Role Models and Cautionary Tales: Three Health Insurance Programs Demonstrate How Standardized Health Benefits Protect Consumers

HEALTH POLICY BRIEF

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SUMMARY

After witnessing the impact of giving insurers broad discretion in designing benefit packages, policymakers in Massachusetts and at the federal level have begun taking steps to simplify plan selection by standardizing benefits and ensuring that the benefit designs provide consumers with reliable and adequate financial protection against catastrophic medical expenses.

The experience of three existing programs provides instructive lessons on how standard benefit designs can help consumers choose affordable, high-quality health coverage and, more importantly, on what can go wrong when weak regulatory oversight leaves benefit design largely in the hands of insurance companies.

The three health coverage programs examined in this report are:

- **Medicare Advantage (MA):** These private Medicare health plans are largely free to design their own benefit packages, as long as they do not impose costs on enrollees that are greater than the average enrollee faces under Original Medicare. People eligible for Medicare struggle to make sense of a cluttered marketplace, featuring a tremendous amount of plan options, where a bad choice can mean high out-of-pocket costs for medical care.

- **Commonwealth Care:** In 2007, Massachusetts residents with limited incomes gained access to subsidized coverage options featuring fully standardized benefit designs. Furthermore, the standard designs help ensure that copayments for medical care and prescription drugs are affordable.

- **Commonwealth Choice:** Plans for Massachusetts residents who do not qualify for help paying premiums are categorized into three "tiers" based on "actuarial" or average value of their benefits. This leaves companies with great flexibility in designing benefit packages, as long as deductibles and out-of-pocket limits do not exceed specified amounts.

As the experience of Medicare Advantage and Commonwealth Choice shows, standards that establish a general "actuarial" target for the overall value of benefits do not provide consumers with sufficient protections. This approach still allows wide variation in benefit design and insurers are well versed in shifting costs onto the sickest plan enrollees through hard-to-decipher benefit designs. For example, the absence of standardized benefit designs means many people with Medicare can, and do, select a Medicare Advantage plan that will charge them more for high-cost treatment, including chemotherapy or rehabilitation in a skilled nursing facility after a stroke, than they would pay under Original Medicare or under a different Medicare Advantage plan. Consumers face similar risks when

selecting a Commonwealth Choice plan, which can have cost-sharing features that mean thousands of dollars in additional out-of-pocket spending for treating diseases like cancer or diabetes compared to a competing plan.

In comparison, the risks of incurring higher costs in a Commonwealth Care plan are much more limited: consumers can choose a plan that charges a higher premium, but their copayments and annual caps on out-of-pocket spending are standard across all their plan choices.

Recognizing the vulnerabilities for consumers, regulators are taking steps to simplify plan choices for consumers in both the Medicare Advantage and Commonwealth Choice programs. Federal regulators are pushing insurers that offer Medicare Advantage plans to include an out-of-pocket limit and to limit the number of plans they put on the market, although they are not requiring them to standardize benefits. Massachusetts authorities have standardized certain benefit features for Commonwealth Choice plans for 2010, but plans still can decide which costs do, or do not, count toward the out-of-pocket limit.

Drawing from the pitfalls and positive developments in all three programs, this brief makes two recommendations for consumer protections Congress should include in health reform legislation:

- **Require all health plans to include a comprehensive annual cap on what consumers pay out-of-pocket for medical care and prescription drugs.** All deductibles, copayments and coinsurance for medical care and prescription drugs covered by the plan should count toward the out-of-pocket maximum. This policy will ensure that plan enrollees with serious illnesses receive understandable, reliable and adequate financial protection.

- **Plans should feature a limited number of standard benefit designs.** A standard benefit design means the deductibles, copayments and coinsurance for covered services such as doctor visits, hospital admissions, prescription drugs and, most importantly, annual out-of-pocket maximums are the same within a given benefit design, no matter which company is offering it. Standardized benefits drive competition on the basis of premiums among easily comparable products, which could moderate the rise in health care costs. By simplifying benefit selection, consumers can more easily choose their plan on the basis of access to providers, an important concern of consumers, and, if comparative information is provided, on the basis of quality, which could help drive system improvements.

Introduction

Consumers enroll in health insurance plans so they can receive medical care when they need it, and afford the bills for the care they receive. But selecting a health insurance plan can be a challenge. Plan benefits can determine whether the prescription drugs, diagnostic tests and doctor visits needed to manage a chronic disease are affordable, or whether an acute episode such as a heart attack has the secondary effect of personal bankruptcy. Similarly, plan benefits determine whether a life-threatening disease, like breast cancer, is a death sentence or a manageable chronic disease, thanks to the wonderful, but expensive, medical advances in recent years.

In today's insurance market, there is a near-infinite variation in the rules insurers set for deductibles, copayments, coinsurance, annual out-of-pocket limits and annual or lifetime maximums, all of which combine to determine how much the insurer pays and how much the consumer pays for health care. Consumers have a difficult time just understanding the terms insurers use; and it is all but impossible to determine their potential financial liability for health care, especially for diseases and treatments that are unforeseen at the time a plan is purchased.

The monthly premium for health insurance is the point of comparison most familiar to consumers and the one that most influences consumers' choice of plan. But consumers can not really make an informed choice between a high- and a low-premium plan, when the plans may, or may not, cover the same array of services, such as prescription drugs or physical therapy, and when each plan uses its own combination of copayments, coinsurance and deductibles to determine cost-sharing. Even for the rare consumer who may be able to wade through the reams of paper to compare these features, the plan document that tells the "whole" story is likely to be available only after enrollment.[1]

If the choice is not between two plans, but among 20 or 50 plans, then consumers may give up in frustration and rely on a substitute for informed choice. That substitute can be the plan's use of a respected brand or the advice of an agent or broker who earns a commission by selling a particular plan. In either case, the choice may be a plan that interrupts access to a trusted medical provider, or results in medical bills that can lead consumers to forgo needed care or fall deep into debt.

As our nation debates health care reform, policymakers are considering proposals that will make insurance plan selection easier for consumers. Specifically, these policies will help simplify their choices and ensure that the choices are "good" ones (containing adequate financial protection for the consumer). At the heart of such measures are policies that standardize the health insurance benefit design. Once plan designs are more uniform, it becomes easier to reduce the sheer number of plan choices, provide consumer-friendly decision tools and ensure that policies contain reliable financial protection for consumers across a wide variety of medical scenarios.

In order to provide consumers with the ability to make informed plan choices, and to promote the type of competition that moderates premium increases and improves quality, an exchange must go hand-in-hand with vigorous government regulation over the insurers on the exchange and the health benefits they provide.

This paper examines three programs and shows how their radically different approaches to benefits standardization have resulted in very different experiences for consumers. First, we will examine the Medicare Advantage program, which provides people with Medicare the option to choose from a range of private plan types and benefit designs as an alternative to coverage under Original Medicare. Then we will look at two programs that are the outgrowth of recent health reform initiatives in Massachusetts. One program—Commonwealth Care—offers plans featuring subsidized premiums to low-income Massachusetts residents. The other—Commonwealth Choice—offers unsubsidized plans to residents who do not qualify for subsidized coverage.

Role of Benefits Standardization in Health Reform

To help consumers make an informed choice of health insurance plans, policymakers drafting health reform legislation are considering establishing *exchanges* that enable consumers to better compare their coverage options.[2] But a robust exchange is more than a website that helps consumers make side-by-side comparisons of their plan options. In order to provide consumers with the ability to make informed plan choices, and to promote the type of competition that moderates premium increases and improves quality, vigorous government regulation over the insurers in the exchange must also be present.

One critical regulation is strong minimum coverage standards for health insurance sold over the exchange. This standard must mandate coverage for the wide ranges of services and products that are needed for effective treatment of illness and injury. Another key

reform is to establish minimum criteria to ensure both affordability of coverage and adequate financial protection against the potentially catastrophic costs of medical care. To be equitable, the standards for affordability and financial protection must work for everyone, including individuals who have limited incomes or who need high-cost treatment.

As illustrated below, standards that establish a general "actuarial" target for the overall value of benefits do not provide consumers with sufficient protections. This approach still allows wide variation in benefit design and insurers are well versed in shifting costs onto the sickest plan enrollees through hard-to-decipher benefit designs.

A standard benefit design means the deductibles, copayments and coinsurance for core services such as doctor visits, hospital admissions, prescription drugs and, most importantly, annual out-of-pocket maximums are the same across a given benefit design, no matter which company is offering it.

On the other hand, implementing a robust standard benefit design requirement would eliminate such discriminatory benefit designs and standardize the cost-sharing terms for the services most important to health care consumers. A standard benefit design means the deductibles, copayments and coinsurance for core services such as doctor visits, hospital admissions, prescription drugs and, most importantly, annual out-of-pocket maximums are the same across a given benefit design, no matter which company is offering it. It also means the definitions for these terms—which services are covered before the deductible, which services count toward the out-of-pocket cap and which services are covered by the hospital copayment—are the same for all companies selling that benefit design. This type of standardization enables consumers to more easily compare plan designs as well as the cost of competing plans of the same design. In the absence of standard benefit designs, too many plan choices, coupled with too much variation in plan design, inhibit many consumers from effectively exercising their options and selecting the most appropriate coverage.

The benefits from simplifying the health plan selection process could be extensive. By allowing comparisons of plans with identical benefit designs, consumers can focus on premium costs, potentially driving enrollment toward plans that are more efficient, rather than plans that keep premiums down by shifting costs onto less healthy enrollees. Simplifying plan choices can also allow more consumers to make a plan selection without the "advice" of an agent or under the influence of advertising, which can reduce the share of premium revenue that is diverted from health care costs toward commissions and marketing. Finally, by simplifying the choice of benefit design, consumers are more likely to consider other factors, such as how plans perform on quality measures.

Medicare Advantage

People with Medicare have long been allowed to receive their Medicare coverage through a private health plan instead of through the government-administered program, sometimes termed "original" Medicare. But it was only after the 2003 Medicare Modernization Act[3] ramped up subsidies provided to these plans that beneficiaries in all parts of the country saw a sharp increase in the number of companies offering these private "Medicare Advantage" plans as well as in the number and variety of benefit packages each company put on the market.

Medicare Advantage Plan Benefits Must Meet an Actuarial Minimum

Medicare Advantage (MA) plans must cover all the medical services that are covered under Medicare Part A, such as inpatient care in hospitals and skilled nursing facilities, and Medicare Part B, such as doctor visits, wheelchairs and other medical equipment, and other outpatient care. With some exceptions, all MA plans must offer at least one benefit package that includes prescription drug coverage under Part D. Most plans are HMO-style health plans with restricted networks, although enrollment has been growing in other types of plans that permit, but do not necessarily guarantee, less restricted access to providers. These Medicare Advantage plans essentially compete with standardized Medigap plans that people with Original Medicare can purchase to cover most, or all, of the cost-sharing under Original Medicare, combined with a stand-alone Part D drug plan (see text box on page 8).

This actuarial equivalence standard allows MA plans to impose cost-sharing for specific services, such as inpatient hospital stays, that is greater than what beneficiaries would pay under Original Medicare.

MA plans are required to set up cost-sharing so that the plan is at least *actuarially* equivalent to the benefit package under Original Medicare. That means that the *average* MA enrollee will not spend more on deductibles, copayments and coinsurance for medical services than the *average* person in Original Medicare would spend.[4]

MA plans can meet this requirement by paying more for some services and less for others. For example, this actuarial equivalence standard allows MA plans to impose cost-sharing for specific services, such as inpatient hospital stays, that is greater than what beneficiaries would pay under Original Medicare. Because the actuarial equivalence approach leaves wide latitude in benefit

design, the Centers for Medicare & Medicaid Services (CMS), Medicare's enforcement body, engages in several layers of review.

For example, CMS reviews plans' cost-sharing for specific services to ensure it does not discriminate against beneficiaries in poor health. In recent years, in response to complaints from consumer advocates and congressional representatives, CMS has tightened the criteria it employs for determining whether cost-sharing is discriminatory. CMS now views MA benefit packages to be discriminatory if cost-sharing for Part B drugs (including chemotherapy drugs), kidney dialysis, psychiatric hospitalization, home health and skilled nursing facilities exceed cost-sharing for these services under Original Medicare.[5] All these services are high cost and used by beneficiaries with serious health conditions.

Particularly vulnerable are Medicare beneficiaries with limited incomes, for whom high copayments or coinsurance create barriers to care, and the absence of a comprehensive out-of-pocket limit commensurate with their income could spell financial disaster.

CMS has used its authority to encourage insurers to include an annual out-of-pocket limit in plan benefits, by promising less rigorous benefit reviews to plans that establish a limit below a specific monetary threshold. (Only one type of MA plan—regional PPOs—are required by statute to include an out-of-pocket limit, although a maximum level is not set.) Success has been limited to date; about 50 percent of MA enrollees in 2008 were enrolled in a plan with any limit. Even fewer were enrolled in plans with a limit that covered all medical services under Parts A and B or that provided a limit at or below the monetary threshold recommended by CMS.

Particularly vulnerable are Medicare beneficiaries with limited incomes, for whom high copayments or coinsurance create barriers to care, and the absence of a comprehensive out-of-pocket limit commensurate with their income could spell financial disaster.[6] An estimated 69 percent of people with Medicare earn less than 300 percent of the federal poverty level.[7]

Using Original Medicare as the actuarial standard leaves many beneficiaries with inadequate protection from high medical costs. In Original Medicare, beneficiaries face high cost-sharing for many essential services, and there are no limits on annual out-of-pocket costs. In fact, on average, Original Medicare, including Part D drug coverage, pays just 76 percent of medical and drug costs (before supplementary coverage such as Medigap), considerably less than the typical employer-sponsored HMO, which covers 93 percent of costs on average.[8] (For the benefits review process, MA plans must meet two separate actuarial standards, one for the medical services

covered by Original Medicare under Part A and Part B, and another that is pegged to the standard for the Part D drug benefit.)

Medigap Plans and Part D Prescription Drug Plans

For Medicare consumers who do not have supplemental coverage through a former employer or do not have incomes low enough to qualify for Medicaid, an alternative to Medicare Advantage is enrollment in a supplemental Medigap plan and a stand-alone prescription drug plan.

Medigap plan benefits have been fully standardized in all 50 states since the early 1990s. Consumers currently have the choice of 13 plans, labeled A through L (with an additional high-deductible F plan). With the exception of two plans that do not cover Medicare copayments for lengthier stays in skilled nursing facilities, all plans effectively limit out-of-pocket costs for medical services as long as consumers use providers who participate in Medicare. The most popular option is Plan F, which covers all Part A and B deductibles, copayments and coinsurance as well as balance billing by nonparticipating providers.

Premiums for Medigap plans have risen sharply in recent years. The typical monthly premium for Plan C, which covers all cost-sharing under Original Medicare, was almost $150 in 2007.[9] Efforts to provide lower premium options that limit out-of-pocket costs but require consumers to pay some cost-sharing for services have not been successful. Around 1 percent of consumers are enrolled in such plans. Experts attribute the low market share to consumers' preference for the predictability and security of first-dollar coverage, as well as to the influence of agents, who earn higher commissions on plans with richer coverage.

Medigap plans are offered by private insurance companies. Consumers pay the full cost of premiums.

Part D drug plans first became available in 2006. All plans must provide coverage that is at least actuarially equivalent to the standard benefit. The standard benefit requires coverage of 75 percent of drug costs between the deductible ($295) and the initial coverage limit ($2,700). Consumers then enter the "doughnut hole," where they pay the full cost of drugs until their out-of-pocket costs on drugs reaches $4,350. Benefit parameters change each year to keep pace with the rise in Medicare drug spending. Plans that initially provided full coverage in the doughnut hole (including coverage for brand-name drugs) have dropped out of the market after receiving a disproportionate share of enrollment by people with Medicare with very high drug costs. The standard benefit allows considerable variation in the copayments or coinsurance assessed, as well as on coverage rules for specific drugs, making plan selection complicated. Medicare Advantage plans that offer drug coverage are subject to the same requirements as stand-alone drug plans.

Premiums are partially subsidized by the government, and low-income people with Medicare can qualify for additional premium subsidies and reduced copayments, which are standardized for those with the lowest incomes. Part D coverage is available only through private plans; there is no option to obtain a drug plan administered by Original Medicare.

The low actuarial standard and weak regulatory oversight for MA benefits mean that, in practice, the benefit packages offered by MA plans are determined not by the actuarial standard but primarily by the interaction between the payment formula for MA plans and the dynamics of the marketplace. MA plans receive a monthly subsidy for each enrollee. Plans submit a bid, or cost estimate, to provide the standard Medicare benefit. If the bid is below a statutorily

determined payment benchmark, plans receive a rebate equal to 75 percent of the difference between the bid and the benchmark (the remaining 25 percent reverts to the federal government) and are required to use the rebate to reduce cost-sharing for A and B services, provide additional benefits not covered by Medicare (such as dental or vision benefits, or to reduce the beneficiary premium for Part D drug coverage or for Part B). Because MA payment benchmarks average 18 percent above Original Medicare costs, almost all MA plans have rebate revenue to pay for lower cost-sharing.[10]

Plan Choices

Choosing a plan that provides affordable coverage and protection against catastrophic costs is made more difficult by the sheer number of plan choices consumers face and the wide variety in copayment and coinsurance structures employed by MA plans.

In 2009, Medicare beneficiaries in many parts of the country face a choice of over 30 MA plan options, and in areas that have traditionally seen large numbers of beneficiaries opt for private health plans, such as parts of South Florida, there are as many as 71 plan choices.[11] The numbers are the product of two factors: the number of participating insurers and the number of plan options they offer. Table 1 illustrates how consumers can easily choose a plan that imposes high cost-sharing for medical services without the protection of an out-of-pocket limit if they use the premium as a benchmark for the value of coverage.

Table 1: Gambling with Your Health: 3 of 28 MA Plans, Atlantic City, NJ

Benefits/Costs	Plan A	Plan B	Plan C
Estimated Costs for a 65-year-old in poor health (from Medicare.gov)	$3,750	$4,350	$4,650
Premium(not including Part B premium of $96.40)	$37.50	$56.00	$74.90
Inpatient Admission	$150 per day/10 days	$150 per day/5 days	⚠ $195 per day/5 days
PCP Copay	$15	$20	$20-$35
OOP Limit	⚠ $10,000 out-of-network/no limit in-network	⚠ None	$3,000
Chemotherapy	$0 Copay	⚠ 20%	⚠ 20%

Individual companies have as many as 17 plan offerings in some markets. Large national insurers typically have a half dozen or more plan offerings in local markets.[12] All together there are 283 companies, each offering multiple plans, contracted with CMS to offer MA benefits.[13] The number of plan choices and benefit variations also make it more difficult to provide consumers with easy-to-use decision-making tools, either through the Internet or in print.

CMS does not screen out potential MA plan sponsors on the basis of their track record in managing the care of plan members, or on whether plan offerings meet minimum affordability standards. It has allowed plans that are under investigation for fraudulent practices as well as companies that do not meet state financial solvency standards for insurers to continue to participate.[14] That is beginning to change. In 2009, CMS has frozen enrollment in major MA insurers that have demonstrated a failure to meet minimum regulatory requirements on coverage, appeals procedures and marketing conduct, and whose actions put the health of plan enrollees at risk.[15]

Pitfalls in Plan Benefits

The third worst plan for beneficiaries in poor health, which cost its sickest enrollees almost $2,000 more than a high-premium Medigap plan, had nearly one quarter of the MA enrollees in the local market.

Independent research shows that some MA enrollees are at considerable risk of selecting a plan that saddles them with out-of-pocket costs for health care that are higher than they would be under Original Medicare.

The availability of rebate revenue allows MA plans to generally provide a richer benefit than Original Medicare. However, the broad discretion given to plans means that benefit enhancements do not necessarily reduce cost-sharing for all enrollees. For example, enrollees who need high-cost care can pay more than they would have paid under Original Medicare. A study found that MA enrollees in good health generally spent less out of pocket than their similarly healthy counterparts enrolled in Original Medicare plus a Medigap plan. But those in poor health sometimes spent far more:

- 22 percent of MA plans imposed higher cost-sharing on their least healthy enrollees;
- Five of the thirteen market leaders (20 percent or more of the local market) imposed higher costs on their less healthy enrollees;

- The third worst plan for beneficiaries in poor health, which cost its sickest enrollees almost $2,000 more than a high-premium Medigap plan, had nearly one quarter of the MA enrollees in the local market.[16]

A survey by the AARP Public Policy Institute of MA plan benefits offered in 2008 found that:

- The average MA enrollee faced a $1,390 charge for a 20-day stay in a skilled nursing facility. (Original Medicare enrollees would have no copayment for a 20-day stay; less than 10 percent of MA enrollees were in plans that required no copayment for the first 20 days.)

- Over one-quarter of MA enrollees were in plans that charged more than 20 percent (the Original Medicare rate) for chemotherapy drugs.

29 percent of MA plans excluded chemotherapy and other Part B drugs from the out-of-pocket maximum, but consumers were more likely to enroll in plans with this exclusion.

- Almost half of MA enrollees were in plans without an out-of-pocket limit, although it was unclear how many plans with an out-of-pocket maximum counted all Medicare services toward the limit.

- 12 percent of MA enrollees were in plans charging $2,000 or more for a 10-day hospital stay (compared to the $1,068 hospital deductible in Original Medicare).[17]

Looking at 2007 MA plan benefits, the Government Accountability Office found that:

- Nearly one in five MA enrollees had chosen plans that imposed cost-sharing for home health services, which Original Medicare covers with no copay. For those who chose PPOs, 84 percent would face copayments or coinsurance for home health services, even if they stayed in network.

- 16 percent faced higher copayments for the average length of stay in the hospital than they would have under Original Medicare.

- 29 percent of MA plans excluded chemotherapy and other Part B drugs from the out-of-pocket maximum, but consumers were more likely to enroll in plans with this exclusion—40 percent of MA enrollees were in plans that did not count spending on Part B drugs toward the out-of-pocket maximum.

- Over 20 percent of MA enrollees had chosen plans that excluded at least one of the following services from the out-of-pocket maximum: care by a physician specialist, outpatient mental health or substance abuse treatment, home health services, durable medical equipment (wheelchairs, oxygen tanks), prosthetics or medical supplies.[18]

A more recent study found the percentage of plans charging more than 20 percent for chemotherapy drugs, a discriminatory benefit design repeatedly criticized by advocates, had dropped from 25 percent to zero. [19] The same report, however, found that patient cost-sharing increased in other areas. For example, the number of plans using fixed copayments instead of coinsurance for Part B drugs dropped from 24 percent to 14 percent. Because of the high cost of many chemotherapy drugs—$50,000 is not uncommon for a typical course of treatment for colon cancer[20]—coinsurance shifts a much larger share of costs onto the patients than flat copayments. Similarly, the report shows a doubling in the percentage of plans with out-of-pocket limits set at $5,000 or above, and a decrease in the number of plans that covered the first 20 days in a skilled nursing facility at no charge. MA plan enrollees who fail to re-examine benefit packages for the coming year may find that the plan they signed up for the previous year has changed considerably.[21] These year-to-year benefit changes stand in marked contrast to standard Medigap plans, which are guaranteed renewable—meaning that the plan's provisions can't change each year.

CMS asked insurers to eliminate plans with "virtually indistinguishable benefit differences as well as plans with very low enrollment."

New Regulatory and Legislative Initiatives

For the 2010 plan year, CMS informed insurers that it would streamline the number of plan choices available to consumers, expressing concern that the multitude of plan choices could conceal disadvantageous aspects of benefit design, such as high cost-sharing for certain services. Setting a target of no more than three MA plans per contractor, per market, CMS asked insurers to eliminate plans with "virtually indistinguishable benefit differences as well as plans with very low enrollment." One quarter of plans have 10 enrollees or less.[22] A recent analysis shows that by eliminating low enrollment plans, and limiting variation in network access designs, CMS could significantly simplify the MA market.[23]

In addition, CMS has created stronger incentives for plans to include an annual out-of-pocket maximum of $3,400 or lower that

covers all Part A and Part B services. Specifically, the agency warned that plans using coinsurance for any services were more likely to be viewed as having discriminatory benefit designs than plans that employed only flat copayments. The agency also indicated it was considering amending regulations to require plans to have an annual out-of-pocket limit and to limit the number of benefit designs in any market.[24]

There is also considerable congressional interest in setting stronger standards for MA plan benefits. A policy options paper issued by the Senate Finance Committee proposed to reduce the amount of variation in additional benefits and to simplify the amount and type of extra benefits offered. The options paper considers a requirement that MA plans first dedicate funding for additional benefits toward an annual out-of-pocket maximum before paying for supplemental benefits such as dental or vision coverage.[25] Separately, health reform legislation issued jointly by three House committees includes provisions strictly limiting MA plans' ability to charge more than Original Medicare for specific services.[26]

Consumer Counselors' Views

"Out-of-pocket caps are different. Drug plans are different. The result is that enrollment decisions are made based on emotion and with incomplete data. The situation is bewildering and scary for many seniors."

People with Medicare in all 50 states can receive help with MA plan selection and with other consumer problems from trained counselors in State Health Insurance Assistance Programs (SHIP) and Area Agencies on Aging. Without exception, the counselors interviewed for this report stated that the large number of MA plans available in their states, and the wide variability in plan benefits, make it very difficult for people with Medicare to choose a plan, even with counseling assistance, and leave consumers vulnerable to high and unexpected out-of-pocket costs.

"First, a senior needs to know the difference among HMOs, PPOs and [non-network] private fee-for-service plans. Then, assuming they can decide the best option among these, they can choose from zero-premium plans to one for $152 per month. But unless one has access to each plan's Summary of Benefits, it isn't possible to compare the 30 or so different features from plan to plan. Copayments are different. Out-of-pocket caps are different. Drug plans are different. The result is that enrollment decisions are made based on emotion and with incomplete data. The situation is bewildering and scary for many seniors," a Maine SHIP counselor says.

Counselors across the country echo this view. Confused by their plan options, many people with Medicare wind up taking shortcuts in choosing a plan. Some rely on brand recognition, choosing a plan because it bears the AARP name or because the insurer is well known. The ability to continue seeing their doctor is a primary consideration, but, even after that is determined, the variety of plan benefits makes choice difficult. Others use the premium as a benchmark, assuming a high-premium plan will offer more financial protection. Others assume the low- or zero-premium plan is the most affordable.

"Sometimes the cheapest monthly plan isn't the cheapest all around. We have to do the math because it's hard for seniors to visualize," a Massachusetts SHIP counselor says.

Another common strategy is to rely on the advice of a neighbor, but plans can work very differently for people with different health care needs, counselors say. Others ask the counselors to make a decision for them, even after counselors have worked to narrow the choices to just a few options. Often the advice on plan selection comes from an insurance agent working on commission.

"There are too many options and too many variables. There are insurance companies with a half-dozen plans out there. The public is not able to tell the difference unless you come down to premiums. I'd like to see the variation trimmed dramatically."

"People retiring now, unless they have experience with insurance issues, they have no clue what they are getting into. They're at the mercy of anyone with an insurance license," a Washington state counselor reports. "What they wanted and what they got are not the same thing."

Many counselors report that their first contact with consumers is after they have chosen a plan and are locked in for the year and are struggling to pay medical bills they did not expect to have under their plan. Even after a negative experience with a plan, the difficulty in choosing a plan makes many consumers resistant to go through the selection process again. This can be problematic for consumers, because benefits can change considerably from year to year. Counselors often struggle to explain that the benefits some consumers find enticing are less comprehensive than they appear.

"A lot of what drives them to the plans is the dental and we try to explain to them that it's not very much," a New York City counselor says.

Counselors say that limiting the number of plans and standardizing the benefits would greatly simplify the selection process, enabling consumers to compare the same plan from different companies.

"There are too many options and too many variables. There are insurance companies with a half-dozen plans out there. The public is not able to tell the difference unless you come down to premiums. I'd like to see the variation trimmed dramatically," a Washington State counselor says.

The Bottom Line

Insurers have wide latitude in benefit design. The near impossibility of comparing dissimilar plan designs leaves consumers without a method of determining whether coverage from competing companies is equivalent, as premiums bear no clear relationship to the value of coverage.

The risks of a bad choice are considerable; consumers who select the wrong plan can wind up paying thousands of dollars more for medical care than they would under a different plan or under Original Medicare. Recent regulatory efforts to limit the number of choices and limit overall out-of-pocket liability may help, but consumers will still not be able to make "apples-to-apples" plan comparisons because significant benefit variation will remain.

The risks of a bad choice are considerable; consumers who select the wrong plan can wind up paying thousands of dollars more for medical care than they would under a different plan or under Original Medicare.

Massachusetts Health Reform

In 2006, Massachusetts enacted a series of comprehensive health care reforms, including many that are now being considered at the national level. These include: an expansion of eligibility for Medicaid; an individual mandate, subject to affordability, to purchase insurance that meets a standard for minimum creditable coverage; assessments on certain employers who fail to make coverage available to employees; and the provision of new subsidized and unsubsidized coverage options through an exchange called the Commonwealth Health Insurance Connector. Together, these reforms have reduced the number of uninsured and the financial burden of health care costs among Massachusetts residents.[27]

Under reform, Massachusetts residents with incomes up to 300 percent of the federal poverty level (FPL) can qualify for subsidized coverage under the Commonwealth Care program.[28] Residents earning above 300 percent FPL can purchase, with their own money but with no government subsidies, health insurance under the Commonwealth Choice program. Although both programs are

administered by the Commonwealth Health Insurance Connector Authority, they represent two distinct approaches to the issue of benefits standardization. In turn, both approaches have a very different regulatory structure than the review process governing Medicare Advantage benefits.

Commonwealth Care

A Highly Standardized Benefit

Benefit packages offered through Commonwealth Care are highly standardized. There are no deductibles under any plan type, and all plan types provide certain services, such as cardiac rehabilitation and maternity care, at no charge. All plans include comprehensive out-of-pocket limits.

Benefit packages offered through Commonwealth Care are highly standardized. As shown in Table 2, there are three standard benefit packages. All three designs cover the full range of medical services provided under the state's minimum creditable coverage standard. The scope of covered services differs only in that Plan Type 1 includes dental coverage.[29] There are no deductibles under any plan type, and all plan types provide certain services, such as cardiac rehabilitation and maternity care, at no charge. All plans include comprehensive out-of-pocket limits.

Commonwealth Care benefits are designed by the Connector Authority to scale down from the Medicaid benefit, which serves people at the lowest income level, to a package that approximates a generous employer-sponsored benefit for enrollees with incomes just below 300 percent FPL. However, the specific premium levels, benefit packages, and the participation of insurers are established through negotiations between the Connector Authority and insurers responding to a request for bids. These negotiations may scale the existing copayment levels up or down, but they do not introduce additional variation in the benefit design.

To develop the 2009 benefit packages and establish enrollees' premiums, the Connector Authority engaged in protracted negotiations with participating insurers aimed at moderating the increase in the state's monthly, per member payment for coverage. The result was an increase in copayment levels and premium contributions for Commonwealth Care enrollees at income levels that require such cost-sharing. For 2009, the Connector Authority also eliminated a second benefit package that had been available to enrollees at the upper end of the Commonwealth Care income scale. This higher premium, lower copayment option had seen disproportionate enrollment by residents with high health care needs, and benefit claims were substantially higher under this benefit option than under the alternative package.[30]

The Connector Authority seeks to achieve several additional goals in these negotiations. These goals include minimizing costs to both the state and Commonwealth Care enrollees, as well as minimizing the "crowd out" of unsubsidized employer-sponsored insurance and maintaining equity among state programs. Further, Commonwealth Care plans are required to have provider networks that meet Connector Authority approval and fulfill additional requirements, such as how they handle grievances and appeals.[31]

Through 2009, health plan participation has been limited by regulation to insurers that were contracted with the state to provide Medicaid plans. In most parts of the state, consumers have at least three choices of insurer in each plan type, although in four western Massachusetts communities, only one choice of insurer provides all three plan types. For 2010, when the requirement that limits Commonwealth Care insurers will lapse, an additional insurer will provide coverage in some parts of the state.

Plan Choices

There are three standard benefit packages under Commonwealth Care—Plan Type 1 is for enrollees with incomes up to 150 percent FPL, Plan Type 2 is for enrollees with incomes above 150 percent FPL and up to 200 percent FPL, and Plan Type 3 is for enrollees with incomes above 200 percent FPL and up to 300 percent FPL.

There are no premiums charged for individuals or families with incomes low enough to qualify for Plan Type 1. For Plan Type 2, enrollee premiums for the lowest-cost plan are set by the Connector Board at a level designed to be affordable for this income range (150 percent FPL to 200 percent FPL). Enrollees who choose a higher-cost Type 2 plan pay a higher premium. For Plan Type 3 enrollees, there is one minimum premium set to meet the affordability standard established by the Connector Board for those between 200 percent FPL and 250 percent FPL, and a higher minimum premium set for those between 250 percent FPL and 300 percent FPL. As with Plan Type 2, consumers who choose the lowest-cost plan pay this minimum premium; those who select a more expensive alternative pay a higher premium.

There are approximately 181,000 Commonwealth Care enrollees, with about 60 percent qualifying for premium-free coverage.[32] Over 50 percent of enrollees who qualify for zero-premium plans select their own plan. The remainder are automatically enrolled in a plan, either into the lowest-cost plan or their previous Medicaid plan.

Enrollees over 50 years of age make up 30 percent of Commonwealth Care enrollees, followed by the youngest group (aged 19 to 26), with 27 percent.

Table 2: The Three Types of Commonwealth Care Plans

Benefits/Costs	Plan Type 1	Plan Type 2	Plan Type 3	
Income Eligibility	Less than 150% FPL*	150.1% FPL to 200% FPL	200.1% FPL to 250% FPL	250.1% FPL to 300% FPL
Premium Range (Statewide, 2009)	$0	$39 (statewide) to $107.80 (Northern Massachusetts)	$77 (statewide) to $180.42 (Central Massachusetts)	$116 (statewide) to $219.42 (Central Massachusetts)
Deductible	None	None	None	None
PCP Copay	$0	$10	$15	
Rx Drug Copays Generic/brand-name/nonpreferred	$1/$3	$10/$20/$40	$12.50/$25/$50	
Hospital Stay	$0	$50 per admission	$250 per admission	
Annual OOP Cap (Rx Drugs)	$200	$500	$800	
Annual OOP Cap (Medical Services)	$0	$750	$1,500	
OOP Exclusions	None	None	None	

*2009 Federal Poverty Level: $10,830 per year for an individual; $22,050 per year for family of four

With benefit packages standardized by income group, consumer choice of plans is primarily determined by provider access and premiums (for Plan Type 2 and 3 enrollees). All Commonwealth Care plans are network HMOs, so maintaining access to current providers, for those who have them, is a primary consideration. In addition to competition on the basis of provider access and premiums, insurers use ancillary benefits—discounts on dental services, nurse hotlines, debit cards for purchase of medical supplies—as enticements to enrollees.

Consumer Counselors' Views

In order to maximize enrollment in the new health insurance options for Massachusetts residents, the Blue Cross Blue Shield Foundation provided grants for outreach and education to organizations across the state. Grantees included community health centers, legal aid organizations and a range of community-based and ethnic organizations. Interviews with staff of these organizations revealed overwhelming support for standardizing

benefits to simplify the enrollment process. Consumers were able to focus on whether their medical providers were in a plan's network, and premium-paying consumers in plan types 2 and 3 could consider their monthly premium as well.

"Most often people choose the HMO that has their doctor in their network so they don't have to change," a counselor outside Boston explains.

A few consumers consider ancillary benefits, such as whether plans will pay for "weight watchers" classes, counselors said, but these considerations seldom trump concerns over provider access. In addition, the standardized benefits, and in particular the comprehensive out-of-pocket caps in all plans, reduce the risk of a bad choice, counselors said. The benefit packages provide valuable protection and have helped people afford regular care, counselors said. A common concern is that, for premium-paying enrollees, the addition of a new lower-premium plan for 2010 could mean that some patients will face a difficult choice between paying a higher premium and maintaining access to current providers, including community-based clinics, or having to switch providers to avoid paying the higher premium.

By capping total out-of-pocket spending, eliminating deductibles and limiting copayments, the Commonwealth Care program helps to provide consumers on limited incomes with affordable care and protection against catastrophic expenses.

The Bottom Line

The Commonwealth Care plans provide valuable protections to consumers. By capping total out-of-pocket spending, eliminating deductibles and limiting copayments, and tying these benefit parameters to consumers' incomes, the Commonwealth Care program helps to provide consumers on limited incomes with affordable care and protection against catastrophic expenses. Fully standardized benefits simplify health plan selection, enabling consumers to focus on premium costs and whether the plan allows access to preferred health care providers.

Commonwealth Choice

Adheres to Actuarial Targets with Some Consumer Protections

Both participating insurers and benefit designs for Commonwealth Choice are approved by the Connector Board after negotiations between the Connector Authority and insurers that respond to a

request for bids. The Connector Authority has much more limited leverage over insurers in the Commonwealth Choice program than it does over companies seeking to offer Commonwealth Care plans, or than CMS has over MA plans. In both the MA program and in Commonwealth Care, the government is paying for most or all of the cost of the coverage offered. In the Commonwealth Choice program, negotiation is for the Connector's seal of approval and for the right to offer plans and receive enrollment through the Connector. [33]

The Connector Authority's leverage over benefit design is limited because insurers remain free to market and sell individual insurance products outside the Connector, including the same plans offered under the Connector, plans with different benefit designs that meet the state's minimum creditable coverage standards as well as plans that fall short of that standard. However, the Connector now accounts for roughly 50 percent of new individual policies sold in the state, creating an incentive for insurers in the individual market to win the Connector's seal of approval.[34] For the launch of the program, the Connector Authority approved contracts for six of the ten insurers who had sought to participate.

The establishment of a statewide minimum creditable coverage standard and the use of the Connector to negotiate benefit packages and facilitate consumer comparison provide Massachusetts consumers with protections that do not exist in most states. Despite these achievements, consumers who need treatment for serious chronic and acute conditions remain at risk of incurring very high out-of-pocket costs and may face considerable difficulty identifying Commonwealth Choice plans that could protect them against catastrophic medical bills. One of the principal causes is that the minimum creditable coverage regulation allows insurers to *exclude* any copayments up to $100 and any deductibles, coinsurance or copayments for prescription drugs from the annual out-of-pocket limit. Only coinsurance and copayments in excess of $100 and deductibles for medical services *must count* toward the out-of-pocket maximum.[35]

Plan Choices

Commonwealth Choice offers consumers a choice of plans categorized into three benefit tiers—Gold, Silver and Bronze—reflecting decreasing levels of actuarial value. (The Connector also offers young adult products with lower premiums and much more limited coverage, including benefit caps and, under some plans, no

coverage for prescription drugs. Because these plans are so different in scope, they are not part of this analysis.) Like Commonwealth Care, the Choice plans cover all the services required under the state's minimum creditable coverage regulations, including prescription drugs, hospital care and outpatient care.

As we saw with the Medicare Advantage plans, a benefit standard defined in terms of actuarial value—that is, the average out-of-pocket spending by plan members—can accommodate a wide variety of benefit designs. Commonwealth Choice plans exhibit considerable variation in deductibles, coinsurance and copayments for individual services, as well as in the dollar amounts and the services that count toward an out-of-pocket limit. In accordance with the minimum creditable coverage standard (see text box), there is no annual or lifetime cap on covered services, although caps for a limited number of services, such as durable medical equipment, are permitted and widely employed. A key shortcoming of the minimum creditable coverage standard are rules governing which copayments plans can exclude from an out-of-pocket maximum.[36] This means that some plans offered through the Connector have out-of-pocket provisions that are structured so that an enrollee's cost can far exceed the stated limit.

Massachusetts Minimum Creditable Coverage Standard

Massachusetts requires most residents to have health insurance that meets a minimum creditable coverage (MCC) standard or pay a penalty. Residents who do not have access to affordable coverage that meets the MCC standard—the Connector Authority defines what level of premium is affordable for different levels of income—are exempted from the requirement as are residents who qualify for hardship waivers. Residents with certain types of coverage, such as people with Medicare, are automatically considered to have fulfilled the requirement. Young adult policies sold through the Connector also qualify, even though they have certain features, such as overall dollar caps on coverage, that do not meet the MCC standard. Some of the key features of the MCC standard are:

- In-network deductibles can be no higher than $2,000 for an individual or $4,000 for a family.
- Plans that use deductibles must cover some preventive care and/or primary care visits before the deductible and can assess no more than the regular copayment for such services.
- Plans that charge deductibles or coinsurance must have an annual in-network out-of-pocket maximum of no more than $5,000 for an individual and $10,000 for a family.
- Plans may exclude copayments up to $100 and any cost-sharing (deductibles, copayments or coinsurance) for prescription drugs from counting toward the out-of-pocket maximum.
- Plans must cover a broad range of services, including outpatient and inpatient care, and for 2010, prescription drugs.
- Plans cannot impose lifetime or annual dollar caps on most services. (Limits are allowed for physical therapy, substance abuse treatment and durable medical equipment.)

Bronze plans, generally the option with the lowest premium and the one selected most often by consumers, impose the highest cost-sharing. Coverage hews closely to the minimum creditable coverage standard, with out-of-pocket limits set at $5,000 for an individual and $10,000 for a family, with most deductibles hovering around $2,000 for an individual and $4,000 for a family. Although all Bronze plans have similar actuarial values, variations in benefits can be significant for consumers (see Table 3).

Table 3: Three Bronze Plan Options in Boston

Benefits/Costs	Plan A	Plan B	Plan C
Monthly premium for a 58-year-old	$424.82	$459.97	$473.71
Deductible	$2,000	$1,750	$2,000
OOP Limit	$5,000	$5,000	$5,000
OOP Exclusions	Rx count toward OOP	⚠ Rx excluded from OOP	⚠ Rx excluded from OOP
PCP Copay	$25 after deductible	⚠ $25 for first three visits, then deductible, then 20%	$25 after deductible
Inpatient Care	20%	20%	$0 after deductible
Physical Therapy	90 days per illness	⚠ 20 visits per year	60 visits per illness
Mental Health	$25, predeductible	⚠ $25 for first three visits, then deductible, then 20%	$40, predeductible

Among Commonwealth Choice plans, Silver plans exhibit the most variability in benefit structures (see Table 4). In fact, premiums for some Silver plans are below those of competing Bronze plans, while other Silver plans cost more than competing Gold plans. Some plans have no deductibles, but impose a separate deductible for prescription drugs as high as $500. Others have deductibles as high as $1,000, but no deductibles for prescription drugs. Copayments for admission into a mental health facility range from $0 to $600 per year. Out-of-pocket maximums range from $2,000 to $5,000 for an individual, but as with all plan levels, what counts towards the cap varies by plan.

Table 4: Three Silver Plan Options in Greenfield

Benefits/Costs	Plan A	Plan B	Plan C
Monthly premium for a 58-year-old	$405.68	$524.29	$723.05
Deductible	$2,000	$250	None
OOP Limit	$5,000	$5,000	$2,000
OOP Exclusion	None	⚠ Rx Drugs	⚠ Rx Drugs
PCP Copay	$25 after deductible	$25 after deductible	$30
Rx Deductible	⚠ Overall $2,000 deductible applies	Separate $250 deductible	Separate $250 deductible
Hospital Admission	$500 after deductible	⚠ 35% after deductible	$1,000 after deductible
Inpatient Physician	$0	⚠ 25%	$0

Gold plans, the most generous and most expensive option, employ flat copayments instead of coinsurance for almost all services (see Table 5). Gold plans do not have deductibles. Out-of-pocket caps can run as high as $4,000 for a family, or as low as $2,000. The majority of Gold plans are not required to have out-of-pocket maximums, because copayments are generally low. (According to the minimum creditable coverage standard, copayments for prescription drugs or those that are $100 or less do not have to count towards an annual cap on out-of-pocket spending.) Few residents have enrolled in these plans.

Table 5: Three Gold Plan Options in Worcester

Benefits/Costs	Plan A	Plan B	Plan C
Monthly premium for a 58-year-old	$750.72	$826.00	$867.33
Deductible	None	None	None
OOP Limit	No limit	$1,000	$2,000
OOP Exclusion	Not Applicable	⚠ Rx Drugs	⚠ Rx Drugs
PCP Copay	$15	$15	$15
Hospital Admission	$100	$100	$100

Pitfalls of Poor Plan Choice

A recent study shows how Massachusetts residents afflicted with coronary artery disease or breast cancer could, primarily because of the allowed exclusions to the out-of-pocket limits, incur health care expenses well in excess of the $5,000 out-of-pocket cap that is mandated in the state's minimum creditable coverage standard.[37] In

Variability in plan benefits makes it difficult for consumers to select a plan that is best for them without knowing the medical condition they might incur in the next year.

addition, differences in benefit design resulted in considerable variation in out-of-pocket spending across plans. For someone with diabetes, variations in benefit designs result in out-of-pocket spending for medical care that can differ by more than $3,000 under plans that compete in the same coverage tier and that have similar actuarial values. By using the costs of clinically based treatment protocols for the three conditions, the study found:

- An early-stage breast cancer patient undergoing an 87-week course of treatment, including surgery, radiation and chemotherapy, would incur $12,807 in out-of-pocket costs under one Bronze plan, and would spend more than $5,000 on medical bills and prescription drugs in two successive years. Under a competing Bronze plan, which counted all copays toward the out-of-pocket maximum and eliminated cost-sharing for chemotherapy and radiation after the deductible, the full course of treatment cost the patient $7,631, and less than $5,000 in each year of care.

- An ambulance trip, hospital stay, heart surgery and follow-up treatment with prescription drugs and cardiac rehabilitation would cost an individual who suffers a heart attack $8,364 over 56 weeks under one Bronze plan, and $7,759 under a competing Bronze product. Under both plans, out-of-pocket costs exceed the $5,000 limit in the first year. Copay for cardiac rehabilitation therapy under both plans cost $900. In contrast, a Silver plan that waived copays for cardiac rehabilitation after the deductible cost $3,351 for the same course of treatment.

- An individual with Type 1 diabetes that is well managed by prescription drugs, regular testing of blood sugar levels and office visits would incur an annual cost of $4,383 in one Bronze plan, $3,373 in another Bronze product and $960 in a third. The third plan had the lowest costs because it did not impose copayments for diabetic test strips, lancets and syringes, and charged the generic drug copay of $15 for insulin, which is available only as a brand-name drug. As a result, this Bronze plan was more than $1,500 cheaper than a competing Silver plan.

The financial protection provided by the plans varied considerably depending on the medical condition being covered. For example, the Bronze plan with the lowest cost-sharing for the diabetes patient ($960) had the highest cost ($8,364) for treatment of coronary artery disease. This variability makes it difficult for consumers to

select a plan that is best for them without knowing the medical condition they might face in the next year. Realistically, even consumers whose current health allows them to predict what type of treatment they might need in the upcoming year cannot be expected to duplicate the detailed analysis done in this study to unearth expected out-of-pocket costs.

New Regulatory Initiatives

In June 2009, the Connector Board approved a proposal to standardize core benefit features for Commonwealth Choice plans that are eligible for enrollment, effective January 2010. Instead of relying on insurers to develop benefit designs that meet broad actuarial standards, the Connector Authority selected standard benefit designs for each tier that reflect consumer plan preferences and serve to moderate premium increases. The decision was a response to consumer preferences for more standardized plan options. The standards were designed to meet five policy goals identified by the Connector Board:

- Select and offer high-value plans;
- Align choice of plan designs and insurers with consumer demand;
- Simplify the shopping experience;
- Minimize risk selection among plans in the Commonwealth Choice program and between Commonwealth Choice plans and plans sold outside the Connector;
- Maintain continuity of coverage for existing Commonwealth Choice enrollees.

As result of the decision, consumers will have seven Commonwealth Choice benefit designs to choose from in 2010, down from 21 in 2009.

As a result of the decision, consumers will have seven Commonwealth Choice benefit designs (not counting young adult products) to choose from in 2010, down from 21 in 2009. Instead of the four Gold benefit designs available in 2009, consumers will have one standard Gold plan, which is based on the current Gold benefit design most selected by consumers. (Enrollees in the remaining 2009 Gold plans can maintain current coverage, but the plans will be closed to new members.) The change in the Silver tier is the most dramatic, with the number of benefit options reduced from 11 to 3 in 2010. The number of Bronze benefit options will drop from six to three, the number of benefit design choices that most consumers felt was appropriate in surveys and focus groups. Reducing the number of different benefit designs consumers must evaluate was an explicit goal of the Connector Authority.[38]

"If you don't know the difference between copays and coinsurance, you can't make sense of the muddle. You have people looking at deductibles, but deductibles only cover certain services in some plans. There are maximum out-of-pocket limits, but drug copays don't count."

The Connector Board did not fully standardize Commonwealth Choice benefits, however. The minimum creditable coverage regulation, which allows insurers not to count medical copays up to $100 and any cost-sharing for prescription drugs toward the out-of-pocket maximum, is unchanged. As a result, insurers retain the existing flexibility over how to define the out-of-pocket maximum, and the new standard Gold benefit design, which uses copays for all services, will have no out-of-pocket maximum at all. In addition, the standardized benefit designs cover only certain core benefit features, such as deductibles, copays for doctor visits and inpatient admissions and, for the Bronze and Silver plans, out-of-pocket limits. Commonwealth Choice plans also retain the flexibility to offer value-added services, such as waivers of cost-sharing for preventive services, and to modify inpatient mental health cost-sharing consistent with mental health parity regulations.

Under the new standardized benefit designs, consumers will have the opportunity to compare the premiums charged by different insurers for plans that have identical cost-sharing for many but not all medical services (see Table 6).

The Gold plan will have no deductible, $20 copays for primary care, $150 copays for both outpatient and inpatient hospital care, and drug copays that range from $15 for generics to $50 for nonpreferred brands.

All Silver plans will have a $2,000 out-of-pocket limit ($4,000 for a family). Consumers will be able to choose a plan with a $1,000 deductible for medical services, one with a $500 deductible for medical services, or one with a $250 deductible for prescription drugs (family deductibles are double.) The zero-deductible Silver plan will have the highest copays ($500 for hospital admission), while the deductible plans will waive copays for hospital admissions and other services after the deductible is paid.

The three standard Bronze plans will all have a $5,000 individual/$10,000 family out-of-pocket maximum. An option with separate $250 individual deductibles for medical services will charge relatively high coinsurance rates—35 percent—for inpatient and outpatient hospital care. The other two Bronze plans will have $2,000 deductibles, with one charging 20 percent for hospital admissions and outpatient surgery and the other using copayments ($500 for inpatient care, $250 for outpatient care) for all services.

Table 6: Benefit Designs of Commonwealth Choice Plans in 2009 and 2010

Benefits/Costs	2009	2010
Deductibles	Variable	Standardized within Plan Type
OOP Maximum	Variable	Standardized within Plan Type
PCP Copay	Variable	Standardized within Plan Type
Specialist Copay	Variable	Standardized within Plan Type
Inpatient/Outpatient Care	Variable	Standardized within Plan Type
Rx Copays/Coinsurance/Deductible	Variable	Standardized within Plan Type
OOP Exclusions	Variable	Variable
Rehab Limits/DME Limits	Variable	Variable
Copay Waived for Preventive Care	Variable	Variable
Premium	Variable	Variable

Views of Consumers and Consumer Counselors

Given the relatively low enrollment in Commonwealth Choice (22,000[39]) as compared to Commonwealth Care, and the focus of community health centers, legal aid organizations and other grant recipients on low-income residents, consumer counselors had comparatively little experience in assisting with enrollment in Commonwealth Choice plans. Counselors said that the Connector website did provide a valuable service for consumers looking to buy insurance on the individual market, and that it was an improvement for consumers to be able to see multiple plans from insurers presented in standardized format. Still others said that, in comparison to the standardized choices under Commonwealth Care, the Commonwealth Choice program offered a "free-for-all" in benefit designs.

"If you don't know the difference between copays and coinsurance, you can't make sense of the muddle," a counselor outside Boston explained. "You have people looking at deductibles, but deductibles only cover certain services in some plans. There are maximum out-of-pocket limits, but drug copays don't count."

Counselors said they were in favor of moving toward greater standardization of Commonwealth Choice plans in 2010, saying it marked another step in the state's phase-in of health insurance reforms. Surveys and focus groups of consumers conducted for the Connector Authority also reveal support for standardizing benefits

and limiting the number of plan designs for consumers. Limiting insures to three benefit designs per tier received the greatest support among consumers.

"This seems like the best option for members to choose plans—standardized information," one focus group member said.

Bottom Line

The establishment of a statewide minimum creditable coverage standard and the use of the Connector to negotiate benefit packages and facilitate consumer comparisons provide Massachusetts consumers with protections that do not exist in most states. However, without standardized benefit designs, categorizing plans into three tiers based on actuarial value may give consumers the false impression that plans on the same tier will result in similar out-of-pocket costs. Recent moves to standardize major benefit features may simplify consumer choice, but insurers retain the flexibility to decide what counts and what does not count toward an out-of-pocket maximum. Consumers who need treatment for serious chronic and acute conditions remain at risk of incurring very high out-of-pocket costs and may face considerable difficulty identifying Commonwealth Choice plans that could protect them against catastrophic medical bills.

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Lessons for Health Reform

Federal legislative proposals in both the House and Senate establish health insurance exchanges to help consumers compare and purchase insurance that meets minimum standards. It is unclear, however, whether the final form of this legislation will authorize the development of standard benefit packages for plans sold through the exchange. Another open question is whether the out-of-pocket maximum will be defined in statute in a way that prohibits plans from excluding certain services or copayments, and shifting costs onto the backs of enrollees struggling to afford high-cost treatments.

The experiences, policy missteps and more recent positive policy initiatives in the Medicare Advantage, Commonwealth Care and Commonwealth Choice programs provide valuable lessons to policymakers as they complete the process of crafting comprehensive health reform legislation.

The experiences, policy missteps and more recent positive policy initiatives in the Medicare Advantage, Commonwealth Care and Commonwealth Choice programs provide valuable lessons to policymakers as they complete the process of crafting comprehensive health reform legislation.

Standardized benefits allow consumers in the Commonwealth Care program to focus on two crucial decision points: premium costs and provider access. The coverage and benefit standards established for Commonwealth Care plans are designed to make coverage affordable to low-income consumers. By capping total out-of-pocket spending and tying these caps to consumers' incomes, the Commonwealth Care program helps to provide consumers on limited incomes with protection against catastrophic expenses.

The protections offered under Commonwealth Choice plans are less comprehensive, but consumers (with the exception of enrollees in young adult products) are ensured of coverage for the full range of services under the state's minimum creditable coverage regulation, and deductibles are standardized (albeit at a high level). The move towards standardizing Commonwealth Choice plans will limit the sheer number of plan choices and enable premium comparisons across largely similar benefit designs. The danger is that these standardized benefit designs create an illusion that products are identical, when important benefit rules, such as which services count toward the out-of-pocket maximum, can have a large impact on enrollees' financial liability.

Compared to the Commonwealth Care program, Medicare Advantage provides relatively weak financial protection against high medical costs—especially for enrollees with limited incomes. Stricter review of cost-sharing for specific services, such as chemotherapy, seems to have eliminated some of the most egregiously discriminatory benefit designs employed by MA plans. Recent efforts to cull low-enrollment plans and to require insurers to consolidate duplicative benefit designs have the potential to at least reduce the clutter in the marketplace. It remains to be seen whether the new terms established by CMS for benefit reviews will prompt all plans, or at least those with the highest copayment and coinsurance rates, to establish a comprehensive out-of-pocket cap on medical expenses.

CMS is much less far along in enacting standardized benefits. However, recent analysis shows that it would be feasible to develop a limited number of standard benefit designs, based on certain features of the most prevalent MA plan benefit designs, without disrupting coverage for the majority of MA enrollees.[40] This is similar to the approach adopted by the Connector Authority in 2009 to standardize Commonwealth Choice plans.

Recommendations:

A Comprehensive Out-of-Pocket Cap

All deductibles, copayments and coinsurance for medical care and prescription drugs covered by the plan should count toward the out-of-pocket maximum. Requiring that all plans sold through an exchange adopt this definition will ensure that plan enrollees with illnesses requiring a particular form of therapy, such as with high-cost prescription drugs or biologics, or who must pay multiple copayments for doctor visits, lab tests or hospital care over the course of a treatment, will receive adequate financial protection. A common, universally applied definition of the out-of-pocket cap will provide a benchmark that consumers can use to compare plans without hunting through the fine print to find the exclusions.[41] This type of requirement also helps prevent adverse selection (disproportionate enrollment of the sickest, costliest individuals) into plans with a comprehensive limit as the least healthy consumers steer clear of plans that impose higher costs through exclusions to the cap.

Insurers participating on the exchange must be responsible for calculating progress toward the out-of-pocket maximum during the course of the year, and ensuring plan providers do not assess copayments after the out-of-pocket cap is reached. Insurers should not be allowed to require enrollees to collect receipts for medical care and submit them to the insurer in order to have their out-of-pocket spending recognized by the plan and count toward their out-of-pocket limit.[42] Claims processing is a core function of insurance providers; they must not be allowed to shift responsibility onto consumers. Some insurers occasionally protest that they lack the systems capability to integrate pharmacy and medical claims, but other insurers have been able to do so (including MA plans that count Part B pharmacy drugs toward an out-of-pocket cap).

Finally, insurers sometimes raise objections that an out-of-pocket maximum is unnecessary for benefit packages that assess relatively low copayments for all services and products. Indeed, in the Center for American Progress's look at how patients with diabetes, coronary artery disease and breast cancer fared under different Commonwealth Choice plans, the Gold plan, which had low copayments but no out-of-pocket cap, required the lowest cost-sharing for all three courses of treatment. It is likely true that enrollees in a plan that charges low copayments for all services

would only very rarely exceed even a low out-of-pocket cap. But if that is the case, then the additional cost of including a cap should be relatively low. And the same rules that allow a copayment-only Gold plan to dispense with an annual cap also allows a Bronze plan not to count low copayments toward the cap, even as it imposes high deductibles and coinsurance that do count. The result—for example, for a Bronze plan enrollee who accumulates many medical and drug bills over the course of the year—is total spending that exceeds the nominal cap. Requiring all plans to establish a comprehensive out-of-pocket cap enables consumers to use it as one benchmark, along with the copays, deductibles and coinsurance charged for different services, for comparing plans. If the best plans do not have an out-of-pocket cap, that makes it more difficult to provide consumers with consistent guidance on plan selection.

Standardized Benefit Designs

Plans offered on the exchange for both subsidized and unsubsidized coverage should be based on a limited number of standard benefit designs. Standardized benefits drive competition on the basis of premiums among easily comparable products, and lower costs. By simplifying benefit selection, consumers can also choose plans on the basis of provider access, an important concern of consumers, and, if comparative information is provided, on the basis of quality, which could help drive system improvements.

A common objection to standardized benefits is that, if the specific standards are written in statute, there is less flexibility to update benefits to accommodate changing consumer preferences or medical practice patterns. The inflexible structure of the Original Medicare benefit, and the political difficulties that have accompanied efforts to add prescription drug coverage to the benefit, or to impose a cap on catastrophic expenses, are often cited as prime examples. This is a valid concern. But it can be adequately addressed by providing a mandate to the authority administering the exchange to develop standard benefit packages while providing sufficient flexibility to periodically update the standard benefit designs. Legislation can establish criteria for revising standard benefit packages, including affordability, ease of comparison, and consumer preference, as well as for a process of designing standard benefit packages that includes substantial consumer input.

A second objection is that standardized benefits may inhibit plans from developing creative benefit designs that encourage use of

preventive care and other high-value services. But it seems clear that such value-added benefit designs can be a component of standard benefits. Massachusetts's minimum creditable coverage standard, for example, includes requirements that high-deductible plans cover at least a limited number of primary care visits or preventive care services before the deductible. An overwhelming majority of MA plans also require no copayment for Medicare-covered preventive services; it is a short step to making this common, widely accepted practice a requirement. It is also possible for standard benefit designs to accommodate creative efforts that serve to increase access to high-value care. Placement of brand-name insulin on the generic tier, or free coverage of diabetic supplies—benefit features that help reduce the cost of properly managing diabetes—can coincide with a benefit structure that complies with a standard benefit design. In fact, a standard benefit design may help draw consumers' attention to these innovative features.

This report was prepared by Paul Precht of the Medicare Rights Center, with support from Consumers Union, nonprofit publisher of Consumer Reports *magazine.*

Summary of Key Differences across Three Programs

Key Differences	Medicare Advantage	Massachusetts Commonwealth Care	Massachusetts Commonwealth Choice
Income/Eligibility	Legal residents over 65 and people with disabilities No income limits (70% are below 300% Federal Poverty Level)	Certain Massachusetts residents Limited to income levels up to 300% Federal Poverty Level	All Massachusetts residents Above 300% Federal Poverty Level
Government Helps Pay Premiums	Yes	Yes	No
Standardized Benefits	Minimum actuarial value of benefits Limits on cost-sharing for certain services Must cover wide array of benefits (Rx drugs, inpatient and outpatient care, etc.)	Standardized benefits by income level Must cover wide array of benefits (Rx drugs, inpatient and outpatient care, etc.)	Plans ranked by actuarial value Limits on deductibles Limits on out-of-pocket caps (for plans with deductibles, coinsurance or high copays) Must cover wide array of benefits (Rx drugs, inpatient and outpatient care, etc.)
Out-of-Pocket Caps	Not Required Plans have discretion on which services count toward out-of-pocket cap	Required Out-of-pocket maximum tied to income Separate limits for medical services, Rx drugs No exclusions	Required for plans with deductibles or coinsurance Plans may exclude Rx drug cost-sharing, copays of $100 or less for medical care from out-of-pocket cap
Range in out-of-pocket costs for consumers with high health care needs under different plans	Varies widely	Limited by out-of-pocket caps	Varies widely
Views of Consumer Counselors	"There are too many options and too many variables. There are insurance companies with a half-dozen plans out there. The public is not able to tell the difference unless you come down to premiums. I'd like to see the variation trimmed dramatically."	Simple: plan choice based primarily on premium and access to providers	"If you don't know the difference between copays and coinsurance, you can't make sense of the muddle. You have people looking at deductibles, but deductibles only cover certain services in some plans. There are maximum out-of-pocket limits, but drug copays don't count."
Current Bottom Line:	With no standardized benefit packages, consumers find it difficult to compare plans. Consumers who select the wrong plan can wind up paying thousands of dollars more for medical care than they would under Original Medicare.	Fully standardized benefits simplify health plan selection. Caps on out-of-pocket spending and copayment levels are tied to consumers' income levels and provide protection against high out-of-pocket costs.	Without standardized benefit designs, consumers may get the false impression that plans on the same tier will result in similar-out-pocket costs. Exclusions to out-of-pocket caps can mean thousands of dollars in additional costs to consumers.
New Regulatory Initiatives for 2010	Efforts to limit number of plan choices, encourage comprehensive out-of-pocket cap	Benefit packages already fully standardized; out-of-pocket caps cover all services	Standardization of key benefits, plans retain flexibility on exclusions to out-of-pocket cap

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