Determining the Minimum Set of Required Benefits

(with help from The Onion)

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Overview

- Policy dimensions of minimum benefit design
- Approaches to minimum benefits
- Related policy approaches designed to support affordable, comprehensive benefits

> Study: Most Self-Abuse Goes Unreported
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Policy Dimensions of Benefit Design

Highway Department Discontinues "*Bridge Out 8 Feet Ahead*" Sign

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Defining a minimum set of benefits involves resolving several policy trade-offs . . .

- The list of “minimum” benefits is a state’s determination of what constitutes “being insured”
- Establishing “minimum benefits” involves striking a state’s balance between its role to protect its citizens, and its duty to respect individual liberty/autonomy to purchase services in the market
- “Minimum benefits” also involve an underlying, and often unspoken, trade-off between covering more people with leaner benefits, or fewer people with more complete benefits
- Comprehensive benefits and selection bias
  - More mandated benefits skews coverage toward larger, wealthier groups
  - More mandated benefits leads to a wider range of conditions within the coverage group (e.g. mental health parity; coverage of In Vitro Fertilization; coverage of HIV/AIDS)

. . . including whether other adjustments should be made so people can afford comprehensive benefits.

- Mandating a provider type = mandating a benefit (e.g. chiropractor)
- Without eliminating benefits, alternatives exist to create “affordable” insurance
  - Cost sharing rules
  - Open vs. closed provider networks
  - Utilization/authorization rules (and related grievance and appeals processes; second opinions; and other patient rights)
- Purchasing pools themselves generally do not produce material savings in premiums, so establishing “minimum benefits”, in an attempt to create standard “products” in the market with larger enrolled groups won’t necessarily drive affordability

Approaches to Minimum Benefits

Man Has Mixed Feelings About $39 Flight

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State-mandated health benefit requirements vary across the states.

- All 50 states and D.C. have mandates requiring carriers to include certain benefits. *
- The amount and type of benefit mandates vary tremendously from state to state.*
- In January 2008, states had over 1,900 coverage mandates, cumulatively.**
- Mandates range from less than 20 in some states (AL, DC, ID) to more than 60 in others (MD and MN).**

*GAO. (September 2003) Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses. GAO-03-1133.

** Bunce, VC and Wieske JP. (2008) Health Insurance Mandates in the States 2008. Council for Affordable Health Insurance.

Some states combine mandatory minimum benefit laws with discrete exemptions.

- Some states have enacted mandate-light and mandate-free laws.
- These laws allow carriers to offer some/none of the state-mandated benefits.
- States include: AK, CO, FL, GA, KY, MN, TX, and WA.

Source: State Coverage Initiatives. Coverage Matrix. http://statecoverage.net/matrix/limitedbenefitplans.htm

The most frequently mandated benefits include:

- Mammograms
- Diabetes Supplies
- Breast Reconstruction (Post-Mastectomy)
- Mental Health
- Alcoholism

Source: Bunce, VC and Wieske JP. (2008). Health Insurance Mandates in the States 2008. Council for Affordable Health Insurance.

Individually, most mandated benefits don't add a lot to the cost of coverage . . .

Benefit	# States	Est. Costs
Alcoholism	45	1% to3%
Alzheimer's	2	<1%
Ambulatory Surgery	12	1% to 3%
Ambulatory Services	8	<1%
Anti-Psychotic Drugs	3	<1%
Autism	11	<1%
Birthing Centers/Midwives	8	<1%
Blood Lead Poisoning	7	<1%
Blood Products	2	<1%
Bone Marrow Transplants	11	<1%
Bone Mass Measurement	15	<1%
Breast Reconstruction	49	<1%
Cancer Medications	3	<1%
Cervical Cancer/HPV Screening	29	<1%
Cleft Palate	14	<1%

Source: Bunce, VC and Wieske JP. (2008). Health Insurance Mandates in the States 2008. Council for Affordable Health Insurance.

. . . because sometimes the service is not expensive, and sometimes the percentage of users in the group is small . . .

Benefit	# States	Est. Costs
Clinical Trials	23	<1%
Colorectal Cancer Screening	28	<1%
Diabetes Self-Management	27	<1%
Diabetes Supplies	47	<1%
Drug Abuse Treatment	34	<1%
Early Intervention Services	3	<1%
Hair Prostheses	10	<1%
Home Health Care	18	<1%
Hospice Care	11	<1%
In Vitro Fertilization	13	3% to 5%
Long-Term Care	4	1% to 3%
Mammogram	50	<1%
Mastectomy	24	<1%
Maternity	21	1% to 3%

Source: Bunce, VC and Wieske JP. (2008). Health Insurance Mandates in the States 2008. Council for Affordable Health Insurance.

. . . but for services with high costs, and a high percentage of users, a new mandate can add significantly to the premium (and dropping a mandate can save premium dollars).

Benefit	# States	Est. Costs
Mental Health General	39	1% to 3%
Mental Health Parity	47	5% to 10%
Morbid Obesity Treatment	4	1% to 3%
Newborn Hearing Screening	17	<1%
Off-Label Drug Use	36	<1%
Orthotics/Prosthetics	12	<1%
Other Infertility Services	8	<1%
Ovarian Cancer Screening	3	<1%
Psychotic Drugs	2	<1%
PKU/Formula	32	<1%
Prescription Drugs	2	5% to 10%
Prostate Cancer Screening	33	<1%
Rehabilitation Services	8	1% to 3%
Smoking Cessation	2	1% to 3%
Well-Child Care	31	1% to 3%

Source: Bunce, VC and Wieske JP. (2008). Health Insurance Mandates in the States 2008. Council for Affordable Health Insurance.

A case study from our Center's work.

- In 2007, Rhode Island wanted to know how much money might be saved by moving generally healthy adults from a Medicaid benefit package (in RIte Care) into various other potential benefit designs.
- The only benefit change (as opposed to cost sharing change) that significantly reduced the premium would have been to eliminate inpatient benefits, like the Utah Primary Care Network model

Rhode Island RIte Care

Estimated Savings by Changing from Medicaid to alternative benefit designs

	Rite Care (Medicaid)	UT PCN	ARHealthNet	ID	KY	RI BCBS
Reduced Coverage	–	$ (37.88)	–	–	–	–
Inpatient Co-pays	–	–	$(5.31)	–	$ (0.27)	$ (0.02)
Inpatient PMPM	**$ 37.88**	**–**	**$32.56**	**$ 37.88**	**$ 37.60**	**$ 37.86**
Reduced Coverage	–	$ (3.69)	–	–	–	–
Outpatient Co-pays	–	$ (0.41)	$ (9.61)	–	$ (0.72)	$ (1.82)
Outpatient PMPM	**$ 64.04**	**$ 59.94**	**$ 54.43**	**$ 64.04**	**$ 63.31**	**$ 62.22**
Reduced Coverage	–	$ (8.21)	–	–	–	–
Professional Co-pays	–	$ (3.06)	$ (10.84)	–	$ (1.94)	$ (7.79)
Professional PMPM	**$ 72.55**	**$ 61.28**	**$ 61.71**	**$ 72.55**	**$ 70.61**	**$ 64.76**
Reduced Coverage	–	–	–	–	–	–
Pharmacy Co-pays	–	$(6.62)	$ (9.94)	–	$ (1.99)	$ (21.19)
Pharmacy PMPM	**$ 62.47**	**$ 55.84**	**$ 52.53**	**$ 62.47**	**$ 60.48**	**$ 41.27**
Reduced Coverage	–	$ (0.70)	$ (0.70)	$ (0.10)	–	–
Home/Hosp Co-pays	–	–	–	–	–	–
Home/Hosp PMPM	**$ 0.71**	**$ 0.00**	**$ 0.00**	**$ 0.61**	**$ 0.71**	**$ 0.71**
Reduced Coverage	–	$ (0.45)	–	–	–	$ (8.71)
Out-of-Plan Co-pays	–	$ (0.87)	$ (1.40)	–	$ (0.18)	$ (0.03)
Out-of-Plan PMPM	**$ 9.32**	**$ 8.01**	**$ 7.92**	**$ 9.32**	**$ 9.14**	**$ 0.57**
Total Reduced Coverage	–	$ (50.92)	$ (0.70)	$ (0.10)	–	$ (8.71)
Total Co-pays	–	$ (10.97)	$ (37.09)	–	$ (5.11)	$ (30.85)
Grand Total PMPM	**$ 246.95**	**$ 185.07**	**$ 209.16**	**$ 246.86**	**$ 241.85**	**$ 207.39**
PMPM Savings vs. Current Benefit		**$ 61.89**	**$ 37.79**	**$ 0.10**	**$ 5.11**	**$ 39.57**

Source: Center for Health Program Development and Management (February 2007), "Reforming RIte Care for Parents: Fiscal Impact Assessment for Rhode Island Medicaid."

With 6,383 enrollees, the potential annual savings to RI of adopting alternative benefit designs ranged from $7,467 to $4.74 MM.

State	RI*	UT PCN	ARHealthNet	ID	KY	RI BCBS
PMPM	$246.95	$185.07	$209.16	$246.86	$241.85	$207.39
Annual Cost	$18,915,728	$14,175,547	$16,020,982	$18,908,261	$18,524,377	$15,885,060
Annual Savings	-	$4,740,181	$2,894,745	$7,467	$391,351	3,030,668

Reflects total dollars – state and federal.
* N = 6,383

Source: Center for Health Program Development and Management (February 2007), “Reforming RIte Care for Parents: Fiscal Impact Assessment for Rhode Island Medicaid.”

Achieving political support for the reforms in Massachusetts partly depended on the state's minimum benefit laws.

- An individual mandate was palatable to some ***only if***:
  - There was a subsidy for people below 300% FPL, AND
  - Individuals would be protected in the market because carriers couldn't offer "skinny" benefit packages: the coverage would be good
- As a result, the Massachusetts model was dependent, in part, on the mandatory minimum benefit law that was already in existence in MA, plus
  - Rx was added as a new required benefit.
  - The combination of Rx plus the state-mandated benefits is defined as "Minimum Creditable Coverage" to fully the standards of the individual mandate.
- Penalties will be assessed against individuals who fail to purchase coverage that meets this standard.

Yet Massachusetts also recently created exemptions to the Minimum Creditable Coverage rules.

- Young adults (19-26) are exempt from some of the Minimum Creditable Coverage standards:
  - RX coverage is optional

- Federal Health Savings Accounts are also exempt from Minimum Creditable Coverage standards.

Source: 956 CMR §5.00-.03 and 211 CMR §63.01 -.08

Related Policy Approaches Designed to Support Affordable, Comprehensive Benefits

Gun Pays for Itself on First Day

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Offering an affordable, comprehensive insurance package might involve policies about enrollee cost sharing . . .

- Monthly premiums are affected by coinsurance and copayment rules
  - Coinsurance/copays typically are designed to influence the selection of services (e.g. differential drug copays; ER copays)
  - Some research suggests that individuals make "better" decisions with these policies, and some research suggests that enrollees equally avoid necessary and unnecessary treatments
- Health savings accounts and related models blur lines between covered benefits and enrollee cost sharing
  - Premise: individuals will become prudent shoppers/utilizers if they are at first-dollar financial risk for services
  - Premise: third-party payment, combined with minimum benefits, leads to moral hazard in benefit use (people overutilize unnecessary services because they don't bear the cost)

. . . or a government subsidy . . .

- If a state has the capacity to subsidize an insurance program, the subsidy could take many forms, all of which reduce the cost of the coverage to the enrollee. For example:
  - Subsidy to the individual to buy a product inside a purchasing pool (the Massachusetts model for people 100-300% FPL);
  - Subsidy to the individual to buy available coverage (a premium assistance model);
  - A subsidy in the form of reinsurance (like Healthy NY)
    - This reduces the actual premium

. . . or a stop-loss, without reinsurance or a subsidy.

- New Mexico's State Coverage Insurance includes a comprehensive benefit package, but the insurance carriers do not offer coverage beyond $100,000 per person per year
  - This design feature significantly reduced the premiums
  - Yet it converts the "insured" to "uninsured" at that level
  - This design feature affects less than 10 people/year, but affects them significantly

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