MODELING MEDICARE+CHOICE STANDARDIZED BENEFIT PACKAGES IN LOCAL MARKETS

FINAL REPORT

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I. INTRODUCTION

Introduction

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

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

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

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

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

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

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

Purpose of Report

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

Specifically, for this project, CMS asked BearingPoint to:

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

Summary of Data and Methods

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II. BACKGROUND ON BENEFIT DESIGN STANDARDIZATION

Medigap Plans

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

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

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

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

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

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

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

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

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

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

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

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

Lessons from Medigap Standardization

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Federal Employees Health Benefit Plan

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

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

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

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

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

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

Lessons from FEHBP

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

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

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

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

[30] Op cit.

Oregon's Medicaid Proposal[31]

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

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

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

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

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

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

Step 1: Creating Condition-Treatment Pairs

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

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

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

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

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

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

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

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

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

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

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

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

Step 3: Ranking Categories of Services

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

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

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

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

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

Step 4: Categorizing CT Pairs

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

Step 5: Ranking CT Pairs Within Categories

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

Step 6: Reviewing CT Pairs Line-by-Line

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

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

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

Lessons from Oregon's Medicaid Proposal

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

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

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

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

California Public Employees' Retirement System[34]

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

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

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

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

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

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

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

[37] *Understanding CalPERS*, October 2002.

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

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

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

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

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

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

[39] *Understanding CalPERS*, October 2002.

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

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

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

Lessons from CalPERS

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

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

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

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

III. ISSUES IN STANDARDIZING M+CO BENEFIT PACKAGE

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

Advantages of Standardization

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

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

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

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

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

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

- Confusing benefit design.

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

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

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

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

Disadvantages of Standardization

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

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

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

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

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

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

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

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

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

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

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

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

Standardization Principles

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[54] Discussion with Key Informant.

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

Alternatives to Full Standardization

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

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

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

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

3) Standardize only within major categories of benefits.

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

4) Establish a minimum benefit package.

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

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

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

5) Implement a core-plus-rider approach.

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

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

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

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

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

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

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

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

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

TABLE 1. ENHANCED BENEFITS, 2001 and 2002

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V. MODEL STANDARDIZED BENEFIT PACKAGES

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

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

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

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

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

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

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

Model Core Benefit Packages

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

Table 2. Summary of Core Benefit Package Provisions

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

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

Core Benefit Package #1

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

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

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

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

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

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

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

Core Benefit Package #2

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

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

Core Benefit Package #3

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

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

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

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

Model Rider Options

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

Dental Services

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

Table 3. Dental Rider Benefit Packages

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

Vision Services

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

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

Hearing Services

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

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

Outpatient Prescription Drugs

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

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

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

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

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

Table 6. Prescription Drugs Rider Benefit Packages

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

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

VI. VALUATION OF MODEL STANDARDIZED BENEFIT PLANS

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

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

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

Core Benefit Packages

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

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

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

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

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

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

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

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

Rider Options

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

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

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

Collapsed Rider Options

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

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

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

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

APPENDIX A: KEY INFORMANT INTERVIEWS

Key Informant Interview Guide

(For academic key informants, we will phrase the questions as hypotheticals about Medicare benefits and supplemental benefits.)

1. Standardization of Benefit Packages - Description

a. Would you briefly describe the background data and issues that led to your organization's decision to initiate a standardization initiative? What was the impetus for the initiative?

b. What were the market conditions for the benefits your initiative addressed at the time that the standardization initiative began? What variance in the insurance market did your initiative attempt to mitigate (i.e., price, access, quality, choice, diversity of offerings, number and desirability of benefits, consistency)? Was there a degree of importance assigned to these factors?

c. Was your standardization initiative locally, regionally, or nationally focused?

d. What particular group of benefits did your standardization initiative focus on (i.e., medical, mental health, etc.), and why?

2. Standardization of Benefit Packages – Expected Outcomes

a. How did you expect this standardization initiative to affect the local insurance market?

b. Which groups/demographics did you hope to address with this initiative?

c. What were some of the key outcomes that you expected from this initiative?

d. Prior to designing the standardization project, did you conduct any research on "best practices" for this type of work? Do you have any written reports on this research that you could share with us?

3. Standardization of Benefit Packages – Process

a. What were the criteria for selecting the benefits to be standardized?

b. Which data or process did you use for developing your list of criteria, and/or which data or process did you use as the baseline for developing the standardized benefits?

c. Does your initiative require a minimum benefits package? If so, how was that minimum package developed?

d. What supplemental benefits were standardized in addition to the minimum benefits package and why?

e. What tools were used to assess the proposed standardized benefit package(s) in terms of pricing, employee/beneficiary expected out-of-pocket costs, consumer acceptance, etc., once it (they) were designed? What factors were assessed?

4. Standardization of Benefit Packages – Project Team

a. How did you structure the work for this initiative (i.e., timeline for work and analysis)?

b. Which individuals did you include in the design and implementation of the standardization process? What expertise was necessary for these individuals to possess to participate in this initiative?

c. What were the major tasks for this initiative?

5. Standardization of Benefit Packages - Implementation

a. Were you or your team involved in the implementation of the standardization initiative?

b. If so, what kinds of program management techniques were employed to manage the implementation of the initiative?

c. What challenges/unforeseen issues arose during implementation, if any?

Do you have any written materials you could share with us?

Key Informants

Individual/Institution	Type	Interviewee(s)	Rationale
Humana	Health Plan	John Bertko, Vice President and Chief Actuary	Humana Inc. is one of the nation's largest health benefits companies. Mr. Bertko also served on the national advisory board for the CMS-sponsored Medicare Competitive Pricing Demonstration.
Patient Choice Healthcare	Health Plan	Ann Robinow, Co-Founder, President, and CEO	Ms. Robinow has also served as executive director, Care Systems and Finance, for the Buyers Health Care Action Group (BHCAG). While at BHCAG, Ms. Robinow led the design, development, implementation and operation of their innovative, competing care delivery system purchasing model.
Blue Cross Blue Shield Association (BCBSA)	Health Plan/ Industry Group	Joel Slackman, Director of Policy	Blue Cross and Blue Shield Plans have served as partners to the federal government in administering the Medicare program since its inception in 1966. BCBSA possesses an in-depth knowledge of the Medicare program and its intricacies.
Health Insurance Association of America (HIAA)	Trade Association/ Industry Group	Marianne Miller, Director of Federal Regulatory Affairs and Policy Development; Tom Wildsmith, Policy Research Actuary	Experts from HIAA have testified before Congress' Health Subcommittee of the House Ways and Means Committee regarding changes to Medigap policies in relation to the components of a modernized Medicare benefits package.

Individual/Institution	Type	Interviewee(s)	Rationale
Buyers Health Care Action Group	Industry Group	Carolyn Pare, CEO	BHCAG is a coalition of health care purchasers dedicated to reforming the health care market. One of BHCAG's most innovative efforts was the launch of ChoicePlus, a direct contracting health benefits program.
Tom Elkins	Industry Group	Former head of CalPERS Health Benefits Program, 1990-1995	California Public Employees' Retirement System (CalPERS) offers a set of standardized health benefit packages and negotiates health premiums for many public employers in California.
Geraldine Dallek	Academic	Independent Consultant, Former Director of the Georgetown University Institute for Health Care Research and Policy	Co-author, "Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages," prepared for The Commonwealth Fund, October 2001; Co-author, *Should Medicare HMO Benefits be Standardized?*, prepared for The Commonwealth Fund, February 1999.
Health Insurance Reform Project, George Washington University	Academic	Sandra Foote, Director	The Health Insurance Reform Project (HIRP) fosters improvements in health insurance and health care, especially for Medicare beneficiaries and people with severe and disabling conditions.
Tom Rice	Academic	Professor and Chair of the Department of Health Services at the UCLA School of Public Health	Co-author, "Medigap Regulation: Lessons for Health Care Reform", *Journal of Health Politics, Policy, and Law*, 1995, 20(1): 31-48; Co-author, *Should Medicare HMO Benefits be Standardized?*, prepared for The Commonwealth Fund, February 1999.

Individual/Institution	Type	Interviewee(s)	Rationale
Medicare Rights Center	Consumer Group	Diane Archer, Executive Director	The Medicare Rights Center (MRC) is a national, not-for-profit, non-governmental organization that helps ensure that older adults and people with disabilities get high quality and affordable health care.
California Health Advocates	Consumer Group/California SHIP	Bonnie Burns, Director of Consumer Education	Ms. Burns is a consultant and consumer advocate with extensive knowledge of Medicare, Medigap, long-term care insurance, and managed care issues. She has worked with Medicare beneficiary county and state counseling programs for many years. Ms. Burns is also a Funded Consumer Liaison Representative for the National Association of Insurance Commissioners.

APPENDIX B: DATA AND METHODOLOGY

Data Source

The objective of one of the primary tasks under this project was to clearly, and in detail, characterize the full range of benefit packages being offered by M+COs, including covered and non-covered Medicare benefits. However, because there have been substantial declines in M+C plan benefits and increases in beneficiary cost-sharing and premiums in many Medicare markets since 1999,[68] analyzing the structure of M+C benefit packages available since then may not provide the full range of benefit designs that beneficiaries have had access to in the past and that CMS wanted us to consider in constructing the model standardized packages. On the other hand, CMS data on M+C plan design has improved markedly since 1999 with the adoption of the Plan Benefit Package (PBP) data system in 2001. In 2001, CMS began requiring M+COs to report plan information through the PBP system. This system captures detailed information on all plan benefits, including supplemental and "high option" benefits, such as point-of-service options. Medicare Compare for 1999 and 2000, which has been used in the past to document M+C plan benefit design, sometimes has incomplete, missing, or ambiguous benefit and patient cost-sharing information, and does not provide good information on optional benefits.[69] These problems are particularly prevalent for vision, dental, and hearing benefits, which are likely to be important to this project. For this project, there is a need to balance the decline in M+C plan generosity over the past few years with the increased availability of more complete and accurate information on the range of plan designs since 2001.

To balance these needs, we used the 2001 and 2002 PBP databases, but focused our review of benefit package designs on Medicare markets with a greater number of M+COs and competition, higher M+C payment rates, and recent market stability.[70] These are the markets that were most likely to still offer fairly generous M+C benefit packages and low cost-sharing and premium requirements in 2001 and 2002. With respect to M+C payment levels, Cook (2001) found that benefit packages tend to be more generous, and premiums tend to be lower, in markets with relatively higher M+C payment rates. In markets where the payment rates exceeded the USPCC by 15 percent or more, they found that 62 percent of the basic benefit packages still offered prescription drug coverage at no premium. With respect to market stability, in a comparison of M+COs that withdrew from Medicare+Choice in 2001 with those that chose to stay, Achman and Gold (2002) found that M+COs that withdrew or reduced their services areas in 2001 offered less generous benefit packages in 2000, had higher average premiums, were less likely to have offered a zero-premium package, and experienced less stability of benefits over the past few

[68] Cook, A. *Trends in Benefits Offered by Medicare+Choice MCOs, 1999-2001.* Prepared by Mathematica Policy Research, Inc., for the Centers for Medicare & Medicaid Services, December 19, 2001.
[69] This information is based on E. Peppe and G. Trapnell. *Trends in Benefits Offered by Medicare+Choice MCOs, 1999-2001, Volume II: Appendices.* Prepared by the Actuarial Research Corporation for the Centers for Medicare and Medicaid Services, December 19, 2001; and discussion with Carlos Zarabozo, CMS, on February 22, 2002.
[70] Another reason for focusing the project on a limited number of markets was to ensure that the scope of the project was manageable within the timeframe and project budget. Examining all plans offered in all Medicare markets in the United States in 2001 would involve documenting approximately 800 different plans.

years compared with M+COs that remained in the program.[71] Cook (2001) also found that the value of benefits covered by the M+C plans in their basic benefit packages that stayed in the market between 1999 and 2001 grew faster than their M+C payment rates plus the monthly M+C premium for 10 of the 16 case study markets.

Although on average M+C benefits have declined and premiums have increased since 1999, Cook (2001) documented that 63 percent of the basic benefit packages still offered a prescription drug benefit in 2001; 85 percent covered eye exams and 72 percent covered both eye exams and glasses; 74 percent covered hearing tests; 32 percent covered preventative dental services; and 45 percent still offered a zero-premium plan. In fact, 72 percent of plans offered in the highest M+C payment rate markets had a zero premium plan in 2001. While our project chose to focus on markets most likely to have maintained fairly generous benefits packages in 2001 and 2002, we also examined some plans in markets with lower M+C payment rates and less market competition to capture the full range of M+C benefit package designs. BearingPoint obtained complete PBP data files for 2001 and 2002 from CMS on March 20, 2002.

County/M+CO Selection

Our first step for this task was to select 22 counties that had M+COs operating in them in 2001, based in part on the number of M+COs available in a county. Other selection criteria included regional diversity, and diversity with respect to M+C payment rates, county Medicare beneficiary enrollment in M+COs, and M+CO withdrawal from the county in the previous two years. Plan and market characteristics were constructed from publicly available 2001 CMS data. These included the State/County/Plan Quarterly Market Penetration file, the M+C Payment file, the Withdrawals/SAR file, and the Monthly Reports file. Plan benefit package information for all plans offered by all M+COs operating in the selected counties in 2001 were analyzed for 2001 and 2002.

CMS's Geographic Service Area file for November 2001 was used as the basis for determining the number of M+COs operating in all counties in the United States in 2001. This file most closely matches the M+CO list in the 2001 PBP database. In 2001, a total of 171 CCPs were available in 1,260 counties (we excluded PFFS and demo plans and used the term M+CO to represent only CCPs). Also included in the selection file was the number of beneficiaries enrolled in all M+COs operating in each county, and a calculation of each county's 2001 M+C payment rate compared with the 2001 USPCC. A random number generator was used to assign a number to each county in the file.

The file was sorted by number of M+COs, then by enrollment category (see the key on the following page), then by M+C payment rate category (see the key on the following page), and then by the random number. As specified in the Work Plan, we randomly chose 10 counties from those with 1 M+CO; 7 counties from those with 2 to 4 M+COs; and 5 counties from those with 5

[71] Achman L. and M. Gold. *Medicare+Choice 1999-2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premium.*, Prepared by Mathematica Policy Research, Inc., for The Commonwealth Fund, February 2002.

or more M+COs. Also, we computed the percentage of high, moderate, and low M+C payment counties among all the counties with an M+CO and chose the same percentage from the total of 22 counties (i.e., 6 high payment; 12 moderate payment; and 4 low payment counties). We did the same for M+C enrollment category, resulting in the selection of 9 counties from the set of all low-enrollment counties; 5 from low-moderate; 5 from moderate; and 3 from high enrollment counties (tabulations are shown below).

Within each of a set of matrices based on number of M+COs by enrollment category by M+C payment rate, we determined the number of counties that should be selected from each cell based on a ranking of percentages in each cell and such that the number of counties totaled to the above three metrics (e.g., 27 percent of counties with 1 M+CO operating in them had low enrollment and a moderate M+C payment rate, so 2 of these counties were to be randomly selected from all counties in that cell).

Once the 22 counties were randomly selected from each of the cells above, we examined geographic diversity and urban/rural status. Initially, there was not as much diversity as desired to assure that a wide range of plan benefit packages would be selected for analysis. Therefore, the next county in the list that ensured greater diversity than originally occurred in the random selection was selected instead. Once the desired amount of geographic diversity was reached, we collected the other statistics on the counties and M+COs operating in those counties. Because the 22 final selected counties showed acceptable diversity in the rest of the variables in which we were interested, no further selections were made. The 22 counties selected are shown in the following tables and summary statistics for the selected counties are indicated below.

1 M+CO in the county (10 counties; 10 M+COs; 15 plan benefit packages)

State	County	M+CO Count	Enroll Cat.	M+C Payment	Census Region	Census Division	MSA	2001 WD	2002 WD
MO	DALLAS	1	1	L	MW	West North Central	non-MSA	0	0
OR	HOOD RIVER	1	1	L	West	Pacific	non-MSA	0	0
NH	HILLSBOROUGH	1	1	M	NE	New England	Boston-Brockton-Nashua, MA-NH	0	0
TX	WALLER	1	1	M	South	West South Central	Houston, TX (large)	4	1
TN	DE KALB	1	1	H	South	East South Central	non-MSA	0	0
OH	GREENE	1	2	M	MW	East North Central	Dayton-Springfield, OH	1	0
IA	POTTAWATTAMIE	1	2	M	MW	West North Central	Omaha, NE-IA	0	0
MI	INGHAM	1	3	M	MW	East North Central	Lansing-East Lansing, MI	0	1
WA	SPOKANE	1	3	M	West	Pacific	Spokane, WA	0	1
WV	MARION	1	4	L	South	South Atlantic	non-MSA	0	1

Key:

M+CO Count: =1 if county has only one M+CO; =2 if county has 2-4 M+COs; =3 if county has 5 or more M+COs.

Enroll Cat.: =1 if number of M+CO enrollees in county is <= 1,000; =2 if enrollees >1,000 and <=3,0000; =3 if enrollees > 3,000 and <=10,000; = 4 if enrollees > 10,000.

M+C Payment: =H if M+C payment rate in county is greater than the USPCC by 15% or more; =M if M+C payment rate in county is greater than the USPCC but by less than 15%; =L if M+C payment rate in county is less than the USPCC.

2001 WD: = number of M+COs that withdrew from the county effective 1/1/01.

2002 WD: = number of M+COs that withdrew from the county effective 1/1/01.

2-4 M+COs in the county (7 counties; 19 M+COs; 25 plan benefit packages)

State	County	M+CO Count	Enroll Cat.	M+C Payment	Census Region	Census Division	MSA	2001 WD	2002 WD
PA	CENTRE	2	1	L	NE	Middle Atlantic	State College, PA	1	0
MA	HAMPDEN	2	1	M	NE	New England	Springfield, MA	0	0
NC	ORANGE	2	1	M	South	South Atlantic	Raleigh-Durham-Chapel Hill, NC	1	0
NJ	CAMDEN	2	1	H	NE	Middle Atlantic	Philadelphia, PA-NJ (large)	2	2
MN	DAKOTA	2	2	M	MW	West North Central	Minneapolis-St. Paul, MN-WI	0	0
AL	SHELBY	2	2	H	South	East South Central	Birmingham, AL	0	0
PA	MONTGOMERY	2	3	M	NE	Middle Atlantic	Philadelphia, PA-NJ (large)	1	1

5 or more M+COs in the county (5 counties; 41 M+COs; 85 plan benefit packages)

State	County	M+CO Count	Enroll Cat.	M+C Payment	Census Region	Census Division	MSA	2001 WD	2002 WD
CA	SAN BERNARDINO	3	2	H	West	Pacific	Riverside-San Bernadino, CA (large)	2	1
AZ	MARICOPA	3	3	M	West	Mountain	Phoenix-Mesa, AZ (large)	0	1
FL	BROWARD	3	3	H	South	South Atlantic	Fort Lauderdale, FL (large)	2	2
CA	KERN	3	4	M	West	Pacific	Bakersfield, CA	0	2
NY	QUEENS	3	4	H	NE	Middle Atlantic	New York-Newark, NY-NJ-PA (large)	1	0

Summary Statistics

Alabama (East South Central-South)
Arizona (Mountain-West)
California (2) (Pacific-West)
Florida (South Atlantic-South)
Iowa (West North Central-Midwest)
Massachusetts (New England-Northeast)
Michigan (East North Central-Midwest)
Minnesota (West North Central-Midwest)
Missouri (West North Central-Midwest)
New Hampshire (New England-Northeast)
New Jersey (Middle Atlantic-Northeast)
New York (Middle Atlantic-Northeast)
North Carolina (South Atlantic-South)
Ohio (East North Central-Midwest)
Oregon (Pacific-West)
Pennsylvania (2) (Middle Atlantic-Northeast)
Tennessee (East South Central-South)
Texas (West South Central-South)
Washington (Pacific-West)
West Virginia (South Atlantic-South)

Midwest (5 counties)
Northeast (6 counties)
South (6 counties)
West (5 counties)

18 urban/MSA counties
4 rural/non-MSA counties

1 PPO
69 HMOs

6 high M+C payment counties
12 moderate M+C payment counties
4 low M+C payment counties

9 low enrollment counties (<=1,000 beneficiaries)
5 medium-low enrollment counties (1,001-3,000 beneficiaries)
5 medium enrollment counties (3,001-10,000 beneficiaries)
3 high enrollment counties (>=10,001 beneficiaries)

2 counties also have a Sterling PFFS plan (Hood River, OR; Greene, OH)

9 counties had at least one M+CO withdraw from it effective 1/1/01
10 counties had at least one M+CO withdraw from it effective 1/1/02
4 counties had M+CO withdrawals in both 2001 and 2002

The final selection of 22 counties had good variation in terms of geographic diversity, M+C county payment rates compared with the USPCC, M+C county enrollment, and withdrawing M+COs. There was less diversity in terms of urban versus rural counties, because not many M+COs operated in rural counties in 2001, and only one PPO was in operation that year (no PSOs or other M+C organizational types were in operation except for one PFFS, which was available in two of the counties selected; we did not include PFFS plans in the analysis). Eighteen of the counties are located in 17 distinct Metropolitan Statistical Areas (six of which are categorized as "large" (over a million population) MSAs), and four are in rural/non-MSA counties.

BearingPoint sent a list of the proposed 22 counties to CMS on March 18, 2002. In total, 70 county/M+CO pairs were selected, offering a total of 97 benefit packages to their Medicare members in 2001 (after excluding health plans that covered only Medicare Part B services; the above health plan counts include these health plans) and 74 benefit packages in 2002.

Based on a review of the proposed counties and M+COs, CMS recommended that we drop Independence Blue Cross, the only PPO serving Medicare beneficiaries in 2001, because it transitioned to a demonstration M+CO in 2002. This reduced by one the number of M+COs and plan benefit packages to be analyzed.

Methodology for Constructing Standardized Benefit Packages

The first step was to create an analysis file containing plan benefit information for all M+COs operating in the selected counties in 2001 and 2002. The analysis file contained benefits, beneficiary cost-sharing, premiums, and payment limits information for all plans offered by all M+COs operating in the selected counties (including county segments). We included additional supplemental benefits (those included in the plan for no premium), mandatory supplemental benefits (those included in the plan that require a mandatory premium), and optional

supplemental benefits, including "high option" POS plans (those included in the plan that can be purchased for a premium).

We looked both at all plans and a set of "basic" plans, one for each M+CO/county pair. The PBP does not specify which is an M+CO's basic plan. We therefore defined it similarly to other studies of M+C plans,[72] as follows:

a. The basic package is the one offered by the M+CO in a given county of set of counties that has the lowest premium;

b. In case two or more packages have the same premium, we chose the one with the lowest primary care physician (PCP) copayment;

c. If two plans had the same PCP copayments, we selected the plan with the more generous outpatient prescription drug coverage;

d. In the case of further ties, we chose the first "basic benefit package" plan in the file for the M+CO and count(ies).

Next, we extracted plan information from the 26 separate PBP files for 2001 for the selected 96 M+CO benefit packages, creating frequencies and univariates to explore the variation in benefit packages across and within markets. The following provides details about our initial and secondary extraction of plan benefits from the 2001 PBP files.

- From the Section A file:
  - ◊ Identify whether the M+CO offers both Part A and Part B services or Part B services only. Print a frequency of M+COs that offer only Part B services. If only Part B services are offered by some M+COs, we will separate the file into two segments based on this information, and initially look only at plans with Part A and Part B services.
  - ◊ Identify whether the M+CO offers a POS option in the county, and, if so, whether it's an Additional, Mandatory, or Optional Supplement and the services offered under the POS option. Print a frequency of the number of M+COs that offer a POS option. For these M+COs, print a frequency of types of services offered under the POS option. If a POS option is offered by some M+COs, we will separate out all of the following benefits by POS/non-POS plans.
- From the Section B file, print out "global notes" by M+CO and plan ID.
- From the Section D file:
  - ◊ Indicate if there is an overall plan deductible (Y/N), and if so, the amount;

[72] See, for example, Cook, A. *Trends in Benefits Offered by Medicare+Choice MCOs, 1999-2001*. December 2001, prepared by Mathematica Policy Research, Inc., for the Centers for Medicare & Medicaid Services; and Achman, L. and M. Gold. *Medicare+Choice: Beneficiaries Will Face Higher Cost-Sharing in 2002*. March 2002, prepared by Mathematica Policy Research, Inc., with support from The Commonwealth Fund.

- ◊ Indicate if there is an overall maximum plan benefit coverage amount (Y/N) (by non-POS and POS option), maximum amount, and periodicity.
- ◊ Indicate if there is an overall maximum enrollee out-of-pocket cost (Y/N) (by non-POS and POS option), amount, and periodicity.
- ◊ Indicate if there is a plan premium (Y/N) (by Part A and B and Part B only plans), and premium amount.
- ◊ Produce frequencies and univariates (when appropriate) for each of the above variables, by service type.

♦ From the Section D_opts file:

- ◊ Indicate if there is an optional premium amount (Y/N), the amount, and benefits included for the option premium. Print a frequency and univariate.
- ◊ Print out "Describe" other benefits, by M+CO and plan ID.

♦ From the following Medicare-covered benefits files (Inpatient Hospital Acute Care, Inpatient Psychiatric Hospital Care, Skilled Nursing Facility, Comprehensive Outpatient Rehabilitation Facility Care (CORF), Emergency Care/Urgent Care, Partial Hospitalization, Home Health, Primary Care Providers, Chiropractic Providers, Independent Occupational Therapy Providers, Physician Specialists (excluding Psychiatric Providers), Mental Health Providers (non-physician), Podiatry Services, Other Health Care Professional Services, Psychiatric Services, Physical Therapy and Speech-Language Pathology Services, Outpatient/Clinical/Diagnostic Services, Outpatient X-rays, Outpatient Hospital Services, Ambulatory Surgical Center Services, Outpatient Substance Abuse Services, Cardiac Rehabilitation Services, Ambulance, DME Services, Medical Supplies, Renal Dialysis, and Outpatient Blood), initially extract the following data:

For a Medicare-covered benefit:

- ◊ Indicate the number of benefit days per period covered and the benefit period definition;
- ◊ Indicate if prior authorization must be received (Y/N);
- ◊ Indicate if there is a service-specific enrollee coinsurance, copay, and/or deductible (Y/N for each variable) and, if yes, the amount (by stay or by day for inpatient hospital and inpatient psychiatric; by number of days for SNF);[73]
- ◊ Indicate if there is a service-specific maximum enrollee out-of-pocket cost (Y/N), maximum, and periodicity (and type if available);
- ◊ Indicate if there is a service-specific maximum plan benefit coverage amount (Y/N), maximum, and periodicity.

[73] No co-pays by number of days of stay are available for inpatient hospital services in the 2001 PBP, but are available in 2002.

- In the second step of the extraction for Medicare-covered benefits, determine:
  - ◊ If the plan has selected enhanced benefits (Y/N);
  - ◊ Indicate for each benefit whether it is additional, mandatory, or optional;
  - ◊ Indicate specifics about each benefit (e.g., number of additional days covered, upgrades, whether it is an unlimited benefit, coinsurance/copay/deductible for benefit);
  - ◊ Produce frequencies and univariates (when appropriate) for each of the above variables, by service type;
  - ◊ Determine if the plan offers any additional enhanced benefits by reading the notes fields for each service type.
- For the following Medicare- and non-Medicare-covered benefits (Transportation, Acupuncture, Preventive Benefits (health education, immunizations, routine physical exams, pap/pelvic exams, prostrate screenings, colorectal screenings, bone mass measurement, mammography, and diabetes monitoring), Dental Preventive Services, Dental Comprehensive Services, Eye Exams, Eye Wear, Hearing Exams, Hearing Aids, Visitor/Travel Services, and Other1, Other2, and Other3), extract the following data:
  - ◊ Determine whether the benefit is offered (Y/N), or is offered as an enhanced benefit (Y/N);
  - ◊ Determine whether the benefit is offered as an additional, mandatory, or optional supplemental benefit (AMO);
  - ◊ Indicate the type of enhanced benefit and details about enhanced benefit (from check-off list and from notes);
  - ◊ Indicate if prior authorization must be received (Y/N);
  - ◊ Indicate if there is a service-specific enrollee coinsurance, copay, and/or deductible for the Medicare-covered part of the benefit (Y/N for each variable) and, if yes, the amount; do the same for the enhanced part of the benefit;
  - ◊ Indicate if there is a service-specific maximum enrollee out-of-pocket cost (Y/N), maximum, and periodicity (and type if available);
  - ◊ Indicate if there is a service-specific maximum plan benefit coverage amount (Y/N), maximum, and periodicity;
  - ◊ Produce frequencies and univariates (when appropriate) for each of the above variables, by service type.

- For Outpatient Prescription Drugs, initially extract the following data:
  - ◊ Whether the benefit is offered (Y/N), and whether it is offered as an additional, mandatory, or optional supplemental benefit (AMO);
  - ◊ Whether a formulary is used (Y/N), drug types covered by formulary, and whether prior authorization is needed (Y/N);
  - ◊ Whether non-formulary drugs are covered (Y/N), drug types covered, and whether prior authorization is needed (Y/N);
  - ◊ Whether there is a maximum plan benefit coverage for drugs (Y/N), (by formulary, non-formulary, and Medicare-covered) and, if so, details concerning the maximum;
  - ◊ Whether there is a maximum enrollee out-of-pocket cost for drugs (Y/N), and if so, details concerning the maximum;
  - ◊ Whether there is a coinsurance, copay, deductible (Y/N for each variable), and, if yes, the amounts.
  - ◊ Produce frequencies and univariates (when appropriate) for each of the above variables, by service type.
- In the second step of the data extraction for Outpatient Prescription Drugs, provide:
  - ◊ Details about formulary and non-formulary coverage of drugs, by drug type (generic, brand, preferred brand).

The same steps were conducted for the 2002 PBP file, and frequencies and univariate values for 2002 data were compared with 2001 data.

Based on the data extraction, we constructed a matrix of benefits and beneficiary cost-sharing arrangements and limits for all benefit packages offered within the selected counties, separately for 2001 and 2002. The matrices of benefits consisted of Medicare-covered benefits plan enhancements to Medicare-covered benefits, and non-Medicare-covered services, including physical exams, prescription drug benefits, dental benefits, vision benefits, and hearing benefits. The matrices can be obtained upon request.

Based on 2001 plan benefit designs as represented in the matrices, findings from our focused literature review, and discussions with key informants, we designed three model standardized core packages and four rider benefits, each containing a low and high option. The core and riders were based on the rules discussed in the main sections of this report. The next step in the analysis was to examination of whether a benefit was covered as an additional, mandatory, or optional benefit; whether or not it was included in the M+CO's "basic" benefit package; whether the supplemental notes provided in the 2001 PBP files suggested modifications; whether there were significant changes in coverage of the benefit or beneficiary liability in 2002; and whether recommendations from our key informant interviews suggested changes to the 2001 benefit designs. Findings from these steps were used to modify the initial set of core and riders, as

discussed in the main sections of this report. For each core and rider option, HayGroup provided an actuarial value in terms of total costs and beneficiary cost-sharing amounts, presented in the main sections of this report.

APPENDIX C: SUMMARY MATRICES

Key to Understanding Table C-1

Except for the first five rows in Table C-1, which provide general information about the 96 plans' benefit packages, the other rows in the table provide summary information for each health benefit/service category included in CMS's Plan Benefit Package (PBP) database. To provide assistance in reading the table, the rows summarizing "Inpatient Hospital benefits" are repeated below and described.

MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
1. Inpatient Hospital benefits		3% ($500-$750)			N/A	9% at $150-$1,050/yr	98% (PCP)
2. Medicare-covered benefits	100%		None	32% (72% at $50-$500/stay, mode=$100; 28% at $50-$275/day, mode=$50 and $75			
3. Additional IP days (99% of offering plans have an unlimited number of days)	90% (75% additional, 25% mandatory)		None	7% at $50-$275/day, mode=$75			
4. Room upgrades	4%		None	None			
5. POS Option	5 plans	None	2 plans at 20%	3 plans at $150/stay	1 plan at $10,000/yr	None	4 of the 5 (PCP)

Row 1 applies to inpatient hospital benefits in total, including those covered by Medicare and the plan (Medicare-covered benefits) and those not covered by Medicare but that are covered by the plan (i.e., "additional inpatient hospital days" and "room upgrades"). The row indicates that only 3 percent of the 96 health plans (3 plans) charge a deductible for inpatient hospital services, ranging from $500 to $700, which applies to both Medicare-covered and plan-only-covered inpatient hospital services, if any are provided. No plan charges a service-wide coinsurance or copay for inpatient hospital services and no plan has a service-wide maximum plan benefit for inpatient hospital services. Nine percent of plans (9 plans) have a maximum enrollee out-of-pocket cost limit, ranging from $150 to

$1,050 annually, that applies to both Medicare-covered and plan-covered inpatient hospital services. Nearly all plans (98 percent) require authorization from a primary care physician (PCP) for any inpatient hospital services to be paid for by the plan.

Row 2 applies only to inpatient hospital services covered by Medicare. All plans (100 percent) cover all Medicare-covered inpatient hospital benefits (as required by CMS). No plan charges a coinsurance for Medicare-covered inpatient hospital benefits. Thirty-one plans (32 percent of the 96 plans) charge a copy for Medicare-covered inpatient hospital services: 72 percent of the 31 plans (22 plans) charge a per stay copayment, ranging from $50 to $500, with the mode charge equaling $100; the other 28 percent of the 31 plans (9 plans) charge a per day copayment, ranging from $50 to $275, with bi-modal charges equaling $50 and $75. No plan charges a deductible or has a maximum plan benefit or enrollee out-of-pocket cost that applies *only* to Medicare-covered inpatient hospital benefits.

Row 3 applies to plan-enhanced benefits that are not covered by the Medicare program, consisting of additional inpatient days that are covered by the plan beyond Medicare's covered days. All but one plan (99 percent) of the plans that offer this benefit cover an unlimited number of additional inpatient hospital days beyond Medicare's limits. Ninety percent (86 of the 96 plans) cover additional inpatient hospital stays: 75 percent of these 86 plans provide this coverage as an additional benefit (meaning that the plan does not charge an additional premium for this benefit); 25 percent of the 86 plans provide this coverage as a mandatory benefit (meaning that beneficiaries who want to enroll in the plan receive this benefit as part of the plan but are charged an extra premium for the benefit). No plan charges a coinsurance for additional inpatient hospital days. No plan charges a deductible or has a maximum plan benefit or enrollee out-of-pocket cost that applies *only* to additional inpatient hospital day benefits.

Row 4 applies to plan-enhanced benefits that are not covered by the Medicare program, consisting of a room upgrade. Only 4 percent of plans (4 plans) cover a room upgrade, charging no enhanced-benefit-specific deductible, coinsurance, or copay for the upgrade. No plan charges a deductible or has a maximum plan benefit or enrollee out-of-pocket cost that applies *only* to room upgrade benefits.

Row 5 indicates that 5 of the 96 plans have a point-of-service (POS) option that applies to inpatient hospital services. None of the 5 plans charges a deductible for out-of-network inpatient hospital services, 2 of the 5 plans charge a 20 percent coinsurance for out-of-network services, and 3 of the 5 plans charge a per stay copayment for such services of $150 per stay. One of the 5 plans has an annual maximum plan benefit for out-of-network inpatient hospital services of $10,000, after which the plan no longer pays for any out-of-network inpatient hospital services. None of the 5 plans has an enrollee out-pocket-cost limit for the POS option. Four of the 5 plans require prior authorization from a PCP in order for the plan to pay for out-of-network inpatient hospital services.

Table C-1. Summary Matrix of Plan Benefit Packages for 96 Selected M+C Plans, 2001

MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
Overall Characteristics for the 96 plans:	All plans cover both Medicare Part A and Part B Services	1% at $750	Service-Specific	Service-Specific	None for non-POS option	8% at $300-$3,500/yr; mode $3,500 (non-POS option)	Service-Specific
87 plans are an HMO; 7 are an HMO POS; 2 are a state-licensed PSO	6/7 POS plans provide limited types of services under the POS option				2 plans with POS option: 1 plan at $10,000/yr; 1 plan at $1 million/ "other" period	7/7 POS - option plans at $75-$2,500/yr	
Premium for Med-covered additional and mandatory benefits: 47.5%=$0; 52.0%= $4-$116/mth (mode=$30)	Most frequent POS benefit is inpatient hospital coverage (5 plans)						
Premium for optional benefits: 34%=$5-$224.50/mth (mode=$25)	3 plans offer POS benefits as an additional benefit, 3 as mandatory, 1 as optional						
All plans describe themselves as "gated," most often by a PCP							
Inpatient Hospital benefits		3% ($500-$750)			N/A	9% at $150-$1,050/yr	98% (PCP)
Medicare-covered benefits	100%		None	32% (72% at $50-$500/stay, mode=$100; 28% at $50-$275/day, mode=$50 and $75			

MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
Additional IP days (99% of offering plans have an unlimited number of days)	90% (75% additional, 25% mandatory)		None	7% at $50-$275/day, mode=$75			
Room upgrades	4%		None	None			
POS Option	5 plans	None	2 plans at 20%	3 plans at $150/stay	1 plan at $10,000/yr	None	4 of the 5 (PCP)
Inpatient Hospital Psychiatric benefits		3% ($500-$750)			N/A	9% 4 plans combined w/IP amt.; 5 plans at $150-$500/yr or stay	98% (PCP)
Medicare-covered benefits	100%		None	22% at $50-$500/stay, mode=$100; 7% at $25-$275/day, mode=$150			
Additional IP Psych days (half offer unlimited, half limited 30-60 days)	9% (67% additional, 33% mandatory)		None	None			
POS Option	4 plans	None	1 plan at 20%	3 plans at $150/stay	None	None	4 of the 4 (PCP)
Skilled Nursing Facility		1% at $250			N/A	None	100% (PCP)
Medicare-covered benefits	100%		None	1% at $300/stay; 5% at $25-$100 for days 1-20; 9% at $25-$100 for days 21-100			
No prior hospital stay	81% (73% additional, 27% mandatory)		None	None			
Additional SNF days	2% (up to 50 additional days)		None	None			

MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
> 30-day discharge from hosp prior to SNF admission	16% (67% additional, 33% mandatory)		None	None			
POS Option	1 plan	None	1 plan at 20%	None	None	None	1 plan (PCP)
Comprehensive Outpatient Rehabilitation Facility (CORF)		None			N/A	None	100% (PCP)
Medicare-covered benefits	100%		2% at 20%	48% at $5-$25; mode=$10			
Enhanced benefits not applicable	N/A			None			
POS Option	1 plan	None	1 plan at 20%	None	None	None	1 plan (PCP)
Emergency/Urgent Care		None					
Emergency MCB	100%		None	91% min/max at $10-$50; mode=$50	N/A	None	N/A
				(89% waive copay upon hosp adm (19% immediate, 64% w/in 24hrs, 16% w/in 3 days))			
World-wide EC	93% (76% additional, 24% mandatory)		None	83% at $20-$500; mode=$50			
				(86% waived for hosp adm)			
Urgent Care MCB	100%		None	92% min/max at $5-$50; mode=$10 for min, $50 max	N/A	None	N/A

MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
				56% waived for hosp adm (13% immediate, 71% w/in 24hrs, 16% w/in 3 days)			
World-wide UC	87% (78% additional, 22% mandatory)		None	78% at $5-$500; mode=$50			
				(52% waived for hosp adm)			
POS Option	N/A						
Partial Hospitalization		None			N/A	None	100% (PCP)
Medicare-covered benefits	100%		2% at 20%	34% at $5-$30; mode=$15			
Enhanced benefits not applicable	N/A						
POS Option	2 plans	None	1 plan at 20%	None	None	None	1 plan (PCP)
Home Health		None		None	N/A	None	100% (PCP)
Medicare-covered benefits	100%		3% at 0%				
Homemaker services	2% (mandatory)		None				
Custodial Care	3% (33% additional, 67% mandatory)		None				
Respite Care	8% (25% additional, 75% mandatory)		None				
POS Option	1 plan	None	1 plan at 20%	None	None	None	1 plan (PCP)
Primary Care Physicians		None			N/A	None	N/A
Medicare-covered benefits	100%		None	86% min/max at $5-$20; mode=$10			
Enhanced benefits not applicable	N/A						

MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
POS Option	1 plan	None	1 plan at 20%	None	1 plan at $10,000/yr	None	N/A
Occupational Therapy Services		None			N/A	None	100% (PCP)
Medicare-covered benefits	100%		2% at 20%	69% min/max at $5-$25; mode=$10-$15			
Enhanced benefits not applicable	N/A						
POS Option	1 plan	None	1 plan at 20%	None	None	None	1 plan
Physician Specialist (excl. Psychiatric Services)		None			N/A	None	99% (PCP)
Medicare-covered benefits	100%		None	92% min at $5-$25, mode=$10; max at $5-$100, mode=$10			
Enhanced benefits not applicable	N/A						
POS Option	3 plans	None	1 plan at 20%	2 plans at $25	None	2 plans at $75/yr	None
Mental Health Services (Non-Physician)		None			N/A	None	81% (PCP)
Medicare-covered benefits	100%		4% (Min=20% (indiv or grp session); Max=20% or 50% (2 plans each))	85% min/max for indiv at $5-$35, bimodal=$10 and $25; Min/max for group at $5-$30,bimodal=$10 and $25			
Enhanced benefits not applicable	N/A						
POS Option	1 plan	None	1 plan at 20% (indiv or grp session)	None	None	None	None

MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
Podiatry Services (Med-cov only for certain medical conditions)		None			None	None	86% (PCP)
Medicare-covered benefits	100%		3% at 20%	86% min/max at $5-$25,mode=$10;			
Routine foot care	48% (78% additional, 17% mandatory, 4% optional); (22% unlimited, 78% limited between 1-12 visits/yr)		3% at 20%	38% min/max at $5-$25, mode=$10			
POS Option	1 plan	None	1 plan at 20%	None	None	None	None
Other Health Care Professional Services		None			N/A	None	86% (PCP)
Medicare-covered benefits	100%		1% at 100%	70% min at $3-$25, mode=$10; Max at $5-$50, mode=$10			
Enhanced benefits not applicable	N/A						
POS Option	1 plan	None	1 plan at 20%	None	None	None	None
Psychiatric Services		None			N/A	None	81% (PCP)
Medicare-covered benefits	100%		11% (min/max=20% or 50%; mode 50%) (indiv or grp session)	85% min/max for indiv at $5-$35, mode=$10-$25; Min/max for group at $5-$30, mode=$10-$20			
Enhanced benefits not applicable	N/A						
POS Option	1 plan	None	1 plan at 20% (indiv or grp session)	None	None	None	None

MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
Physical Therapy and Speech-Language Pathology Services		None			None	None	100% (PCP)
Medicare-covered benefits	100%		2% (min/max=20%)	71% min/max at $5-$25; bimodal=$10 and $15			
Enhanced benefits not applicable	N/A						
POS Option	1 plan	None	1 plan at 20%	None	None	None	None
Clinical/Diagnostic/ Therapeutic Radiological Lab Services		1 plan at $0			N/A	1 plan at $500/yr	98% (PCP)
Outpatient C/D/T MCB			2%				
Clinical MCB	100%		Min/max at 20%	16% min/max at $5-$20; bimodal=$5 and $20			
Diagnostic MCB	100%		Min/max at 20%	17% min at $5-$20, mode=$5;max at $5-$100, bimodal=$5 and $20			
Therapeutic MCB	100%		Min/max at 20%	26% min at $5-$20, mode=$5;max at $5-$25, mode=$20			
Enhanced benefits not applicable	N/A						
POS Option	1 plan	None	1 plan min/max at 20%	None	None	None	None

MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
Clinical/Diagnostic/ Therapeutic Radiological Lab Services		None			N/A	None	97% (PCP)
Outpatient X-rays MCB	100%		2% (min/max=20%)	20% min at $5-$20, mode=$5;max at $6-$100, mode=$20			
Enhanced benefits not applicable	N/A						
POS Option	2 plans	None	2 plans min/max at 20%	None	1 plan at $10,000/yr	None	None
Outpatient Hospital Services		None			N/A	1 plan at $500/yr	100% (PCP)
Medicare-covered benefits	100%		None	34% min at $5-$200, mode=$15;max at $5-$275, mode=$15			
Enhanced benefits not applicable	N/A						
POS Option	1 plan	None	1 plan at 20%	None	None	None	1 plan (org.)
Ambulatory Surgery Centers		None			N/A	1 plan (amount not in database)	100% (PCP)
Medicare-covered benefits	100%		3% (min/max=0%)	27% min at $5-$200, bimodal=$5 and $20;max at $5-$275, trimodal=$5, $15, $50			
Enhanced benefits not applicable	N/A						
POS Option	1 plan	None	1 plan min/max at	None	None	None	1 plan (org.)

MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
			20%				
Outpatient Substance Abuse Services		None			N/A	None	88% (PCP)
Individual Session Medicare-covered benefits	100%		4% (min=20%; max=20% or 50%) (indiv or grp sessions)	81% min/max at $5-$35; mode=$10			
Group Session Medicare-covered benefits	100%		4% (min=20%; max=20% or 50%) (indiv or grp sessions)	81% min/max at $5-$30; mode=$10			
Enhanced benefits not applicable	N/A						
POS Option	1 plan	None	1 plan min/max for indiv and grp session at 20%"	None	None	None	None
Cardiac Rehabilitation Services		None			N/A	None	100% (PCP)
Medicare-covered benefits	100%		None	52% min/max at $5-$50; mode=$15			
Enhanced benefits not applicable	N/A						
POS Option	1 plan	None	1 plan at 20%	None	None	None	1 plan (org.)
Ambulance Services		None			N/A	None	94% (PCP)
Medicare-covered benefits	100%		2% at 20% (not waived on hosp adm)	22% at $20-$150; mode=$50 (40% waive copay on hosp adm)			
Enhanced benefits not applicable	N/A						
POS Option	N/A						

MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
Durable Medical Equipment/Medical Supplies		None			N/A	None	
DME Medicare-covered benefits	100%		14% (12% min/max=20%; 2% min/max=10%)	1% at $25			100% (PCP)
Enhanced DME not applicable	N/A						
Medical Supplies MCB	100%		14% (12% min/max=20%; 2% min/max=10%)	4% at $5-$25, mode=$10			98% (PCP)
Enhanced MS not applicable	N/A						
POS Option	1 plan	None	1 plan at 20%	None	None	None	None
Renal Dialysis		1 plan at $0			N/A	1 plan at $0/yr	97% (PCP)
Medicare-covered benefits	100%		5% (in- and out-of-area=20%)	15% at $5-$20; mode=$15 Amount per session for both in and out-of-area MCB			
Enhanced benefits not applicable	N/A						
POS Option	N/A						
Outpatient Blood		1 plan at $0			N/A	None	78% (PCP)
Medicare-covered benefits	100%		None	None			
3-pint deductible waived	75% (74% additional, 26% mandatory)		N/A	N/A			
POS Option	1 plan	None	None	None	None	None	None
Immunizations		None			N/A	None	54% except for flu shots (PCP)
Medicare-covered benefits	100%		3% at 0%	13% at $5-$10, mode=$10 (Hep B)			

MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
Additional immunizations	41% (72% additional, 28% mandatory)		3% at 0%	10% at $5-$15, mode=$10			
POS Option	None						
Pap/Pelvic Screening		None			None	None	46% (PCP)
Medicare-covered benefits	100%		None	1% Med-cov pap at $5; 21% Medic-cov pelvic $5-$25, mode=$15			
Addtl pap/pelvic exams (most common 1 addtl/yr)	44% (83% additional, 17% mandatory)		None	None for addtl pap; 16% for addtl pelvic at $5-$25, mode=$15			
POS Option	None						
Prostate Cancer Screening		None			None	None	71% (PCP)
Medicare-covered benefits	100%		None	9% at $5-$20, mode=$15			
Addtl prostate exams (1 addtl/yr)	6% (additional)		None	None			
POS Option	None						
Colorectal Screening		None			None	None	69% (PCP)
Medicare-covered benefits	100%		None	9% min/max at $5-$20; mode=$15			
Addtl colorectal exams (most common 1 addtl/yr)	13% (additional)		None	None			
POS Option	None						
Bone Mass Measurement		None			N/A	None	84% (PCP)
Medicare-covered benefits	100%		None	11% at $5-$50; bimodal=$5, $20			
Enhanced benefits not applicable	N/A						

MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
POS Option	None						
Mammography Screening		None			None	None	98% (PCP)
Medicare-covered benefits	100%		None	5% at $10-$20; bimodal=$15, $20			
Addtl mammogram exams (1 addtl/yr)	3% (additional)		None	None			
POS Option	None						
Diabetes Monitoring		None			N/A	None	90% (PCP)
Medicare-covered benefits	100%		4% at 20%	4% at $5-$20; mode=$5			
Enhanced benefits not applicable	N/A						
POS Option	None						

NON MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
Transportation Services	17% offer some type of Enhanced Benefit	None	1% at 100%	2% at $5	None	None	98% ("other")
Trips	(94% offer plan-approved location (80% additional, 20% mandatory)						
	27% of these offer unlimited trips; 73% limited between 4-40 trips						
	50% of these offer one-way; 50% offer round-trip						

NON MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
	6% offer any location, unlimited trips, round-trip (100% additional))						
POS Option	N/A						
Chiropractic Services (Routine Care)	21% (60% additional, 25% mandatory, 15% optional) (25% offer unlimited visits; 75% limit between 6-25 visits/yr)	None	3% at 20% for MCB; None for Routine Care	85% min/max at $5-$25 for MCB; mode=$10 15% min/max at $5-$20 for Routine Care; mode=$10	N/A	None	72% (PCP)
POS Option	1 plan	None	1 plan at 20%	None	None	None	1 plan (org.)
Acupuncture Treatments	9% (44% additional, 22% mandatory, 33% optional) (44% offer unlimited visits; 56% limited between 6-20 visits/yr)	None	None	7% at $10-$15, mode=$10	None	None	34% (PCP)
POS Option	None						
Other Services							
Other 1	36% (20% transplant, 11% outpatient injectables, 9% adult day care, 9% diaphragms (66% additional, 34% mandatory))	None	2% at 25%	28% at $5-$1,500; mode=$1,500, then $25	9% ($15/3 months-$1,050/yr; bimodal=$45 and $500/yr)	None	99% (PCP)
Other 2	20% (21% dental silver, 16% optional dental, 16% personal medical emergency (37%	None	None	13% at $5-$25; mode=$10	20% ($20/3 months or $300/yr; mode=$300/yr)		

NON MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
	additional, 26% mandatory, 37% optional))						
POS Option	None						
Health Education/Wellness Programs	84% offer some type of Enhanced Benefit	None	2% (1 plan at 100% for HEW programs; 1 plan at 80% for health club)		1% at $25/"other period"; 1% at $250/"other period"	None	41% ("other")
health education/wellness programs	65% (73% additional, 27% mandatory)			2% at $15 for HEW			
newsletter	73% (76% additional, 24% mandatory)			None			
nutritional training	48% (74% additional, 26% mandatory)			2% at $10 for nutritional training			
smoking cessation	49% (72% additional, 28% mandatory)			None			
congestive heart program	45% (72% additional, 28% mandatory)			2% at $10 for congestive heart prog			
alternative medicine program	3% (100% additional)			None			
health/fitness membership	16% (80% additional, 20% mandatory)			2% at $1-$15 for health club			
nursing hotline	49% (81% additional, 19% mandatory)			None			
disease mgmt program	61% (75% additional, 25% mandatory)			4% at $10-$15 for disease mgmt class			
other HEW benefit	23% (68% additional, 32% mandatory)			None			
POS Option	None						

NON MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
Routine Physical Exams	100% (71% additional, 29% mandatory) (76% of these offer one extra exam (97% 1/yr, 3% 1/2 yrs); 24% offer unlimited visits)	None	None	64% at $5-$15, mode=$10	3% at $1/yr	2% at $5/yr	51% (PCP)
POS Option	1 plan	None	1 plan at 20%	None	1 plan at $10,000/yr	None	
Dental Services (Preventive)	52% offer some type of Enhanced Benefit	None	None		1% at $50/yr	1% at $280/yr	12% ("other")
Oral exams	52% (62% additional, 22% mandatory, 16% optional)			28% min between $5-$30, max between $3-$35; mode=$10			
	(32% unlimited, 68% limited (35% 1/yr, 65% 2/yr))						
Prophylaxis	50% (67% additional, 17% mandatory, 17% optional)			25% min between $5-$42, max between $5-$46; mode=$10			
	(10% unlimited, 90% limited (14% 1/yr, 84% 2/yr, 2% 3/yr))						
Flouride treatment	23% (59% additional, 23% mandatory, 18% optional)			18% min between $2-$16, max between $2-$16; mode=$5 and $10			
	(27% unlimited, 73% limited (6% 1/2yrs, 25% 1/yr, 69% 2/yr))						

NON MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
Dental x-rays	43% (66% additional, 15% mandatory, 20% optional)			19% min between$1-$30, max between $5-$65; mode=$5 and $10			
	(32% unlimited, 68% limited (7% 1/3yrs, 18% 1/2yrs, 29% 2/yr, 7% 1/"other"))						
POS Option	None						
Dental Services (Comprehensive)	34% offer some type of Enhanced Benefit	None	2% for Med-cov services; 1% at 20%, 1% at 100%	40% (min at $5-$25, max at $5-$35 for MCB; mode=$10)	None	1% at $0/yr	59% (PCP)
Prosthodontics/other oral/ maxillofacial surgery/other services	29% (57% additional, 11% mandatory, 32% optional)		1% at 20%	26% min at $5-$218, max at $5-$890; mode=$20 (min) and $390 (max)			
	(86% unlimited, 14% limited (1 plan 1/3yrs, 2 plans 1/"other", 1 plan 4/yr))						
Emergency services	27% (67% additional, 17% mandatory, 17% optional)		None	20% min at $3-$35, max at $3-$720; mode=$5 and $10			
	(92% unlimited, 8% limited (1 plan 1/yr, 1 plan 1/6mos))						
Diagnostic services	29% (57% additional, 11% mandatory, 32% optional)		None	21% min at $1-$17, max at $5-$65; mode=$12 and $15			

NON MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
	(82% unlimited, 18% limited to 1/yr or 1/6mos)						
Restorative services	33% (63% additional, 9% mandatory, 28% optional)		1% at 20%	30% min at $2-$50, max at $5-$396; mode=$17,$30, and $285			
	(97% unlimited, 3% limited to 4/yr)						
Endodontics/Periodontics/ Extractions	29% (57% additional, 11% mandatory, 32% optional)		None	26% min at $3-$103, max at $103-$738; mode=$20 (min) and $363 (max)			
	(89% unlimited, 11% limited to 4/yr)						
POS Option	None						
Vision Care (Routine Eye Exams)	91.7% (75% additional, 25% mandatory, 0% optional) (3% unlimited exams; 93% limited; 4% 1/2ys, 91% 1/yr, 1% 1/6mos, 4% 1/"other", 1% 2/yr	None	None	79% min/max at $5-$25 for Med-cov services; mode=$10 71% min/max at $5-$25 for routine exams; mode=$10	3% at $30-$150/yr	None	50% (PCP)
POS Option	None						
Vision Care (Eye Wear)	66% offer some type of Enhanced Benefit	None	2% at 0% and 20%	5% Med-cov services at $10	43% (66% at $45-$150/2yrs; 29% at $45-$150/yr; 5% at $45-$150/"other")	None	45% (PCP)

NON MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
Contact lenses	42% (68% additional, 35% mandatory)		1% at 80%	3% at $10-$45; no mode			
	(15% unlimited, 85% limited (29.4% 1/2yrs, 47.1% 1/yr, 2.9% 1/6mos, 8.8% 1/"other"))						
Eye glasses (lenses & frames)	53% (73% additional, 27% mandatory)		None	8% at $10-$25; bimodal=$10, $20			
	(12% unlimited, 88% limited (35.6% 1/2yrs, 40% 1/yr, 8.9% 1/6mos, 4.4% 2/yr, 2.2% 100/2yrs?))						
Eye glasses (lenses only)	34% (55% additional, 45% mandatory)		1% at 0%	6% at $10-$30; mode=$10			
	(12% unlimited, 88% limited (31.03% 1/2yrs, 44.8% 1/yr, 6.9% 1/"other", 3.5% 2/yr))						
Eye glasses (frames only)	32% (58% additional, 42% mandatory)		1% at 0%	6% at $10-$30; mode=$10			
	(13% unlimited, 87% limited (44.4% 1/2yrs, 29.6% 1/yr, 7.41% 1/"other", 3.7% 2/yr))						
Upgrades	7% (43% additional, 57% mandatory)		None	1% at $25			
POS Option	None						
Hearing Services (Hearing Exams)	84% offer some type of Enhanced Benefit	None	None	73% Med-cov benefit $5-$25; mode=$10	2% (50% at $50/yr; 50% at $500/3 yrs)	1% at $250/3yrs	74% (PCP)

NON MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
Routine hearing test	84% (73% additional, 27% mandatory)			59% min/max at $5-$25; mode=$10			
	(5% unlimited, 95% limited (1 plan 3/yrs, 74 plans 1/yr, 1 plan 2/yr))						
Fitting/evaluation	26% (80% additional, 20% mandatory)			7% min/max at $10-$25; mode=$10			
	(36% unlimited, 64% limited (5 plans 1/3yrs, 2 plans 1/2yrs, 10 plans 1/yr))						
POS Option	None						
Hearing Services (Hearing Aids)	52% offer some type of Enhanced Benefit	1% at $50			48% (1 plan "covered under hearing," 45 plans "plan specified amt/period") 72% between $100-$750/3yrs; 9% between $100-$750/2 yrs; 15% between $100-$750/yr; 2% between $100-$750/"other"	None	46% (PCP)
Inner ear	48% (52% additional, 48% mandatory)		2% at 50% and 85%	None			
	(39% unlimited, 61% limited (15 plans 1/3yrs, 4 plans 1/2yrs, 4 plans 1/yr, 1 plan 2/"other"))						

NON MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
Outer ear	51% (55% additional, 45% mandatory)		2% at 50% and 85%	None			
	(37% unlimited, 63% limited (17 plans 1/3yrs, 4 plans 1/2yrs, 4 plans 1/yr, 1 plan 2/yr))						
Over ear	50% (56% additional, 44% mandatory)		2% at 50% and 85%	1% one over the ear at $250; 1% two over the ear at $500			
	(38% unlimited, 62% limited (16 plans 1/3yrs, 4 plans 1/2yrs, 4 plans 1/yr, 1 plan 1/"other", 1 plan 2/yr))						
Replacement battery	9% (78% additional, 22% mandatory)		None	None			
	(56% unlimited, 44% limited (1 plan 1/yr, 3 plans 1/"other"))						
POS Option	None						

NON MEDICARE-COVERED BENEFITS	Benefits Coverage	Deductible	Coinsurance	Copay	Max. Plan Benefit (only applies to enhanced benefits)	Max. Enrollee Out-of-Pocket Cost	Prior Authorization
Visitor/Travel Services	29% (79% additional, 21% mandatory) (89% must be traveling 0 days, 11% must be traveling at least one day) (Max number of days: 7% at 0 days, 7% at 90 days, 14% at 180-182 days, 18% at 270 days, 54% at 365 days)	None	10% (8% at specified PBP service categories 1-18; 2% at 20%)	2% at $10	4% (50% at $2500/yr; 25% at $5000/yr; 25% at $100,000/yr)	1% at $1,250/yr	82% (PCP)
POS Option	N/A						

Table C2. Outpatient Drug Benefits, 2001 and 2002				
	2001		2002	
	Number of Plans	Proportion of Plans	Number of Plans	Proportion of Plans
Total Plans Offering Drug Benefit(s)	65 (of 96)	68%	51 (of 73)	70%
Benefit Type				
The percentages presented in this section are out of 65 plans in 2001 and 51 plans in 2002				
Additional benefit	42	65%	28	55%
Mandatory benefit	21	32%	19	37%
Optional benefit	2	3%	4	8%
Formulary Coverage	57	88%	43	84%
The percentages presented in this section are out of 57 plans in 2001 and 43 plans in 2002				
Only formulary	26 (40%/65)	45%	23 (45%/51)	53%
Formulary and non-formulary	31 (48%/65)	55%	31 (61%/51)	47%
Generic, brand, preferred brand	4	7%	6	14%
Generic, brand	41	72%	12	28%
Generic, preferred brand	6	11%	6	14%
Generic only	4	7%	16	37%
Brand only	0	0	0	0%
Preferred brand only	2	4%	3	7%

Table C2: Outpatient Drug Benefits, 2001 and 2002				
	2001		2002	
	Number of Plans	Proportion of Plans	Number of Plans	Proportion of Plans
Must receive authorization for formulary drugs (most frequently from a PCP)	25	44%	24	56%
Does not need auth for formulary drugs	32	56%	19	44%
Formulary Generic Coverage	55	96%	40	93%
The percentages presented in this section are out of 55 plans in 2001 and 40 plans in 2002				
Max plan benefit (1 plan $400/yr; 1 plan $100/3 months; 1 plan $500/3 months; 1 plan published national AWP; 2 plans discount of published national AWP)	3	5%	4	10%
MPB amount for F-G is less a copay amt	2 (of 3)	67%	3 (of 4)	75%
MPB amount for F-G includes copay	1 (of 3)	33%	1 (of 4)	25%
F-G drugs can be acquired from either designated retail pharmacy and/or mail order	39	71%	39	97%
F-G drugs acquired from other combo (retail pharm, HMO pharm, mail order, other)	16	29%	1	3%
Coinsurance for F-G drugs (1 plan = 20%) based on published M+CO fee schedule	1	2%	0	0%
Copay for F-G drugs:				

Table C2: Outpatient Drug Benefits, 2001 and 2002				
	2001		2002	
	Number of Plans	Proportion of Plans	Number of Plans	Proportion of Plans
Designated retail pharmacy ($4-$12)	47	85%	34	85%
HMO-owned pharmacy ($2-$10)	7	13%	5	13%
Mail order ($5-$27)	43	78%	30	75%
Other type of acquisition ($2)	1	2%	1	3%
Day supply limit for F-G drugs:				
Designated retail pharmacy (84%=30 days)	55	100%	40	100%
HMO-owned pharmacy (78%=30 days)	9	16%	5	13%
Mail order (85%=90 days)	46	84%	33	83%
Other type of acquisition (1 plan=30 days)	1	2%	1	3%
Formulary Brand Coverage	45	79%	18	42%
The percentages presented in this section are out of 45 plans in 2001 and 18 plans in 2002				
Max plan benefit (most common (65%) apply annually, ranging from $400-$2,500; most common is published national AWP or discount of published national AWP)	17	38%	2	11%
MPB amount for F-B is less a copay amt	12 (of 17)	71%	2 (of 2)	11%
MPB amount for F-B includes copay	5 (of 17)	29%	0 (of 2)	0%
F-B drugs can be acquired from either designated retail pharm and/or mail order	32	71%	17	94%
F-B drugs acquired from other combo	13	29%	1	6%

Table C2: Outpatient Drug Benefits, 2001 and 2002

	2001		2002	
	Number of Plans	**Proportion of Plans**	**Number of Plans**	**Proportion of Plans**
Coinsurance for F-B drugs (1 plan=20%) based on published M+CO fee schedule	1	2%	0	0%
Copay for F-B drugs:				
Designated retail pharmacy ($10-$50)	44	98%	16	89%
HMO-owned pharmacy ($5-$25)	8	18%	4	22%
Mail order ($8-$120)	39	87%	15	83%
Other type of acquisition ($5)	1	2%	1	6%
Day supply limit for F-B drugs:				
Designated retail pharmacy (82%=30 days)	45	100%	17	94%
HMO-owned pharmacy (78%=30 days)	9	20%	4	22%
Mail order (85%=90 days)	39	87%	15	83%
Other type of acquisition (30 days)	1	2%	1	6%
Formulary Preferred-Brand Coverage	12	21%	15	37%
The percentages presented in this section are out of 12 plans in 2001 and 15 plans in 2002				
Max plan benefit (2 plans $500/3 months; 1 plan $625/3 months; 1 plan published wholesale price; 1 plan published national AWP plus disp. fee; 1 plan discount of published national AWP)	3	25%	1	7%

Table C2 Outpatient Drug Benefits, 2001 and 2002*				
	2001		2002	
	Number of Plans	Proportion of Plans	Number of Plans	Proportion of Plans
MPB amount for F-PB is less a copay amt	2 (of 3)	67%	1 (of 1)	100%
MPB amount for F-PB includes copay	1 (of 3)	33%	0 (of 1)	0%
F-PB drugs can be acquired from either designated retail pharm and/or mail order	10	83%	15	100%
F-PB drugs acquired from designated retail pharmacy only	2	17%	12	80%
Coinsurance for F-PB drugs	0	0%	0	0%
Copay for F-PB drugs:				
Designated retail pharmacy ($10-$25)	12	100%	14	93%
HMO-owned pharmacy	0	0%	0	0%
Mail order ($25-$50)	10	83%	12	80%
Other type of acquisition	0	0%	0	0%
Day supply limit for F-PB drugs:				
Designated retail pharmacy (100%=30 days)	12	100%	15	100%
HMO-owned pharmacy	0	16%	0	0%
Mail order (100%=90 days)	10	83%	12	80%
Other type of acquisition	0	0%	0	0%

Table C2: Outpatient Drug Benefits, 2001 and 2002				
	2001		2002	
	Number of Plans	Proportion of Plans	Number of Plans	Proportion of Plans
Non-Formulary Coverage	39	60%	28	55%
The percentages presented in this section are out of 39 plans in 2001 and 28 plans in 2002				
Only non-formulary	8 (12%/65)	20% (12%)	8 (16%/51)	29%
Formulary and non-formulary	31 (48%/65)	80% (48%)	20 (39%/51)	71%
Generic, brand, preferred brand	0	0%	0	0%
Generic, brand	25	64%	17	61%
Generic, preferred brand	0	0%	0	0%
Generic only	5	13%	5	18%
Brand only	9	23%	6	21%
Preferred brand only	0	0%	0	0%
Must receive authorization for non-formulary drugs (most frequently from a PCP)	17	44%	6	21%
Does not need auth for non-formulary drugs	22	56%	22	79%
Non-Formulary Generic Coverage	30	77%	22	79%
The percentages presented in this section are out of 30 plans in 2001 and 22 plans in 2002				

Table C2: Outpatient Drug Benefits, 2001 and 2002

	2001		2002	
	Number of Plans	Proportion of Plans	Number of Plans	Proportion of Plans
Max plan benefit (1 plan $200/yr; 1 plan $400/yr; 1 plan $300/3 months; 1 plan $500/3 months; 1 plan published wholesale price; 1 plan published national AWP plus disp. fee; 1 plan discount of published national AWP; 1 plan "other")	4	13%	0	0%
MPB amount for NF-G is less a copay amt	4 (of 4)	100%	0 (of 0)	0%
MPB amount for NF-G includes copay	0 (of 4)	0%	0 (of 0)	0%
NF-G drugs can be acquired from either designated retail pharmacy and/or mail order	20	67%	21	95%
NF-G drugs acquired from other combo (retail pharm, HMO pharm, mail order, other)	10	33%	1	5%
Coinsurance for NF-G drugs	0	0%	2	9%
Copay for NF-G drugs:				
Designated retail pharmacy ($5-$50)	28	93%	18	82%
HMO-owned pharmacy ($5-$25)	5	17%	1	5%
Mail order ($5-$135)	23	77%	15	68%
Other type of acquisition ($10)	1	3%	1	5%

Table C2: Outpatient Drug Benefits, 2001 and 2002				
	2001		2002	
	Number of Plans	Proportion of Plans	Number of Plans	Proportion of Plans
Day supply limit for NF-G drugs:				
Designated retail pharmacy (70%=30 days)	30	100%	22	100%
HMO-owned pharmacy (60%=30 days)	5	17%	1	5%
Mail order (92%=90 days)	24	80%	18	82%
Other type of acquisition (1 plan=30 days)	1	3%	1	5%
Non-Formulary Brand Coverage	34	87%	23	82%
The percentages presented in this section are out of 34 plans in 2001 and 23 plans in 2002				
Max plan benefit (most common (64%) apply every 3 months, ranging from $125-$625; most common is discount of published national AWP)	14	41%	3	13%
MPB amount for NF-B is less a copay amt	10 (of 14)	71%	3 (of 3)	100%
MPB amount for NF-B includes copay	4 (of 14)	29%	0 (of 3)	0%
NF-B drugs can be acquired from either designated retail pharm and/or mail order	21	62%	22	96%
NF-B drugs acquired from other combo	13	38%	1	5%
Coinsurance for NF-B drugs	0	0%	2	9%
Copay for NF-B drugs:				

Table C2: Outpatient Drug Benefits, 2001 and 2002*

	2001		2002	
	Number of Plans	**Proportion of Plans**	**Number of Plans**	**Proportion of Plans**
Designated retail pharmacy ($10-$50)	34	100%	20	87%
HMO-owned pharmacy ($10-$45)	7	21%	1	4%
Mail order ($10-$135)	25	74%	16	70%
Other type of acquisition ($15)	1	3%	1	4%
Day supply limit for NF-B drugs:				
Designated retail pharmacy (79%=30 days)	34	100%	23	100%
HMO-owned pharmacy (71%=30 days)	7	21%	1	4%
Mail order (92%=90 days)	25	74%	1	4%
Other type of acquisition (30 days)	1	3%	1	4%
Maximum Plan Benefit Coverage	57	88%	36	71%
The percentages presented in this section are out of 57 plans in 2001 and 36 plans in 2002				
Unused amounts carried forward to next period	5	9%	5	14%
Cannot carry unused amounts forward	52	91%	31	86%
MPB amount applies to a combo of drug types:	42	74%	19	53%
Non-formulary brand and formulary brand	10 (of 42)	24%	2 (of 19)	11%
Formulary generic and formulary brand	8 (of 42)	19%	3 (of 19)	16%
All except formulary preferred brand	5 (of 42)	12%	0 (of 19)	0%
Other combinations of drug types	19 (of 42)	45%	14 (of 19)	74%

Table C2: Outpatient Drug Benefits, 2001 and 2002				
	2001		2002	
	Number of Plans	Proportion of Plans	Number of Plans	Proportion of Plans
MPB amount for combo of drug types: (In 2001, 4 plans had both an annual and a quarterly MPB; in 2002, 1 plan had a monthly and "other" MPB)				
Annually, ranging from $400 to $3,000 (22%=$500, $1,000, $2,000 each)	23 (of 42)	55%	9 (of 19)	47%
Every 6 months, ranging from $500-$800	3 (of 42)	7%	2 (of 19)	11%
Every 3 months, ranging from $75-$625	16 (of 42)	38%	5 (of 19)	26%
Every month, ranging from $150-$250	3 (of 42)	7%	3 (of 19)	16%
"Other" periodicity	1 (of 42)	2%	1 (of 19)	5%
MPB amount for combo is less a copay amt	34 (of 42)	81%	36	100%
MPB amount includes copay	8 (of 42)	19%	0	0%
Generic is unlimited after MPB is reached	6	11%	1	3%
Generic is limited after MPB is reached	51	89%	35	97%
MPB coverage basis (two most common):				
◦ Discounted % of published national AWP	11	26%	12	41%
"Other" coverage basis	19	45%	10	34%
MPB amount applies to all drug types	15	26%	10	28%

Table C2: Outpatient Drug Benefits, 2001 and 2002

	2001		2002	
	Number of Plans	**Proportion of Plans**	**Number of Plans**	**Proportion of Plans**
Maximum Enrollee Out-of-Pocket Cost	0 (of 96)	0%	0 (of 73)	0%
Deductible (1 plan = $50 for all drug types except formulary preferred brand)	1 (of 96)	1%	0 (of 73)	0%
Coinsurance: Medicare-covered benefits (20%)	24 (of 96)	25%	25 (of 73)	34%
The percentages presented in this section are out of 24 plans in 2001 and 25 plans in 2002				
Published national AWP	2	8%	3	12%
Published natl AWP plus dispensing fee ($2-$3)	3	13%	1	4%
Published M+CO fee/charge schedule	3	13%	3	12%
Percentage discount of published retail price	0	0%	0	0%
Percentage discount of AWP	0	0%	0	0%
M+CO acquisition cost +	0	0%	0	0%
Medicare Fee Schedule	0	0%	2	8%
"Other"	16	67%	16	64%
Copayment: Medicare-covered benefits	24 (of 96)	25%	22 (of 73)	30%
	Min ranges from $2 to$12 Mode=$10		Min ranges from $2 to$25 Mode=$10	
	Max ranges from $15 to $80 Mode=$15, $40		Max ranges from $15 to $550 Mode= $40	

NOTE: Any dollar amounts, percentages, or other figures included in the first column apply to the 2001 health plans only (not to the 2002 plans).

APPENDIX D: MODEL CORE BENEFIT PACKAGES

Medicare-Covered Benefits, Core Benefit Package #1					
Benefit Description	**Deduct-ible**	**Coinsur-ance**	**Copay-ments**	**Max Plan Benefit**	**Max OOP**
Plan-wide	None	None	None	None	None
Inpatient Hospital	$500/yr	None	None	None	None
IP Psychiatric	$500/yr	None	None	None	None
Skilled Nursing Facility (100 days limit; for Medicare-covered stays only)	None	None	$100/day for days 1-100[74]	None	None
CORF	None	None	$10	None	None
Emergency Care	None	None	$50 waived on hosp adm	None	None
Urgent Care	None	None	$50 waived on hosp adm	None	None
Partial Hospitalization	None	None	$20	None	None
Home Health	None	None	None	None	None
Primary Care Physicians	None	None	$10	None	None
Occupational Therapy	None	None	$10	None	None
Physician Specialist (exc. psychiatric)	None	None	$10	None	None
Mental Health (non-physician)	None	None	$10 min $20 max /indiv or group	None	None
Podiatry	None	None	$10	None	None
Other Health Care Professionals	None	None	$10	None	None
Psychiatric	None	None	$10 min $20 max /indiv or group	None	None
Physical Therapy/Speech-Language Pathology	None	None	$10	None	None
Clinical/Diagnostic/Therapeutic Radiological Lab Clinical Diagnostic Therapeutic Outpatient X-Rays	None	None	$5; plus $10 office visit copay	None	None

[74] Copay charges and patterns for SNF stays do not appear to have changed much between 2001 and 2002. In each year, about 10 percent of plans charged a copay, with almost all consisting of a per day (rather than per stay) copay. About half of these had a copay per day for days 1-100 and the other half for only days 21-100. The greater beneficiary cost-sharing amounts (i.e., for 100 days of a Medicare-covered stays) were adopted for Core Package #1.

Medicare-Covered Benefits, Core Benefit Package #1					
Benefit Description	**Deduct-ible**	**Coinsur-ance**	**Copay-ments**	**Max Plan Benefit**	**Max OOP**
Outpatient Hospital	None	None	$20	None	None
Ambulatory Surgery Centers	None	None	$5 min $20 max	None	None
Outpatient Substance Abuse	None	None	$10/indiv or group	None	None
Cardiac Rehabilitation	None	None	$15	None	None
Ambulance	None	None	$50	None	None
Durable Medical Equipment	None	None	$10	None	None
Medical Supplies	None	None	$10	None	None
Renal Dialysis	None	None	$15 in- and out-of-area	None	None
Outpatient Blood	None	None	None	None	None
Immunizations/Screenings	None	None	(In addition to $10 office visit copay)	None	None
Immunizations (except for pneumococcal, influenza, Hepatitis B=no charge)			$10		
Pap/Pelvic Exams			$15		
Prostate Exams			$15		
Colorectal Exams			$15		
Bone Mass Measurement			$15		
Mammogram Exams			$15		
Diabetes Monitoring			$5		
Medicare-covered Chiropractic Treatment	None	None	$10	None	None
Medicare-covered Vision Exams (including office visit copay)	None	None	$10	None	None
Medicare-covered Hearing Exams (including office visit copay)	None	None	$10	None	None
Medicare-covered Dental Services	None	None	$10	None	None

Enhanced Benefits, Core Benefit Package #1					
Benefit Description	**Deduct-ible**	**Coinsur-ance**	**Copay-ments**	**Max Plan Benefit**	**Max OOP**
Additional Inpatient Hospital Days for an unlimited number of days	None	None	$75/day	None	None
No Prior Hospital Stay Required for SNF Benefits to be Covered	None	None	None	None	None
World-Wide Emergency Care	None	None	$50 waived on hosp adm	None	None
World-Wide Urgent Care	None	None	$50 waived on hosp adm	None	None
3-pint outpatient blood deductible waived	None	None	None	None	None
Routine Physical Exam/1 Addtl Per Year	None	None	$10	None	None
Routine Eye Exam/1 Addtl Per Year	None	None	$10	None	None
Routine Hearing Test/1 Addtl Per Year	None	None	$10	None	None

Medicare-Covered Benefits, Core Benefit Package #2					
Benefit Description	**Deduct-ible**	**Coinsur-ance**	**Copay-ments**	**Max Plan Benefit**	**Max OOP**
Plan-wide	None	None	None	None	None
Inpatient Hospital	None	None	$100/stay[75]	None	$300/yr
IP Psychiatric	None	None	$100/stay	None	$300/yr
Skilled Nursing Facility (100 days limit; for Medicare-covered stays only)	None	None	$100/day for days 21-100[76]	None	None
CORF	None	None	$10	None	None
Emergency Care	None	None	$50 waived on hosp adm	None	None
Urgent Care	None	None	$50 waived on hosp adm	None	None
Partial Hospitalization	None	None	$20	None	None
Home Health	None	None	None	None	None
Primary Care Physicians	None	None	$10	None	None
Occupational Therapy	None	None	$10	None	None
Physician Specialist (exc. psychiatric)	None	None	$10	None	None
Mental Health (non-physician)	None	None	$10 min $20 max /indiv or group	None	None
Podiatry	None	None	$10	None	None
Other Health Care Professionals	None	None	$10	None	None
Psychiatric	None	None	$10 min $20 max /indiv or group	None	None
Physical Therapy/Speech-Language Pathology	None	None	$10	None	None

[75] Of the 33 percent of the plans that charged a copay for Inpatient Hospital services in 2001, 72 percent had a "per stay" charge and the other 28 percent had a "per day" charge. Therefore, the per stay structure was adopted, with the mode of $100. The 2001 PBP did not allow plans to break per day charges into day intervals with different copay amounts, while the 2002 PBP did allow for this. Of the 62 percent of plans that charged a copay in 2002, a slight majority had a per stay charge (mode=$250) and no per day charge. Most of the rest had a per day charge only for days 1-5 of the inpatient hospital stay (10 plans, mode=$50)) or for days 1-90 (8 plans, mean=$185 (no mode)). A very similar pattern occurred for Inpatient Psychiatric services in the two years: the number of plans instituting a per day charge increased, but still about half of plans charged only a per stay copay (but it was higher than in 2001).

[76] Copay charges and patterns for SNF stays do not appear to have changed much between 2001 and 2002. In each year, about 10 percent of plans charged a copay, with almost all consisting of a per day (rather than per stay) copay. About half of these had a copay per day for days 1-100 and the other half for only days 21-100. Because the Original Medicare plan and half of the M+CO plans did not charge anything for the first 20 days of a SNF stay, we adopted this design for Core Package #2.

Medicare-Covered Benefits, Core Benefit Package #2					
Benefit Description	**Deduct-ible**	**Coinsur-ance**	**Copay-ments**	**Max Plan Benefit**	**Max OOP**
Clinical/Diagnostic/Therapeutic Radiological Lab Clinical Diagnostic Therapeutic Outpatient X-Rays	None	None	$5; plus $10 office visit copay	None	None
Outpatient Hospital	None	None	$20	None	None
Ambulatory Surgery Centers	None	None	$5 min/ $20 max	None	None
Outpatient Substance Abuse	None	None	$10/indiv or group	None	None
Cardiac Rehabilitation	None	None	$15	None	None
Ambulance	None	None	$50	None	None
Durable Medical Equipment	None	None	None	None	None
Medical Supplies	None	None	None	None	None
Renal Dialysis	None	None	None	None	None
Outpatient Blood	None	None	None	None	None
Immunizations/Screenings Immunizations Pap/Pelvic Exams Prostate Exams Colorectal Exams Bone Mass Measurement Mammogram Exams Diabetes Monitoring	None	None	None (in addition to $10 office visit copay)	None	None
Medicare-covered Chiropractic Treatment	None	None	$10	None	None
Medicare-covered Vision Exams (including office visit copay)	None	None	$10	None	None
Medicare-covered Hearing Exams (including office visit copay)	None	None	$10	None	None
Medicare-covered Dental Services	None	None	$10	None	None

Enhanced Benefits, Core Benefit Package #2					
Benefit Description	**Deduct-ible**	**Coinsur-ance**	**Copay-ments**	**Max Plan Benefit**	**Max OOP**
Additional Inpatient Hospital Days for an unlimited number of days	None	None	None	None	None
No Prior Hospital Stay for SNF	None	None	None	None	None
World-Wide Emergency Care	None	None	$50 waived on hosp adm	None	None
World-Wide Urgent Care	None	None	$50 waived on hosp admission	None	None
3-pint outpatient blood deductible waived	None	None	None	None	None
Routine Physical Exam/1 Addtl Per Year	None	None	$10	None	None
Routine Eye Exam/1 Addtl Per Year	None	None	$10	None	None
Routine Hearing Test/1 Addtl Per Year	None	None	$10	None	None
Routine Foot Care/4 Visits Per Year	None	None	$10	None	None
Additional Immunizations (but no separate office visit cost share)[77]	None	None	$10	None	None
Additional Pap/Pelvic Exam/1 Addtl Per Year	None	None	$0 Pap/ $15 Pelvic	None	None

[77] Additional immunizations might include Hepatitis A, Typhoid, travel immunizations, Lyme disease vaccination, Tetanus, Anti-rabies shots, Botulin antitoxin, etc.

Medicare-Covered Benefits, Core Benefit Package #3					
Benefit Description	**Deduct-ible**	**Coinsur-ance**	**Copay-ments**	**Max Plan Benefit**	**Max OOP**
Plan-wide	None	None	None	None	$3,500
Inpatient Hospital	None	None	None	None	None
IP Psychiatric	None	None	None	None	None
Skilled Nursing Facility (100 days limit; for Medicare-covered stays only)	None	None	None	None	None
CORF	None	None	$10	None	None
Emergency Care	None	None	$50 waived on hosp adm	None	None
Urgent Care	None	None	$50 waived on hosp adm	None	None
Partial Hospitalization	None	None	$15	None	None
Home Health	None	None	None	None	None
Primary Care Physicians	None	None	$10	None	None
Occupational Therapy	None	None	$10	None	None
Physician Specialist (exc. psychiatric)	None	None	$10	None	None
Mental Health (non-physician)	None	None	$10 min $20 max /indiv or group	None	None
Podiatry	None	None	$10	None	None
Other Health Care Professionals	None	None	$10	None	None
Psychiatric	None	None	$10 min $20 max /indiv or group	None	None
Physical Therapy/Speech-Language Pathology	None	None	$10	None	None
Clinical/Diagnostic/Therapeutic Radiological Lab Clinical Diagnostic Therapeutic Outpatient X-Rays	None	None	None (in addition to $10 office visit copay)	None	None
Outpatient Hospital	None	None	None	None	None
Ambulatory Surgery Centers	None	None	None	None	None
Outpatient Substance Abuse	None	None	$10/indiv or group	None	None
Cardiac Rehabilitation	None	None	$15	None	None
Ambulance	None	None	None	None	None
Durable Medical Equipment	None	None	None	None	None

Medicare-Covered Benefits, Core Benefit Package #3					
Benefit Description	**Deduct-ible**	**Coinsur-ance**	**Copay-ments**	**Max Plan Benefit**	**Max OOP**
Medical Supplies	None	None	None	None	None
Renal Dialysis	None	None	None	None	None
Outpatient Blood	None	None	None	None	None
Immunizations/Screenings Immunizations Pap/Pelvic Exams Prostate Exams Colorectal Exams Bone Mass Measurement Mammogram Exams Diabetes Monitoring	None	None	None (In addition to $10 office visit copay)	None	None
Medicare-covered Chiropractic Treatment	None	None	$10	None	None
Medicare-covered Vision Exams (including office visit copay)	None	None	$10	None	None
Medicare-covered Hearing Exams (including office visit copay)	None	None	$10	None	None
Medicare-covered Dental Services	None	None	None	None	None

Enhanced Benefits, Core Benefit Package #3					
Benefit Description	**Deduct-ible**	**Coinsur-ance**	**Copay-ments**	**Max Plan Benefit**	**Max OOP**
Additional Inpatient Hospital Days for an unlimited number of days	None	None	None	None	None
No Prior Hospital Stay for SNF	None	None	None	None	None
World-Wide Emergency Care	None	None	$50 waived on hosp adm	None	None
World-Wide Urgent Care	None	None	$50 waived on hosp admission	None	None
3-pint outpatient blood deductible waived	None	None	None	None	None
Routine Physical Exam/1 Addtl Per Year	None	None	$10	None	None
Routine Eye Exam/1 Addtl Per Year	None	None	$10	None	None
Routine Hearing Test/1 Addtl Per Year	None	None	$10	None	None
Routine Foot Care/4 Visits Per Year	None	None	$10	None	None
Additional Immunizations (but no separate office visit cost share)[78]	None	None	$10	None	None
Additional Pap/Pelvic Exam/1 Addtl Per Year	None	None	$0 Pap/ $15 Pelvic	None	None
SNF coverage after >30 days IP discharge (up to 365 days)	None	None	None	None	None
Colorectal Screening/1 Addtl Per Year	None	None	None	None	None
Transportation Services (40 trips per year to a plan-approved location/round-trip coverage)	None	None	None	None	None
Routine Chiropractic Care (12 visits/year)	None	None	$10	None	None
Other Services (Transplant Services, Outpatient Injectables (excluding insulin), Enhanced Dental, Personal Medical Emergency	None	None	Varies	$500/yr	None
Visitor/Travel Services (365 days, first day coverage)	None	None	Same copays as in regular package	$2,500/yr	None

[78] Additional immunizations might include Hepatitis A, Typhoid, travel immunizations, Lyme Disease vaccination, Tetanus, Anti-Rabies shots, Botulin Antitoxin, etc.

APPENDIX E: METHOD FOR VALUING MODEL STANDARDIZED BENEFIT PACKAGES

Introduction

MedicareBVC version 1.9 was used to value the Medicare+Choice plans. The version number shows that this is the first version of the model and that costs were determined for calendar year 1999. This PC-based model was developed by the HayGroup to derive the value of a health care plan based on the services covered by the plan, such as in- and outpatient hospital and surgical services; primary and specialty care visits; preventive services; X-ray, laboratory, and emergency services; mental-health services; dental; pharmaceutical and vision. The model also accounts for cost-sharing requirements such as annual deductibles, coinsurance and copayments, and annual maximum out-of-pocket limits for participants, as well as the interactions that occur between maximum limits and deductibles and coinsurance. The model's primary output is the annual per capita value of the health care benefit. The model uses a standard set of assumptions about utilization and risk so that variations in benefit plan values are attributable only to differences in benefit design.

For each plan being evaluated, the model requires data entry for a multitude of design features. These include information about the general plan deductible and coinsurance rate, information about hospitalization and surgical coverages, outpatient services, inpatient and outpatient mental health services, plan maximum out-of-pocket limits, emergency and diagnostic services, preventive care services, and additional benefits such as dental and prescription drugs, if provided.

The MedicareBVC model estimates the relative cost of health benefits for Medicare participants. The claims distribution for the current model, MedicareBVC 1.9, is from the 1994 Medicare Current Beneficiary Survey (MCBS) and the baseline was established using Centers for Medicare & Medicaid Services (CMS) costs for 1999.

Medicare expense data are taken from 1994 MCBS, which is the latest MCBS data available when version 1.9 was developed. The data were updated to reflect 1999 values and then modified to produce an input grid that contains expenses as they would occur under a "free" plan with all benefits covered and no copayments by the participant.

Core Benefit Packages

Initially, HayGroup calculated the 2001 Medicare plan design in order to compare the different benefit designs and out-of-pocket costs associated with the core packages. Next, they calculated the cost of the three core packages using the plan designs provided to us by BearingPoint. Each of the three core benefit packages has all of the Medicare-covered services in its design, yet also includes selected enhanced benefits not currently available to Medicare recipients. When calculating the core packages in MedicareBVC, HayGroup included all enhanced benefits outlined in the BearingPoint report. Table 2 in the main report summarizes the major provisions of each of the core benefit packages, and Appendix D provides details.

HayGroup's approach was to enter into the model the benefit design parameters for each of the various M+C plans that may be available to Medicare recipients. They used the Medicare design information for covered benefits and services in effect for 2001. Costs were projected from the 1999 model base year to 2001; $6,539 in the case of Core Package #1.

Beneficiary out-of-pocket expenses were first determined for all Medicare beneficiaries, including Original Fee-for-Service Medicare beneficiaries. The total expenses not paid by Medicare were offset by the estimated amount paid by third parties (Medicaid, Medigap policies, and employers plans) to estimate the amount paid by the participant. These amounts were further adjusted to take into account differences in out-of-pocket expenditures between M+C and Original Medicare beneficiaries.

As shown in Table 7 in the main report, the total expenditures increase as the amount paid by the plan increases. This is a result of the increase in induced demand when out-of-pocket expenses decline. For example, if a patient would have $10,000 in expenses if the patient paid the entire bill; the expected expenses would increase substantially above $10,000 if the entire bill were paid by the plan.

HayGroup's model determines the induced demand on all out-of-pocket expenses in combination. Therefore, a reduction in out-of-pocket expenditures for covered services, such as physician office visits, will increase the expenditures for non-covered services, such as prescription drug costs. As a result, the non-covered expenses increase as the value of the core benefits package increases. For example, the prescription drug expenditures increase from $1,211 for Core Package #1 to $1,217 for Core Package #3.

Assumptions

When coding the various Medicare plan designs in the model, HayGroup made certain assumptions with regard to the benefit options, and to convert plan specifications into the input model needed for MedicareBVC. The values input into the model can be viewed at the end of this Appendix. The assumptions that were made for certain current Medicare designs are explained in HayGroup's MedicareBVC User's Guide. Other assumptions made for this valuation are explained below.

HayGroup applied certain factors to plan features that are stated in dollar terms. Their estimate is that an office visit cost $111 in 2001. They then took that $111 and divided it into the $20 copay for Core Package #1 for a copayment rate of 18 percent or a plan coinsurance rate of 82 percent. For the other core packages with a $10 copay amount, they used the same methodology to obtain a coinsurance rate of 91 percent.

The MedicareBVC accounts for dental services by allowing the user to input either a flat percentage for covered services, or scheduled amounts that the plan will pay for with regard to certain procedures. The dental plan provided to HayGroup was designed using a copayment structure for specific dental services. To accommodate for this design, they took the average cost

of the services covered and then deducted the copay amount in order to determine the scheduled amounts for that particular service. For example, the high dental option has a $363 maximum copay for endodontia. The average cost for endodontic services in 2001 was $535. Subtracting the maximum copay from the average cost for that service produces a $172 scheduled amount for endodontia that was input into the model.

Some of the plan provisions could not be incorporated in the model. HayGroup assumed that there would be a minimal increase in cost for most such services and, for that reason, did not add any cost to the model results (e.g., for World-Wide Urgent Care). However, for Core Package #3, there were additional benefits with substantial value, such as the four visits per year for routine foot care available for a $10 copay per visit. HayGrouop assumed that these additional benefits would cost $25 per year and added that number to the total value of the benefit plan design. This same type of methodology was used when accounting for the high and low riders of vision and hearing. For hearing, it was assumed that the average cost of a hearing aid replacement was $1,000 and the probability was that there was a 1 in 12 chance that the participant would need a new hearing aid in a given year. For vision, it was assumed that one set of eyeglasses or contact lenses a year costs $150, 80 percent of the participants would need eyeglasses or lenses in a given year, and the average cost would be $150 per participant.

Parameter Questions		2001 Medicare	Core #1	Core #2	Core #3	Core #2 - High Dental	Core#2 - High Hearing	Core #2 - High Rx	Core #2 - Low Dental	Core#2 - Low Hearing	Core #2 - Low Rx
	Single	6068.1	6539.43	6746.69	7061.65	6938.03	6747.1	8522.81	6830.27	6747.1	7449.49
100 to 136 Deductibles, General Coinsurance, and Maximum Out of Pockets											
General											
100 *Is there a Maximum Out of Pocket for the entire Plan?*		2	2	2	2	2	2	2	2	2	2
105 *What is the Maximum Out of Pocket for the entire Plan?*		0	0	0	0	0	0	0	0	0	0
Part A											
110 Deductible		0	0	0	0	0	0	0	0	0	0
112 Coinsurance		50	50	50	50	50	50	50	50	50	50
114 Is there a Maximum Out of Pocket?		2	2	2	2	2	2	2	2	2	2
116 What is the Maximum Out of Pocket?		0	0	0	0	0	0	0	0	0	0
118 Is Deductible in Maximum Out of Pocket?		1	1	1	1	1	1	1	1	1	1
Part B											
120 Deductible		100	100	100	100	100	100	100	100	100	100
122 Coinsurance		80	80	80	80	80	80	80	80	80	80
124 Is there a Maximum Out of Pocket?		2	2	2	2	2	2	2	2	2	2
126 What is the Maximum Out of Pocket?		0	0	0	0	0	0	0	0	0	0
128 Is Deductible in Maximum Out of Pocket?		1	1	1	1	1	1	1	1	1	1
Part Z											
130 Deductible		0	0	0	0	0	0	0	0	0	0

Parameter Questions		2001 Medicare	Core #1	Core #2	Core #3	Core #2 - High Dental	Core#2 - High Hearing	Core #2 - High Rx	Core #2 - Low Dental	Core#2 - Low Hearing	Core #2 - Low Rx
	Single	6068.1	6539.43	6746.69	7061.65	6938.03	6747.1	8522.81	6830.27	6747.1	7449.49
132 Coinsurance		50	91	91	92	91	91	91	91	91	91
134 Is there a Maximum Out of Pocket?		2	2	2	1	2	2	2	2	2	2
136 What is the Maximum Out of Pocket?		0	0	0	3500	0	0	0	0	0	0
138 Is Deductible in Maximum Out of Pocket?		2	2	2	2	2	2	2	2	2	2
150 to 174 Inpatient Hospitalization: General Health											
150 Coverage in: 1) Part A 2) Part B 3) Part Z 4) No Coverage		1	3	3	3	3	3	3	3	3	3
152 Does the Part's General Deductible apply to hospital expenses?		2	2	2	2	2	2	2	2	2	2
154 Separate deductible		792	500	100	0	100	100	100	100	100	100
156 Is Separate deductible 'per admission'		1	2	1	2	1	1	1	1	1	1
158 Maximum days covered in first tier		60	90	90	90	90	90	90	90	90	90
160 Daily Copay for first tiet		0	0	0	0	0	0	0	0	0	0
162 Maximum days covered in second tier		30	275	275	275	275	275	275	275	275	275
164 Daily Copay for second tier		198	0	0	0	0	0	0	0	0	0
166 Maximum days covered in third tier		60	0	0	0	0	0	0	0	0	0
168 Daily Copay for third tier		396	0	0	0	0	0	0	0	0	0
170 Is this third tier a Lifetime Reserve?		1	2	2	2	2	2	2	2	2	2
172 Are days over the limit covered days included in the MaxOOP?		2	2	2	2	2	2	2	2	2	2
174 Separate deductible in Plan MaxOOP?		2	2	2	2	2	2	2	2	2	2
176 Pints of whole blood before 100% coverage		3	3	3	3	3	3	3	3	3	3
200 to 224 Inpatient Mental Health											
200 Coverage in: 1) Part A 2) Part B 3) Part Z 4) No Coverage		1	3	3	3	3	3	3	3	3	3

Parameter Questions		2001 Medicare	Core #1	Core #2	Core #3	Core #2 - High Dental	Core#2 - High Hearing	Core #2 - High Rx	Core #2 - Low Dental	Core#2 - Low Hearing	Core #2 - Low Rx
	Single	6068.1	6539.43	6746.69	7061.65	6938.03	6747.1	8522.81	6830.27	6747.1	7449.49
202 Does the Part's General Deductible apply to hospital expenses?		2	2	2	2	2	2	2	2	2	2
204 Separate Deductible		792	500	100	0	100	100	100	100	100	100
206 Is Separate Deductible 'per admission'		1	2	1	2	1	1	1	1	1	1
208 Is there a Separate MaxOop		2	2	1	2	1	1	1	1	1	1
210 Separate MaxOOP		0	0	300	0	300	300	300	300	300	300
212 Maximum days covered in first tier		60	90	90	90	90	90	90	90	90	90
214 Daily Copay for first tier		0	0	0	0	0	0	0	0	0	0
216 Maximum days covered in second tier		30	275	275	275	275	275	275	275	275	275
218 Daily Copay for second tier		198	0	0	0	0	0	0	0	0	0
220 Maximum days covered in third tier		60	0	0	0	0	0	0	0	0	0
222 Daily Copay for third tier		396	0	0	0	0	0	0	0	0	0
224 Is this third tier a Lifetime Reserve?		1	1	1	1	1	1	1	1	1	1
226 Are days over covered days included in the MaxOOP (plan or separate)		2	2	2	2	2	2	2	2	2	2
228 Separate deductible in Plan MaxOOP		2	2	2	2	2	2	2	2	2	2
230 Total Number of Inpatient MH Days per Life		190	365	365	365	365	365	365	365	365	365
250 to 264 Skilled Nursing Facility											
250 Coverage in: 1) Part A 2) Part B 3) Part Z 4) No Coverage		1	3	3	3	3	3	3	3	3	3
254 Maximum days covered in first tier		20	100	20	100	20	20	20	20	20	20
256 Daily Copay for first tier		0	100	0	0	0	0	0	0	0	0
258 Maximum days covered in second tier		80	0	80	0	80	80	80	80	80	80
260 Daily Copay for second tier		99	0	100	0	100	100	100	100	100	100
262 Are days over the maximum covered included in the MaxOOP?		2	2	2	2	2	2	2	2	2	2

Parameter Questions		2001 Medicare	Core #1	Core #2	Core #3	Core #2 - High Dental	Core#2 - High Hearing	Core #2 - High Rx	Core #2 - Low Dental	Core#2 - Low Hearing	Core #2 - Low Rx
	Single	6068.1	6539.43	6746.69	7061.65	6938.03	6747.1	8522.81	6830.27	6747.1	7449.49
264 Is prior Inpatient Hospitalization required?		1	2	2	2	2	2	2	2	2	2
266 Min. Hospital stay required to receive benefits		3	0	0	0	0	0	0	0	0	0
270 to 282 Home Health Care											
270 Coverage in: 1) Part A 2) Part B 3) Part Z 4) No Coverage		1	3	3	3	3	3	3	3	3	3
272 Is there coverage under a second Part?		1	2	2	2	2	2	2	2	2	2
274 What is the Second Part? 1) Part A 2) Part B 3) Part Z		2	3	3	3	3	3	3	3	3	3
276 Percentage of Expenses Covered Under Second Part		50	0	0	0	0	0	0	0	0	0
278 Maximum visits		365	365	365	365	365	365	365	365	365	365
280 Coinsurance		100	100	100	100	100	100	100	100	100	100
282 Is it necessary to have a homebound condition?		1	1	1	1	1	1	1	1	1	1
290 to 296 Hospice Care											
290 Coverage in: 1) Part A 2) Part B 3) Part Z 4) No Coverage		1	3	3	3	3	3	3	3	3	3
294 Maximum days		365	365	365	365	365	365	365	365	365	365
296 Coinsurance		100	100	100	100	100	100	100	100	100	100
300 to 305 Outpatient Hospitalization: Non-Mental											
300 Coverage in: 1) Part A 2) Part B 3) Part Z 4) No Coverage		2	3	3	3	3	3	3	3	3	3
305 Coinsurance		80	82	82	100	82	82	82	82	82	82
310 to 315 Providers											
310 Coverage in: 1) Part A 2) Part B 3) Part Z 4) No Coverage		2	3	3	3	3	3	3	3	3	3

Parameter Questions		2001 Medicare	Core #1	Core #2	Core #3	Core #2 - High Dental	Core#2 - High Hearing	Core #2 - High Rx	Core #2 - Low Dental	Core#2 - Low Hearing	Core #2 - Low Rx
	Single	6068.1	6539.43	6746.69	7061.65	6938.03	6747.1	8522.81	6830.27	6747.1	7449.49
315 Coinsurance		80	91	91	92	91	91	91	91	91	91
320 to 326 Imaging/Clinical Lab											
320 Coverage in: 1) Part A 2) Part B 3) Part Z 4) No Coverage		2	3	3	3	3	3	3	3	3	3
322 Subject to Plan deductible?		1	1	2	2	2	2	2	2	2	2
324 Subject to MaxOOP?		2	2	2	1	2	2	2	2	2	2
326 Coinsurance		90	91	91	92	91	91	91	91	91	91
350 Other Medical											
350 Coverage in: 1) Part A 2) Part B 3) Part Z 4) No Coverage		2	3	3	3	3	3	3	3	3	3
400 to 410 Long Term Care: Non-Mental											
400 Coverage in: 1) Part A 2) Part B 3) Part Z 4) No Coverage		4	4	4	4	4	4	4	4	4	4
405 Is there an annual benefit limit?		1	1	1	1	1	1	1	1	1	1
410 Annual Limit (in $)		0	0	0	0	0	0	0	0	0	0
415 Coinsurance		50	50	50	50	50	50	50	50	50	50
450 to 460 Long Term Care: Mental											
450 Coverage in: 1) Part A 2) Part B 3) Part Z 4) No Coverage		4	4	4	4	4	4	4	4	4	4
455 Is there an annual benefit limit?		1	1	1	1	1	1	1	1	1	1
460 Annual Limit (in $)		0	0	0	0	0	0	0	0	0	0
465 Coinsurance		50	50	50	50	50	50	50	50	50	50

Parameter Questions		2001 Medicare	Core #1	Core #2	Core #3	Core #2 - High Dental	Core#2 - High Hearing	Core #2 - High Rx	Core #2 - Low Dental	Core#2 - Low Hearing	Core #2 - Low Rx
	Single	6068.1	6539.43	6746.69	7061.65	6938.03	6747.1	8522.81	6830.27	6747.1	7449.49
500 to 555	**Prescription Drugs**										
500	*Coverage in: 1) Part A 2) Part B 3) Part Z 4) No Coverage*	4	4	4	4	4	4	3	4	4	3
505	*Coverage: 1)Regular 2)Separate 3)Copay*	2	2	2	2	2	2	3	2	2	3
510	*Subject to Plan Deductible?*	1	1	1	1	1	1	2	1	1	2
515	*Subject to Plan MaxOOP?*	2	2	2	2	2	2	2	2	2	2
	Questions for a Separate Plan										
520	*Separate deductible*	0	0	0	0	0	0	0	0	0	250
525	*Separate Coinsurance*	50	50	50	50	50	50	0	50	50	0
530	*Is there a Separate Maximum Out-of-Pocket?*	2	2	2	2	2	2	1	2	2	2
535	*Amount of Separate Maximum Out-of-Pocket*	0	0	0	0	0	0	4500	0	0	0
540	*Is there an Rx Maximum Benefit?*	2	2	2	2	2	2	2	2	2	1
545	*Amount of Rx Maximum Benefit*	0	0	0	0	0	0	0	0	0	1000
	Questions for a Plan with Copayments										
550	*Generic copay*	0	0	0	0	0	0	10	0	0	20
552	*"Preferred" copay*	0	0	0	0	0	0	10	0	0	20
555	*Brand name copay*	0	0	0	0	0	0	20	0	0	35
560	*Is use of a Generic required when available?*	2	2	2	2	2	2	2	2	2	2
565	*Is a mail order plan provided 1)Voluntary 2)Mandatory 3)Not offered*	3	3	3	3	3	3	1	3	3	1
570	*Assumed Percentage Reduction due to PBMs*	0	0	0	0	0	0	0	0	0	0
575	*Assumed Percentage Reduction due to Formulary basis*	0	0	0	0	0	0	0	0	0	0

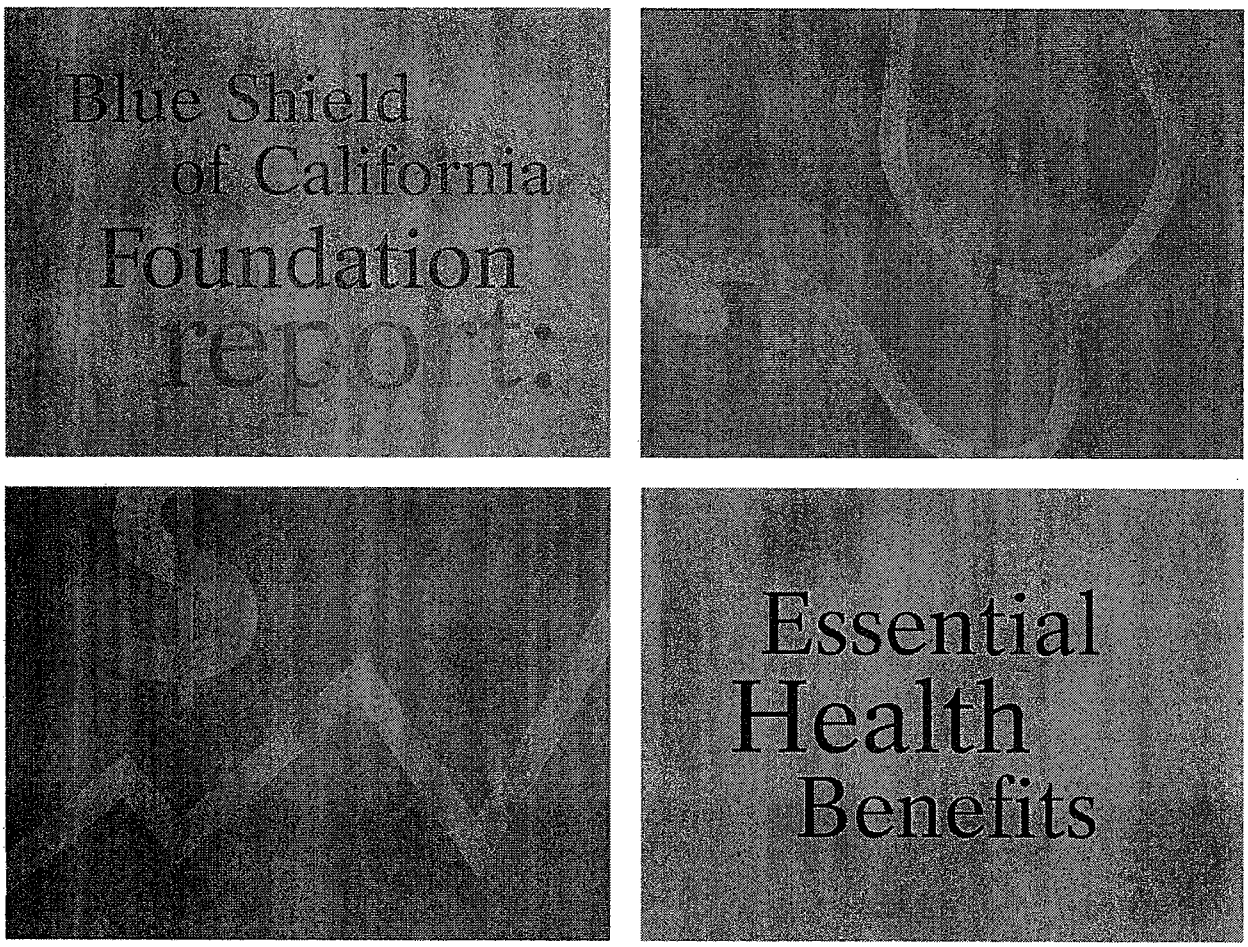
Parameter Questions		2001 Medicare	Core #1	Core #2	Core #3	Core #2 - High Dental	Core#2 - High Hearing	Core #2 - High Rx	Core #2 - Low Dental	Core#2 - Low Hearing	Core #2 - Low Rx
	Single	6068.1	6539.43	6746.69	7061.65	6938.03	6747.1	8522.81	6830.27	6747.1	7449.49
580 Is Drug Deductible in Maximum Out-of-Pocket?		2	2	2	2	2	2	2	2	2	2
600 to 648 Dental											
600 Coverage in: 1) Part A 2) Part B 3) Part Z 4) No Coverage		4	4	4	4	3	4	4	3	4	4
610 Based on schedule amounts?		2	2	2	2	1	2	2	1	2	2
612 Flat % for preventive care		50	50	50	50	0	50	50	0	50	50
614 Flat % for basic restorative care		50	50	50	50	0	50	50	0	50	50
616 Flat % for major restorative care		50	50	50	50	0	50	50	0	50	50
620 Schedule amount for preventive exams		0	0	0	0	45	0	0	43	0	0
622 Schedule amount for oral surgery		0	0	0	0	26	0	0	0	0	0
624 Schedule amount for fillings		0	0	0	0	54	0	0	0	0	0
626 Schedule amount for endodontia		0	0	0	0	172	0	0	0	0	0
628 Schedule amount for periodontia		0	0	0	0	0	0	0	0	0	0
630 Schedule amount for prosthodontia		0	0	0	0	648	0	0	0	0	0
632 Schedule amount for inlays & crowns		0	0	0	0	464	0	0	0	0	0
640 Subject to 1)no deductible 2)plan deductible 3)Separate deductible		1	1	1	1	1	1	1	1	1	1
642 Separate deductible amount		0	0	0	0	0	0	0	0	0	0
644 Separate deductible waivers: 1)preventive 2)preventive and fillings 3)none		1	1	1	1	3	1	1	1	1	1
646 Is there an Annual maximum benefit?		2	2	2	2	2	2	2	2	2	2
648 Amount of separate maximum		0	0	0	0	0	0	0	0	0	0
700 to 725 Hearing											
700 Coverage in: 1) Part A 2) Part B 3) Part Z 4) No Coverage		4	3	3	3	3	3	3	3	3	3

Parameter Questions		2001 Medicare	Core #1	Core #2	Core #3	Core #2 - High Dental	Core#2 - High Hearing	Core #2 - High Rx	Core #2 - Low Dental	Core#2 - Low Hearing	Core #2 - Low Rx
	Single	6068.1	6539.43	6746.69	7061.65	6938.03	6747.1	8522.81	6830.27	6747.1	7449.49
705 Hearing coverage subject to Plan deductible & coinsurance?		2	1	1	1	1	1	1	1	1	1
710 Number of hearing aid replacements covered		0	0	0	0	0	1	0	0	1	0
715 Hearing exams covered?		2	1	1	1	1	1	1	1	1	1
720 Maintenance treatments covered?		2	2	2	2	2	2	2	2	2	2
725 Hearing coinsurance		50	92	92	92	92	92	92	92	92	92
750 to 782 Preventive											
750 Physicals covered in: 1) Part A 2) Part B 3) Part Z 4) No Coverage		4	3	3	3	3	3	3	3	3	3
752 Physicals subject to Plan deductible & coinsurance?		2	1	2	2	2	2	2	2	2	2
754 Physical covered every ___ year(s)		0	1	1	1	1	1	1	1	1	1
760 Diagnostic tests covered in: 1) Part A 2) Part B 3) Part Z 4) No Coverage		2	3	3	3	3	3	3	3	3	3
762 Diagnostic tests subject to Plan deductible & coinsurance?		2	1	2	2	2	2	2	2	2	2
764 Cholesterol tests covered every ___ year(s)		0	0	0	0	0	0	0	0	0	0
766 Fecal occult blood tests covered every ___ year(s)		1	1	1	1	1	1	1	1	1	1
768 Sigmoidoscopes covered every ___ year(s)		4	4	4	4	4	4	4	4	4	4
770 Colonoscopies covered every ___ year(s)		2	2	2	2	2	2	2	2	2	2
772 Colorectal tests only for high risk population?		1	1	1	1	1	1	1	1	1	1
774 Immunizations covered?		1	1	1	1	1	1	1	1	1	1
776 Mammograms covered every ___ year(s)		1	1	1	1	1	1	1	1	1	1
778 Pap smears covered every ___ year(s)		3	3	1	1	1	1	1	1	1	1
780 Prostate cancer screening covered every ___ year(s)		1	1	1	1	1	1	1	1	1	1
782 Tuberculosis tests 1)all 2)at risk only 3)none		3	3	3	3	3	3	3	3	3	3

Parameter Questions		2001 Medicare	Core #1	Core #2	Core #3	Core #2 - High Dental	Core#2 - High Hearing	Core #2 - High Rx	Core #2 - Low Dental	Core#2 - Low Hearing	Core #2 - Low Rx
	Single	6068.1	6539.43	6746.69	7061.65	6938.03	6747.1	8522.81	6830.27	6747.1	7449.49
784 Are flu shots covered?		1	1	1	1	1	1	1	1	1	1
786 Are bone-density measurements covered?		1	1	1	1	1	1	1	1	1	1
788 Are self-management training services covered for diabetics?		1	1	1	1	1	1	1	1	1	1
800 to 860 Assumptions											
800 Trend		1	1	1	1	1	1	1	1	1	1
802 Rx Trend		29	29	29	29	29	29	29	29	29	29
805 Management factor for Part A		100	100	100	100	100	100	100	100	100	100
810 Management factor for Part B		100	100	100	100	100	100	100	100	100	100
815 Management factor for Part Z		100	100	100	100	100	100	100	100	100	100
820 Administration factor for Part A		1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8
825 Administration factor for Part B		1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8
830 Administration factor for Part Z		0	0	0	0	0	0	0	0	0	0
835 What is the induction factor for general hospitalizations?		30	30	30	30	30	30	30	30	30	30
840 What is the induction factor for prescription drug?		100	100	100	100	100	100	100	100	100	100
845 What is the induction factor for other?		70	70	70	70	70	70	70	70	70	70
850 What is the induction factor for Inpatient Mental Health?		30	30	30	30	30	30	30	30	30	30
855 What is the induction factor for Mental Health Long-Term Care?		100	100	100	100	100	100	100	100	100	100
860 Average percentage reduction in non-Rx OOP due to supplemental coverage		62.5	62.5	62.5	62.5	62.5	62.5	62.5	62.5	62.5	62.5
865 Average percentage reduction in Rx OOP due to supplemental coverage		50	50	50	50	50	50	50	50	50	50

APPENDIX F: BLUE SHIELD OF CALIFORNIA FOUNDATION REPORT: ESSENTIAL HEALTH BENEFITS

Blue Shield
of California
Foundation



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THE UNINSURED IN CALIFORNIA

- 6.3 million – nearly one in five Californians – lacked health insurance in 2001. Only two states, New Mexico and Texas, have higher rates of uninsured.

- More than 11 million California residents under age 65 were uninsured during 2001-02, including 45% who were uninsured more than a year.

- Only 61% of California employers offer health insurance coverage to their employees, the lowest rate of employer-sponsored insurance in the country.

- About 30% of the uninsured in California are eligible for public programs, including two thirds of uninsured children and 100,000 high-risk Californians that have been turned down by private insurers.

- California faces a budget deficit of approximately $38 billion and the Governor is proposing Medi-Cal cuts that will increase the number of uninsured by 500,000.

- Last year, California was forced to return $740 million of federal money to expand the Healthy Families program because the state couldn't afford to fund its one-third share of the cost.

- Medi-Cal ranks last among all states in spending per enrollee and pays less than half of what physicians would receive from a private payer. As a result, only 50% of California physicians participate.

- A disproportionate number of minorities lack health insurance. In 2001, 28 % of Latinos were uninsured, compared with 13 % of Asians and 9% of whites and African Americans. Latinos, which represent one-third of California's population, are its fastest growing segment.

- Many Californians support expanding access to health care. For example, in Los Angeles County, 73% of voters supported a tax increase to help aid the county's troubled trauma care system.

Special thanks to John D. Golenski, Ed.D., Executive Director of the Institute for Ethics & Health Policy, who carried out the benchmarking study of benefits plans, assisted in the design of the process for creating the Essential Benefits Package, and facilitated all the physicians meetings which devised the elements of the package.

INTRODUCTION

Nearly one in five Californians – 6.3 million people – lacked health insurance in 2001. One reason for the high percentage of uninsured Californians is the relative scarcity of employer-sponsored plans. Over a third of employers in the state offer no health insurance benefit to workers. All other states have a higher percentage of covered workers. With the State of California facing an unprecedented budget deficit, the Medi-Cal program is certain to continue the lowest spending per enrollee in the country. If proposed Medi-Cal cuts are implemented, the number of uninsured will grow by at least another 500,000 individuals. The uninsured are disproportionately members of minority groups, especially Latinos who are three times more likely to be uninsured than whites or African Americans. Surely, it is time for a comprehensive solution.

In December 2002, Blue Shield of California announced a plan that supports universal health insurance coverage for all Californians. "Universal Coverage, Universal Responsibility" emphasizes a public/private partnership, preserving the current employer based system while expanding enrollment in current state sponsored systems. Two critical elements of the plan include a "play or pay" requirement for employers and an individual mandate requiring all citizens to have insurance either through individual purchase, employer sponsorship or a qualifying state program. Another key feature of this plan is the development of an essential benefits package designed by medical professionals to describe the minimum coverage level required for all individual and employer sponsored plans.

Blue Shield of California's *Universal Coverage, Universal Responsibility* proposal builds upon the existing employer-based system, which has successfully insured a majority of American workers and their families for six decades. Here are the details:

- Employers would be required either to offer coverage or contribute toward an essential benefits package for all their employees. Subsidies would be available to assist low income individuals.
- Every eligible California would be enrolled in Medi-Cal or Healthy Families. The state needs to work with the private sector to create effective marketing and outreach strategies to achieve this goal.
- All other uninsured Californians would be required to purchase coverage in the individual market on a "guaranteed issue" basis, with no one denied coverage based on a pre-existing condition. Those who could not afford the full cost would pay their fair share and be subsidized for the rest.
- An essential benefits package, defined by independent medical professionals, would specify the minimum level of coverage, which would include preventive care, physician services, hospital care and prescription drugs.
- Funding, from a modest, broad-based tax, would supplement additional business and individual contributions to the insurance pool that come from having everyone insured.
- Savings would be achieved through expanded preventive care, earlier treatment of the formerly uninsured, reduced use of emergency rooms and more secure financing.

Process and Participants:

Following the public announcement of the "Universal Coverage, Universal Responsibility" proposal, the Blue Shield of California Foundation engaged the Institute for Ethics & Health Policy to design and facilitate a process for independent medical professionals to describe a detailed, concrete Essential Benefits Package. The Essential Benefits Package created was intended to serve as the basis of comparison to the costs and coverage of existing plans as well as current proposals for providing universal health insurance to Californians. In particular, defining an essential benefits package was intended to initiate a statewide dialogue about benefits priorities.

Phase One: Benchmarking

With the single exception of the Oregon Health Plan, no benefits package in the United States is designed by independent medical professionals. The Essential Benefits Package process was a modification and expansion of the Oregon process, which was originally designed by the Institute for Ethics & Health Policy in 1988 and 1989 and continues today. After an initial process design phase in December 2002, Institute staff conducted a Benchmarking Study to review the content of existing comprehensive benefits packages in use in California. These included benefits covered by the Healthy Families Program, the Federal Employee Health Benefits Plan, Medicare, Medi-Cal, CalPERS, and a Kaiser Permanente Group policy. The Benchmarking Comparison is included in Appendix II.

Phase Two: Essential Benefits as Described by Physicians

While the Benchmarking Study was underway, in January 2003, the Foundation contacted the California chapters of the professional societies representing pediatrics, internal medicine, family practice, general surgery, and obstetrics and gynecology requesting nominations for participants in the design process. In addition the Foundation contacted the American Geriatrics Society requesting nominees based in California. All nominated physicians were invited to participate in the project. To supplement these physicians, the Foundation also recruited four outcomes experts – a VA-based medical economist expert in neonatal outcomes, a UCLA-based clinical outcomes expert in pediatric specialty care, a UCSF-based quality outcomes expert specializing in adult medicine, and a DHS-based public health director expert in geriatric outcomes. To these experts, the Foundation added a specialist in adolescent medicine, a hospital quality expert, and a medical director for a large clinic for the uninsured in order to ensure adequate expertise was available for the project. A complete list of physician participants is included in Appendix VII.

During the month of March 2003, the participating physicians and experts were divided into four Clinical Work Groups. These Groups represented the major epochs in the human life-cycle: Maternity and Childbirth, Childhood and Adolescence, Adulthood, and Geriatrics. Each Group developed a detailed description of the components of a package of necessary medical benefits for their patient populations. Available bodies of evidence were cited and the experts' judgments were solicited, but generally consensus professional judgments determined the content of the arrays of benefits from each Clinical Working Group. While the Groups created arrays with predictable content such as hospitalizations, medications, clinic visits, some preventive measures, all of the Groups added non-traditional benefits as well. Some examples follow:

Maternal/Childbirth Group:

- Genetic work-ups by qualified genetics counselors
- Risk-adjusted data on outcomes for all hospitals made available to providers and patients
- Maternal transport to secondary level of care during prenatal period
- Unique patient identifier/record to follow patient

Childhood/Adolescence Group:

- Skilled nursing care at home for technology-dependent children
- Basic dental care
- Non face-to-face clinical visits (phone, email, fax)

Adulthood Group:

- Medications coverage determined by statewide, evidence-based formulary process
- Nutrition counseling especially with serious chronic diseases
- Case management for medically or socially complex patients
- New medical technologies reviewed by statewide, evidence-based process

Geriatrics Group:

- Provision of a "Medical Home" for patients
- Inter-facility transport
- Comprehensive geriatric assessment with selected patients
- Devices necessary for maintaining independent function (e.g. hearing aides, glasses, walkers, canes, wheelchairs, etc.)

The Clinical Work Groups ranked all individual items according to consensus judgments of relative medical efficacy. Complete benefits packages with rankings are included in Appendices I and III.

THE ESSENTIAL BENEFITS PACKAGE continued

In early April 2003, all four Clinical Working Groups met in plenary session. In preparation for their work, they were provided with the original Benchmarking Study of six comprehensive health benefits plans with the items from their own ranked packages compared within specific categories of interventions. The plenary meeting of the Clinical Working Groups merged their arrays into a single proposed package of benefits and prioritized their recommendations using a set of operating values determined by the Group. The listing of values considered is included in Appendix IV. At the plenary meeting, the combined Groups chose the following operating values as the basis for prioritizing the content of the Essential Benefits Package:

- **Clinically Efficacious**
  Interventions should improve clinical outcomes such as extensions of longevity, improvements in perceived or measured quality of life.
- **Equal Access to Care**
  Benefits should be uniformly available to all participants, as clinically appropriate.
- **Evidence-Based Care, Efficiently Provided**
  There is a connection between care which is evidence-based and the ability to provide that care efficiently.

The combined Clinical Working Groups merged and prioritized the elements of the four distinct packages of benefits. As the prioritizing process unfolded, it became clear to the participants that an Essential Benefits Package *described by practicing physicians* will not be "thin". If improved clinical outcomes are important, the clinicians agreed that a more comprehensive approach was necessary.

In general, the Essential Benefits Package is closer to a comprehensive package than a minimum. It emphasizes, for example, prevention and early intervention services as well as a number of non-traditional benefits which facilitate access to care, such as medical transportation and non face-to-face visits.

While the physicians did not directly address delivery system issues or medical management interventions, they recognized that these other system components also need to be evaluated. In two instances, they spoke to these systems issues when they proposed a voluntary, statewide formulary process and a similar process for the assessment of new medical technologies. In addition, they strongly supported the use of outcomes information, made publicly available, to designate regional centers of excellence for tertiary care and complex surgeries and interventions.

Once the Plenary Clinical Working Groups devised a prioritized Essential Benefits Package, it was submitted to an actuarial firm, Milliman USA, for a cost analysis based on experience data in California. An Executive Summary of the report by Milliman USA is included in Appendix V. The following table (table 1) was created to inform the physicians in the Plenary Groups of the range of plan costs in relation to medical management levels and reimbursement rates for the benefits they recommended:

Table 1: Comparison of Milliman USA Estimates for the Essential Benefits Package – Relative Annual Premium Costs for a Single Individual

Note: the Milliman report does not reflect selection and anti-selection issues by market

Plan Design [1] Plan Characteristics	HMO A no co-pays	HMO B modest copays	PPO A low cost sharing	PPO B modest cost sharing	PPO C moderate cost sharing	PPO D** highest cost sharing
Tightly managed Medi-Cal paym't	0.77	0.63				
Tightly managed 100% SF RBRVS	1.13	0.99*				
Not managed Medi-Cal paym't	0.97	0.75				
Not managed 100% SF RBRVS	1.46	1.22				
90% in network 100% CA RBRVS			1.25	1.18	1.07	1.0*
90% in network 125% CA RBRVS			1.32	1.25	1.15	1.06
90% in network 100% SF RBRVS			1.31	1.24	1.31	1.06
90% in network 125% SF RBRVS			1.40	1.32	1.21	1.13

* Plan premium levels for these options are below the statewide premium average paid by California employers and are similar to typical Blue Shield of California DMHC licensed plans currently sold in the California small group market

**most similar in design to BSC proxy plan used in Blue Shield of California Universal Coverage, Universal Responsibility proposal

[1] See Appendix VI

The physician participants recognized that this benefits package, in order to be financially viable, would need to have significant cost-sharing by the insured. In particular, the physician group supported the idea of **means-tested co-pays and deductibles.** Though they expressed concerns that broad, undifferentiated cost-sharing usually serves as a barrier to necessary care, they strongly supported the implementation of cost-sharing which takes into account the individual's or family's ability to pay. Of note, out of pocket costs of $1000 for a single adult making 250% of the federal poverty level (FPL) represent approximately 5% of total income.

Physician Recommendations Regarding Cost-sharing Strategies:

- Deductibles (possibly means-tested)
  - Simple to administer
  - Annually reviewed
  - Sliding scale, even to zero for indigent
  - No higher than $1000 per year
- Co-pays
  - Sliding scale, even to zero for indigent
  - Reduced for priority, targeted benefits

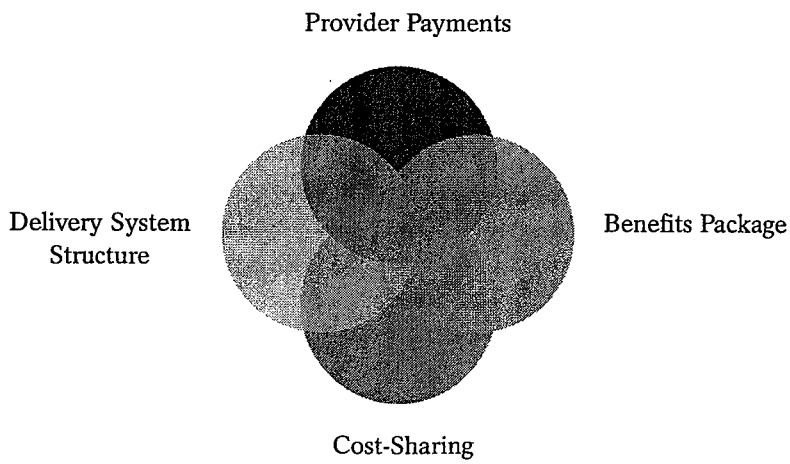
In addition to cost sharing, other significant strategies suggested by the physicians for consideration included

- Regionalization of tertiary and specialized care for select conditions
- Creation of a "Medical Home" for patients, possibly a primary care physician
- Use of a "smart card" for medical and benefits information

Phase Three: Stakeholders Response

On May 1, 2003, the Plenary Group of Physicians met with a group of additional stakeholders representing various sectors of the California health economy – patients, consumer groups, labor, health plans and insurers, large employers, government, brokers, policy experts and academics. All participants are listed in Appendix VII. At this last meeting, the prioritized Essential Benefits Package was presented to the whole group along with the comparison with the other existing benefits plans and the cost analysis summary of the Milliman USA report.

The reactions of the general group of stakeholders were supportive. No participant questioned the validity or appropriateness of the Essential Benefits Package as designed by the Clinical Work Groups. Most participants concluded that other features of the health system will need redesign if universal coverage is to be economically and politically viable. The major levers which affect health care costs – benefits covered, delivery system structure, provider payments, and cost-sharing – were viewed by the group as interconnected:



In addition to the extensive discussion of the scope of the benefits package, the physicians and stakeholders also discussed cost sharing. As part of this discussion, the audience was introduced to the results of a study of the overall costs of Blue Shield of California's "Universal Coverage/ Universal Responsibility" proposal. This work was done in April 2003 by Ken Thorpe, Ph.D. and associates from Emory University. Both the Thorpe and Milliman USA studies make it clear that a viable benefits package offered within a PPO option would require a deductible, while an HMO option would require co-pays as envisioned by the physician participants. In addition, several participants in the stakeholder group emphasized that any essential benefits package that serves as a "floor" for universal coverage must be financially affordable to the business community. Based on this work, the Blue Shield of California Foundation has requested that Milliman USA further model a third HMO Plan (HMO Plan "C") that would include additional cost sharing, including an inpatient copay.

While the physicians and stakeholders did not directly address delivery system issues, provider payment levels, or medical management interventions, they recognized that these other system components contribute significantly to the cost of any benefits package, and need to be considered in any discussion of an essential package. Concretely, with the support of the Stakeholder Group, the Plenary Clinical Work Groups recommended (in priority order):

1. Summary and Analysis of the Known Consequences of Cost-Sharing Strategies;

Before embarking on a means-tested cost-sharing strategy, a careful description of what is known about the consequences of various cost-sharing strategies should be conducted and published. This should be done by knowledgeable researchers in a short period of time in order to provide the data base for experimentation in the near term future.

2. Development of a uniform, voluntary statewide process for New Healthcare Technology Assessment;

The creation of a semi-public entity to gather and analyze evidence regarding new medical technologies could reduce redundancy among health plans' processes for new healthcare technology assessment.

3. Development of an explicit, staffed process for applying evidence to the description of benefits;

Both public and private plans would benefit from the work of a statewide, independent research entity to apply consistent evidence criteria and analysis to proposals for new benefits.

4. Establishment of a Formal Process for Devising and Refining the Essential Package of Benefits;

The application of evidence, particularly population outcomes data, to the description of covered benefits could be carried out by an objective body of clinical experts, supported by researchers. The proposals of such a body can also be submitted to a broader commission of representatives of the major stakeholder groups in the state.

5. Development of an independent, voluntary statewide formulary management process;

While some health plans have expressed concern that a single, voluntary statewide formulary will raise anti competitive issues and curtail their leverage to negotiate significant rebates, the potential for improving overall purchasing power and increasing consistency in pharmacy offerings deserves more formal consideration within the limits of existing law and regulation. For example, Oregon Law SB 819 authorized the creation of a Practitioner-Managed Prescription Drug Plan for the Oregon Health Plan. A number of other states have joined this collaborative effort to produce scientific reviews comparing prescription drugs in therapeutic classes. Prescribing clinicians and patients are intended recipients of drug-specific information. [1]

6. Development of an outcomes-based designation process for regionalized centers-of-excellence for tertiary care and complex interventions, perhaps through a certificate-of-need process;

What Has Been Accomplished So Far?

Blue Shield of California and the Blue Shield of California Foundation set out to demonstrate that their "Universal Coverage, Universal Responsibility" proposal can include a process for devising an Essential Benefits Package designed by independent medical professionals. The process thus far has demonstrated that clinicians can work together to devise and prioritize a package of benefits, and this package can be competitively priced in the current market. Opportunities exist to further moderate premium levels of this package without reducing the clinician derived scope of benefits. This essential benefits package is presented as a starting point for any statewide dialogue about benefits priorities.

[1] Concerns about anti-competitiveness, collusion issues posed by a private collaborative initiative are addressed by a white paper done by David Balto, J.D., of White & Case, sponsored by the California HealthCare Foundation in 2002.

APPENDICES

I. Prioritized Essential Benefits by Plenary Physicians Group

II. Benchmarking Comparison of Existing Health Plans (with sources)

III. Individual Clinical Group Reports

1. Maternal Care/Childbirth Clinical Group Report

2. Childhood/Adolescence Clinical Group Report

3. Adulthood Clinical Group Report

4. Geriatrics Clinical Group Report

IV. Potential Prioritization Criteria for Determining Essential Benefits

V. Executive Summary, Essential Benefits Package Premium Estimates, Milliman USA (reproduced with permission)

VI. Essential Benefit Plan Package Summary, Milliman USA (reproduced with permission)

VII. Roster of Physician Participants and Participants in the Stakeholder Group

Appendix I

PRIORITIZED ESSENTIAL BENEFITS BY PLENARY PHYSICIANS GROUP

Unless otherwise noted, all major categories below were given highest priority, (***) by the physicians.

• Allergy *(priority given depends on age)*	• 0-18 • >18 ** • For 0-18, Symptomatic treatment • For 0-18, Skin testing and desensitization** • >18, testing and therapy with a copay
• Alternative Treatment *(priority given differs among treatment types)*	• All types must be evidence-based • Acupuncture ** • Other *
• Blood	• Blood and Blood Products • Blood work associated with lab tests moved to diagnostic category
• Cancer Diagnostics and Treatment	• Note – recommendation made to move BRCA-1, BRCA-2 testing to genetics category
• Cancer Screening	• Recommendation made to use the U.S. Prevention Task Force Guidelines
• Case Management	• By a physician or appropriate licensed professional with selected population
• Chemical Dependancy	• Includes testing and treatment. Only in appropriate settings and by qualified providers. • To include prenatal care related to chemical dependency • To include smoking and substance abuse
• Circumcision	• Neonatal • Later, only when medically necessary
• Clinical Trials	• For routine care associated with qualified clinical trials
• Dental	• Must be included with prenatal care – screening, prevention, treatment • Adulthood and geriatrics to include screening, prevention and treatment • This category should be defined further using the advice of qualified dental experts as to what is appropriate to include • Should exclude cosmetics and orthodontia except for trauma • Excludes dentures unless necessary for mastication – means tested with co-pays • Dental screenings should reference the U.S Task Force on Prevention
• Diabetic Supplies and Services	• Testing and treatment • Health education relating to diabetes *(e.g., nutrition by dieticians or certified diabetes educators).*

• Diagnostics, x-rays, and Laboratory services	• Should be evidence-based • Includes prenatal – diagnosis of pregnancy, dating ultrasound if indicated, standard diagnostics *(per ACOG)*, Antenatal testing indicated • Post partum – fetal chromosome testing, fetal autopsy for greater than 500 grams, depression screening • Screening for infections – STDs *(for women and their partners)*, bacterial vaginosis, UTIs. • In-patient care, diagnostics • Imaging *(when medically indicated)* • History/exam • Consults/referrals • Procedures • New modalities – after evaluation by NHTA • Blood work • Microbiology • Pathology • Cytology • HPV/Pap Smear
• Disease Management	• Defined as special programs to supplement regular care. Must be evidence-based. • Examples include hypertension, congestive heart failure, diabetes, depression, asthma, and HIV
• Durable Medical Equipment	• As appropriate
• Emergency Services	• Recommendation made to ensure the availability of non-emergency room urgent care • Recommendation made to provide education programs on the appropriate use of the emergency room • Recommendation made to have triage at the emergency room • The group stated that ideally the patient would have a secure medical home so inappropriate emergency room visits would decrease
• Eye Care	• Vision testing • Screening • Specialty referral services for glaucoma and cataracts • Glasses • Contact lenses in special cases
• Family Planning	• Birth control • Fertility regulation • Sterilization • Reproductive health counseling, contraceptive follow-up • Terminations • STDs with diagnosis and treatment of partners
• Foot Care	• For vascular problems related to diabetes • Podiatry with medical need • Orthotics only with expert review

PRIORITIZED ESSENTIAL BENEFITS BY PLENARY PHYSICIANS GROUP continued

• Genetics	• Genetic work-up *(with gate-keeping by qualified genetics counselors)* for: – History of mental illness – Chronic medication use – Survivors of childhood/adolescence cancer – Prior child with positive diagnosis – Personal positive diagnosis – High risk for cancers *(e.g. positive BRCA-1, BRCA-2)* – Family history – Mental illness – Recurrent pregnancy loss • Genetic work-up to include: – Some counseling – First and second trimester screening – CVS – First trimester maternal serum with ultra sound by "certified" provider or standard second trimester if AFP abnormal – Amniocentesis • Must be evidence-based
• Health Education	• Note – For children and adolescents, cognitive evaluation, learning disabilities, nutrition should be part of a community education system
• Hearing	• Screenings • Basic hearing aids • Assisted listening devices • Cochlear implants not covered
• Home Health Care	• Respite care • Skilled care by home health agencies • Home health aides – means tested (**)
• Hospice	
• Hospital Inpatient Care	• Treatment of acute illness • For elective inpatient, prior authorization required
• Infertility	• Diagnosis and treatment *(not to include gamete manipulation or IVF)* • Diagnostic imaging • Ovulation test (x1) and secondary diagnostic work-up • Semen analysis (x2)
• Informatics	• Risk-adjusted data on outcomes for all hospitals made available to providers and patients.
• Kidney Dialysis	
• Maternity Care	• Deliveries – Consultants for medical/surgical issues – Anesthesia – Immediate post-partum sterilization – Any licensed facility for deliveries with "privileged" practitioners

• Maternity Care *continued*	– Blood products – All medications – Maternal transport – Indicated inductions • Termination of pregnancy, medical/surgical
• Medical Transportation	• For basic access to care – covered based on medical or financial need • Medical transport – covered • Inter-facility transport – covered
• Medications	• Prenatal • Prescription medications • Certain OTCs with evidence • Note – Group agreed on the notion of a voluntary uniform formulary process for the state.
• Mental Health	• Covered per Assembly Bill 88 • To include diagnosis and treatment of ADD, ADHD by pediatricians and qualified PCPs. • Includes initial evaluation, comorbidities, and depression • Includes biofeedback • Group recommends some limit on substance abuse treatment *(e.g. number of days)*.
• Non face-to-face Visits	• Includes telephone, email, fax
• Nursing Homes	• Skilled • Custodial – means tested
• Outpatient Care	• Office visits for prenatal care *(per ACOG)* • Gynecology – Therapy for ectopic pregnancy – Therapy for abnormal cervical screening – Therapy for chronic pelvic pain syndromes (**) – Surgery for prolapse (**) – GYN/urology (AHRQ guidelines)(**) – Early and late menopause (*) – Abnormal vaginal bleeding (*) • Treatment of acute illnesses • Licensed provider visits
• Physical, Occupational and Speech Therapy	• Speech therapy should include treatment of developmental speech delays as well as treatment for stroke and trauma.
• Preventive Care	• According to U.S. Prevention Task Force, AAP, AAFP guidelines • Examples include smoking cessation, vaccines, immunizations, nutrition, and rehabilitation.
• Prosthetics	• Necessary for functionality • Includes breast prosthesis • Implantables
• Reconstructive Surgery	• Necessary to correct functional defect or create "normal appearance"
• Translation and Interpretation Services	
• Transplants	
• Unique Patient Identifier/record *(to follow patient with important medical information)*	

Appendix II

BENCHMARKING COMPARISON OF EXISTING HEALTH PLANS (WITH SOURCES)

Blue Shield of California Foundation Essential Benefits Package Project

	Healthy Families	Federal Employees Health Benefits	Medicare
Allergy care	Testing and treatment, co-pay	Allergy serum, testing and treatment/ injections customized antigens are covered. Not covered includes provocative food testing and sublingual allergy desensitization	Not mentioned
Alternative Treatments	Acupuncture and Chiropractic-20 visits year, co-pay. Biofeedback, 8 visits year.	Chiropractic services, up to 20 medically necessary visits per year. Members may self-refer to American Specialty Health Plans (ASHP) providers.	Acupuncture, not covered. Covers manipulation of the spine to correct a subluxation, when provided by chiropractors or other qualified providers.
Blood	Processing, storage, and administration of blood and blood products in inpatient and outpatient settings. Includes the collection and storage of autologous blood when medically indicated.	Administration of blood, blood plasma, and other biologicals. Blood and blood plasma, if not donated or replaced-$50 per treatment	Covers all but the first 3 pints of blood
Cancer – Clinical Trials & Treatment *Clinical Trials*	Not mentioned	Benefits are covered for routine patient care for a member whose personal physician has prior authorization from the plan and has been accepted into an approved clinical trial. Provided that the clinical trial has a therapeutic intent and has a meaningful potential to benefit the member, recommended by the treating physician, and the hospital/physician conducting the trial is a plan provider, unless the trial is not available through a plan provider.	Covers routine costs, like doctor visits and tests if part of a qualifying clinical trial. Does not pay for experimental item being investigated in most cases.
Treatment/ Surgery	Covered when medically necessary	Chemotherapy and radiation covered. Covered surgical procedures include biopsy procedures, and removal of tumor and cysts. All stages of breast reconstruction surgery following a mastectomy, such as surgery to produce a symmetrical appearance on the other breast, treatment of any physical complications, such as lymphedemas.	Chemotherapy and radiation covered for inpatient, outpatient, and in freestanding clinics. Breast prostheses (including a surgical brassiere) after a mastectomy.

CalPERS	Kaiser Permanente Group	Medi-Cal	Prioritized Essential Benefits by Plenary Physician Group
Supplies, except for prescription drugs, related to allergy testing and treatment are covered. Charges incurred conjunction with allergy treatment may not be payable.	Includes coverage for allergy services, including diagnostic evaluation, testing and treatments. No additional charge for allergy serum.	Not mentioned	(priority given depends on age) • 0-18 *** • >18 ** • For 0-18, Symptomatic treatment *** • For 0-18, Skin Testing and desinstitization** • >18, testing and therapy with a copay
Chiropractic and acupuncture, up to 20 visits a year	Acupuncture is covered as an alternative to standard treatment modalities when, in the judgment of a Plan physician, it is the most appropriate treatment for the specific condition. Acupuncture is primarily used as a component of a multidisciplinary pain management program for treatment of chronic pain. Chiropractic service are specifically excluded from all plans. Chiropractic x-rays are also excluded.	Chiropractic and acupuncture treatment limited to no more than two treatment or assessment services each month.	(Varies among treatment types) • All types must be evidence-based • Acupuncture ** • Other * • Note – recommendation was made to move biofeedback to mental health
Covered	Blood used in conjunction with covered services is covered	Administration of blood and blood products covered	• Blood and Blood Products • Blood work associated with lab tests moved to diagnostic category
Not mentioned	Not mentioned	Will cover, with prior authorization, services that are investigational, provided they meet regulatory criteria.	Group recommends having a category called "clinical trials," not specific to Cancer. Within that category, they recommend covering routine care associated with qualified clinical trials.
Medically necessary diagnostic therapeutic and/or surgical services performed at a hospital or outpatient facility, including, but not necessarily limited to kidney dialysis, chemotherapy, and radiation therapy.	Not specified	Not specified	Group recommends changing this category to "Cancer diagnosis and treatment." This was given.*** Note-Recommendation made to move BRCA-1, BRCA-2 testing to genetics category.

BENCHMARKING COMPARISON OF EXISTING HEALTH PLANS (WITH SOURCES)

Blue Shield of California Foundation Essential Benefits Package Project

	Healthy Families	Federal Employees Health Benefits	Medicare
Cancer – Screening			
Colorectal	Not specified	Covers Fecal occult blood test, Sigmoidosopcy, every five years starting at 50, Colonoscopy-once every 10 years at age 50.	Covers several colorectal cancer screening tests. Colonoscopy: once every 24 months if high risk, otherwise once every 10 years, but not within 48 months of a screening sigmoidoscopy. Fecal Occult Blood Test: Once every 12 months. Flexible Sigmoidoscopy: Once every 48 months, not within 10 years of a screening colonoscopy. Barium Enema: Doctor can use instead of a flexible sigmoidoscopy or colonoscopy.
Mammogram	Covered	Covered for women age 35 and older as follows: From age 35 through 39, one during five year period. From age 40 through 49, once every one of two years. From age 50 through 64, one every year. At age 65 and older, one every two years.	Once every 12 months for age 40 or older. Also one baseline between 35 and 39. Covers new digital technologies for mammogram screenings.
Pap Tests	Annual Pap smear exams covered	Routine Pap tests, or other DFA approved cervical cancer screening tests every year.	Covered for all women once every 24 months. If high risk for cervical or vaginal cancer, or have an abnormal Pap Test, covered once every 12 months.
Prostate	Not specified	Routine Prostate Specific Antigen (PSA) test, one annually for men 40 or over.	Covers screening tests for all men 50 or older once every 12 months. Includes Digital Rectal Examin-ation, Prostate Specific Antigen (PSA) test.
Chemical Dependency	Alcohol and drug abuse: Inpatient: As medically appropriate to remove toxic substances from the system. Outpatient: 20 visits per benefit year (some plans may choose to increase the number of visits if services are determined medically necessary).	Not mentioned	Covers substance abuse treatment in an out-patient treatment center if they have agreed to participate in the Medicare program.

CalPERS	Kaiser Permanente Group	Medi-Cal	Prioritized Essential Benefits by Plenary Physician Group
Not specified	Not specified	Not specified	Recommendation made to use the U.S. Prevention Task Force Guidelines for this entire category. (will need to be tracked as these are updated often).
Covered (timing not specified)	Not specified	Not specified	
Covered (timing not specified)	Not specified	Not specified	
Not specified	Not specified	Not specified	
Benefits are provided for hospital and physician services medically necessary for short-term(3-5 days) medical management of detoxification or withdrawal symptoms, up to fifteen days per calendar year. Inpatient charges in connection with chemical dependency rehabilitation services and programs are not covered. Inpatient benefits may be utilized to cover outpatient day or evening chemical dependency treatment programs when precertified in advance by the Review Center.	Alcohol and drug dependency treatment covered. Including: Day treatment programs, intensive outpatient programs, counseling (both individual and group visits) for alcohol or drug dependency, medical treatment for withdrawal symptoms, methadone maintenance treatment for pregnant members during pregnancy and for two months after delivery at a licensed treatment center approved by the Medical Group. Methadone maintenance treatment in any other circumstance is not covered.	Covered services include treatment by psychiatrists, psychologists, and licensed clinical social workers; hospitalization or institutional treatment; rehabilitative services; targeted case management, and medication management.	• Includes testing and treatment. Only in appropriate settings and by qualified providers. • To include prenatal care related to chemical dependency. • To include smoking and substance abuse.

BENCHMARKING COMPARISON OF EXISTING HEALTH PLANS (WITH SOURCES)

Blue Shield of California Foundation Essential Benefits Package Project

	Healthy Families	Federal Employees Health Benefits	Medicare
Circumcision	Not mentioned	Covered if performed during newborn's post delivery stay in hospital.	Not mentioned
Dental *Preventive Care/ Fillings/ Diagnostic Services*	Teeth cleaning, topical fluoride covered. Sealants as needed only for permanent 1st and 2nd molars. X-rays, consultation covered.	Not covered	Not covered
Major procedures	Root canals, oral surgery, crowns and bridges, dentures covered. Orthodontia service provided through CCS when condition meets their criteria.	Hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of a patient. The treatment of damage to natural teeth caused solely by an accidental injury is limited to medically necessary services until the services result in initial, palliative stabilization of the member.	Hospital stays if emergency or complicated dental procedures are needed
Diabetic Supplies and Services *Testing*	Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL and Hemoglobin A-1C (Glycohemoglobin). Covers insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin, blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices.	Diabetic supplies limited to disposable insulin syringes, needles, pen delivery systems for the administration of insulin as determined to be medically necessary. Glucose testing tablets and strips are covered. Insulin is covered.	Covers some diabetic supplies (insulin users and non-insulin users). These include limited quantities of: blood glucose test strips, blood glucose meter, and lancet devices and lancets. Covers glucose control solutions for checking the accuracy of test strips and monitors. Covers therapeutic shoes for severe diabetic foot disease. Covers diabetes self-management training, foot exam every six months for people with diabetic peripheral neuropathy, glaucoma screening, and medical nutrient therapy services for diabetes when referred by a doctor.

CalPERS	Kaiser Permanente Group	Medi-Cal	Prioritized Essential Benefits by Plenary Physician Group
Covered if newborn is enrolled as a family member.	Covered during the newborn period, which is defined as the first 30 days following birth. If cannot be performed during the newborn period for medical reasons, circumcision will be covered at the earliest medically appropriate time. Thereafter, circumcision is only covered when it is determined to be medically necessary by a Plan physician.	Not mentioned	• Neonatal, • Later, only when medically necessary.
Not covered	To prepare the jaw for radiation treatment for cancer, covers evaluations, x-rays, extraction of teeth and fluoride treatment. Covers the medical treatment of conditions of the mouth or jaw (but not teeth).	Dental services and for children, dental sealants covered. The provider must get Medi-Cal approval before providing the services.	• Must include prenatal care – screening, prevention, treatment. • Adulthood and geriatrics to include screening, prevention and treatment. • This category should be defined further using the advice of qualified dental experts as to what is appropriate to include. • Should exclude cosmetics and orthodontia except for trauma. • Excludes dentures unless necessary for nutrition. • Dental screenings should reference the U.S Task Force on Prevention.
Acute care hospitalization and general anesthesia services are covered in connection with dental procedures when hospitalization is required because of the individual's underlying medical condition an clinical status. This applies if 1) the member is less than seven years old, 2) the member is developmentally disabled, or 3) the member's health is compromised and general anesthesia is medically necessary. Services of a dentist or oral surgeon are excluded.	Covers the medical treatment of temporomandibular joint (TMJ) disorder if a Plan specialist determines the member's problem to be a medical etiology.	Dental services covered, must get Medi-Cal approval before providing services.	
Coverage includes an instruction program that 1) is designed to educate patients and their family members about the disease process and the daily management of diabetic therapy, 2) includes self-management training, education and medical nutrition therapy to enable proper use of equipment, supplies, and medications, and 3) is supervised by a physician.	Not referenced specifically	Not referenced specifically	• Testing and Treatment • Health education relating to diabetes (e.g., nutrition by dieticians)

BENCHMARKING COMPARISON OF EXISTING HEALTH PLANS (WITH SOURCES)

Blue Shield of California Foundation Essential Benefits Package Project

	Healthy Families	Federal Employees Health Benefits	Medicare
Diagnostics, X-rays, and Laboratory Services	Diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, treat, and follow-up on the care of subscribers. Other diagnostic services, which shall include, but not be limited to, electrocardiography, electro-encephalography, and mammography for screening or diagnostic purposes.	Tests such as: blood tests, urinalysis, pathology, x-rays, CAT scans/MRI, ultrasound, and electrocardiogram and EEG are covered.	Covers diagnostic tests like CT Scans, MRIs, EKGs, and X-rays. Also covers clinical diagnostic tests and lab services provided by certified laboratories that are participating in Medicare. Diagnostic tests and lab services are done to help diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking cholesterol.
Drugs *Basic prescriptions*	Medically necessary drugs when prescribed by a licensed practitioner acting within the scope of his or her licensure. Includes injectable medication and needles and syringes necessary for the administration of the covered injectable medication. Medically necessary drugs administered while a patient is in a rest home, nursing home, or similar facility when prescribed.	Prescribed drugs and medications are covered. Disposable needles and syringes for the administration of covered medications.	Covers a limited number of outpatient prescription drugs, including: some antigens, osteoporosis drugs, erythropoietin (Epogen), Hemophilia clotting factors, injectable drugs, immunosuppressive drugs, oral cancer drugs, oral anti-nausea drugs, and some drugs used in infusion pumps and nebulizers if considered reasonable and necessary.
Contraceptives	All FDA approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered, including internally implanted time release contraceptives such as Norplant.	Formulary and non-formulary oral contraceptive drugs and diaphragms.	Not covered
Smoking Cessation	Coverage for one cycle or course of treatment of tobacco cessation drugs per year is covered.	Smoking cessation medication requiring a physician's prescription (one 12 week course per year).	Not covered
Generic Drugs	Health plans may specify that generic equivalent prescription drugs must be dispensed if available, provided that no medical contraindications exist.		Not mentioned

CalPERS	Kaiser Permanente Group	Medi-Cal	Prioritized Essential Benefits by Plenary Physician Group
Outpatient services from all providers, including diagnostic x-rays, diagnostic examinations, clinical laboratory services. Outpatient magnetic resonance imaging (MRI) of the upper and lower spine require precertification by the Review Center.	Covers diagnostic and therapeutic imaging, laboratory testing, and special procedures. Coverage includes clinical laboratory services, pathology, cytology, genetic testing. X-ray include CT scan, PET, MRI, ultrasound and nuclear medicine. Special procedures include Electrodiagnostic services, neurological testing, and pulmonary function tests.	Covers testing for diagnostic purposes. Covers imaging for preventive care, diagnostic imaging and therapeutic imaging. Covers electrocardiograms, and electroencephalograms. Covers UV (ultraviolet) light treatment.	• Should be evidence-based • Includes prenatal – diagnosis of pregnancy, dating ultrasound if indicated, standard diagnostics (per ACOG), Antenatal testing indicated • Post partum – fetal chromosome testing, fetal autopsy for greater than 500 grams, depression screening • Screening for infections – STDs (for women and their partners), bacterial vaginosis, UTIs • In-patient care, diagnostics • Imaging (when medically indicated) • History/exam • Consults/referrals • Procedures • New modalities – after evaluation by NHTA • Blood work • Microbiology • Pathology • Cytology • HPV/Pap
Covers prescription drugs which are: a) prescribed in connection with a covered illness or accidental injury; b) dispensed by a registered pharmacist, c) pre-approved.	Drugs are covered if prescribed in accord with drug formulary guidelines. They are covered if a physician determines they are medically necessary. Drugs and accessories necessary for services excluded are also excluded from coverage (example, in-vitro fertilization).	The Medi-Cal pharmacy benefit includes a list of contract drugs (formulary) that includes all major therapeutic categories of drugs and many over-the-counter (OTC) drugs. In order to prescribe a drug excluded from the, a provider must obtain prior authorization from the California Department of Health Services. Limit of six prescriptions per month.	• Prenatal • Prescription Medications • Certain OTCs with evidence Note: Group recommends changing the title of this category from "drugs" to "medications".
Oral contraceptives and diaphragms covered.	Covered	Covered	Covered
Not covered	Covered under supplemental drug plan (included in most plans)	Covered	Covered
Not mandatory, but encouraged.	Co-payments less for generic drugs.	Requires substitution of generic drug for brand, when cost effective.	Not specified

BENCHMARKING COMPARISON OF EXISTING HEALTH PLANS (WITH SOURCES)

Blue Shield of California Foundation Essential Benefits Package Project

	Healthy Families	Federal Employees Health Benefits	Medicare
Drugs *(continued)*			
Formulary	The use of a formulary, maximum allowable cost (MAC) method and mail order programs by health plans is encouraged.	Formulary and non-formulary drugs and medicines that by federal law of the United States require a physician's prescription for their purchase.	Not mentioned
Other drugs mentioned as covered	Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins which require a prescription are covered	Formulary and non-formulary drugs for sexual dysfunction or sexual inadequacies will be covered when the dysfunction is caused by medically documented organic disease.	
Durable Medical Equipment	Medical equipment appropriate for home use which is 1) intended for repeated use, 2) is generally not useful to a person in the absence of illness or injury, and 3) primarily serves a medical purpose.	Purchase or rental up to the purchase price, including repair and adjustment, of durable medical equipment prescribed by a plan physician. Includes: colostomy/ostomy supplies, hospital beds, wheelchairs, crutches, walkers, canes, traction equipment, peak flow monitor for self-management of asthma, glucose monitor for self-management of diabetes, apnea monitor for management of newborns	Covered if prescribed
Emergency Services	Twenty-four hour emergency care for a medical condition manifesting itself by acute symptoms of a sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following A) Placing the patient's health in serious jeopardy, b) serious impairment to bodily functions, c) serious dysfunction of any bodily organ or part.	Defined as "the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care" . Covered at an urgent care center, as an outpatient or inpatient at a hospital, including doctor's services.	A medical emergency is "when you believe that your health is in serious danger. You may have a bad injury, sudden illness, or an illness quickly getting much worse" . Covered

CalPERS	Kaiser Permanente Group	Medi-Cal	Prioritized Essential Benefits by Plenary Physician Group
Copay varies by generic, formulary, or non-formulary brand drugs.	Only formulary drugs covered. Episodic drugs for the treatment of sexual dysfunction. Insulin, glucagon, other prescriptive medications for the treatment of diabetes, contraceptives used for non-contraceptive purposes, disposable needles and syringes for injecting covered drugs.	Only formulary drugs covered.	Group agreed on the notion of a voluntary uniform formulary process for the state.
Rental or purchase, including repair and maintenance, of standard outpatient prosthetic appliances and standard durable medical equipment if covered. Examples of prosthetic appliances includes artificial limbs and eyes and their fitting, and orthopedic braces, including shoes only when permanently attached to such braces. Examples include crutches, standard wheelchairs and hospital beds. Lancets are covered for the purpose of administration of a covered drug.	Covered	Covered (upon pre-approval)	As appropriate
Services in a physician's office, outpatient facility or an emergency room of a hospital are covered when required for the alleviation of the sudden onset of severe pain or the immediate diagnosis and treatment of an unforeseen illness or injury which could lead to further significant disability or death, or which would so appear to a layperson. Covered. Also covers emergency maternity admissions if due to unexpected premature delivery (prior to eight month of pregnancy). Only physician charges shall be payable for non-emergency services received in an emergency room of a hospital.	Covers emergency care and urgent care (i.e. minor injury care). Any x-ray, lab and special procedures that are provided during a covered ED visit are provided at no charge.	Covered. The provider must call Medi-Cal or the managed care organization promptly to get emergency authorization.	• Recommendation made to ensure the availability of non-emergency room urgent care. • Recommendation made to provide education programs on the appropriate use of the emergency room. • Recommendation made to have triage at the emergency room. • The group stated that ideally the patient would have a secure medical home so inappropriate emergency room visits would disappear.

BENCHMARKING COMPARISON OF EXISTING HEALTH PLANS (WITH SOURCES)

Blue Shield of California Foundation Essential Benefits Package Project

	Healthy Families	Federal Employees Health Benefits	Medicare
Eye Care			
Examinations	For subscriber children, eye refractions to determine the need for corrective lenses and dilated retinal eye exams are covered. For subscriber parents, eye refraction is optional for plan. Eye examinations covered once every 12 months.	Annual exam covered	Glaucoma screening once every 12 months for people at high risk for glaucoma. This includes people with diabetes, a family history of glaucoma, or African-American who are age 50 or older.
Glasses/ Contact lenses	Prescription glasses, once every 12 months. Necessary contact lenses covered upon prior authorization for certain conditions such as 1) following cataract surgery, 2) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses, 3) certain conditions of Anisometropia, and 4) keratoconus. Elective contact lenses may be chosen instead of corrective lenses and a frame at a maximum benefit allowance of $110. Limited to once each twelve month period, beginning at the date of the last exam.	Contact lenses, if medically necessary to treat eye conditions such as keratoconus and keratitis sicca or when required as a result of cataract surgery when no intraocular lens has been implanted are covered.	Generally not covered. Following cataract surgery with an intraocular lens, Medicare will help pay for cataract glasses, contact lenses or intraocular lenses provided by an optometrist.
Other services	A Low Vision benefit for people with severe visual problems that are not correctable with regular lenses. Requires prior approval. Includes supplementary testing and supplemental care, including low vision therapy as visually necessary or appropriate.		Covers a treatment for some patients with 'wet' age-related macular degeneration with predominantly classic legions. (Ocular photodynamic therapy with verteporfin).
Family Planning	Voluntary family planning services including counseling and surgical procedures for sterilization as permitted by state and federal law, diaphragms, and coverage for other FDA approved devices and contraceptive drugs pursuant to the prescription drug benefit.	A broad range of family planning is covered such as physician office visit fitting a diaphragm, surgically implanted contraceptives, injectable contraceptive drugs (such as Depo Provera), intrauterine devices (IUDs), and Diaphragms. Oral contraceptives covered under the prescription drug benefit.	Not mentioned

CalPERS	Kaiser Permanente Group	Medi-Cal	Prioritized Essential Benefits by Plenary Physician Group
Not covered	Covered	Covered	Covered
Not covered	Coverage includes an allowance to be used toward the purchase of lenses, frames and/ or cosmetic contact lenses, fitting and dispensing. The allowance may be used toward options such as progressive multi-focal lenses, high-index lenses, ultraviolet inhibiting lenses, scratch coating and eyeglass lenses. Special contact lenses when prescribed are covered, including two contact lenses per eye every 12 months to treat aniridia (missing iris). Five aphakic contact replacement lenses per eye for children from birth through age 9. If contact lenses will significantly improve vision not obtainable with eyeglass, covered.	Glasses and special contact lenses covered.	Glasses covered. Contact lenses only covered in special cases.
Visits and consultations by an ophthalmologist for an active illness are covered.		Corneal transplants covered	Specialty referral services for glaucoma and catheracts.
Services for voluntary sterilization, including tubal ligation and vasectomy, and medically necessary abortions are covered. Office visits for contraceptive management, including services of a physician in connection with the prescribing and fitting of contraceptive diaphragms or injectable drugs for birth control administered during the office visit are covered. Intra-uterine devices (IUDs) and time-released subdermal implants are covered. Oral contraceptives and diaphragms covered under prescription drug program.	Covered. Services include counseling, office visits, sterilization procedures, and the prescribing, fitting and insertion of contraceptive drugs and devices. Covered contraceptive drugs include: Emergency contraception, injectable contraception, Implantable contraception, and Intrauterine devices. Oral contraceptives covered. mifeprex (i.e. RU 486, a.k.a., "the abortion pill" covered). Both elective and medically necessary abortions (interrupted pregnancies) are covered. Includes pre-abortion and post-abortion counseling.	Covers counseling, surgical procedures for sterilization, contraceptives, pregnancy tests, care for medical problems related to birth control methods. Elective abortion covered (referenced as covered by the San Francisco health plan for medical members, not specifically referenced in Medi-Cal state benefit summary.	• Birth control • Fertility regulation • Sterilization • Reproductive health counseling, contraceptive follow-up • Terminations • STDs with diagnosis and treatment of partners

BENCHMARKING COMPARISON OF EXISTING HEALTH PLANS (WITH SOURCES)

Blue Shield of California Foundation Essential Benefits Package Project

	Healthy Families	Federal Employees Health Benefits	Medicare
Foot Care	Not mentioned	Routine foot care not covered	Covers the services of a podiatrist for medically necessary treatment of injuries or diseases of the foot (such as hammer toe or bunion deformities and heel spurs) Covers therapeutic shoes for diabetics with severe foot disease. A foot exam is covered every six months for people with diabetic peripheral neuropathy and loss of protective sensations.
Health Education	Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan are covered.	Coverage is limited to: Health education newsletter, Mayo Clinic Guide to Self-Care for new members, First Steps prenatal education program, and Preventive health reminders and educational publications.	Not covered
Hearing	Hearing aids are covered.	Hearing screening for children through age 17. Audiometry examinations when performed by a physician or by an audiologist at the request of a physician.	In some cases, diagnostic hearing exams are covered by part B.
Home Health Care	Covered if prescribed, including physical, occupational, and speech therapy visits performed in home.	Home health care ordered by a plan physician and provided by a register- ed nurse, Physical Therapist, Occupa-tional Therapist, Speech Therapist, Respiratory Therapist, licensed vocational nurse or home health aide is covered. Services include oxygen therapy, intravenous therapy and medications. Home visit by physician covered.	Covered if 1) a physician decides it is necessary and makes a plan for at home care. 2) a patient needs at least one of the following intermittent (and not full time) skilled nursing care, or physical therapy or speech language pathology services, or a continued need for occupational therapy, and 3) Patient is homebound, 4) the home health agency is approved by the Medicare program. Also covers the visit by a home health nurse to administer a drug.

CalPERS	Kaiser Permanente Group	Medi-Cal	Prioritized Essential Benefits by Plenary Physician Group
Not mentioned	Not mentioned	Requires prior authorization for most podiatry services.	• For vascular problems related to diabetes. • Podiatry with medical need. • Orthodics only with expert review.
Not mentioned	Covered as a basic benefit. Includes group or individual sessions for specific diseases or conditions, such as diabetes, high cholesterol, and high blood pressure. When available, general health education services not addressed to a specific condition are also offered. These include classes in topics such as childbirth preparation, weight control, and smoking cessation.	Health education materials and classes are covered	Covered. Note – cognitive evaluation, learning disabilities, nutrition should be part of a community education system.
Hearing aids are covered, including fitting, counseling, adjustment, and repairs for a one-year period following the provision of a covered hearing aid	Covers ear examinations to determine the need for hearing correction. Includes medical examination of the ear and audiometric examinations to measure hearing acuity. Hearing aids are not covered.	Hearing tests and hearing aids are covered	• Screenings • Basic hearing aids • Assisted listening devices • Cochlear implants not covered
Medically necessary skilled care for continued treatment of an injury or illness furnished by a Home Health Agency is covered if the Member is homebound. Coverage is for up to one hundred visits per calendar year.	Home health services and supplies necessary during a home health visit is covered. A physician must determine that it is feasible to maintain effective supervision and control of care in the member's home.	Medically necessary skilled care (not custodial), home visits, physical, occupational and speech therapy	• Custodial care where indicated with means testing • Respite care

BENCHMARKING COMPARISON OF EXISTING HEALTH PLANS (WITH SOURCES)

Blue Shield of California Foundation Essential Benefits Package Project

	Healthy Families	Federal Employees Health Benefits	Medicare
Hospice Care	Coverage includes nursing care, medical social services, home health aide services, physician services, drugs, medical supplies and appliances, counseling and bereavement services. Benefit also includes physical, occupational and speech therapy, short-term inpatient care, pain control and symptom management. May include (option for the health plan) homemaker services, services of volunteers, and short-term inpatient respite care.	Covered through a participating hopsice agency when member has a terminal illness with a prognosis of one year or less as determined by the member's plan provider's certification. Coverage includes interdisciplinary team care to develop and maintain an appropriate plan of care. Nursing care services are covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain a member at home. Hospitalization is covered when the interdisciplinary team makes the determination that skilled nursing care is required at a level that can't be provided in the home. Skilled nursing services, certified health aide services and homemaker services under the supervision of a qualified registered nurse. Drugs and medicine, medical equipment and supplies that are reasonable and necessary for the palliation and management of terminal illness and related conditions. Physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills. Social services/ counseling services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, will also be provided when needed. Short-term inpatient care necessary to relieve family members or other persons caring for the member. Such respite care is limited to an occasional basis and to no more than five consecutive days at a time. Volunteer services. Bereavement services.	Hospice care and respite care covered.
Hospital Inpatient Care	Coverage includes general hospital services, in a room of two or more, with customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. All medically necessary ancillary services such as: use of operating room and related facilities; intensive care unit and services; drugs, medications, and biologicals; anesthesia and oxygen; diagnostic laboratory and x-ray services; special duty nursing as medically necessary; physical, occupational, and speech therapy; respiratory therapy; administration of blood and blood products; other diagnostic, therapeutic and rehabilitative services as appropriate; and coordinated discharge planning, including the planning of such continuing care as may be necessary.	Includes room and board (private room when medically necessary). Other services and supplies such as operating, recovery, delivery room, newborn nursery and other treatment rooms, prescribed drugs, diagnostic laboratory and x-rays, administration of blood and blood products, dressings, splints, casts and sterile tray services, medical supplies and equipment, including oxygen, anesthetics, including nurse anesthetist services, take-home items, medical supplies, appliances, medical equipments, and any covered item billed by a hospital for use at home, radiation therapy, chemotherapy, and renal dialysis.	Covered hospital services include: a semiprivate room, meals, general nursing, and other hospital services and supplies. This includes access to inpatient mental health care. This does not include private duty nursing or a television or telephone in the room. It also does not include a private room, unless medically necessary.

CalPERS	Kaiser Permanente Group	Medi-Cal	Prioritized Essential Benefitsa by Plenary Physician Group
Covered services are provided under the direction of the treating physician as follows: Full time, part-time or intermittent skilled nursing services provided by a registered nurse or licensed vocational nurse in the home or in a hospice facility; part-time or intermittent home health services that provide supportive care; homemaking services; counseling; up to 5 days of inpatient hospital care for the patient.	Covered for a terminal illness with a life expectancy of one year or less. Coverage includes: plan physician services; skilled nursing care; physical, occupational, speech therapy, respiratory therapy, medical social services, home health aide and homemaker services, palliative drugs for pain control, durable medical equipment, respite care, inpatient care, counseling and bereavement services, dietary counseling.	Hospice and respite care covered for patients with a terminal illness with a 12 month or less life expectancy. Includes medically necessary skilled care; counseling	Covered
Medically necessary accommodations in a semi-private room and all medically necessary ancillary services, supplies, unreplaced blood and take-home prescription drugs, up to a three (3) day supply. Covered benefit will not include charges in excess of the hospital 's prevailing semi-private room rate unless your physician orders a private room as medically necessary.	Covers all medically necessary, acute, general hospital services as prescribed by a physician. Includes, but not limited to: Room and board, including a private room if medically necessary, specialized care and critical care units, general and special nursing care, operating and recovery room, physicians' and surgeons' services and supplies, anesthesia, medical supplies, durable medical equipment, blood, blood products and their administration, obstetrical care and delivery, respiratory therapy, medical social services and discharge planning, prescribed medication, laboratory, imaging and special procedures.	Medically necessary facility charges, general nursing care, ancillary services including operating room, prescribed drugs, laboratory, chemotherapy, and radiology during inpatient stay.	• Treatment of acute illness • For elective inpatient, prior authorization required

BENCHMARKING COMPARISON OF EXISTING HEALTH PLANS (WITH SOURCES)

Blue Shield of California Foundation Essential Benefits Package Project

	Healthy Families	Federal Employees Health Benefits	Medicare
Infertility Services	Not covered	Covers artificial insemination such as intravaginal insemination (IVI), intracervical insemination (ICI), intrauterine insemination (IUI). Covers injectable and oral fertility drugs.	Not mentioned
Kidney Dialysis	Covered	Covered	Covers some kidney dialysis services and supplies, including: inpatient dialysis treatments, outpatient maintenance dialysis treatment, self-dialysis training, home dialysis equipment and supplies, certain home support services (including visits by trained dialysis workers to check equipment and supplies), certain drugs for home dialysis, including Heparin, topical anesthetics and Erythropoietin.
Maternity care	Medically necessary professional and hospital services relating to maternity care including: pre-natal and post-natal care and complications of pregnancy, newborn examinations and nursery care while the mother is hospitalized. Includes providing coverage for participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein Program.	Complete maternity (obstetrical) care such as: Prenatal care, delivery, postnatal care. Hospital stay up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Extended if medically necessary. Routine nursery care of the newborn child during the covered portion of the mother's maternity stay. Covers other care of an infant who requires non-routine treatment only if the infant is covered.	Not mentioned
Medical Transportation	Medical Transportation Services: Emergency ambulance transportation in connection with emergency services to the first hospital which actually accepts the subscriber for emergency care. Includes ambulance and ambulance transport services provided through the "911" emergency response system. Non-emergency transportation for the transfer of a subscriber from a hospital to another hospital or facility or facility to home when: (A) medically necessary, and (B) requested by a plan provider, and (C) authorized in advance by the participating health plan.	Local professional ambulance service when ordered or authorized by a plan physician is covered.	Medicare covers limited ambulance services. If patient needs to go to a hospital or skilled nursing facility (SNF), ambulance services are covered only if transportation in any other vehicle could endanger health. Generally, transportation from a hospital or SNF is not covered. If the care is not available locally, Medicare helps pay for necessary ambulance transportation to the closest facility outside the local area that can provide the necessary care. If patient chooses to go to another facility farther away, Medicare payment is based on how much it would cost to go to the closest facility. All ambulance suppliers must accept assignment. Medicare does not pay for ambulance transportation to a doctor's office. Air ambulance is paid only in emergency situations.

CalPERS	Kaiser Permanente Group	Medi-Cal	Prioritized Essential Benefits by Plenary Physician Group
Not covered	Covers medical services required to diagnose the cause of involuntary infertility and to treat involuntary infertility. Services include physician, hospital inpatient care imaging, laboratory and special procedures.	Not mentioned	• Diagnosis and treatment (not to include gamete manipulation or IVF) • Diagnostic imaging • Ovulation test (x1) and secondary diagnostic work-up • Semen analysis (x2)
Covered	Covered. Includes services and supplies for dialysis services for acute renal failure and chronic (end-stage) renal disease. Equipment, training, and medical supplies for home dialysis are provided.	Not mentioned	Covered
Medically necessary physician and hospital services relating to prenatal and postnatal care and complications of pregnancy. Examination, nursery care and circumcision of the newborn are provided if the newborn is enrolled. An alternative birthing center may be used instead of hospitalization. Any earlier discharge of a mother and newborn child than mandated by Health Protection Act of 1996, must be made by the attending provider in consultation with the mother. Natural childbirth classes covered.	Coverage for obstetrical services include: outpatient professional services, including prenatal and postnatal visits to physicians, nurse-midwives, and nurse practitioners. Hospital services, including vaginal delivery or Cesarean section, medications, and anesthesia. Outpatient and inpatient laboratory, radiology, diagnostic imaging, and special procedures.	Coverage includes: prenatal visits, prenatal care and postnatal care, inpatient, delivery (including C-section) newborn nursery care	• Deliveries – Consultants for medical/surgical issues – Anesthesia – Immediate post-partum sterilization – Any licensed facility for deliveries with "privileged" practitioners – Blood products – All medications – Maternal transport – Indicated inductions • Termination of Pregnancy, medical/surgical
Covered: Emergency transportation by professional ambulance services (ground or air) required for emergency care. Medically necessary professional ambulance services (ground or air) required to transfer the patient from one facility to another, including services provided as a result of a 911 emergency response system request for assistance.	Covered: Emergency ground and air ambulance transportation in accord with the prudent layperson standard, not covered when it is used as transportation because other forms of transportation (automobile, taxi, bus, etc.) are not available. Covers non-emergency transportation including repatriation from a non-Plan hospital to a plan hospital.	Ambulance services covered when medically necessary.	• For basic access to care – covered based on medical or financial need • Medical transport – covered • Inter-facility transport – covered

BENCHMARKING COMPARISON OF EXISTING HEALTH PLANS (WITH SOURCES)

Blue Shield of California Foundation Essential Benefits Package Project

	Healthy Families	Federal Employees Health Benefits	Medicare
Mental Health – Inpatient	Covered. For subscriber children determined by their county mental health department to meet the criteria for Serious Emotional Disturbances (SED) for a serious mental disorder, pursuant to Section 5600.3 of the Welfare and Institutions Code, plans may limit services to 30 days per benefit year. Plans shall be responsible for identifying subscriber children who may be SED or may have a serious mental disorder and shall refer these individuals to their respective county mental health department for determination. For subscriber children who are determined as SED or as having a serious mental disorder by the county mental health department, participating plans shall provide up to 30 days of inpatient care and shall then refer these individuals to their county mental health department for continued treatment of the condition.	Covered: all diagnostic and treatment services recommended by plan providers and contained in a pre-approved treatment plan. Coverage includes professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers; medication management diagnostic tests; services provided by a hospital or other facility; services approved in alternative care settings such as partial hospitalization; half-way house, residential treatment, full-day hospitalization; facility based intensive outpatient treatment.	Covered when furnished by a doctor or health care professional who can be paid by Medicare. Services can be given in a general hospital, or in a specialty psychiatric hospital that only cares for people with mental health problems.
Mental Health – Outpatient	Covered when ordered and performed by a participating mental health professional. This includes the treatment of children who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, or divorce and bereavement. Family members may be involved in the treatment to the extent it is appropriate for the health and recovery of the child. No visit limits for severe mental illnesses, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa and bulimia nervosa.	Covered (see above for details)	Covers services by either a doctor, clinical psychologist, clinical social worker, clinical nurse specialist or physician assistant in an office setting clinic, or hospital outpatient department.
Outpatient Care	Diagnostic, therapeutic and surgical services performed at a hospital or outpatient facility. Includes: physical, occupational, and speech therapy as appropriate, and those hospital services which can reasonably be provided on an ambulatory basis. Related services include operating room, treatment room, ancillary services, anesthesia, and medications.	Covers operating, recovery and other treatment rooms, prescribed drugs and medicines, diagnostic laboratory tests, x-rays, and pathology services, administration of blood, blood plasma, and other biologicals, blood and blood plasma, if not donated or replaced, pre-surgical testing, dressings, casts, and sterile tray services, medical supplies, including oxygen, anesthetics and anesthesia services	Covers medically necessary services from an outpatient Medicare-participating hospital for the diagnosis or treatment of an illness or injury. Coverage includes: Services in an emergency room or outpatient clinic, including same-day surgery, laboratory tests billed by the hospital, mental health care in partial hospitalization program, x-rays and other radiology services, medical supplies such as splints and casts, and drugs and biologicals cannot be self-administered.

CalPERS	Kaiser Permanente Group	Medi-Cal	Prioritized Essential Benefits by Plenary Physician Group
Benefits are provided for hospital and physician services medically necessary to stabilize an acute psychiatric condition up to thirty days per calendar year. Covered services for treating severe mental illness and serious emotional disturbances of a child are not subject to 30 visits limit.	Coverage for the following severe mental health diagnoses, plus the Serious Emotional Disturbances (SED) of children: Schizophrenia, Schizoaffective disorder, Major depressive disorders, Panic disorder, Obsessive-compulsive disorder, Pervasive developmental disorder or autism, Anorexia nervosa, Bulimia nervosa. Mental health care visit and day limits do not apply to the parity diagnosis (listed above) and SED for children. For all other mental health conditions, covers evaluation, crisis intervention and treatment when a physician or other mental health professional determines the condition will significantly improve with relatively short-term therapy. Coverage is for psychiatric hospitalization, including medical services and supplies of physicians and mental health professionals.	Mental Health services are delivered through a set of county systems, distinct form other Medi-Cal services. Each plan is responsible for inpatient and outpatient mental health specialty care for Medi-Cal beneficiaries who meet specific impairment criteria.	• Covered per assembly bill 88. • To include diagnosis and treatment of ADD, ADHD. • Includes initial evaluation, comorbidities, and depression. • Includes biofeedback. • Group recommends some limit on substance abuse treatment (e.g. number of days).
Coverage includes individual and group sessions; physician/psychiatrist visits for mental health medication management, physician/psychiatrist outpatient consultations (any combination up to 30 visits per year). Covered services for treating severe mental illness and serious emotional disturbances of a child are not subject to 30 visits limit.	Coverage for the following severe mental health diagnoses, plus the Serious Emotional Disturbances (SED) of children: Schizophrenia, Schizoaffective disorder, Major depressive disorders, Panic disorder, Obsessive-compulsive disorder, Pervasive developmental disorder or autism, Anorexia nervosa, Bulimia nervosa. Mental health care visit and day limits do not apply to the parity diagnosis (listed above) and SED for children. For all other mental health conditions, covers evaluation, crisis intervention and treatment when a physician or other mental health professional determines the condition will significantly improve with relatively short-term therapy. Includes coverage for: individual, group and couples therapy for diagnostic evaluation and psychiatric treatment; psychological testing; visits for the purpose of monitoring drug therapy.	Mental Health services are delivered through a set of county systems, distinct form other Medi-Cal services. Counties. Each plan is responsible for inpatient and outpatient mental health specialty care for Medi-Cal beneficiaries who meet specific impairment criteria.	Group recommends combining mental health inpatient and outpatient categories.
Requires precertification by the Review Center.	Outpatient surgery covered. House calls covered when medically necessary.	Medically necessary services covered, such as facility charges, general nursing care, ancillary services including operating room, prescribed drugs, laboratory, chemotherapy, and radiology.	• Office visits for prenatal care (per ACOG) • Gynecology – Therapy for ectopic pregnancy (***) – Therapy for abnormals – Therapy for chronic pelvic pain syndromes (**) – Surgery for prolapse (**) – GYN/Urology (AHRQ guidelines)(**) – Early and late menopause (*) – Abnormal vaginal bleeding (*) • Treatment of acute illnesses • Licensed Provider Visits

BENCHMARKING COMPARISON OF EXISTING HEALTH PLANS (WITH SOURCES)

Blue Shield of California Foundation Essential Benefits Package Project

	Healthy Families	Federal Employees Health Benefits	Medicare
Physical, Occupational, and Speech therapies	Physical, occupational, and speech therapy covered in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility or home.	Covered when determined to be medically necessary and it is demonstrated that the member's condition will significantly improve as a result of the services. Must be by qualified physical and occupational therapists. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. Also covered: cardiac rehabilitation.	Covered when the doctor or therapist sets up the plan of treatment, and the doctor periodically reviews the plan to see how long therapy is needed.
Preventive Care *Children*	Well-baby visits, immunizations, vision and hearing testing, health education services.	Immunizations recommended by the American Academy of Pediatrics, well-child care for routine examinations, immunizations, and care, including eye and ear screenings through age 17.	Not applicable
Adult	Periodic health examinations, family planning services, prenatal care, vision and hearing testing, immunizations, venereal disease tests, confidential HIV/AIDS counseling and testing, annual Pap smear exams, health education services.	Routine screenings such as total blood cholesterol and cancer screenings (see cancer screening section). Routine immunizations as recommended by the United States Public Health Service: Tetanus-diphtheria (Td) booster-once every 10 years, ages 19 and over, influenza vaccines, annually, age 50 and older, pneumococcal vaccine for adults 65 and older, recommended travel immunizations, hepatitis A, hepatitis B and lyme disease immunization for individuals at high risk.	Covers: bone mass measurement, colorectal cancer screening, diabetes services, flu shot, glaucoma screening, mammogram screening, medical nutrition therapy, pap test and pelvic examination, prostate cancer screening, vaccinations including: flu shots, pneumococcal pneumonia shots, hepatitis B shots.
Prosthetics	When medically necessary. Coverage includes initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy, and therapeutic footwear for diabetics. Also prosthetic devices to restore and achieve symmetry incident to mastectomy.	Coverage includes: surgically implanted breast implant following mastectomy, externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy, surgically implanted prosthetic devices such as artificial joints, pacemakers, orthopedic devices (and their repair) such as braces and functional foot orthoses, and contact lenses necessary to treat certain medical eye conditions.	Covers prosthetic devices need to replace a body part or function. Includes corrective lenses after a cataract operation, ostomy bags and certain related supplies, and breast prostheses (including a surgical brassiere) after a mastectomy. Also covers artificial limbs and eyes, and arm, leg, back, and neck braces.

CalPERS	Kaiser Permanente Group	Medi-Cal	Prioritized Essential Benefits by Plenary Physician Group
Speech therapy covered only for: a speech or swallowing disorder caused by documented illness or injury to the vocal organs or oral cavity, speech or swallowing disorder due to a stroke or injury to the brain, congenital anomalies following corrective surgery, cerebral palsy, and/or a severe mental illness. Covered when medically necessary is: physical therapy and occupational therapy; cardiac rehabilitation, and pulmonary rehabilitation.	Physical, occupational, and speech therapy all covered. In addition, a specialized program called multidisciplinary rehabilitation covered when prescribed. Provides an intense level of coordinated rehabilitation services in more than one therapy.	Covered when deemed medically necessary.	Covered
Benefits include health care services designed for the prevention and early detection of illness in Members who have not experienced any symptoms. Preventive care generally includes routine physical examinations, tests and immunizations.	Benefits include well child visits, and pediatric immunizations.	Includes the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, a federal Medicaid obligation for those under 21. Includes screening services, including both an initial and periodic screens ("well-baby visits", and inter-periodic screens. Includes assistance with transportation and scheduling of the assessment appointment.	• According to U.S. Prevention Task Force, AAP, AAFP guidelines. • Examples include smoking cessation, vaccines, immunizations, nutrition, and rehabilitation.
Benefits include health care services designed for the prevention and early detection of illness in Members who have not experienced any symptoms. Preventive care generally includes routine physical examinations, tests and immunizations.	Immunizations are covered.	Immunizations, periodic health exams, STD tests, cytology exams, prenatal care.	• According to U.S. Prevention Task Force, AAP, AAFP guidelines. • Examples include smoking cessation, vaccines, immunizations, nutrition, and rehabilitation.
Not specified	Coverage includes: internally implanted devices during a covered surgery, podiatric devices (including footwear) to prevent or treat diabetes-related complications, prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx, prostheses following a covered mastectomy, elastic compression garments, low-elastic extremity wraps, and adjustable compression garments for the treatment and maintenance of lymphedema, enteral formula for members that require tube-feeding, prosthetic device to replace the eye, ostomy and urological supplies.	Covered if medically necessary	• Necessary for functionality • Includes breast prosthesis • Implantables

BENCHMARKING COMPARISON OF EXISTING HEALTH PLANS (WITH SOURCES)

Blue Shield of California Foundation Essential Benefits Package Project

	Healthy Families	Federal Employees Health Benefits	Medicare
Reconstructive Surgery	Covered when surgery is to improve function, or to create a normal appearance to the extent possible. Includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.	Coverage includes: surgery to correct a functional defect, surgery to correct a condition caused by injury or illness if the condition produced a major effect on the member's appearance, and the condition can reasonably be expected to be corrected by such surgery, surgery to correct congenial anomalies, all stages of breast reconstruction surgery following a mastectomy.	Cosmetic surgery is generally not covered unless it is needed because of accidental injury or to improve the function of a malformed part of the body.
Skilled Nursing Care	Services prescribed by a plan physician or nurse practitioner and provided in a licensed skilled nursing facility when medically necessary. Coverage is on a 24-hour per day basis; bed and board; x-ray and laboratory procedures; respiratory therapy; physical, occupational and speech therapy; medical social services; prescribed drugs and medications; medical supplies; and appliances and equipment ordinarily furnished by the skilled nursing facility. Limited to 100 days per year.	Covered: home health care ordered by a registered nurse, physical therapist, occupational therapist, speech therapist, respiratory therapist, licensed vocational nurse, or home health aid. Services include oxygen therapy, intravenous therapy and medications. Home visits by physician also covered.	Covers skilled care in a skilled nursing facility under certain conditions for a limited time. Covered if: patient has Medicare Part A, has a qualifying hospital stay, doctor has prescribed it, care is under the direct supervision of skilled nursing or rehabilitation staff, the staff has been certified by Medicare, and services are needed for a medical condition that was treated during a 3-day hospital stay, or started while patient was getting Medicare-covered SNF care. Up to 100 days a year.
Transplants	Coverage for medically necessary organ transplants and bone marrow transplants which are not experimental or investigational in nature. Reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor if these expenses are directly related to the transplant for a subscriber. Charges for testing of relatives for matching bone marrow transplants covered.	Limited to: cornea, heart, skin, heart/lung, kidney, kidney/pancreas, liver, lung, single-double, intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach and pancreas.	Covers transplants of the heart, lung, kidney, pancreas, intestina/multivisceral, bone marrow, cornea, and liver at Medicare-approved facilities. Includes necessary tests, labs, and exams before surgery for patient and organ donor, follow-up care for patient and a live donor, and procurement of organs and tissues.

CalPERS	Kaiser Permanente Group	Medi-Cal	Prioritized Essential Benefits by Plenary Physician Group
Covered to the extent that surgery is coincident with and necessary to the repair or alleviation of bodily damage caused by illness, congenital anomaly, or accidental injury.	Covered when surgery is to improve function, or to create a normal appearance to the extent possible. Includes reconstructive surgery to restore and achieve symmetry incident to mastectomy. Conditions generally considered necessary are port wine stains, cleft lip/palate, microtia, and keloids.	Covered	Necessary to correct functional defect or create "normal appearance".
Covered if 1. prescribed by the patient's physician, 2. for skilled and not custodial care; and 3. for the continued treatment of an injury or illness.	Covered. Includes physician and nursing services, room and board, medical social services, prescribed drugs n accord with formulary guidelines, blood, blood products, and their administration, medical supplies, durable medical equipment, nursing facility, laboratory, imaging, and special procedures, physical, speech and occupational therapy.	Covers comprehensive preventive, acute, and long-term custodial care services.	Group recommends changing the heading of this category to "Nursing Homes." Skilled and custodial care covered.
Covers kidney, cornea, and skin transplants.	Organ, tissue or bone marrow transplants covered.	Covered	Covered

Appendix III

INDIVIDUAL CLINICAL GROUP REPORTS

Maternal Care/Childbirth

Session 1
Monday, March 17, 2003
Skirball Cultural Center
Los Angeles, CA

Present: *Kimberly Gregory, M.D., Nathan Lurvey, M.D., Ciaran Phibbs, Ph.D., Robert Reid, M.D. (Jeff Rideout, M.D.; John Golenski, Ed.D.)*

Ranked Benefits Descriptions:

Gynecology:

*** Therapy for ectopic pregnancy

*** Cancer screening *(USPH, ACOG guidelines)*
- Pap Smears as primary screening
- HPV typing as secondary

*** Therapy for abnormals
- Cryotherapy
- Incisional therapy

*** Mammograms *(ACS guidelines)*

*** Screening for infections
- STD's
- Bacterial vaginosis
- UTI's

** Therapy for chronic pelvic pain syndromes

** Abnormal vaginal bleeding
- Work-up *(ectopics, cancer, anemia)*
- Treatment *(favor definitive vs. "temporizing" treatment)*

** Surgery for prolapse

** Osteoporosis prevention, screening, and treatment

** GYN/Urology *(AHRQ guidelines)*
- Diagnostics for incontinence
- Treatment for incontinence *(supplies, behavior mod., surgery)*

* Vaccines
- Rubella
- Hepatitis B
- Influenza

* Early and late menopause
- Symptomatic treatment *(HRT)*
- Counseling
- Exercise

Nutrition, supplements *(e.g. folates)*

General Med/Surg:

*** Treatment of pregnancy-induced diabetes

*** Treatment of hypertension

*** Treatment of asthma

*** Out-patient medications *(with formulary structure and co-pays)*

*** Vaccines

** Treatment of hyper- and hypo-thyroidism

** Clinically-proven treatment for obesity

Reproductive Health:

(Diagnosis and treatment of sexual dysfunction relates to many of the categories in this benefits description)

*** Infertility diagnosis and treatment
(not to include gamete manipulation or IVF)
- Diagnostic imaging
- Ovulation test (x1) and secondary diagnostic work-up
- Semen analysis (x2)

*** Preconceptual counseling by qualified consultant for high risk individuals, i.e.:
- Medical history
- Recurrent pregnancy loss

*** Testing for and treatment of STDs for women and their partners

*** Termination of pregnancy
- Medical
- Surgical

*** Birth control and fertility control

*** Sterilization

* Preconceptual counseling for low risk individuals

* – *** lower to higher priority

Oncology:

*** Chemotherapy

*** Radiotherapy

*** Referral for oncologist, oncology surgeon

*** Reconstructive surgery

* BRCA-1, BRCA-2 testing for high risk individuals

Mental Health:

*** Domestic violence

*** Depression screening

** Post-incident counseling
(e.g. neonatal or fetal loss/life-threatening diagnosis, etc.)

Genetics:

*** Genetic work-up
(with gate-keeping by qualified genetics counselors) for:

- History of mental illness
- Chronic medication use
- Survivors of childhood/adolescence cancer
- Prior child with positive diagnosis
- Personal positive diagnosis
- High risk for cancers *(e.g. positive BRCA-1, BRCA-2)*
- Family history
- Mental illness
- Recurrent pregnancy loss

Genetic work-up to include:

- Some counseling
- First and second trimester screening
- CVS
- First trimester maternal serum with ultrasound by "certified"provider or standard second trimester if AFP abnormal
- Amniocentesis

Informatics:

*** Risk adjusted, reliable data on outcomes for all hospitals made available to providers and patients

*** Unique patient identifier/record to follow patient with important medical information
(e.g. Pap results, blood type, prenatal labs, drug allergies, etc.)

Research:

** All related medical needs for anyone enrolled in clinical trials

Appropriate clinical trials for covered conditions

Obstetrics:

*** Prenatal:

- Maternal transport to secondary level of care
- Coordination of care with appropriate providers
- Psychiatric treatment
- Substance abuse counseling and treatment
- All therapeutic medications during pregnancy
- Diagnosis of pregnancy
- Dating ultrasound if indicated
- Standard diagnostics *(per ACOG)*
- Office visits for prenatal care *(per ACOG)*
- Antenatal testing as indicated
- Prenatal nutritional counseling with medical indications *(prevention of pregnancy-related diabetes)*

Dental care

*** Deliveries:

- Consultants for medical/surgical issues
- Anesthesia
- Immediate post-partum sterilization
- Any licensed facility for deliveries with "privileged" practitioners
- Blood products
- All medications
- Maternal transport
- Indicated inductions
- All ICU care

*** Post Partum:

- Lactation counseling
- Breast pumps
- Fetal chromosome testing
- Fetal autopsy for greater than 500 grams
- Depression screening

Session 1
Thursday, March 20, 2003
Skirball Cultural Center
Los Angeles, CA 90049

Present: *Jeff Hankoff, M.D., Thomas Klitzner, M.D., Ph.D., Harry Pellman, M.D., Michelle Roland, M.D., Richard Walls, M.D., Elliott Weinstein, M.D., Richard Zachrich, M.D. (Jeff Rideout, M.D., Tanir Ami, John Golenski, Ed.D.)*

Ranked Healthcare Benefits

Catastrophic Illnesses:

*** Cardiac surgery

*** Complex Oncology Treatments *(e.g., ABMT, BMT)*

*** Dialysis

*** Organ Transplants – renal, heart, liver
(With appropriate expert panel review)

*** Neonatology/NICU

In-Patient Care:

*** Emergency care

*** Surgery
- T & A *(per AAP Guidelines)****
- Tubes *(per AAP Guidelines)****
- Eyes

*** Reconstructive Surgery post trauma or for congenital problems
- Reconstructive ***
- Cosmetic to replace functionality ***
- Cochlear implants

*** Diagnostics

*** Medical treatment

*** Blood and blood products

*** Specialty referrals *(As appropriate, with pediatric subspecialty preferred – AAP Guidelines)*
– **Substantial Dispute & Discussion**
- With Exceptions Process

*** Treatment of acute illnesses

*** On-going management of disease

Prevention:

*** Routine newborn care
- Hearing assessment **
- Blood screening *(e.g., PKU)* ***

*** Health education *(As part of Well Child Visits, e.g., safety)*

*** Vaccinations *(Including supplies, educational materials, disposal of sharps, storage costs, counseling time, registry)*

*** Screenings *(According to AAP, AAFP Guidelines)*
- Hearing/Vision
- Dental
- Urine/Blood
- Psychological
- Newborn *(in hospital)*
- Developmental
- STD's, TB, Other Infectious Diseases
- Pap/HPV

*** Periodic Exams Including Developmental Screenings *(Per AAP, AAFP Guidelines)*

*** Vision *(Glasses)*

*** Hearing *(Basic aides)*

Out-Patient:

*** Treatment of Chronic Conditions

*** Treatment of Diabetes
- Insulin, Syringes
- Glucose Monitors

*** Foot Care
- For diabetics ***
- Orthotics – only with expert review

*** Reproductive Health
- Counseling
- Contraceptive follow-up
- Terminations
- STD's With diagnosis and treatment of partners

*** Allergy
- Symptomatic treatment ***
- Skin tests and desensitization therapy *

** Care Coordination by physician

* Circumcision

* – *** lower to higher priority

Mental Health:

*** Substance abuse treatment

*** Treatment of eating disorders and obesity

*** Diagnosis and treatment of major psychiatric disorders *(AB88)*

*** Diagnosis and treatment of ADD/ADHD

- Initial evaluation **
- Co-morbidities
- Depression

Other Forms of Care:

*** Skilled nursing care at home

- Technology-dependent children *(Ventilators, hyperalimentation)*
- IV therapy
- Phototherapy

*** Skilled nursing homes *(where available)*

*** Hospice

Dental Care:

*** Basic Dental Care

*** Acute Treatment

*** Trauma

? Orthodontia

Medications:

*** Prescription Medications *(Including OTC)*

- P & T Process
- Formulary
- Exceptions process
- Special coverage for orphan drugs

DME's and Prosthetics:

*** All medically necessary prostheses and DME's *(Expert Review for Appropriateness)*

Problem-Identified Evaluation/Screening:

*** Developmental evaluation *(For high risk)*

*** Genetic testing/work-up *(For high risk)*

*** Smoking cessation

Allied Services:

** Nutrition

** Physical therapy *(with referral)*

** Occupational therapy *(with referral)*

** Speech therapy *(Medical and developmental depending on differential)*

* Learning disabilities *(Counseling and training)*

- Cognitive evaluation *(school vs. physician's office)*
- Treatments *(Depending on Differential)* – Medical treatment and/or "learning" training

Alternative Therapies:

** Biofeedback

* Acupuncture *(For pain, symptom management)*

Chiropractic

Alternative Formulary

Non Face-To-Face "Visits":

*** Telephone, Email, Fax *(With Criteria and Documentation)*

Clinical Trials:

Off-Label uses *(With Practice Guidelines)*

Orphan technologies *(Evidence-Based)*

Issues Identified by Group:

- Age for Coverage of "Pediatric" Patients?
- Continuity of Care Issues with Coverage Changes – *(Initial Diagnosis, On-Going Therapies, Treatment of Co-Morbidities)*
- Specialty Referrals Should Come Through the Primary Physician *(With Appeal Process)*
- Appropriate Role of Medical Office versus School System for Addressing "Developmental" Problems Associated with Learning Difficulties?
- "Allied" Interventions?
- How to Allow for Clinical Trials for One Patient/Specialty Referrals to Research?
- Setting for Testing/Treatment for Various STD's, Infectious Diseases Due to Confidentiality Concerns?
- Access?
- Coverage for "Reduction of Parental Anxiety"?
- Need for an On-Going Process, Evidence-Based, to Evaluate New Medical Technologies.

Session 1
Tuesday, March 18, 2003
California Academy of Family Physicians
San Francisco, CA

Present: *Chester Choi, M.D., Philip Darney, M.D., Jeffrey Doty, M.D., Susan Fleischman, M.D., Leonard Fromer, M.D., Glen Littenberg, M.D., Melvyn Sterling, M.D., Jeffrey A. Tice, M.D. (Jeff Rideout, M.D., Tanir Ami, John Golenski, Ed.D.)*

Ranked Medical Services

Diagnostics:

Group agreed that the determination of coverage for many clinical interventions should be reviewed in an "overarching process" led by clinicians and informed by evidence.

*** Imaging *(Covered when medically indicated)*
- Cardiology ***

*** History/exam

*** Consults/referrals

*** Labs
- Blood work
- Microbiology *(Including DNA for STD's)*
- Pathology
- Cytology
- HPV/Pap
- Genetic Work-Up *(with indications)*

*** Procedures
- Endoscopy
- Invasive cardiology testing
- Angiography

*** Telemedicine diagnostics

** Allergy testing
- Skin
- Vitro

* — *** lower to higher priority

Treatments:

Group agreed that the determination of coverage for many clinical interventions should be reviewed in an "overarching process" led by clinicians and informed by evidence. The Group also described the need for a Statewide New Healthcare Technology Assessment function to review emerging medical technologies.
- Needs input of practicing physicians
- Permanently staffed and funded
- Research-based

Examples of issues to be reviewed in light of medical necessity doctrine:
- Therapy for Myomata *(uterine ablation; drug therapy; endoscopic surgery)*
- Therapy for Incontinence *(uterine artery embolization; hormonal therapy, including intrauterine)*
- Therapy for Refractory Depression *(Successive SSRI's)*
- AFPT for Sepsis
- External Counter Pulsation for Heart Failure
- CNS Imaging for Headache
- Arthroscopy
- HRT
- Chronic Pain Syndromes *(with unknown etiology)*

*** Emergency Services
(Group raised questions about the "prudent lay person" standard for ER Use)
— Out of area care and transport

*** Treatment of Acute Illnesses, both in-patient and ambulatory settings

*** Blood and blood products

*** Diabetes treatment
- Testing, glucose monitors
- Syringes and supplies

*** Medications
- **Formulary**
  - **Evidence-Based** *(Efficacy/Safety)*
  - Favoring Class A generics
  - Including OTC drugs
  - Rational resupply allowances
  - Process for exceptions
  - "Lifestyle" drugs *(E.g., Viagra)* Only for medical necessity
- **Income-Based Co-Pays**

*** Durable Medical equipment/devices
- Ostomy bags
- Sleep Apnea equipment
- C-Pap
- Catheters
- Hospital Beds
- Wheelchairs *(Motorized where appropriate)*
- Crutches/splints
- Peak flood meters
- Nebulizers
- Oxygen

*** Eye Care
- Vision testing, glasses
- Contact lenses *(In selected cases)*

*** Foot Care
- Diabetic neuropathic foot care
- Podiatry *(With medical need)*

*** Hearing
- Testing
- Hearing aides (Basic)
- Cochlear implants

*** Kidney dialysis

*** Home health care
- When "efficient"
- With disease management *(E.g., wound care, IV antibiotics, CHF)*

*** Skilled nursing facilities *(Especially for Technology-Dependent Patients)*

*** Custodial care *(Where Indicated)*
- Dementia
- Strokes
- HIV/AIDS

*** Infertility *(With Age cut-off, Perhaps 40)*
- Stimulating Ovulation ***
- Evaluation ***
- Egg, sperm storage during chemotherapy *

*** Contraception

*** Allergy
- Testing
- Desensitization

*** Health education
- Nutrition counseling *** *(HIV, Diabetes, BP, renal failure, high cholesterol)*
- Pregnancy Prevention, emergency contraception *(OTC)* ***
- Breast, testicular self-exam *
- Life Style/health status *(community responsibility)*
- Health hazards/safety *(community responsibility)*
- Gun safety *(community responsibility)*
- Substance Abuse *(community responsibility)*

*** Telemedicine *(Email, fax, telephone)*
- Local *(When face-to-face visits are impossible or not efficient)*
- Distant

*** Physical Therapy
*** Occupational Therapy
*** Speech Therapy

With "Tight Oversight" & Protocols

*** Prosthetics
- Necessary for functionality
- Breast implants
- Artificial larynx

*** Reconstructive Surgery
- Necessary for functionality *(post trauma; post burns)*
- Breast reconstruction *(post surgery)*

*** Transplants *(When medically indicated)*
- Kidney
- Liver
- Cornea
- Heart
- Heart/lung
- Bone marrow
- Cord blood
- Donor coverage!

*** Mental health services *(Question as to evidence base)*
- Screening, diagnosis and treatment of major disorders *(AB88)*
- Substance Abuse *(Including De-Tox)*
  - For high risk
  - Age-appropriate
  - Evidence-Based

*** Enabling services
- Translation/interpretation ***
- **Case Management for very selected patients** ****(Includes Paying MD)*
  - Medically complex
  - Socially complex
- Case finders in community *(This is a public health function and/or the responsibility of health plans)*
- Medical Transportation ***
  (Including ambulance, paratransit, cab, bus)
  - Transport to primary care setting *(when indicated)*
  - To ER
  - Inter-facility

*** Disease management
- Palliative care ***
- Chronic disease ***
  (E.g., CHF, Diabetes, asthma, lipids, anticoagulants)
- HIV care ***
- Hospice ****(one year)*
- Consulting pharmacist **
- Group visits *
- Depression
- Obesity
- Hypertension

** Dental care
- For Diabetics *(screening, prevention)*
- Orthodontia for nutritional issues

* Alternative care *(Evidence-Based)*
  - Chiropractic
  - Acupuncture
  - Massage
  - Biofeedback

Clinical Trials:

*** Routine care associated with clinical trial

Prevention:

*** Fertility regulation

*** Immunizations
(influenza, pneumonia, Hepatitis-A, Hepatitis-B, tetanus)

*** Follow-up to infectious diseases
(measles, rubella, varicella, meningococcal virus)

* Immunizations and drugs for foreign travel

Screenings:

*** Smoking and Substance Abuse

*** Depression

*** Vision/Hearing

*** Contagious Disease

*** Mammograms

*** Domestic Violence

** Cervical Cancer

*** Skin Cancer

*** Colon Cancer

? Prostate Cancer *(PSA, DRE's)*

*** Osteoporosis

*** Hypertension

*** High Cholesterol

*** STD's *(including HIV)*

*** Avoidance of Auto Accidents

*** Falling *(In elderly)*

Geriatrics

Session 1
Wednesday, March 19, 2003
Sierra Health Foundation
Sacramento, CA 95833

Present: *Cathy Alessi, M.D., Ronald W. Chapman, M.D., M.P.H., Rebecca Conant, M.D., David Reuben, M.D., Theodore R. Schrock, M.D., Edwin J. Whitman, M.D. (Jeff Rideout, M.D., John Golenski, Ed.D.)*

Important Issues:

Group participants identified a number of key issues outside of the description and ranking of benefits process:

- Continuity of Care, having a "medical home" is essential for quality geriatric care.
- With increasingly healthy, mobile geriatric populations, having out-of-area chronic and emergency care coverage become more important.
- Although care must be available in all settings, it is important to emphasize that it should be delivered in the setting which is least restrictive, promoting the greatest independent functioning.
- Means-testing for many forms of coverage is encouraged.
- Case management is important for home-bound patients.
- Reform of the three-day hospital stay requirement prior to transfer to SNF.
- All delivery systems should have defined standards of care. This will include incentives for QI activities and outcomes measures.
- Many procedures and minor surgeries ("bumps and lumps") can be dealt with effectively in the out-patient setting.

* – *** lower to higher priority

Ranked Benefits Descriptions:

Group participants divided medical benefits according to site of delivery – hospital; nursing home (skilled and custodial; out-patient/community; home) and then extracted those benefits or interventions which are common to all settings. These are listed first.

Common Services:

*** Medications/IV's *("Clinically-derived, Research-informed")*
- Formulary
- Means-tested co-pays
- Exceptions process

*** Inter-Facility transport
- Least expensive
- Means-tested for payment coverage

*** Translation/Interpretation services

*** Licensed provider visits
- M.D.'s, D.O.'s
- Nurses
- Psychologists
- Physician assistants
- Oral surgeons
- Occupational therapists
- Speech therapists
- Physical therapists
- Social workers
- Chiropractors
- Podiatrists
- Acupuncturists
- Dieticians
- Other *licensed* providers

*** Blood and blood products

*** Durable medical equipment *(as indicated)*

*** Diagnostics *(including Radiology and Labs)*

*** Foot care
- Vascular/diabetic ***
- Other *

*** Disease management *(with good evidence, especially RCT)*
- Congestive heart failure ***
- Depression ***
- Asthma **
- HIV **
- Anticoagulants **
- DM **

*** Nutrition

*** Rehabilitation

*** Second opinions

*** Hospice

In-Patient Setting:

*** Medical Interventions *(e.g., anti-infection therapies; wound care)*

*** Surgical Interventions *(e.g., cancer; trauma; infection; wound care)*
– *Some surgical interventions should only be done in settings with high volumes – e.g. liver resection, organ transplants, etc.*

*** Other necessary interventions *(e.g., OT, PT, ST, rehab)*

*** Diagnostics *(including Radiology and Labs)*

*** Mental health services *(including ECT)*

*** DME's

** In-Patient education *(e.g., diabetes training)*

Nursing Homes *(skilled and custodial)*:

*** Board and care *(Means-tested)*

*** Diagnostics *(With appropriate medical indications)*

*** PT, OT, ST, respiratory therapy

*** IV's and medications *(Including custodial Ssetting)* – *As above*

*** Restorative rehabilitative nursing

*** DME's *(As indicated)*

*** Prevention services *(Evidence-Based)*
- Vaccinations
- Osteoporosis prevention
- Bed Sores prevention

*** Respite care in SNF *(For family care-givers)*

Ambulatory/Community:

*** Screenings *(This item was disputed among the group members with the least common denominator being the U.S. Prevention Task force guidelines.)*
- Breast Cancer/mammography ***
- Skin cancers ***
- Colon/rectal ***
- Cervical Cancer (?) ***
- Other Cancers *(according to Guidelines)*
- Osteoporosis ***
- Hearing/vision ***
- Dental *
- Lipids ***
- Hypertension ***
- Obesity **
- Influenza ***
- Prostate (?)

*** Comprehensive Geriatric Assessment *(With selected patients)*
- Incontinence
- Depression
- Falls
- Dementia

*** Medications/IV's – *As above*

*** Medical Interventions *(As indicated)*
- Dialysis
- Wound care, etc.

Geriatrics *continued*

*** Diagnostics
- Labs
- Radiology
- New modalities – *After evaluation by NHTA*

*** Surgical interventions *(non-cosmetic, as indicated)*

*** DME's *(e.g., BP monitors)*

*** Devices *(e.g., hearing aides, low vision aides, glasses, prostheses, ICD's, walkers, canes, crutches, wheelchairs, artificial larnyxes)*

*** Health Education *(e.g., nutrition by dieticians for diabetes)*

*** Mental Health Services *(evidence-based, with limits)*
- Visits with credentialed providers
- Assessment
- Psychiatric medications
- Chemical dependency programs *(in-patient and detox)*

*** Social work

*** Smoking cessation programs

*** Fall prevention *(For high risk)*
- Exercise **
- Tai Chi

*** Pulmonary/cardiac rehab

** Non Face-To-Face "Visits" *(Telephone, Email, Fax)* – *Disputed*

** Case management *(By RN's or social workers with selected populations)*

** Routine care associated with qualified clinical trials

** Allergy testing and treatment of symptoms

* Alternative care *(Evidence-Based, with indications)*
- Acupuncture **
- Chiropractic
- Massage

Hip Protectors

Home/RCFE:

*** Medications/IV's – *As above*

*** Home health agencies, VNA's

*** Home health aides *(With means-testing)*

*** Hospice

*** DME's *(With indications)*
- C-Pap
- Nebulizers
- Oxygen
- Hospital Beds
- Overlays
- Etc.

Appendix IV

POTENTIAL PRIORITIZATION CRITERIA FOR DETERMINING ESSENTIAL BENEFITS

Potential Prioritization Criteria for Determining Essential Benefits

Longevity

In some sense, this is the opposite of mortality. Does the intervention offer a high probability of life extension?

Quality of Life

There is, of course, a large subjective element built into this criterion. Nonetheless, there are certain dimensions of life which can be described as generally improving life's quality – reduction or elimination of pain, for example.

Independence

While this can be thought of as a form of Quality of Life, individuals value the capacity to function independently at varying levels. Interventions can be compared as to how effectively they improve or sustain independence.

Efficiency

When interventions which are similar as to outcomes are compared, which accomplishes its end with the use of least valuable resources (which can include funds, time, human capital, etc.)?

Equity

Is there a basic, perceivable fairness in the way individuals are treated? This principle is usually formulated as "similar treatment in similar cases".

Individual Need

To some extent opposed to equity, this principle values the unique characteristics of individuals' circumstances. This principle requires that general rules allow for exceptions.

Equal Access

Although related to the equity principle, equal access values availability of basic (i.e., necessary for life) resources to all members of the community.

Appendix V

EXECUTIVE SUMMARY, ESSENTIAL BENEFITS PACKAGE PREMIUM ESTIMATES, MILLIMAN USA

Blue Shield of California Foundation
California Benefit Plan Options Associated with Universal Coverage

I. Executive Summary

In conjunction with its studies of universal health insurance coverage for California residents, the Blue Shield of California Foundation requested Milliman USA to estimate medical costs and premiums for several potential benefit plans and provider reimbursement levels, assuming various degrees of healthcare management. This report summarizes our estimates. We understand that these estimates may be used to develop recommendations regarding a California minimum universal benefit plan for the uninsured and under age 65 non-Medicaid population. These estimates are intended to be part of the Foundation's broad study of a universal health insurance program and are intended to be refined as more of the details of that program are developed.

This report presents medical costs and estimated premiums for a twelve-month period beginning January 1, 2003 (cost midpoint of July 1, 2003), reflecting large group underwriting and demographics. The ramifications from actions or reactions by employers and individuals to the interaction of changes in plan design, premiums and eligibility criteria of the universal plan are not included in the costs/premiums in this report. Such ramifications need to be fully understood before finalizing a benefit package and premiums.

The estimates in this report should be adjusted to reflect effective dates beyond January 1, 2003. The benefit plans, reimbursement levels and levels of health care management shown are intended to represent a range of possibilities to provide a means of benefit comparison by the Blue Shield of California Foundation; other options could be used. These estimates do not yet reflect adjustments due to selection or adverse selection as might occur because of "pay or play" limitations, other eligibility provisions, or rating limitations in the proposal, nor do they reflect differences in costs between individual, small group and large group markets.

We priced two HMO-type benefit plans and four PPO-type plans at different provider reimbursement and medical management levels. The specific benefit provisions were specified by the Foundation. Milliman neither endorses nor criticizes the scope of the proposed benefits as the basis for a universal health insurance coverage program. Exhibits A and B show the results and plan summaries, respectively. Exhibit C shows the detailed development for HMO Plan B and PPO Plan D. We developed the estimated costs for the other plans in a similar manner. Exhibit D shows a description of each of the service categories in Exhibit C, and Exhibit E shows the development of the non-standard benefit costs.

II. Approach and Caveats

Blue Shield of California Foundation California Benefit Plan Options Associated with Universal Coverage

We used the Milliman USA, Inc. *Health Costs Guidelines* for the under age 65 population, targeted to a January 1, 2003 effective date (July 1, 2003 cost midpoint for a twelve-month rating period). The *Guidelines* contain large group medical costs and rating methods to develop costs and premium for the various plan designs. The Guidelines are based upon extensive research by Milliman. Starting utilization and billed charges represent California statewide averages. Several potential benefit plans were chosen to represent a ranged of medical costs based on cost sharing levels. For simplicity, when we used RBRVS reimbursement, we based that upon the San Francisco or "Rest of California" area as indicated. Medicare reimbursement varies within the state. Other benefit plans, reimbursement levels or levels of healthcare management could be used.

Premiums were developed for singles and a family of four as requested by the Blue Shield of California Foundation. We assumed 15% of premium for administrative costs.

Note that the results are representative of large group underwriting and standard large group demographics. Therefore, they do not reflect any impact of selection that is inherent in the small group, individual or uninsured markets without appropriate underwriting and premium risk classifications. In addition, these large group costs/premiums do not reflect any potential costs impact due to the action or reaction by large employers or their employees when a minimum universal benefit plan is introduced.

The assumptions that we used for the non-standard benefits are based primarily on our judgement, and also reflect typical large group underwriting. The costs for these services could increase significantly when sold to small groups, individuals or the uninsured due to selection, especially if these not commonly covered benefits are emphasized in the sales process.

We have modeled the effect of a tightly managed network based on Milliman research. This level of utilization is unlikely to be obtained. Since coverage is desired for the Californian under age 65, non-Medicaid and uninsured population, a very broad network of health care providers will be required. It is unlikely that the degree of network cohesiveness required to achieve the tightly managed utilization levels would be possible in such a broad network.

The results shown in the attached Exhibits are estimates only, reflecting the various assumptions as referenced. Differences between estimates and the actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis.

It is almost certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected. We recommend that actual experience in any universal coverage program be carefully monitored as it emerges, and changes to the program made as appropriate.

III. Limitations on Use

The estimates presented in our report represent the authors' opinions. While these may reflect discussions we have had with other actuaries and consultants within Milliman USA in the course of our work, they represent our personal opinions and not those of Milliman USA.

Our report is intended only for the use of the Blue Shield of California Foundation and their Essential Benefits Package group. This report can be distributed to other parties only with Milliman's prior written consent. Any allowed distribution of our report must be in its entirety because the results and assumptions may be misinterpreted if taken out of context. Therefore, we asked that you not excerpt portions of our report.

Furthermore, we ask that you make no reference to the contents of this report or use Milliman's name in a communication with a third party without our prior written permission unless such third party receives the entire report.

Appendix VI

ESSENTIAL BENEFIT PLAN PACKAGE SUMMARY, MILLIMAN USA

Blue Shield of California Foundation
Essential Benefit Plan Package Summary*

HMO-Type Benefits

Plan	Inpatient Copay	Emergency room copy	Outpatient Surgery Facility Copay	Office Visit Copay[1]	Urgent Care Copy	Ambulance Copay
HMO Plan A	$0	$0	$0	$0	$0	$0
HMO Plan B	$0	$50	$0	$15	$25	$50

Plan	Geriatric Drug Copay – Retail	Geriatric Drug Copay – Mail	Formulary Brand Drug Copay-Retail[3]	Formulary Brand Drug Copay Mail[3]	Non-Formulary Brand Drug Copay – Retail	Non-Formulary Brand Drug Copay – Mail
HMO Plan A	$0	$0	$0	$0	$0	$0
HMO Plan B	$10	$20	$20	$40	$30	$60

PPO-Type Benefits

Plan	Deductible	Coinsurance *(In Network)*	Coinsurance *(Out of Network)*	Out of Pocket Coinsurance Maximum *(In Network)*	Out of Pocket Coinsurance Maximum *(Out of Network)*	Emergency Room Copay
PPO Plan A	$250	80%	50%	$1,000	$2,000	$75
PPO Plan B	$500	80%	50%	$1,500	$3,000	$75
PPO Plan C	$750	80%	50%	$2,500	$5,000	$75
PPO Plan D	$1,000	80%	50%	$4,000	$10,000	$75

Plan	Office Visit Copay2	Geriatric Drug Copay – Retail	Generic Drug Copay – Mail	Formulary Brand Drug Copay – Retail[3]	Formulary Brand Drug Copay-Mail[3]	Non-Formulary Brand Drug Copay – Retail	Non-Formulary Brand Drug Copay – Mail
PPO Plan A	$25	$10	$20	$25	$50	$35	$60
PPO Plan B	$25	$10	$20	$25	$50	$35	$60
PPO Plan C	$45	$10	$20	$25	$50	$35	$60
PPO Plan D	$45	$10	$20	$25	$50	$35	$60

[1] Office visit copay applies to Office Visit Consults, Well Care, and Outpatient Mental Health and Substance Abuse Visits

[2] Office visit copay applies to Office Visits, Urgent Care, Office Consults, Well Care, and Outpatient Mental Health and Substance Abuse Visits

[3] Assumes a broad formulary. *Rebates are not included.*

* Reproduced without change and with permission of Milliman USA

Appendix VII

ROSTER OF PHYSICIAN PARTICIPANTS AND PARTICIPANTS IN THE STAKEHOLDER GROUP

As recommended by:

American College of Obstetrics and Gynecology, District IX (California)
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