit a health insurer's ability to design coverage that steers high-risk patients toward effective and efficient provider organizations, or responds to information that changes what is defined as appropriate clinical care.

## Benefit Design, Preventive Care, and Individual Repsonsibility

Among today's greatest health challenges is the chronic disease epidemic. Five chronic diseases—stroke, cancer, chronic obstructive pulmonary disease, cardiovascular disease, and diabetes—account for two-thirds of all deaths in the United States.[1] An estimated 78 percent of all health spending is attributable to chronic illness.[2] Obesity is a particular concern. A 20-year-old man could see his life expectancy reduced by 17 percent as a result of obesity.[3] If trends continue, children's life spans may be shorter than those of their parents for the first time in about a century.[4]

Unlike some health care challenges, several proven preventive interventions exist to curtail chronic illness, as well as certain lingering infectious diseases. Disease prevention and health promotion are broadly defined as actions to prevent the onset of disease (primary prevention) and to detect and treat disease in its early stages (secondary prevention). Prevention delivered through the health care system is categorized as clinical preventive services, and includes such procedures as screening for cancer or diabetes. The U.S. Preventive Services Task Force, an independent scientific commission, reviews evidence for clinical preventive services and makes recommendations as to its strength. In addition, the CDC-sponsored Community Guide provides evidence-based recommendations on programs and policies to promote health at the population level. Those recommendations include lifestyle changes, such as improved nutrition and increased levels of exercise, that can be as important as medical interventions in preventing disease and promoting good health.

Insurance design could encourage the use of proven preventive services in a number of ways. Health plans could cover them with low or no cost sharing, removing financial barriers to use. Some insurers and employers have successfully adopted value-based insurance designs that encourage high-risk patients to make better use of medications for chronic disease management. Plans could also aggressively promote patient education, that stresses the importance of healthy lifestyles, and the availability and use timely of preventive health services. Finally, insurance design can include financial incentives to promote use of preventative services such as rewards for those who receive their annual flu shot or discounts for health club membership.

State or federal law also could promote the adoption of value-based insurance design by offering preferential tax treatment to consumers who enroll in health plans that encourage the use of preventive health care, or by requiring that insurers offer benefit designs that promote prevention. In addition, public health initiatives could be expanded, and essential preventive services could be financed directly by payers, outside of health insurance.[5]

1 Centers for Disease Control and Prevention. (2004). T*he Burden of Chronic Diseases and Their Risk Factors*. Atlanta, Ga.

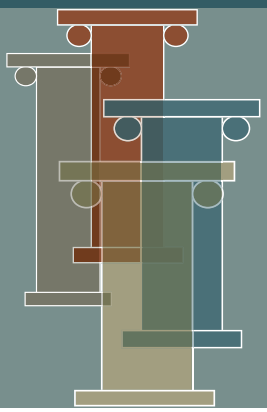
2 Anderson, Gerard, and Jane Horvath. 2004. "The Growing Burden of Chronic Disease in America." *Public Health Reports* 119, no. 3: 263–70.

3 Fontaine, Kevin R., and others. 2003. "Years of Life Lost Due to Obesity." *Journal of the American Medical Association* 289, no. 2:187–93.

4 Olshansky, S. Jay, and others. 2005. "A Potential Decline in Life Expectancy in the United States in the 21st Century." *New England Journal of Medicine* 352, no. 11: 1138–45.

5 Lambrew, Jeanne M., and John D. Podesta. 2006. *Promoting Prevention and Preempting Costs: A New Wellness Trust for the United States*. Washington: Center for American Progress.

# Conclusion



Health insurance design is a critical piece of the health reform puzzle. Depending on the structure of coverage, insurance can promote greater use of effective health care, drive prices, and provide incentives for high-value services and high-quality providers. It can also ensure protection against catastrophic health care costs—a protection afforded too few Americans today. Health insurance design is an essential policy tool in achieving the goals of affordable, high-quality, sustainable health care, and any health care policy reform will need to incorporate strategies for enrolling people into insurance designs that provide financial protection while supporting use of high-value care at the lowest cost.

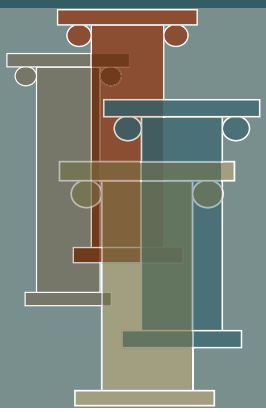
Decisions about health insurance design both affect and are affected by other key policy choices. The generosity of benefits affects who pays for care: slim benefits shift costs to users, while rich benefits shift costs to payers. Insurance design affects how many people are willing to purchase coverage or enroll in a public insurance program. People may not be willing to pay a premium for a plan that does not meet their particular needs. Conversely, they may not be able to afford a benefit design that policymakers determine as the standard.

At the same time, benefit design can be a means to achieve other health system goals. For instance, it can be used to steer patients toward high-quality providers, by reducing cost sharing for physicians and hospitals that meet certain quality standards. Benefit design also could promote individual responsibility for services like prevention and wellness care, by reducing or eliminating related cost sharing. Using insurance design to achieve other policy objectives could tip the balance on which model of benefit design is ultimately adopted.

Yet, insurance design alone cannot leverage comprehensive health system reform. Insurance design can be effective to the extent that it buys the right care and ensures it is delivered in the right way. But promoting such end results requires consideration of policies that ensure sustainable financing, promote value purchasing, enhance quality and prevention, and increase the affordability of health coverage.

APPENDIX

# How Health Benefits Are Determined Today



### *A History*

Although there was a small but unsuccessful movement to create national health insurance during the early 1900s, the Great Depression provided the impetus for the first hospital-centered health plan. Searching for a stable revenue source, hospitals organized payment plans for teachers, firefighters, and hospital employees in what later grew into the Blue Cross system. Consequently, the prevailing pattern of health insurance grew to be organized around workers.[50]

During World War II, price and wage controls forced employers to compete for a dwindling non-military workforce with only "fringe" benefits as an incentive. Established as tax-free by the Internal Revenue Service, in the 1940s, this wartime policy made what was in retrospect one of the most definitional decisions for the nation's health care system.[51] This tax arrangement strongly favored employer-based health insurance over the individual (non-group) market, and conclusively channeled powerful union and worker pressure away from government-provided health care.[52]

In 1965, the passage of Medicare and Medicaid created government health insurance programs for the two largest groups that had arguably been left out of the employer market—the elderly and the poor. What followed is a complicated record of legislative and regulatory policies that only modestly improved the functioning of the health insurance market over the past four decades.

### *Private Insurance*

About 158 million people were covered by employer-based health insurance in 2006, and another 14 million people purchased their own insurance in the individual market.[53] In the same year, private health insurance spent about $723 billion, accounting for about one-third of national health expenditures.[54]

Private insurers develop their benefit offerings based on market demand, which reflects the interaction between the breadth and depth of coverage and the resulting cost reflected in the premium. Tax preferences influence the structure of insurance, and federal and state regulations also impose some limits on what may be sold in private insurance markets.

### *Taxes and Insurance*

Perhaps the most important factor influencing private health insurance today is the generous tax subsidy for employment-based insurance, worth roughly $200 billion in 2008.[55] Employer contributions to health insurance premiums are excluded from workers' taxable incomes, and many firms also allow worker contributions to be made using pre-tax dollars. Individuals purchasing their own coverage, rather than from an employer, are not eligible for this tax subsidy.

Because every dollar paid into an employee's health insurance premium is not subject to income and payroll taxes, employee compensation has tilted toward more generous health benefits. Over the past half-century, employer plans have become more comprehensive, with minimal deductibles and copayments, but higher premiums. As a result, beneficiaries of such plans have incentives to use more health services than they would under a less-generous plan.[56]

Although employers have found that generous health benefits can be an important tool in attracting and retaining good workers, escalating health costs have also limited their flexibility to raise cash wages. In an attempt to reign in spending, employers turned to managed care plans in the 1990s. Stated simply, managed care plans used select contracting and capitation payments to providers to limit price and utilization. These constraints were considered too binding by some patients and providers, leading to a backlash in the late 1990s that reversed the growing enrollment in managed care plans.

Since 2000, consumer-directed health plans have been advanced by policy and the market. There are several kinds of consumer-directed health plans, which combine insurance with a tax-preferred savings vehicle to defray the cost of care. Perhaps the best known are health savings accounts (HSAs), which link tax-preferred savings accounts for health-related expenses to high-deductible plans. Created in 2003, HSAs apply the same tax benefit provided for insured health spending to out-of-pocket spending. By paying more of the cost of care out of their own savings account, HSAs are intended to promote more informed and price-sensitive decision making among consumers. Such plans represented relatively small segment of the private insurance market, with a projected 6.1 million covered lives in January 2008.[57] HSAs are available through employer-based plans, and through the individual insurance market.[58]

Consumers buying their own coverage in the individual insurance market generally do not benefit from the tax exclusion, and thus face the full premium cost of their coverage. Consequently, individual coverage tends to be less generous, with higher deductibles and more limited benefits. Individuals purchasing HSAs in the individual insurance market are eligible for the health accounts' tax benefits.

### *Regulation*

Health insurance has traditionally been regulated by the states. Under the McCarran-Ferguson Act, the Federal Government may regulate insurance as a matter of interstate commerce, but states retain the primary role of regulating the business of insurance.[59] State laws generally apply to insurance purchased by individuals and by small employers. Those laws set minimum capital requirements and establish operating standards—which cover marketing, underwriting, and claims payment—for insurance carriers and other organizations that offer insurance. States also regulate insurers' premiums, impose premium taxes, and may require insurers to offer coverage to small employers or other classes of purchasers.

Every state imposes benefit mandates that require health insurers to cover (or offer to cover) specific providers, procedures, or benefits.[60] Mandated benefit laws can promote access to health services that may be undervalued by consumers or insurers, protect insurers that offer more generous coverage from the risk of attracting a disproportionate number of high-cost patients, and reduce the cost of government programs that might otherwise fill coverage gaps. However, mandates can make coverage more expensive if required benefits would not otherwise be offered.

The Federal Government also regulates private insurance benefits. The 1974 Employee Retirement Income Security Act (ERISA) exempts from state regulation the health benefit plans offered by employers or employee organizations (such as unions) that self-insure.[61] Under this arrangement, the plan sponsor bears the financial risk for most claims. Large firms frequently self-insure because they can handle the risk. Because a few very high medical claims could threaten their solvency, small firms (under 50 employees) generally purchase insurance on the market. Because of the "pre-emption" of state regulation, ERISA-covered plans are free to tailor their benefits to their workers' preferences. About 133 million people were covered by ERISA plans in 2006.[62]

The Health Insurance Portability and Accountability Act (HIPAA), passed in 1996, was designed primarily to protect employees who might lose coverage after changing or losing their jobs. HIPAA limits the ability of group health plans to exclude benefits for new enrollees with pre-existing health conditions.[63] The Act also prohibits discrimination in health care coverage, and guarantees that policies will be issued to certain eligible individuals. HIPAA bars insurers in the group market from considering an employee's health status in determining eligibility for coverage, premium level, or cost-sharing requirements.

Other federal laws that regulate employment-based health benefits include, among others:[64]

- The Family and Medical Leave Act of 1993 (FMLA), which provides for unpaid leave and the continuation of health benefits for a period of time associated with the birth or adoption of a child, or for the serious illness of the employee or a spouse, child, or parent.

- The Newborns' and Mothers' Health Protection Act of 1996, which guarantees a minimum hospital stay for mothers and newborns.
- The Mental Health Parity Act of 1996, which requires that annual or lifetime dollar limits on mental health benefits be no lower than the limits for medical and surgical benefits offered by a group health plan. This act was extended through 2007, and Congress passed the Mental Health Parity and Addiction Equity Act of 2008.[65]
- The Women's Health and Cancer Rights Act of 1998, which sets minimum coverage standards for breast reconstruction surgery.

### *Medicare*

Medicare provides health coverage to virtually all of the nation's elderly and a share of people with disabilities—insuring more than 44 million people in 2007. Medicare spent about $375 billion net of premiums in 2007.[66] Medicare Part A helps pay for hospital, home health, nursing facilities, and hospice care. Medicare Part B covers doctor, outpatient, home health, and preventive services. Part C is the MedicareAdvantage program, in which private plans offer comprehensive health services as an alternative to traditional Medicare. Finally, prescription drug coverage is available through Part D.

Individuals are entitled to coverage under Part A if they have a sufficient period of covered employment. Beneficiaries are subject to cost-sharing requirements, including an initial deductible for hospitalization ($1,024 in 2008) and coinsurance for long hospital stays or the use of nursing home care. The number of days of hospital and skilled nursing home care that Medicare covers is capped.

Although Part B is voluntary, nearly all eligible individuals enroll in the program. The monthly premium is set at 25 percent of Part B's cost ($96.40 in 2008 for most beneficiaries), and a higher amount for those with income above $80,000 ($160,000 for a couple). Beneficiaries are subject to an annual deductible ($135 in 2008) and pay 20 percent of Medicare-approved charges for their care. Part B covers some prescription drugs that are administered in a physician's office, but does not cover other outpatient drugs.

Within these service categories, Medicare covers therapies that are determined to be reasonable and necessary for patients with the appropriate clinical indications. The decision to cover a particular medical service is frequently made by clinicians and contractors who manage Medicare at the local level but most health services are covered nationwide. However, Medicare does not cover certain services in all localities because of decentralized decision-making structure. In addition, Medicare may determine coverage of specific medical benefits that is applicable nationwide.

Medicare also has initiated "coverage with evidence development," which requires that physicians report on patient progress to qualify for payment for services such as implantable cardiac defibrillators or other high-cost interventions.

Medicare beneficiaries may choose to enroll in MedicareAdvantage plans under Part C as an alternative to traditional Medicare. These plans cover all Part A and Part B services, and generally offer a prescription drug benefit. They typically simplify Medicare's cost-sharing arrangements, and offer supplemental benefits. The plans use networks of providers, and may charge higher copayments to beneficiaries who use providers out of the network. Medicare pays the plans a fixed amount on a monthly basis to provide all necessary covered services to their enrollees, who also pay premiums. As of June 2008, there were ten million Medicare beneficiaries enrolled in MedicareAdvantage plans.[67]

Coverage of outpatient prescription drugs under Part D became available to beneficiaries in 2006. Medicare Part D is an optional benefit operated through private plans. In June 2008, over 17 million people were enrolled in stand-alone prescription drug plans, and another 8 million received drug benefits through MedicareAdvantage plans.[68] Part D also subsidizes retiree plans that offer creditable drug coverage to their participants who are enrolled in Medicare.

Like Part B, roughly 25 percent of the cost of Part D is funded through beneficiary premiums, with the remaining cost paid through general tax revenues. Unlike Part B, Medicare's payments to individual plans and enrollee premiums are based on a competitive bidding process. The average monthly premium was $27.39 in 2007.[69] Part D plans are allowed to vary their benefits and coverage of specific drugs so long as the actuarial value of the benefit equals that of a standard plan. Many plans do not require an annual deductible, but all plans require that enrollees pay either a fixed-dollar copayment or coinsurance (that varies with the cost of the drug).

The standard benefit provides both an initial level of drug coverage, and a higher catastrophic level, both of which flank a coverage gap designed to contain program costs. In 2008, the initial benefit offers coverage up to $2,510 in total drug costs, and requires a $275 deductible and 25 percent coinsurance.[70] The enrollee pays the full cost of prescriptions in the coverage gap, between $2,510 and $5,726 in total drug spending. Once this limit is reached, the enrollee then pays five percent of total drug spending. The deductible and benefit thresholds are adjusted yearly in proportion to increased per capita Part D spending.

Plans that offer an actuarial equivalent may adjust premiums and deductibles, replace coinsurance with fixed-dollar copayments, and change the structure of the coverage

gap.[71] All plans have flexibility in benefit design, pharmacy networks, and other key benefit parameters.[72] Though plans can alter formularies, or their lists of covered drugs, Medicare requires that plans not discriminate against any specific condition or perspective group of beneficiaries.[73]

Most beneficiaries also have supplemental insurance to help fill gaps in Medicare coverage. About 11 million people have retiree health benefits sponsored by their former employers, and another seven million low-income beneficiaries are eligible for both Medicare and Medicaid, although some do not receive full Medicaid benefits.[74] In addition, 9 million beneficiaries purchased private "Medigap" policies, and 3 million beneficiaries receive supplemental assistance through the Veterans Administration or some other government program.[75]

### *Medicaid*

Medicaid provides acute and long-term care services to low-income and disabled individuals. About 60 million people were enrolled in Medicaid at some point during 2007.[76] For every dollar spent by a state in Medicaid, the federal government matches at a rate that varies between 50 and about 75 percent, with lower-revenue states receiving a higher match.[77] Total Medicaid spending amounted to about $330 billion in 2007, with federal payments of $190 billion.[78] About two-thirds of Medicaid spending for health benefits was for acute care services.[79] The remaining third was for long-term care services.

Although federal law establishes the program's framework, there is great variability across the states in who is eligible, what services are paid for, and how those services are reimbursed and delivered.[80] To qualify for Medicaid, individuals must meet financial criteria, and also belong to one of the groups that are "categorically eligible" for the program, including children, parents of dependent children, pregnant women, people with disabilities, and the elderly. States also may cover "optional" populations, and have broad authority to expand Medicaid income eligibility beyond federal standards.[81]

States must cover certain mandatory services, including physician, hospital and nursing facility services, laboratory and X-ray services, family planning, nurse midwife services, and some dental services. States also must provide Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for low-income children. EPSDT is intended to provide comprehensive benefits for children with a broad range of health needs, and includes additional services such as vision, dental, hearing and early intervention services to promote their healthy development.[82]

States also can receive federal matching funds for many "optional" services, including prescription drugs, prosthetic devices, hearing aids, and dental care.[83] Coverage of such

services varies considerably. For example, 33 states offer physical therapy, 34 cover hearing aids, and 31 provide for the services of a psychologist, while nearly all states cover hospice care and care provided at rural health clinics.[84]

Federal law requires that Medicaid benefits cover only medically necessary care. However, states employ different definitions of necessary care, and also can limit the extent and the amount of each benefit's use (the number of physician visits per year for example).[85] The 2005 Deficit Reduction Act (DRA) permits states to replace their existing benefit package with "benchmark" coverage for certain eligibility groups.[86] Plans that qualify as benchmarks include the Blue Cross Blue Shield Plan for federal employees, the state's largest commercial HMO plan, or the plan offered state employees. States that implement a benchmark equivalent must maintain EPSDT benefits for children.

Low-income Medicaid beneficiaries do not pay a premium, and are subject to no more than nominal copayments (such as $3 to fill a prescription). However, the DRA permits states to charge premiums and copayments up to 20 percent of the cost of services to beneficiaries with family incomes over 150 percent of the federal poverty level (FPL). Copayments up to 10 percent of the service cost may be charged to beneficiaries with incomes between 100 and 150 percent FPL. Certain individuals (such as pregnant women and children who are eligible for Medicaid by federal mandate) and services (such as preventive services for children, emergency services, and pregnancy-related care) are exempt from the premium and cost-sharing requirements.[87]

### *State Children's Health Insurance Program*

The State Children's Health Insurance Program (SCHIP) was created in 1997 to insure children under age 19 in families with limited incomes, but too high to qualify for Medicaid.[88] The Federal government provides matching funds for state spending under SCHIP, but at a higher rate than under Medicaid. There is no predetermined limit on federal spending in Medicaid but there is a cap on aggregate federal SCHIP funding, with a formula-driven allocation to states. Children must meet income eligibility standards that vary from state-to-state. Some states have used waiver authority to cover low-income adults who are not eligible for Medicaid. Almost 8 million people were enrolled in SCHIP at some point in 2007, with corresponding federal outlays of $6 billion.[89]

To cover those eligible for SCHIP funds, states may expand their Medicaid programs, create a new private program, or use a version of both approaches. A state that expands Medicaid must offer full Medicaid benefits to SCHIP enrollees. A state that chooses a separate program must offer benefits that are substantially equivalent to a "benchmark" plan, an existing state-funded health plan, or one that is approved by the secretary of the U.S. Department of Health and Human Services. The benchmark plan could be the FEHBP Blue Cross Blue Shield Standard Option, a state employees' health plan, or

the most popular HMO in that state. The state also could offer actuarially equivalent benefits, which provide the same aggregate value of services, but may vary from the benefits included in the benchmark plan. SCHIP enrollees may not be charged premiums and cost sharing that, in total, exceed five percent of family income.

### *Federal Employees Health Benefit Program*

As the nation's largest employer insurance program in the nation, FEHBP offers a choice of competing private health plans to over 8 million federal employees (including members of Congress), retirees, and their dependents.[90] Some health plans are available government-wide. Other plans are restricted to specific employee groups, or are available only in specific service areas. Each plan sets its own premium, cost-sharing requirements, and benefit structure under the supervision of the federal Office of Personal Management (OPM).

Like many other large employers, FEHBP coverage is generous and the cost is shared between the Federal Government and the employee. The Federal Government provides a subsidy averaging 72 percent of premium costs, and employees may pay their share with pretax dollars.[91] In 2008, the full monthly premium charged by the popular Blue Cross Blue Shield Standard Option was $1,027.95 for family coverage.[92] Of that, employees paid $314.47 and the government paid $713.48 a month.

The law establishing FEHBP requires that participating plans cover broad categories of inpatient and outpatient health services. Specific benefit packages are determined by health plans with the approval of OPM, which actively manages the program. Over its nearly 50-year history, plans participating in FEHBP have adjusted their benefit structures, premiums, and cost-sharing requirements in response to changing medical practice and market demand. OPM policy is sensitive to the rising costs of the program, and, in recent years has implemented cost containment strategies such as discouraging plans from increasing benefits unless they are offset by other benefit reductions.[93]

### *Military and Veterans' Benefits*

The Military Health System (MHS) and the Veterans Health Administration (VHA) directly provide health care to active-duty and retired military personnel, their dependents, and veterans.[94] Unlike Medicare and Medicaid, which pay for care delivered by private health plans and providers, MHS and VHS provide care in federally owned and operated hospitals and clinics. The two systems provided about $70 billion in health care services to 16 million beneficiaries in fiscal year 2006.

The MHS provides comprehensive health services to active-duty personnel through military treatment facilities. Those facilities also provide care to retirees and dependents on a "space-available" basis under a program known as TriCare Standard, which

operates as a fee-for-service program. Beneficiaries may also enroll in one of two managed care options. Benefits under TriCare have remained stable or have improved over the past decade, in contrast to health benefits offered by civilian employers.

The VHA provides acute and long-term care services to veterans who were seriously injured, or who acquired long-term illnesses because of wartime service. Unlike TriCare, which is an entitlement program, the VHA is funded through annual appropriations. Despite high demand for VHA services, the program has tried to keep enrollment at a level its budget can support.

***Direct Provision of Health Care through the Indian Health Service and Safety Net***

Lastly, the Federal government provides financial support to certain facilities to provide health care to special populations. The Indian Health Service (IHS) is a federal agency that provides health care to roughly 2 million American Indian and Alaskan Natives who belong to federally recognized tribes. The IHS and the Tribes run 46 hospitals and over 600 health centers, clinics, and stations.[95] Like the VHA, the IHS operates under a fixed budget, but because funding is lower on a per-capita basis, the services it offers are limited.

"Safety-net" providers are those that serve low-income, often uninsured populations. They include those in underserved areas, public hospitals, community health centers, local health departments, migrant health clinics—all of which are supported by public programs. Funding is distributed in the form of grants to facilities and special payment programs from Medicare and Medicaid (e.g., disproportionate share hospital payments). In 2004, not counting VHA and IHS funding, the United States spent about $17 billion on direct services through safety-net programs.[96]

In addition, some public programs pay for specific services. For example, the Centers for Disease Control and Prevention (CDC) provide states with grants for the AIDS Drug Assistance Program (ADAP), which provides free or low-cost HIV/AIDS medications, and the National Breast and Cervical Cancer Early Detection Program, which funds cancer screenings. Both provide specific services to low-income, uninsured or underinsured individuals, although funding is capped.

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