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STATE OF MINNESOTA

OFFICE OF THE COMMISSIONER

DEPARTMENT OF COMMERCE

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March 11, 1994

The Honorable Leo J. Redding
Chairman
Minnesota House of Representatives
Committee on Financial Institutions and Insurance
537 State Office Building
St. Paul, Minnesota

Dear Leo:

Enclosed please find a study entitled "Standardization of Health Care Policy Forms." This study, required by the original HealthRight legislation of 1992 (H.F. 2800), addresses some of the issues surrounding standardization and provides several alternatives for the Legislature's review.

Sincerely,

James E. Ulland
Commissioner

OFFICE OF THE COMMISSIONER

STATE OF MINNESOTA

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The Honorable Sam G. Solon
Chairman
Minnesota Senate
Committee on Commerce and Consumer Protection
303 Capitol
St. Paul, Minnesota

Dear Sam:

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STATE OF MINNESOTA

Department of Commerce *Office Memorandum*

TO: Pat Nelson
Deputy Commissioner

FROM: John Gross

DATE: January 12, 1994

SUBJECT: Standardized Health Care Policy

We are to deliver to the chairs of the Senate Commerce and Consumer Protection Committee and the House of Representatives Financial Institutions and Insurance Committee by February 1, 1994.

Enclosed is our draft, which lists different standardized health forms that might be adopted, but we are recommending that standardization be developed by an industry/community task force.

JEG/lmm
Enclosure

REPORT TO THE LEGISLATURE

STANDARDIZATION of HEALTH INSURANCE POLICY FORMS

MINNESOTA DEPARTMENT of COMMERCE
March 1, 1994

— Pursuant to 1993 Minn. Laws Chap. 345 Art. 5 Sec. 16

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INTRODUCTION

The Minnesota legislature has directed the Commerce Department to make recommendations relating to standardized health care policy forms to be used by all insurers, health service plans, or other entities regulated under Minnesota Statutes chapters 62A, 62C, 62E, and 62H. These are the traditional fee-for-service-type insurers, as well as the Blues and the Minnesota Comprehensive Health Association. Health maintenance organizations (HMOs) are not included in these chapters.

The Department understands this review to be consistent with the nationwide discussion regarding standardized benefit packages. The issue of standardized benefit packages has been consistently raised throughout the health care reform debate. Both the Clinton administration and the Minnesota legislature have proposed standardized benefit packages as a method of reducing costs, increasing access, and improving the quality of health care.

In the MinnesotaCare Act of 1993, the legislature directed the Commissioner of Health to "establish not more than five standardized benefit plans which must be offered by integrated service networks....The Plans must vary only on the basis of enrollee cost sharing and encompass a range of cost sharing options from (1) lower premium costs combined with higher enrollee cost sharing, to (2) higher premium costs combined with lower enrollee cost sharing." (Minnesota Statutes 62N.085).

In all of these reforms can be found the primary goals of providing universal access to quality care and cost containment. Consistent with these goals, and the criteria for ISN standard benefits, the Commerce Department recommends pursuing a course that preserves competition and choice.

As noted, a minimum benefit package has been addressed by a wide range of groups spanning the political spectrum from the Clinton administration to the conservative Heritage Foundation. Most have suggested some degree of standardization. The general belief is that the concept of universal access to standard benefits can satisfy both requirements of equity and efficiency. Standard benefits can assure that everyone receives a level of effective health services that is in some sense reasonable and sufficient.

In addition, a standard, minimum benefit package would be highly valuable for comparison purposes; would greatly simplify the market; would be easier for consumers to understand; and, would contribute to simplifying administrative burdens within hospitals, clinics, and provider's offices. Under this scenario, if the benefits are identical, market competition would theoretically be enhanced by compelling insurers to compete on price and quality of service.

The strongest argument against a total and comprehensive benefit standardization is that it would limit competition, creativity, and innovation, and that the market works best where consumers have choices.

BACKGROUND

Mandated health insurance benefits of Minnesota law

The number of health care benefits mandated by Minnesota law is quite comprehensive when compared with the rest of the nation. In fact, one survey ranks Minnesota fifth in terms of common mandated benefits with 26.[1] Health policies sold in Minnesota must include the group or individual mandates of chapter 62A. Accordingly, we can be reasonably sure that existing policyholders are not faced with large gaps in coverage.

Qualified Plans

In 1976, the Minnesota legislature attempted to make minimum health care benefits available to all persons in the state by establishing three "Qualified" Plans with minimum benefit levels.[2]

Chapter 62E requires that all insurers offer the three benefit packages defined by section 62E.06. Policies meeting or exceeding the minimum standards of the statute are designated as "Qualified" and must be prominently labeled as such. Health plans that do not conform to 62E.06 mandates are permitted, but they must be labeled as "Nonqualified."

Despite the intent of this reform, the standardization envisioned has been somewhat undermined by the statute's allowance for actuarial equivalence (62E.02, Subdivision 4). Policy benefits may differ from the standard as long as they are actuarially equivalent to the standard benefit.

Size of the Affected Market

Only a small percentage of the health care market would be affected by this standardization. The scope of this study encompasses those insurance entities regulated under Minnesota Statutes, Chapters 62A, 62C, 62E, and 62H. In essence, these are the traditional fee-for-service-type insurers, as well as the Blues and the Minnesota Comprehensive Health Association. Health maintenance organizations (HMOs) are not included.

According to the 1990 Economic Report to the Governor, these types of insurers paid only 13 percent of Minnesota health care expenditures in 1985. We believe this share is declining steadily. More than 75 percent of Minnesota health care expenditures are paid through government health programs and federally regulated ERISA self-funded employer plans.[3]

More recently, approximately $1.23 billion in premiums were collected by insurers in 1991.[4]

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1 Mandated Benefits: Mixed Signals From the States. Health Benefits Letter, March 13, 1991.

2 The three plans differ only in the amount of their deductibles.

3 1990 Economic Report to the Governor. page 169, Table 3-4.

4 From the Minnesota Comprehensive Health Association interim assessment. Includes commercial insurers and Blue Cross Blue Shield of Minnesota. Updated November 2, 1992.

This compares to an annual state health care bill of approximately $13 to $14 billion.[5] This supports the notion that less than 10 percent of health care dollars are currently paid through insurers and the Blue Cross Blue Shield of Minnesota.

In addition, of that 10 percent only a much smaller subset is actually purchasing and using individual health insurance policies. For many, the purchasing decision is made by the consumer's employer through a group policy.

Other factors to consider include the forthcoming implementation of Integrated Service Networks and the Clinton Administration's proposed health care reforms. Both are likely to significantly decrease the size of the market for traditional health insurance products.

5 Minnesota Department of Revenue estimate.

STANDARDIZATION OPTIONS

There are a large number of models available for benefit standardization, and we have attached a number of them to the appendices to this report. We have also attached for the legislature's reference an issue paper from the Minnesota Department of Health titled "Designing Standard Benefits for Integrated Service Networks" that more fully explores some of the issues surrounding standardization.

We believe that any standardization should be developed by task force. As was the case with the national standardization of Medicare supplement insurance, a task force would be best suited to selecting a benefit package that incorporates the input of the community and affected parties. Similarly, a number of ISN Workgroups recently addressed the issues surrounding standardized benefit packages for the ISNs.

(The legislature should note that all of the options we present here have been considered as models for the ISN benefit packages.)

Should a standard benefit package be chosen, the Commerce Department recommends that the following principals be incorporated into its implementation:

- Required to be offered by all insurers doing business in Minnesota.

- No allowance for actuarially equivalent benefits, but would allow insurers to exceed the minimum specified benefits and/or add additional benefits provided that they are broken out or in some other way specifically distinguished as such in promotional materials and the policy. This step would be vital to maintaining the benefits of this standardization.

- The package should be a minimum base of comparison. The industry should be permitted to offer whatever other policies they wish. We believe this option retains a considerable degree of consumer choice and industry flexibility.

This last point is important because we do not believe that a solution entailing a fixed number of rigid policies similar to Medigap reform is advisable. In the interests of competition, we believe the best course to follow involves allowing individual people to choose the health insurance benefits that suit their particular needs. It would prove difficult, if not impossible, to develop policies that would satisfy individual needs.

Another concern is that there is evidence that some insurers are already abandoning the Minnesota insurance markets as a result of community rating, guaranteed renewability, and other reforms. A major reform similar to national Medicare supplemental may drive others out as well, reducing competition and raising costs for consumers.

Finally, the reform of Medicare supplement insurance was a different situation that justified a higher level of government regulation. Some senior citizens are much more vulnerable to

confusion and deception. Further, as these policies were supplementary -- and not major medical -- policies, they were much more adaptable to simplification and standardization.

Additional Option

In addition to standardization of various policy components, we recommend mandating that all health insurance solicitations and policies include a standardized cover sheet/benefits grid that lists the coverage for common benefits. This grid would be provided with each policy as well as be available with marketing brochures.

This cover sheet would simplify the shopping process and encourage competition by facilitating meaningful comparisons between policy choices and encouraging citizens to be more knowledgeable consumers of health insurance.

The benefits cover sheet involves standardizing a summary of the policy's features and would be similar to the benefit and cost summary that is included with auto insurance premiums. Although this cover sheet would not be a comprehensive restatement of the policies benefits, it would assist consumers in comparing any two policies by simply comparing the cover sheets.

We also recommend updated versions of this form be furnished to consumers with each premium statement and rate increase.

Of course, this option would be significantly more effective and valid as a comparison tool with some degree of standardization as recommended. For instance, when used with a standardized, minimum benefit package, consumers would be able to use such a disclosure to quickly and easily compare two or more companies' prices for that same coverage. As consumers could be assured that the benefits were the same, the companies would be compelled to compete on their price and service. If the policies are the same, why does this one cost more? Is their service better? Are claims handled in a more timely manner?

Even with no other standardization, by keeping the "core" benefits separate on this sheet from riders or additional benefits, consumers would be able to compare insurers' prices for the same core benefits. By putting knowledge in consumer's hands, insurers would be required to justify to potential policyholders the costs for additional benefits and riders. Consumers could then decide when comparing more comprehensive policies whether the added benefit was worth the additional cost.

An example for such a cover sheet appears on the next page.

COVER SHEET

BENEFIT	COVERAGE
Inpatient Hospital Services Room and board Extras	
Outpatient Hospital	
Surgery	
Physician care in hospital	
Home and Office Physician Care	
Maternity	
Diagnostic tests	
X-rays and laboratory tests	
Prescription Drugs	
Ambulance	
Emergency Services	
Mental Health Care	
Durable medical equipment	
Subtotal: Core benefits	
Additional Benefits / Riders	
ANNUAL PREMIUM	

APPENDIX A

Minnesota Models for Standardized Benefits

62L.05 Small Employer Plan benefits

Created in 1992 to provide an affordable "scaled back" coverage alternative to small businesses. The legislature could expand the two small-employer insurance plans mandated in the MinnesotaCare law to the individual market. These packages waive some state mandates.

Copayment-type Plan

80% of eligible charges for the health care services listed below in excess of the following copayments:

- $15 per outpatient visit, other than to a hospital outpatient department or emergency room or urgent care center
- $15 per day for the services of a home health agency or private duty registered nurse
- $50 per outpatient visit to a hospital outpatient department or emergency room, urgent care center, or similar facility
- $300 per inpatient admission to a hospital

Deductible-type Plan

80% of eligible charges for the health care services listed below in excess of an annual deductible of $500 per individual and $1,000 per family.

Benefits of Small Employer Plans

Covered Medical Services	Coverage
Inpatient/outpatient hospital services	80%
Physician/nurse practitioner services	80%
Diagnostic x-rays and laboratory tests	80%
Ambulance service	80%
Prenatal/maternity/child health supervision services	80%
Home health services	80%
Prescription drugs	50%
Inpatient/outpatient diagnosis/treatment services for mental health conditions	80%
Private duty registered nurse services	80%
Durable medical equipment purchase/rental	80%
Chemical dependency outpatient treatment 60 hours	80%

62E.06 Qualified Plan benefits

A second option is to build on the Qualified plans of Minn. Stat. § 62E.06. The legislature could make these standardized by eliminating the allowance for actuarial equivalence. As noted earlier, the Minnesota legislature developed these benefit packages in an earlier attempt at standardization. However, the allowance for actuarial equivalence acted to diminish the effectiveness of the law.

	PLAN 3	PLAN 2	PLAN 1
Maximum annual deductible per person	$150	$500	$1,000
Out-of-pocket annual maximum	$3,000	$3,000	$3,000

Covered Medical Services	Coverage
Inpatient/outpatient hospital services	80%
Physician services	80%
Diagnostic x-rays and laboratory tests	80%
Ambulance service	80%
Use of radioactive materials, oxygen, anesthetics	80%
Home health agency services	80%
Prescription drugs	80%
Prostheses *other than dental*	80%
Nursing home services	80%
Durable medical equipment purchase/rental	80%
Occupational and physical therapist services	80%
Oral surgery	80%
Well baby care	80%
Outpatient mental health diagnosis/treatment	80%

APPENDIX B

Minnesota DOH Issue Paper:
Designing Standard Benefits for Integrated Service Networks

Additional Model Standard Benefits Options

DEPARTMENT : Health

DATE : 10/5/93

TO : Interested Parties

SF-00006-05 4-86

STATE OF MINNESOTA

Office Memorandum

FROM : David Haugen
Co-Coordinator, Special Projects Team

PHONE : 623-5375

SUBJECT : **ISSUE PAPER: DESIGNING STANDARD BENEFITS FOR INTEGRATED SERVICE NETWORKS**

Please find enclosed a draft issue paper, Designing Standard Benefits for Integrated Service Networks, prepared with Jake Priester, special projects team staff for benefits.

Purpose and scope of this issues paper: The purpose of this discussion draft is to foster discussion and solicit comments regarding standard benefit plans for Integrated Service Networks (ISNs). The draft briefly summarizes requirements of the MinnesotaCare Act of 1993 (codified in statue under MS 62N) to develop a standard benefits set for Integrated Service Networks (ISNs); identifies issues and questions to be addressed in the design of standard benefits; and offers brief examples of current and proposed standard benefits sets. **The issues, questions, and examples in the draft do not necessarily reflect the views of the Minnesota Health Department.** I have also requested staff to provide additional summary descriptions of current and proposed benefit design models at the ISN Advisory workgroup meetings to facilitate discussion of ISN standard benefits.

Comments, views, and suggestions regarding ISN standard benefits may be directed to:

Irene Goldman
Minnesota Department of Health
717 Delaware Street SE
P.O Box 9441
Minneapolis, MN 55440

ISSUE PAPER: DESIGNING STANDARD BENEFITS FOR INTEGRATED SERVICE NETWORKS

I. Introduction

Minnesota's health reform initiative is designed to address the three fundamental and interrelated problems of inadequate access to care, high cost, and concerns about quality. Its primary goals are universal access (to quality care) and cost containment. But universal access is constrained by the goal of cost containment. Minnesota cannot afford to provide every service of potential benefit to everyone in need. In this sense, health care resources are scarce relative to needs. The challenge is to distribute the scarce resources equitably and efficiently.

The concept of universal access to standard benefits can satisfy both requirements of equity and efficiency. Standard benefits can assure that everyone receives a level of effective health services that is affordable and that is in some sense reasonable and sufficient. By embodying a recognition that we cannot afford all possible care to all people, standard benefits can be a cost-containment measure.

II. Context for Designing Standard Benefits

A. MinnesotaCare Act of 1993 (Act)

The Commissioner of Health is charged with forwarding to the Legislature and the Governor a plan to allow Integrated Service Networks (ISNs) to begin forming by July 1, 1994. A key issue is the definition of the ISN benefit set. Under the Act, the Commissioner shall

"establish not more than five standardized benefit plans which must be offered by integrated service networks. ... The plans must vary only on the basis of enrollee cost sharing and encompass a range of cost sharing options from (1) lower premium costs combined with higher enrollee cost sharing, to (2) higher premium costs combined with lower enrollee cost sharing." (MS 62N.085)

In addition, the Act provides that

> An integrated service network must provide to each person enrolled a set of appropriate and necessary health services. ... "appropriate and necessary" means services needed to maintain the enrollee in good health including as a minimum, but not limited to, emergency care, inpatient hospital and physician care, outpatient health services, preventive health services. The commissioner may modify this definition to reflect changes in community standards, development of practice parameters, new technology assessments, and other medical innovations. These services must be delivered by authorized practitioners acting within their scope of practice. An integrated service network is not responsible for health services that are not appropriate and necessary. ... A network may define benefit levels through the use of consumer cost sharing but remains financially accountable for the cost of the set of required health services. (MS 62N.075)
>
> [and ...] An integrated service network is financially responsible to provide to each person enrolled all appropriate and necessary health services required by statute, by the contract of coverage, or otherwise required under sections 62N.075 to 62N.085. (MS 62N.08)

ISN standard benefits, thus, must include all and only "appropriate and necessary" health services.

B. ISN Rulemaking Criteria and Benefits Design Requirements

The standard benefit plans should be consistent with policy and operational objectives for ISNs described in statute, including:

- **Competition.** The rules must encourage and facilitate competition through the collection and distribution of reliable information on the cost, prices, and quality of each integrated service network in a manner that allows comparisons between networks.

- **Flexibility.** The rules must allow significant flexibility in the structure and organization of integrated service networks. ...

- **Expanding access and coverage.** The rules must be designed to expand access to health care services and coverage for all Minnesotans, including individuals and groups who have preexisting health conditions, who represent a higher risk of

requiring treatment, who require translation or other special services to facilitate treatment, who face social or cultural barriers to obtaining health care, or who for other reasons face barriers to access to health care and coverage. Enrollment standards must ensure that high risk and special needs populations will be included and growth limits and payment systems must be designed to provide incentives for networks to enroll even the most challenging and costly groups and populations. The rules must be consistent with the principles of health insurance reform that are reflected in Laws 1992, chapter 549.

- **Participation of providers.** The rules must encourage and facilitate the participation of midlevel practitioners, allied health care practitioners, and pharmacists, and eliminate inappropriate barriers to their participation. ...

- **Rural communities.** The rules must permit a variety of forms of integrated service networks to be developed in rural areas in response to the needs, preferences, and conditions of rural communities ...

- **Limits on growth.** The rules must include provisions to enable the commissioner to enforce the limits on growth in health care total revenues for each integrated service network and for the entire system of integrated service networks. (MS 62N.05. Subd.3)

Moreover, the Act recites the Legislature's finding that

(1) previous cost containment efforts have focused on reducing benefits and services, eliminating access to certain provider groups, and otherwise reducing the level of care available. Under a system of overall spending controls, these cost containment approaches will, in the absence of controls on cost shifting, shift costs from the payer to the consumer, to government programs, and to providers in the form of uncompensated care.

(2) the ISN benefit package should be designed to promote coordinated, cost-effective delivery of all health services an enrollee needs without cost shifting.

(3) affordability of health coverage is a high priority and that lower cost coverage options should be made available through the use of copayments, coinsurance, and deductibles to reduce premium costs rather than through the exclusion of services or providers. (MS 62N.07)

Finally, the MinnesotaCare Act of 1993 authorizes the Commissioner of Health to establish specific public health goals, and the Regional Coordination Boards to develop regional public health goals. (MinnesotaCare 1993). Design of ISN standard benefits should consider policy objectives of meeting broad public health goals.

CRITERIA in MS 62N for ISNs and STANDARD BENEFIT DESIGN

ISN standard benefits should --

- Be consistent with competitive approach
  - * Promote flexibility
  - * Facilitate formation of ISNs in rural areas
  - * Promote ISN accountability
  - * Encourage use of mid-level practitioners, allied health practitioners, pharmacists
- Comprehensive
  - * Avoid cost-shifting
  - * Provide "full array" of "appropriate and necessary services"
- Contain costs

III. Designing Standard Benefits

A. Objective

To define the set of health services that all ISNs must provide to all enrollees;

B. Substantive issues

Should standard benefits uniformly apply to all private and public health plans in Minnesota?

Should multiple standard benefits be developed?

Interim, less costly standard benefits could be defined in addition to more generous standard benefits, which would be implemented once they become affordable. Or, interim, less specific standard benefits be defined to allow ISNs to move forward after July 1994, in addition to more detailed standard benefits to be implemented later.

What should the state's definition of standard benefits look like?

1. General principles within which standard benefits would be defined;
2. Categories of covered health services (e.g., prevention, inpatient care);
3. Specific covered services (e.g., dialysis) or conditions (e.g., end-stage-renal disease);
4. Covered condition/treatment pairs (e.g., appendicitis/appendectomy);
5. Specific excluded services;
6. Set of health services that provides for all and only "acknowledged health care needs," with needs defined by reference to clinical guidelines; or
7. Specified level of cost per enrollee per year, allowing for actuarial equivalents.

What types of services, if any, should standard benefits emphasize?

1. Emphasize prevention and primary care (on the premise that access to these services provides more overall benefit to more people); and/or
2. Emphasize catastrophic care (on premise that unforseen events that people cannot afford to pay for directly should be covered first)

What level of services should be included in standard benefits, i.e., how restrictive or generous should standard benefits be?

1. "Bare bones" or basic level of services (standby);
2. Comprehensive, but not unlimited, level of services (first class); or
3. "Middle class" level between these two extremes (coach)

Should standard benefits be defined in terms of health services or providers?

C. Procedural issues

The MinnesotaCare Act of 1993 defines ISN standard benefits in terms of "appropriate and necessary" services. This definition must be operationalized.

What types of information are needed to designate appropriate and necessary services?

1. Technical information about the effects, risks, and costs of various health care interventions; and
2. Information about how the risks and effects ought to be valued and weighed.

Who should define appropriate and necessary services?

1. Health care providers;
2. The public, i.e., current and future patients;
3. Elected or other government officials; and/or
4. Publicly appointed body.

Providers can determine which health care interventions work and their relative risks and benefits, but they have no special expertise in deciding how

the effects of health care interventions ought to be weighed or valued. The public ultimately pays for all health care services as well as receives the care, suffers its risks, and enjoys its benefits. They are in the best position to determine whether and when a health care intervention produces enough benefit to warrant the cost and is worth including in the set of all appropriate and necessary services. Defining appropriate and necessary health services may be a quintessential legislative task; however, some suggest a lesson from mandated benefits may be that government-defined benefits tend to grow. Other states' experience indicates that using a special group "that is insulated from legislative politics can be an effective forum for designing a standard benefits package." Such a group can "help to increase the legitimacy and acceptability of the final product."

What process should be followed?

Some argue that the available budget should not drive the definition of appropriate and necessary services; instead, only after such services are defined should attention turn to how to finance them. Such a definition would establish a specific goal for health care reform and set a "gold standard" by which to evaluate existing coverage levels. According to others, appropriate and necessary services can only be defined with reference to existing financial constraints. Standard benefits define the floor we can *afford* to provide to everyone. On this view, the set of appropriate and necessary services would vary according to available resources.

Other possible procedural guidelines options might include:

1. Specifying appropriate and necessary services should be the result of a process of open discussion and fair negotiation. The societal values that should guide this specification should be matters for public discussion.

2. Those who define appropriate and necessary services should be bound by the definition (even if they can "buy up"). Defining appropriate and necessary services should not consist of the "haves" (i.e., the reasonably well-insured) deciding what should be considered appropriate and necessary for the "have-nots."

What criteria should be used to define standard benefits?

1. prolonging life;
2. restoring ability to function;
3. improving/maintaining quality of life;
4. effectiveness;
5. cost/effectiveness; and or
6. impact on substantial patient population

How should standard benefits should be revised? By whom? According to what process? How frequently?

D. Consumer cost-sharing

Minnesota Statues 62N specify that "'consumer cost sharing' or 'cost sharing' means copayments, deductibles, coinsurance, and other out-of-pocket expenses paid by the individual consumer of health care services." Cost-sharing is seen by some as a means to encourage consumers to make better decisions regarding their health care, reduce demand for health services, and control costs. Critics claim cost-sharing (particularly at point of service) erects financial barriers to care and raises health risks.

The 1993 MinnesotaCare Act authorizes the Commissioner of Health to consider whether the following principles should apply to cost sharing in an integrated service network:

(1) consumers must have a wide choice of cost sharing arrangement;

(2) consumer cost sharing must be administratively feasible and consistent with efforts to reduce the overall administrative burden of the health care system;

(3) cost sharing must be based on income and an enrollee's ability to pay for services and should not create a barrier to access to appropriate and effective services;

(4) cost sharing must be capped at a predetermined annual limit to protect individuals and families from financial catastrophe and to protect individuals with substantial health care needs;

(5) child health supervision services, immunizations, prenatal care, and other prevention services must not be subjected to cost sharing;

(6) additional requirements for networks should be established to assist enrollees for whom an inducement in addition to the elimination of cost sharing is necessary in order to encourage them to use cost-effective preventive services. These requirements may include the provision of educational information, assistance or guidance, and opportunities for responsible decision making by enrollees that minimize potential out-of-pocket costs;

(7) cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services; and

(8) cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services. (MS 62.085)

Among the issues to consider in designing cost sharing provisions are: Does cost sharing have harmful health effects? Does cost sharing help to control expenditures/promote efficiency? Does cost sharing promote utilization of cost-effective care and reduce non cost-effective care? Should cost sharing be based on income? Should certain services/groups of patients be exempt from cost sharing? At what level, if any, does cost sharing erect financial barriers and/or potentially harm health?

Most of the evidence on the potential utilization and health effects of consumer cost sharing is derived from the Rand Health Insurance Experiment (HIE) conducted between 1974 and 1982. The experiment demonstrated:

- Coinsurance is a significant deterrent to health care utilization.
  - Coinsurance primarily affected whether or not an individual made an initial contact with the health care system seeking care. (Once a decision had been made to seek care, coinsurance had less effect on the amount and intensity of services.)
  - This deterrent effected all health care, even potentially effective treatment.
- *In general*, HIE researchers did not find that health was harmed from less care.
  - However, persons receiving "free care" (no consumer cost sharing) did respond more favorably than those with cost-sharing in three areas: hypertension; vision; and risk of dying for those with hypertension and related high risks. Low income children also had higher risks of anemia in cost-sharing plans.
- Persons in cost-sharing plans used less preventive care.
  - However, preventive care use was much less for both the cost-sharing and the "free" plan than recommended.
- The health benefits of "free care" may have been offset by the untoward effects of unnecessary care.
  - Persons receiving "free care" used 85% more antibiotics than patients with cost-sharing. Antibiotics were used to a greater degree across all diagnoses, including viral infections, against which antibiotics are ineffective, while at the same time exposing patients to risks associated with antibiotic use.

E. Legal Issues

1. What effect, if any, does the Americans with Disabilities Act (ADA) have on using information on social values and medical effectiveness on defining standard benefits?

The ADA is an extraordinarily broad statute prohibiting discrimination in various contexts against persons with disabilities. The ADA stipulates that disabled persons who meet the essential eligibility requirements for a benefit shall not be excluded from that benefit on grounds of disability. According to the Bush Administration, it is acceptable in designing standard benefits to consider "any content neutral factor [e.g., cost] that does not take disability into account or that does not have a particular exclusionary effect on persons with disabilities." However, "a decision not to cover a treatment based entirely on the existence of a disabling condition . . would violate the ADA." For example, excluding liver transplants for alcoholics on the basis of a disabling condition (alcoholism) would not be permitted; excluding it on the basis of poorer outcomes may be permitted.

2. Will denial of a beneficial service (because it is excluded from standard benefits) survive legal challenge?

The $64,000 question. Some legal commentators argue that because the legal system is principally geared toward relieving the hardship of individual patients in malpractice cases, courts will narrowly construe or even ignore any exclusion of beneficial services--especially if the exclusion stems in part from cost containment objectives.

3. What, if any, protections can/should be afforded providers against liability for damages resulting from withholding care in accordance with standard benefits?

F. Experimental Interventions

"Experimental" can be defined as an intervention "not generally accepted by the professional medical community as an effective and proven treatment for the condition" or "rarely used, novel or relatively unknown." Most health plans have historically excluded coverage for experimental interventions. They claim this exclusion protects subscribers from untested and fringe treatments, while protecting subscribers from increasingly higher premiums. Others argue that plans sometimes use the exclusion to avoid paying for expensive interventions.

The process for making coverage decisions regarding experimental interventions varies. Some third-party payers perform their own assessments to determine when an intervention crosses the experimental/therapeutic threshold. Others, including many smaller insurers, follow industry leaders. The net effect is disagreement among payers about which particular interventions are experimental and thus not covered.

The criteria third-party payers use to identify experimental interventions help to determine whether an intervention works; they do not determine whether the intervention is worth paying for. Thus determining that an intervention is no longer experimental is necessary but not sufficient for determining whether it should be included in standard benefits.

G. Related ISN Issues

A number of other issues addressed by the ISN workgroups will also be important to discussions of ISN standard benefits. These related issues include:

- Competition
  - level playing field
  - (standardization of products)
- ISN inclusion/exclusion of particular providers or types of providers
- Appropriate use of mid-level practitioners and pharmacists
- ISNs and Public health goals
- ISNs and Enrollees
  - consumer bill of rights
  - information that must be provided to enrollees
  - evidence of coverage
- Availability of ISN coverage
  - comprehensiveness of services
  - geographic availability of services
  - folding other programs into ISNs
  - 24-hour coverage (worker's comp, etc.)
  - implications of ADA

Models

A. Minnesota Programs

Minnesotans are covered by many forms of private and public health coverage, governed in turn by different laws and rules. Below are brief summaries of four different health coverages defined in state statute and rules (more information on the programs' benefits sets will be provided at the workgroup meetings):

1) Medical Assistance (MA). MA, established under Title XIX of the Social Security Act is a program intended to furnish necessary medical care to low-income persons. The program is supported by 53% federal funds, 42% state funds, and 5% local funds. Federal law requires some services as mandatory, and gives states options to provide additional services. Minnesota currently provides many optional services, some of which -- such as personal attendant care services -- are rarely, if ever covered by other health insurance.

2) Health Maintenance Organizations (HMO). HMOS are required to provide "a set of comprehensive health services which the enrollees might reasonably require to be maintained in good health including as a minimum, but not limited to, emergency care, inpatient hospital and physician care, outpatient health services and preventive health services." (62D.02) A number of specific mandated benefits are also delineated in the statute. HMOs retain wide latitude for how these services are provided.

3) Small Employer Plan. The Small Employer Plan was created in 1992 to provide a more

affordable "scaled back" coverage alternative to small firms which frequently can not obtain affordable coverage. Health carriers in the small employer market must make available two plans, one using deductibles ($500 per individual and $1,000 per family) and another using copayments (according to a schedule specified in the statute). Both plans cover the same set of health care services (see 62L.05 Subd. 4).

4) MCHA Qualified plan. The Minnesota Comprehensive Health Insurance Act of 1976 (MCHA) is designed to broaden health coverage through (a) a requirement that if employers provide health insurance, a minimum benefits package be provided and (b) establishment of a state administered high risk pool. Employers who either provide or make available a health plan are required to offer (at least one) plan which is certified by the Commissioner of Commerce as a "qualified plan." Three categories of qualified plans are delineated, differing only according to the annual deductible (#3 qualified plan, $150 per person; #1 qualified plan $1000 per person). Qualified plans must include coverage for certain specified services (62E.06) or provide coverage for the actuarial equivalence of those services.

B. Other Models

The 4 models briefly outlined below illustrate a range of alternatives for designing standard benefits. The first two options are most noteworthy for their definitions; the latter two for the processes for defining standard benefits.

President Clinton's proposal

A "national benefit package," defined initially in statute (The American Health Security Act of 1993) and then periodically reviewed and updated by the newly-established National Health Board, would be guaranteed to almost all Americans (Indian Health Service and Medicare, for example, are excluded). The comprehensive benefit package includes coverage for the following "categories of services as medically necessary or appropriate."

- hospital services;
- emergency services;
- services of physicians and other health professionals;
- clinical preventive services;
- mental health and substance abuse services;
- family planning services;
- pregnancy-related services;
- hospice;
- home health care;
- extended-care services;
- ambulance services;
- outpatient laboratory and diagnostic services;
- outpatient prescription drugs and biologicals;
- outpatient rehabilitation services;

durable medical equipment, prosthetic and orthotic devices;
vision and hearing care;
preventive dental services for children;
health education classes.

For selected categories, some specific services--and limitations--are identified (e.g., under clinical preventive services, patients over age 64 are covered for cholesterol tests every 5 years, mammograms every 2 years). Investigational 'treatments' are excluded; however, medically necessary or appropriate medical care provided as part of an investigational trial is covered. Mental health and substance abuse services receive special attention: by the year 2001, a "comprehensive, integrated benefit structure with appropriate management" will replace interim prescribed limits on mental health and substance abuse services.

Health plans may offer consumers one of three cost sharing alternatives (each covering the same set of services): "Low cost sharing", "Higher cost sharing" and a "Combination plan" providing low cost sharing if participants use preferred providers and higher cost sharing if they use out-of-network providers.
The benefit package contains no lifetime limitations on coverage

MN Health Care Access Commission (HCAC)

The HCAC, established in 1989, was charged to recommend to the legislature a plan to provide access to health care for all state residents. The HCAC identified "health care equity" as the guiding principle for defining standard benefits. The HCAC identified two standard benefits sets. An "adequate and affordable" Universal Basic Benefits Set (UBBS), provided through all public programs and constituting the floor for all private health coverage in Minnesota, was to be the ultimate goal of Minnesota's health care system. The HCAC did not define the UBBS. An Intermediate Benefit Set (IBS), which the HCAC defined in detail, would be the interim goal if the state, for reasons of cost, would be unable to assure universal access to the UBBS.

The HCAC cited three underlying principles (in addition to "health care equity") in designing the IBS: (1) an emphasis on primary and preventive care; (2) a balance between expenditures for high-cost and low-cost cases; and (3) a limit on the use of copayments. The IBS lists 8 broad categories (e.g., dental care), with several types of covered services within each category (e.g., inlays, crowns, prosthetics). Copayments levels and any limits on coverage are specified for each service (e.g., 10 hour limit per person per year for outpatient mental health).

Oregon

The 1989 Oregon Basic Health Services Act is designed to ensure universal

coverage to basic health care. The Act establishes the Oregon Health Services Commission (OHSC), charged with producing a prioritized list of health services that could be used to define a basic benefits package, which would serve as the floor for all private and public programs in Oregon.

The 11-member OHSC created a list of 688 condition/treatment pairs to account for virtually all health care interventions (long-term care, for example, is excluded). The OHSC identified 17 general service categories. These categories were then ranked and labeled as either "Essential," "Very Important," and "Valuable to Certain Individuals." Each condition/treatment pair was placed in one of the 17 categories and ranked within categories according to their "net benefit," derived by combining assessment of treatment outcomes and Oregonians' opinions about various states of health. Finally, in a line-by-line review, the Commissioners used their collective judgment to re-rank "out-of-position" condition/treatment pairs. Based on actuarial estimates for each item on the list, the legislature then went as far down the list--that is, covered as many services--as Oregon's Medicaid budget allowed. For the current biennium, the legislature drew the line between items 568 and 569. Oregon will provide the new benefits set under Medicaid beginning in February 1994. At a later date, the same benefits set will also define the floor for all private plans.

Oregon's process for defining standard benefits involved health care professionals and consumers in a public discussion of the relative value of specific health care interventions. This approach is believed to promote OHSC's and the legislature's accountability to the public. On the other hand, such a democratic approach raises concerns, for example, that socially disfavored conditions (e.g., AIDS) might be assigned lower priority.

Standard benefits defined using clinical guidelines

An alternative process for defining standard benefits revolves around the concept of medical need. The standard benefits set would include all and only those health care services that provide for "acknowledged health care needs," where needs would be recognized by reference to "necessary care guidelines." Such necessary care guidelines are clinical care guidelines (practice parameters) that specify the clinical indications for which specified interventions are to be deemed necessary.

Presently, only the process for using "scientifically valid clinical guidelines" as the basis for developing standard benefits has been spelled out, no model for such a benefits set exists. The appeal of this approach seems to lie in its promise that we can objectively distinguish between necessary and unnecessary care, health care needs and mere desires, and, in turn, between services that should be included in standard benefits and those that should be excluded.

According to David Hadorn, a leading proponent of this approach, a panel of health care professionals would develop necessary care guidelines for each preventive, diagnostic, and therapeutic intervention. The guidelines would specify all necessary care, defined as services which, in the panel's judgment, have been "reasonably well demonstrated to provide significant net health benefit." "Significant net health benefit" is a threshold that must be crossed before a service is deemed necessary and therefore included in standard benefits. "Clinical indications for which services offered only insignificant benefit, or where benefit had been inadequately demonstrated, would not be included in the guideline. The sets of necessary care guidelines would collectively constitute" the standard benefits.

These and additional models will be reviewed in greater detail by the ISN workgroups.

Appendix 1

In addition to the criteria for ISN standard benefit plans in MS 62N summarized briefly above, a number of other possible criteria -- reflecting values, principles, and assumptions from a variety of sources -- are briefly summarized below which might also be considered in discussions of ISN standard benefits. Again, the framework of values and assumptions below is does not necessarily reflect the position of the Minnesota Department of Health, but is intended only to aid further exploration of benefits sets issues.

Guiding Values and Principles

Explicitly stated and defined values and principles that relate to standard benefits enable the public to hold policymakers accountable and function as a benchmark, providing a perspective for analyzing and comparing proposed standard benefits sets and the processes for defining them. In addition to the criteria delineated in the statute, a number of values and principles may be considered in designing standard benefits and guiding choices among various policy options, including, for example:

Equity

Health care is of special importance because of "its role in relieving suffering, preventing premature death, restoring functioning, [and] increasing opportunity." Because of its high cost and the great variability in individuals' needs for care at any given time, health care also has unique financial characteristics. The special nature of health care provides the basis for concluding that its distribution should be guided by principles of social justice or equity. In the contemporary reform debate several themes have emerged regarding health care's equitable distribution.

1. Each person should have access to standard benefits.
2. Standard benefits should function as a floor below which no one should fall.
3. Standard benefits should not function as a ceiling.
4. Standard benefits should minimize financial and nonfinancial barriers to care.

Efficiency

Efficiency has two important dimensions--minimizing costs and achieving the most benefit per unit cost. An efficient health care system is not necessarily the least expensive, but obtains the greatest benefit for the lowest cost--the biggest bang for the buck. Efficiency focuses on cost, effectiveness, and cost-effectiveness.

Autonomy (freedom of choice)

Dimensions of autonomy that should guide the design of standard benefits include:

1. Health care providers should have a high degree of clinical autonomy.
2. Patients should have the right and responsibility to make informed, voluntary decisions on their care (including the right to refuse care). This does not mean patients are entitled to every potentially beneficial treatment.
3. Consumer should have the right to information to make informed choices among health care plans.

Personal responsibility

Each person should, within one's means, share in the cost of their health care plan and health services. Each person also should take greater control over one's own health (because of complex ethical and legal concerns, it may be appropriate to recast this as, "health care providers and the health care system should enable each person to take greater control over one's own health.")

Accountability

1. A process for determining standard benefits should be established.
2. The process should be public, and the criteria for determining standard benefits should be publicly debated and reflect social values.
3. Decisions to exclude certain services should be explicit.

Affordability

1. Funding for standard benefits must be economically sustainable (standard benefits must be affordable).

Assumptions

Health care resources are scarce: we cannot provide all Minnesota residents everything that the health care system has to offer

The goal of Minnesota's health care system is to maintain/improve the level of health of each Minnesotan and the mean level of health of the Minnesota population.

Most notions of standard benefits presume that the main (some suggest the sole) aim should be individual health. An alternative is to design standard benefits that would enhance the likelihood of the greatest level of general health. From this perspective, standard benefits should be designed to produce not only the greatest benefit for individuals, but also promote the collective health of society as a whole.

Some health care interventions are more beneficial than others.

This seemingly obvious assumption is critical to any effort to determine whether a particular intervention should be included or excluded from standard benefits. A corollary states it is (theoretically) possible to make such determinations. Where and how to draw the line, and who should be involved, are the key issues.

Defining standard benefits is a political, moral, and social--not only a clinical or scientific--task.

Defining standard benefits is not only a clinical and scientific task. The definition inevitably involves making value judgments. No amount of data on outcomes, risks, effectiveness, and costs can obviate the need for making value judgments about whether a particular service is necessary, worth doing, or should be covered under standard benefits.

Model standard benefits

Minnesota Medical Association (MMA) Medical Benefits Task Force

Who
In 1990, the MMA's Board of Trustees convened a 24 member task force (15 MDs, 9 representatives of other health care interests, no non-md providers).

Objective
Task force was charged to define a "package of universal and equitable minimum medical care benefits." This benefits set would function as a floor for everyone.

Product
After articulating guiding values and principles and a number of background assumptions, the task force identified 6 categories of services (prenatal and maternity care; infant care and immunizations; periodic evaluation and screening; treatment and rehabilitation of injury; diagnosis and treatment of illness and dysfunction; terminal care) and over 100 specific services within those categories.

The task force then defined each service as "essential" (must be included in the minimum benefit set), "desirable" (should be included if additional resources were available and all citizens had access to essential services), and "optional" (should not be included in the minimum set).

For each service, the task force also defined coverage limits. Each service would be covered either with no limits, or with (a) a limit on the number of service units or a dollar cap, (b) cost-sharing requirements, and/or (c) a limit on specific diagnoses under which the service is provided.

The task force's universal benefits set has 60 essential services, 36 desirable services, and 19 optional services. Nearly all services have one or more of the itemized limits.

In September 1993, the MMA reconvened the task force to amend and alter the universal benefits set, where appropriate.

Considerations
Definitions of standard benefits may reflect bias of physician-dominated group.

Final adjustments to the list were made based on what the task force believed to be insufficient information.

Specifying over 100 services is consistent with competitive approach: promotes standardization, increases consumer understanding of covered and excluded services, and facilitates comparisons across ISNs.

Prioritization of "basic services, desirable additional services, and optional services" may guide expansion of standard benefits, should additional resources become available.

Minnesota Medical Association Medical Benefits Task Force

		Appropriate Limitations		
		$ or #	Copay/	Certain
	No Limits	Caps	Deduct.	Diag.
Basic Services				
Ambulance services: emergency			X	
Blood and blood derivatives				
Dental: child preventive		X	X	
Dental: injury treatment		X	X	
Diagnostic services for acute and chronic conditions			X	
Dialysis for chronic conditions		X	X	X
Eye Care: eyeglasses, contact lenses purchase*		X	X	
Eye Care: treatment of eye conditions		X	X	
Eye Care: visual examinations for symptoms		X	X	
Family planning: medication		X	X	
Family planning: pre-conception care		X	X	
Family planning: professional services		X	X	
Hearing: examinations for symptoms		X	X	
Hearing: treatment of hearing conditions		X	X	
Hospice services		X	X	X
Hospital services—inpatient: for diagnostic services only		X	X	X
Hospital services—inpatient: for treatment of illness (bed charges including radiologic & lab.)		X		
Hospital services—inpatient: semi-private room		X	X	
Hospital services—outpatient: outpatient clinic			X	
Hospital services—outpatient: outpatient emergency services		X	X	
Implants: artificial hips*		X	X	X*
Implants: intraocular lenses		X	X	
Implants: pacemakers		X	X	X
Inhalation services: services for ventilator-dependent person (120 hours)		X	X	X
Inhalation services: other medications		X	X	X
Inhalation services: oxygen		X		X
Medical equipment: durable*		X	X	X*
Medical equipment: syringes/chemstrips			X	
Mental illness: inpatient		X		X
Mental illness: outpatient—individual therapy (physicians & other providers)*		X	X	X*
Mental illness: partial hospitalization/day treatment*		X	X	X
Nuclear medicine: diagnostic isotope scanning				
Nuclear medicine: isotope therapy, i.e. thyroid				
Nursing care: short-term (less than 90 days)		X	X	
Obstetrical care: delivery services			X	
Obstetrical care: postnatal care		X		
Obstetrical care: prenatal care	X			
Obstetrical care: prenatal health education		X		
Occupational therapy*		X	X	X
Pharmaceuticals: inpatient			X	
Pharmaceuticals: outpatient (restricted formulary)*		X	X	
Phenylketonuria (PKU) dietary treatment		X	X	
Physical therapy		X	X	X
Physician medical/surgical treatment (inc. rad. & lab. services): chemotherapy				X*
Physician medical/surgical treatment (inc. rad. & lab. services): coronary artery angiography				
Physician medical/surgical treatment (inc. rad. & lab. services): coronary bypass				X*
Physician medical/surgical treatment (inc. rad. & lab. services): free-standing, surgicenter-based		X	X	
Physician medical/surgical treatment (inc. rad. & lab. services): hospital-based				
Physician medical/surgical treatment (inc. rad. & lab. services): office-based		X	X	
Plastic surgical services: Cleft palate tre...				
Plastic surgical services: Craniomandibular disorder*		X	X	X*
Plastic surgical services: correction of functional disorder - congenital abnormality				
Plastic surgical services correction of functional disorder - injury or incidental to covered surgery		X	X	
Screening: cancer		X		X*
Screening: other disease screening (i.e. blood pressure/cholesterol)		X*	X	X*
Speech therapy		X	X	
Transplants: cornea		X	X	X
Transplants: kidney		X		X
Well-child care: preventive check-ups & immunizations	X			
Well-child care: well-baby care				

* Item was adjusted by Task Force

		Appropriate Limitations		
		$ or #	Copay/	Certain
	No Limits	Caps	Deduct.	Diag.
Desirable Additional Services				
Ambulance services: transport services (non-emergency)		X	X	
Chemical dependency: inpatient		X	X	
Chemical dependency: outpatient		X	X	
Chemical dependency: residential (halfway house)		X		
Dental: adult preventive		X	X	
Dental: adult treatment		X	X	
Dental: child treatment		X	X	
Dental: oral surgery		X	X	
Di-ethyl-stilbestrol (DES)-related conditions			X	
Eye Care: routine vision examinations		X	X	
Family planning: abortion				
Family planning: genetic counseling		X	X	
Family planning: sterilization			X	
Hearing: hearing aid purchase*		X	X	X*
Hearing: routine hearing examinations		X	X	
Home care: for diagnosed medical condition & rehabilitation		X	X	X
Home care: long-term home care for disability		X		
Home care: long-term home care for infirmity/frailty		X	X	
Implants: artificial joints other than hips		X	X	
Implants: cochlear			X	
Mental illness: outpatient—group therapy		X	X	X
Mental illness: residential care—adult		X	X	X
Mental illness: residential facility care for emotionally disturbed children		X	X	X
Nursing care: long-term (90 days or longer)		X	X	
Obesity treatment: education/counselling		X	X	
Physician medical/surgical treatment (inc. rad. & lab. services): carotid endarectomy			X	
Plastic surgical services: reconstructive surgery		X	X	
Plastic surgical services: reconstructive surgery following mastectomy			X	
Temporomandibular Joint Disorder - (TMJ) treatment		X	X	
Transplants: bone marrow		X		X
Transplants: heart		X		X
Transplants: heart/lung		X		X
Transplants: liver				X
Transplants: lung				X
Transplants: musculoskeletal		X	X	X
Urgent Care—non-emergency after-hours care			X	

* Item was adjusted by Task Force

		Appropriate Limitations		
		$ or #	Copay/	Certain
	No Limits	Caps	Deduct.	Drug
Optional Services				
Acupuncture				X
Custodial care (as opposed to convalescent nursing care)		X	X	
Experimental treatments not accepted as stand. care (not inc. drug usage other than FDA unapp.)				X
Eye Care: radial keratotomy, or similar procedures not accepted as standard care				
Family planning: artificial insemination			X	
Family planning: in vitro fertilization			X	
Family planning: infertility treatment			X	
Family planning: reversal of sterilization			X	
Hospital services—inpatient: private room differential				
Implants: other				
Implants: penile				
Nursing care: private duty nurse (home)				
Nursing care: private duty nurse (hospital)				
Obesity treatment: surgical			X	
Plastic surgical services: cosmetic surgery				
Scalp prostheses for alopecia areata (wigs)				
Spinal-muscular manipulation		X	X	
Transplants: pancreas		X	X	X
Transplants: parathyroid*		X	X	

* Item was adjusted by Task Force

Model standard benefits

Business Health Care Action Group (BHCAG)

Who

The BHCAG, comprised of at least 16 of the Twin Cities' largest employers, is an employer purchasing coalition. Their stated goal is "to create an organized system of health care that links quality and efficiency."

Objective

The BHCAG created a single health benefit plan that all its members will provide. The benefit plan is based on the principles of CQI, greater provider accountability, increased consumer responsibility, and greater efficiency.

Product

The BHCAG plan has two levels of coverage, "in-network and out-of-network." An enrollee can always choose whether to receive care within the provider network or outside. Generally, out-of-network coverage has higher cost sharing requirements and/or less extensive coverage; some services are covered only in-network.

Covered services are identified by categories, with limitations specified for some services (e.g., lifetime benefit of 2 courses of CD treatment). The plan has 33 specific exclusions. These include commonly accepted broad exclusions (e.g., custodial care; investigational/experimental interventions), specific exclusions (e.g., keratorefractive surgery), and several unique exclusions (e.g., "treatment for injuries resulting during the commission of a felony").

Considerations

Plan was developed by employers for employees, thus may not reflect needs and interests of entire community of ISN enrollees.

Out-of-network option respects consumer/patient freedom of choice; however, some services (e.g., preventive care; inpatient mental health) are not covered out-of-network

Heavy reliance on cost sharing may shift costs to enrollee.

Cost sharing provisions may erect barriers to care (e.g., $10 per visit copay for all preventive services).

Limitations on mental health and chemical dependency treatment may shift costs to government programs and/or generate inefficient use of medical services.

The following gives an overview of your Choice Plus℠ coverage. Exact coverage terms and conditions are described in the Summary Plan Description.

SERVICE	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE
	For medically necessary services provided or referred by network providers.	*For medically necessary services provided by out-of-network providers or by network providers when referrals are not received.*
Office Visits *Including urgent care center visits.*	You pay $10 per visit, then plan pays 100%.	You pay $30 per visit, then plan pays 70%.
Preventive Care *e.g., routine physicals, mammograms, well-child care, immunizations, etc.*	You pay $10 per visit, then plan pays 100%.	Not covered.
Vision Screening		
Routine Eye Exams	You pay $10 per visit, then plan pays 100%.	Not covered.
Eye Glasses/Contact Lenses	Not covered. **Special discounts available at selected optical centers — call the Helpline for more information.**	Not covered.
Prenatal/Maternity Care	You pay $10 per pregnancy, then plan pays 100%, including specified post-partum visit at 6 weeks.	You pay $30 per pregnancy, then plan pays 70%. **Prior approval is required — call the Helpline as soon as you know you are pregnant, or no later than the end of the fourth month of your pregnancy. If you fail to call, there will be a $500 reduction in benefits per pregnancy penalty.** Penalties will not count toward the out-of-pocket maximum.
Scheduled Outpatient Procedures *In diagnostic center, surgicenter, outpatient hospital, etc.*	You pay $10 per visit, then plan pays 100%.	You pay $30 per visit, then plan pays 70%.

SERVICE	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE
Hospitalization *Including Maternity — one copayment per delivery.*	You pay $100 per admission, then plan pays 100%.	You pay $300 per admission, then plan pays 70% for up to 365 days per period of confinement. Prior approval is required for all hospitalizations — call the Helpline at least 7 days prior to admission. Specified procedure must be followed or there will be a $500 reduction in benefits per admission penalty. Penalties will not count toward the out-of-pocket maximum.
Emergency Services Emergency Room	You pay $75 per visit, then plan pays 100% for medical emergencies. If not determined to be a medical emergency, you pay $75 per visit, then plan pays 70%.	You pay $75 per visit, then plan pays 100% for medical emergencies. If not determined to be a medical emergency, you pay $75 per visit, then plan pays 70%.
Emergency Hospitalization *Emergency room copayment waived if hospitalization occurs within 24 hours.*	You pay $100 per admission, then plan pays 100%.	If determined to be a medical emergency, you pay $100 per admission, then plan pays 100%. You must call the Helpline within 48 hours when emergencies require hospitalization. To continue to receive 100% coverage, once the patient is stable and can be moved they must agree to be transferred to a participating in-network facility and be under the care of a participating in-network provider, otherwise coverage will drop to 70% from the date a transfer could have been made. If not determined to be a medical emergency, you pay $300 per admission, then plan pays 70%.
Prescriptions *Over-the-counter drugs are excluded.*	You pay $10 per prescription, then plan pays 100%, for up to a 30-day supply or one vial of insulin. Injections for infertility have 50% coverage. All drugs must be on plan formulary (approved list of drugs).	You pay $10 per prescription, then plan pays 70%, for up to a 30-day supply or one vial of insulin. This benefit will apply when an out-of-network pharmacy is used or when an out-of-network physician writes the prescription.

SERVICE	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAC
Ambulance	Plan pays 90% if medical emergency, otherwise 70% coverage.	Plan pays 90% if medical emergency, otherwise 70% coverage.
Mental Health/Chemical Dependency	All Mental Health and Chemical Dependency services are limited to a $100,000 lifetime benefit.	
Outpatient Mental Health	You pay $10 per group, family or individual visit, then plan pays 100%, for up to 30 visits per year.	*Outpatient mental health and chemical dependency are not covered except for students attending school outside the service area and when pre-approved — call the Helpline. If approved, you pay $30 per visit, then plan pays 70%, for up to 30 visits per year. A total of 30 visits per year will be covered (combined in- and out-of-network).
Outpatient Chemical Dependency	You pay $10 per visit, then plan pays 100%, for up to 130 hours per year.	*Outpatient mental health and chemical dependency are not covered except for students attending school outside the service area and when pre-approved — call the Helpline. If approved, you pay $30 per visit, then plan pays 70%, for up to 30 visits per year. A total of 30 visits per year will be covered (combined in- and out-of-network).
Inpatient Mental Health and Chemical Dependency	You pay $100 per admission, then plan pays 100%, for up to 45 days per year combined Mental Health and Chemical Dependency. Lifetime benefit of 2 courses of Chemical Dependency treatment. For detoxification services you pay $100 per admission, then plan pays 100%, to a maximum of 3 days per admission and 2 admissions per year. (Coverage will only be provided for 4 admissions in a lifetime.)	Not covered.

*The Choice Plus plan service area consists of the following counties: Anoka, Benton, Carver, Chisago, Dakota, Goodhue, Hennepin, Isanti, Le Sueur, McLeod, Mille Lacs, Ramsey, Rice, Scott, Sherburne, Sibley, Stearns, Wabasha, Washington and Wright in Minnesota. Buffalo, Pepin, Pierce, Polk and St. Croix in Wisconsin.

SERVICE	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE
Accidental Dental Care *Treatment for injury to sound, natural teeth. Treatment must begin in 90 days and be completed within 12 months of injury, unless it is medically necessary to extend treatment. To be covered, the injury must have occurred while the enrollee was covered under one of the employer's plans. All other dental treatment is not covered.*	Plan pays 90% for accidental dental care only.	Plan pays 70% for accidental dental care only.
Durable Medical Equipment and Prosthetics *This includes coverage for colostomy, ileostomy, and diabetic supplies.*	Plan pays 90% to maximum of $6,000 per item.	Prior approval is required — call the Helpline. Plan pays 70% to maximum of $6,000 per item.
Physical Therapy Speech Therapy Occupational Therapy	**Referral required by primary care physician.** You pay $10 per visit, then plan pays 100%. Annual $750 benefit maximum for combined in- and out-of-network services.	You pay $30 per visit, then plan pays 70%.
Chiropractic	**Referral required by primary care physician.** *Initial visit:* You pay $10 per visit, then plan pays 100% to $50 maximum benefit per visit, including x-rays. *Subsequent visits:* You pay $10 per visit, then plan pays 100% to $40 maximum benefit per visit. Annual $750 benefit maximum.	Not covered.

SERVICE	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE
Home Health Care	Plan pays 100% for home health services under an approved treatment plan for 180 days per year. Days covered in-network are reduced by visits provided out-of-network.	Plan pays 70% for 60 visits per year. The maximum benefit will be $40 per visit. Visits covered out-of-network are reduced by days provided in-network. Prior approval is required — call the Helpline. Specified procedure must be followed or there will be a $500 reduction in benefits penalty.
Skilled Nursing Facility	Plan pays 100% for 180 days per period of confinement.	Plan pays 70% for 180 days per period of confinement when approved by our case manager. Prior approval is required — call the Helpline. Specified procedure must be followed or there will be a $500 reduction in benefits penalty.
	Maximum benefit of 180 days per period of confinement for in- and out-of-network services combined.	
Out-of-pocket Maximum *Annual. The in-network and out-of-network maximums are separate.*	You pay $1,500 per individual, $3,000 per family (includes copayments and coinsurance).	You pay $4,500 per individual, $9,000 per family (includes copayments and coinsurance).
Lifetime Plan Maximum	$1,000,000 lifetime maximum for all services in- and out-of-network under this plan and any other self-insured plans while covered at the same company.	
Pre-existing Condition Coverage Limitation *For new hires and other situations defined by your employer.*	Plan pays $5,000 benefit maximum per individual in the first 12 months of coverage for all services, in- and out-of-network combined, on all conditions diagnosed or treated within 90 days prior to when you have become covered under this plan.	

EXCLUSIONS FROM COVERAGE

The following are excluded from both in- and out-of-network coverage:

1. Treatment, services or procedures which we determine are not medically necessary.

2. Services which are not provided by, or under the direction and advance approval of network providers are not covered under in-network benefit.

3. Hearing tests, hearing aids or the fitting of hearing aids.

4. Eyeglasses or contact lenses and the measurement, fitting and adjustment of contact lenses.

5. Keratorefractive surgery.

6. Dental care except as specifically provided under the accidental dental benefit. Examples of non-covered dental services are routine preventive exams, tooth extractions, surgery to accommodate dentures, orthodontia (braces), treatment of gum disease, osteointegrated implants and restorative treatment or surgery required to restore, maintain, or alter occlusion.

7. Oral surgery (including jaw adjustments to correct malocclusion) except as a consequence of a medical problem or as specifically provided under the TMD benefit.

8. Cosmetic surgery to repair or reshape a body structure primarily for the improvement of the covered person's appearance or self-esteem including, but not limited to, augmentation procedures, reduction procedures and scar revision. Mammoplasty is covered following surgery for the treatment of a malignancy.

9. Surgical implantation of mechanical devices functioning as a human organ.

10. Physical examination or evaluation or any mental health or chemical dependency examination or evaluation given primarily at the request of, for the protection or convenience of, or to meet a requirement of third parties, including, but not limited to, attorneys, school systems, employers and insurers, unless such examination or evaluation is medically necessary.

11. Procedures, technologies, treatments, facilities, equipment, drugs and devices which are investigative experimental. This includes techniques or services that have been confined largely to laboratory and/or animal research or have progressed to limited human application and clinical trials, but lack wide recognition as proven and effective measures in clinical medicine.

12. Custodial care.

13. Artificial conception processes such as GIFT, ZIFT, in vitro fertilization (except artificial insemination to treat infertility).

14. Reversal of voluntary sterilization procedure.

15. Home care for chronic conditions such as permanent, irreversible diseases, injuries or congenital conditions requiring long periods of care or observation. Acute episodes of chronic conditions are eligible for coverage of skilled care.

16. Religious counseling, marital/relationship counseling, and sex therapy rendered in the absence of a mental disorder.

17. Food, food supplements, vitamins and other nutritional and over-the-counter electrolyte supplements except as required to treat phenylketonuria (PKU).

18. Private duty nursing services.

19. Services associated with or arising as a result of non-covered services including, but not limited to, hospitalization, surgery, diagnostic tests, monitoring, laboratory services, drugs and supplies. This includes complications that arise from confinement, treatment or services excluded under this plan or other employer-sponsored plans.

20. Transportation except as specifically provided under the ambulance or transplant benefit.

21. Routine foot care including services for weak, strained, flat, unstable or unbalanced feet or metatarsalgia or bunions (except open cutting operations) or corns, calluses, or toenails (except removing nail roots and care in the treatment of metabolic or peripheralvascular disease).

22. Treatment for injuries resulting during the commission of a felony.

23. Blood and blood plasma if replaced.

24. Any services not provided by a licensed practitioner.

25. Sexual transformation.

26. Over-the-counter drugs.

27. All services for the purpose of weight reduction.

28. Health club membership, air conditioners, dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic mattresses, home or automobile modifications, whirlpools and similar items even if recommended by a physician.

29. Injury incurred in connection with and while self-employed or employed by someone else for wages or profit, or a disease covered by Workers' Compensation or other similar law. This exclusion applies to any covered person, including the employee, a spouse and dependent children.

30. Service or supplies furnished by any level of government, unless payment is legally required.

31. Illness or injury due to declared or undeclared war, including resistance to armed aggression.

32. Nicotine patches and nicotine gum.

33. Breast reduction surgery.

Exclusions continued on back.

EXCLUSIONS FROM COVERAGE Cont.

The following are excluded from out-of-network coverage:

1. Exclusions described previously.

2. Preventive services including, but not limited to, physical examination, evaluation, or treatment for prevention medical purposes (except routine OB visits maternity care), such as routine immunizations, outpatient office visits for well-child care, preventive dental treatments, routine vision screening, and weight loss programs.

3. Infertility services, including diagnosis, treatment, assisted reproduction and artificial insemination.

4. Health education programs.

5. Growth hormone solution and supplies.

6. Organ transplants, bone marrow transplants, bone marrow/stem cell harvest and any complications arising therefrom.

7. Mental health and chemical dependency services except as specified for students attending school outside the service area.

8. Chiropractic and podiatry services.

9. Charges in excess of usual and customary.

10. Charges from providers who waive deductible and coinsurance payments by the enrollee.

Choice Plus℠, a self-insured plan, is administered by GHI Administrators, Inc., for Business Health Care Action Group member companies.

Choice Plus Helpline: 897-3500

Toll-free: 1-800-851-5700

CP 10-103 (10/92)

Model standard benefits

Oregon

Who
Following the 1989 Oregon Basic Health Services Act, Oregon's governor appointed an 11-member Oregon Health Services Commission (5 doctors, a nurse, a social worker, and four consumers).

Objective
The OHSC was charged with producing a prioritized list of health services that could be used to define a basic benefits package. The basic benefits package would initially be provided to all Medicaid enrollees; it would subsequently serve as the floor for all private and public health plans in Oregon.

Product
The OHSC created a list of 688 condition/treatment pairs to account for virtually all health care interventions (long-term care, for example, is excluded). The OHSC then identified 17 general service categories, which were ranked and labeled as either "Essential," "Very Important," and "Valuable to Certain Individuals."

Each condition/treatment pair was placed in one of the 17 categories and ranked within categories according to their "net benefit," derived by combining assessment of treatment outcomes and Oregonians' opinions about various states of health. Health care professionals provided outcomes data (to the extent it was available). The OHSC obtained information about Oregonians' opinions on health by conducting a telephone poll and holding numerous "town hall" meetings.

Finally, in a line-by-line review, the Commissioners used their collective judgment to re-rank "out-of-position" condition/treatment pairs. Based on actuarial estimates for each item on the list, the legislature then went as far down the list--that is, covered as many services--as Oregon's Medicaid budget allowed. For the current biennium, the legislature drew the line between items 568 and 569. Oregon will provide the new benefits set under Medicaid beginning in February 1994. The employer mandate will become effective in 1995 (?).

Services below the line fall into one or more of the following categories: service is less effective than treatments ranked higher; condition will run its course regardless of treatment; cosmetic treatment; disease is staged and certain stages are covered higher on the list; and alternative treatment is covered.

Considerations
Oregon's process promotes OHSC's and the legislature's accountability to the public (health

care professionals and consumers engaged a public discussion of the relative value of specific health care interventions; the OHSC's standards and processes are open to public debate; and the budget-determined line is explicitly drawn by the legislature).

The standard benefits are, to some extent, defined *by* Oregonians *for* themselves, thereby increasing the probability that the public will view the definition as legitimate and abide by the definition's restrictions.

Oregon's process also raise some concerns, notably that democratically-defined standard benefits might assign lower priority for socially disfavored conditions (e.g., AIDS)

The definition's level of specificity fosters competition (standardization, consumer understanding, and comparisons across ISNs).

However, the high level of specificity may hinder ISN flexibility and restrict provider clinical autonomy and patient freedom of choice.

Also, condition/treatment list still aggregates diverse conditions and thus may lead to unfair or inefficient results.

Box B—Categories of Services Used in the Prioritization Process and Examples of Condition-Treatment (CT) Pairs

Category	Description
"Essential" services	
1. Acute fatal	Treatment prevents death with full recovery. *Example: Appendectomy for appendicitis.*
2. Maternity care	Maternity and most newborn care. *Example: Obstetrical care for pregnancy.*
3. Acute fatal	Treatment prevents death without full recovery. *Example: Medical therapy for acute bacterial meningitis.*
4. Preventive care for children	*Example: Immunizations.*
5. Chronic fatal	Treatment improves life span and quality of life. *Example: Medical therapy for asthma.*
6. Reproductive services	Excludes maternity/infertility services. *Example: Contraceptive management.*
7. Comfort care	Palliative therapy for conditions in which death is imminent. *Example: Hospice care.*
8. Preventive dental care	Adults and children. *Example: Cleaning and fluoride applications.*
9. Proven effective preventive care for adults	*Example: Mammograms.*
"Very important" services	
10. Acute nonfatal	Treatment causes return to previous health state. *Example: Medical therapy for vaginitis.*
11. Chronic nonfatal	One-time treatment improves quality of life. *Example: Hip replacement.*
12. Acute nonfatal	Treatment without return to previous health state. *Example: Arthroscopic repair of internal knee derangement.*
13. Chronic nonfatal	Repetitive treatment improves quality of life. *Example: Medical therapy for chronic sinusitis.*
Services that are "valuable to certain individuals"	
14. Acute nonfatal	Treatment expedites recovery of self-limiting conditions. *Example: Medical therapy for diaper rash.*
15. Infertility services	*Example: In-vitro fertilization.*
16. Less effective preventive care for adults	*Example: Screening of non-pregnant adults for diabetes.*
17. Fatal or nonfatal	Treatment causes minimal or no improvement in quality of life. *Example: Medical therapy for viral warts.*

SOURCE: Oregon waiver application, August 1991.

PRIORITIZED LIST OF HEALTH SERVICES
October 30, 1992

Diagnosis: SEVERE/MODERATE HEAD INJURY: HEMATOMA/EDEMA WITH LOSS OF CONSCIOUSNESS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 850.1-850.5,851.02-851.06,851.1,851.22-851.26,851.3,851.42-851.46,851.5,851.62-851.66,851.7,851.82-851.8
851.9
CPT: 61108,61313-61315,62140-62141
Line: 1

Diagnosis: INSULIN-DEPENDENT DIABETES MELLITUS
Treatment: MEDICAL THERAPY
ICD-9: 250.01,250.1-250.3,250.6,251.3,775.1
CPT: 11400-11402,11420,90000-99999
Line: 2

Diagnosis: PERITONITIS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 567,777.6
CPT: 90000-99999
Line: 3

Diagnosis: ACUTE GLOMERULONEPHRITIS: WITH LESION OF RAPIDLY PROGRESSIVE GLOMERULONEPHRITIS
Treatment: MEDICAL THERAPY INCLUDING DIALYSIS
ICD-9: 580.4
CPT: 90000-99999
Line: 4

Diagnosis: PATENT DUCTUS ARTERIOSUS
Treatment: LIGATION
ICD-9: 747.0
CPT: 33820-33822
Line: 5

Diagnosis: PNEUMOTHORAX AND HEMOTHORAX
Treatment: TUBE THORACOSTOMY/THORACOTOMY, MEDICAL THERAPY
ICD-9: 511.8,512,860
CPT: 32020,32500,90000-99999
Line: 6

Diagnosis: HERNIA WITH OBSTRUCTION AND/OR GANGRENE
Treatment: REPAIR
ICD-9: 550.0-550.1,551-552
CPT: 39502-39541,43330-43331,43885,44050,44346,49500-49611,51500,55540
Line: 7

Diagnosis: APPENDICITIS
Treatment: APPENDECTOMY
ICD-9: 540-543
CPT: 44900,44950,44960
Line: 8

Diagnosis: ADDISON'S DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 255.4,255.5
CPT: 90000-99999
Line: 9

Model standard benefits

MN Health Care Access Commission (HCAC)

Who
The HCAC was an interdisciplinary public commission appointed by the governor in 1989. The 27 member HCAC was charged to recommend to the legislature a plan to provide access to health care for all state residents.

Objective
The HCAC sought to define the standard benefits set that would apply to all public and private health plans. According to the HCAC, "health care equity should serve as the central principle" for defining standard benefits, a process which must begin with a commitment to "'drawing a line' around our entire community, extending health care access to all."

Product
The HCAC identified two standard benefits sets. A uniformly applied "adequate and affordable" Universal Basic Benefits Set (UBBS) was to be the ultimate goal of Minnesota's health care system. The HCAC did not define the UBBS. An Intermediate Benefit Set (IBS) would be the interim goal if the state, for reasons of cost, would be unable to assure universal access to the UBBS. The HCAC provided a detailed description of the IBS (a product of various committees and subcommittees of the HCAC, supplemented by outside actuarial assistance).

The HCAC cited three underlying principles (in addition to "health care equity") in designing the IBS: (1) an emphasis on primary and preventive care; (2) a balance between expenditures for high-cost and low-cost cases; and (3) a limit on the use of copayments.

The IBS lists 8 broad categories (e.g., dental care), with several types of covered services within each category (e.g., inlays, crowns, prosthetics). Copayments levels and any limits on coverage are specified for each service (e.g., 10 hour limit per person per year for outpatient mental health).

Considerations
Using a publicly appointed group to define standard benefits may: insulate the process to a degree from political pressures; increase the objectivity of the decision-making process; facilitate public participation; build support for controversial recommendations; and, in general, help to increase the legitimacy and acceptability of the final product (Alpha Center).

Defining an interim, less precise and/or less generous, standard benefits set may enable reforms to move forward with the expectation that a more precise and/or more generous

standard benefits set would be defined later.

The IBS specifically defines "services performed by physicians" to include "services performed by other qualified health professionals within their licensed scope of practice" thus encouraging the use of non-physician providers.

The HCAC explicitly acknowledged economic constraints (i.e., affordability to the state) in defining the IBS.

The HCAC recommended that "breadth" of coverage take precedence over "depth" of coverage, on the premise that access to primary and preventive care provides more overall benefit to more people.

Emphasizing primary and preventive care may improve efficiency, by encouraging treatment for minor conditions before they become major.

The HCAC recommended that spending for high cost cases (i.e., catastrophic expenditures) be capped at a fixed percentage of total expenditures, thereby promoting the collective health of society as a whole, while still maintaining/improving the health of individuals.

Targeted and limited copayments are used to encourage efficient and appropriate use of health care system--minimizing shifting costs to patients.

Attachment B

INTERMEDIATE BENEFIT SET

Attachment B describes the services covered and terms of coverage under the Intermediate Benefit Set (IBS) offered through the Minnesotans' Health Care Plan. The first column describes the benefit, and the second column describes the terms under which it is covered. Some benefits are covered for children only, or are covered differently for children and adults. These differences are noted under the second column.

In this attachment, references to services performed by "physicians" may also include services performed by other qualified health professionals within their licensed scope of practice, including but not limited to nurse practitioners, physician assistants, chiropractors, podiatrists, physical therapists, occupational therapists, speech therapists, and audiologists. All benefits are subject to the managed-care procedures and requirements of the health plan company or comparable administering entity.

Benefit Description	Coverage Terms
I. PREVENTIVE CARE.	
A. Prenatal and Post-Natal Care. This benefit provides for prenatal and post-natal visits.	Covered in full.
B. Well Baby Exams. This benefit provides for normal periodic examinations of well children under one year of age.	Covered in full.
C. Immunizations. This benefit provides for the professional services and materials associated with administering immunizations.	Covered in full.

Benefit Description	Coverage Terms
D. Selected Preventive Tests/Screening. This benefit provides for the following: 1. Pap tests for women age 20 and over at intervals recommended by the American Cancer Society. 2. Mammograms for women age 50 and over at intervals recommended by the American Cancer Society.	Covered in full
E. Physical Exams. This benefit provides for routine examinations, including well child exams, and includes the cost of lab and x-rays associated with the exam.	*Children 0-17:* Only as part of an EPSDT regimen (Early and Periodic Screening, Diagnosis and Treatment). *Adults:* No coverage.
F. Vision Exams. This benefit provides for eye exams conducted by a licensed opthamologist or optometrist.	*Children 0-17:* Only as part of an EPSDT regimen. *Adults:* No coverage.
G. Hearing Exams. This benefit provides for hearing exams.	*Children 0-17:* Only as part of an EPSDT regimen. *Adults:* No coverage.
H. Speech Exams. This benefit provides for speech exams.	*Children 0-17:* Only as part of an EPSDT regimen. *Adults:* No coverage.

Benefit Description	Coverage Terms

2. OFFICE/HOME VISITS AND DRUGS/SUPPLIES.

A. Primary Care Visits. This benefit provides for office and home visits by primary care physicians (for example, general and family practitioners, internists, pediatricians and obstetrician/gynecologists), nurse practitioners and physician assistants. This benefit includes: 1. Office visits. 2. Visits to the enrollee in his/her home or in a custodial facility. This benefit does not include prenatal and postnatal care, well baby exams, and physical exams---covered under items 1A, 1B & 1E, other health professional visits---covered under item 3A, or inpatient and outpatient pre-surgical or post-surgical visits---which are covered under items 3C and 7B.	*Adults:* 8 visit limit per year for all primary care visits. Additional visits covered when an alternative to inpatient care. *Children 0-17:* Covered in full, no copayments.
B. Prescription Drugs. This benefit provides for outpatient prescriptions ordered by an attending physician, including the dispensing fee.	*Adults:* Very limited formulary, including exclusion of certain types of drugs. $5 copayment. *Children 0-17:* Broader formulary and no copayments.
C. Therapeutic Injections. This benefit provides for professional services and materials associated with therapeutic injections when administered by the staff of the attending physician. Immunizations are not included.	*Adults:* Very limited formulary, including exclusion of certain types of drugs. $5 copayment. *Children 0-17:* Broader formulary, no copays.
D. Durable Medical Equipment, Prosthetic and Orthotic Devices. This benefit provides for the following types of appliances and equipment, including but not limited to: braces (orthotics), canes, crutches, glucosan, glucometer, intermittent positive pressure machines, rib belt for treatment of an accident or illness, walker, wheel chairs, etc. This benefit also provides for prosthetics, and includes artificial parts that replace missing body parts or improve body function (e.g., artificial limbs, heart valves, medically necessary reconstruction).	*Adults:* No coverage. *Children 0-17:* Covered in full.

Benefit Description	Coverage Terms
E. Glasses. This benefit provides for 1 pair of eyeglasses every two years. Contact lenses are excluded.	*Adults:* No coverage *Children 0-17:* Covered in full
F. Hearing Aids. This benefit provides for hearing aids.	*Adults:* No coverage. *Children 0-17:* Covered in full.

3. OUTPATIENT/OFFICE -- SURGERY, TESTING AND SPECIAL THERAPIES.

A. Other Health Professional Visits. This benefit provides for visits to licensed health professionals not covered under other categories---such as item 2A, primary care visits.	*Adults:* Covered in full up to a total of 8 visits. per year for all providers combined. No copayments. Additional visits covered when an alternative to inpatient care. *Children 0-17:* Covered in full. No visit limit or copayments.

1. **Physician Specialists.**
   This benefit provides for specialist consultations, and presumes the primary care physician has due cause to seek consultation. A consultation includes services rendered by a physician or other appropriate professional for the further evaluation and/or management of the patient. When the consulting physician assumes responsibility for the continuing care of the patient, any subsequent visits to the physician will be considered primary care.

2. **Chiropractors.**
   This benefit provides for visits to licensed chiropractors, including those visits involving manipulations.

3. **Podiatrists.**
   This benefit provides for visits to licensed podiatrists.

4. **Physical Therapy and Rehabilitation Services.**
   This benefit provides for physical therapy and occupational therapy.

5. **Speech Therapy.**
   This benefit provides for speech therapy services, including treatment to correct effects of illness, injury or medical condition, and educational therapy for the purpose of correcting speech impediments or assisting the initial development of verbal facility.

6. **Audiology.**
   This benefit provides for audiology services.

Benefit Description	Coverage Terms
B. Hospital - Surgery. This benefit provides for hospital outpatient surgery services performed in a hospital outpatient facility or a freestanding surgical facility.	Covered in full.
C. Hospital - Radiology and Pathology. This benefit provides for the technical component of radiology services and pathology services performed in a hospital outpatient department or a free-standing facility.	Covered in full.
D. Physician - Surgery. This benefit provides for surgery by a physician in a hospital outpatient department, freestanding surgical facility or physician's office. This benefit includes services by an anesthesiologist or anesthetist for outpatient surgeries, and normal pre-surgical and post-surgical encounters with the surgeon.	Covered in full.
F. Physician - Radiology, Pathology. This benefit provides for professional services by the physician when x-rays and lab procedures are performed in the office, hospital outpatient department or freestanding facility.	Covered in full.
G. Cardiovascular Tests and Procedures. This benefit provides for therapeutic services (e.g. CPR), cardiography (EKGs), cardiac catheterization and other cardiovascular services performed or ordered by a physician.	Covered in full.
H. Allergy Testing and Immunotherapy. This benefit provides for professional services and materials associated with allergy testing and immunotherapy (serum, syringes. etc.) when administered by a physician or a physician's staff.	*Adults:* No coverage. *Children 0-17:* Covered in full.
I. Dialysis Procedures. This benefit provides for services by a physician and staff for dialysis treatment including hemodialysis, peritoneal dialysis and miscellaneous dialysis procedures.	Covered in full.
J. Other Miscellaneous Tests and Procedures. This benefit provides for the following professional services: Biofeedback services Chemotherapy services Dermatology services Gastroenterology services Neurology services Non-invasive peripheral vascular diagnostic studies Otorhinolayrngology services Pulmonary services Vestibular functions tests	Covered in full.

Benefit Description	Coverage Terms

4. MENTAL HEALTH AND ALCOHOL/DRUG DEPENDENCY CARE.

INPATIENT CARE -- TERMS OF COVERAGE. 80% coverage is provided for both inpatient mental health care and general inpatient care. 100% coverage is provided after $2,500 in out-of-pocket expenses per household per year, up to a maximum benefit of $70,000 per person per year ($72,500 in total expenses including out-of-pocket). The maximum out-of-pocket expense for inpatient mental health care is a combined maximum with general inpatient care.

A. Inpatient - Mental Health. This benefit provides for inpatient hospitalization for the treatment of mental disorders.	See above.
B. Inpatient - Alcohol & Drug Dependency. Inpatient hospitalization for the treatment of alcohol and drug dependency is excluded.	No coverage.
C. Outpatient -- Mental Health. This benefit provides for mental health treatment by a qualified professional qualified professional performed on an outpatient basis.	10 hour limit per person per year. No copayment. For the purpose of the 10 hour limit, 2 hours of group therapy are counted as 1 hour.
D. Outpatient -- Alcohol & Drug Dependency. This benefit provides for outpatient assessment and treatment of alcohol and/or drug dependency by a qualified professional or outpatient treatment program.	10 hour limit per person per year. No copayment. For the purpose of the 10 hour limit, 2 hours of group therapy are counted as 1 hour.

Benefit Description	Coverage Terms

5. MATERNITY, DELIVERIES, & NON-DELIVERIES.

A. Hospital Inpatient – Deliveries, Non-Deliveries. This benefit provides for hospital inpatient room and board and ancillary services in short-term community hospitals for the following: 1. Normal and caesarean deliveries. This includes coverage for services associated with the mother and baby in cases where there is a normal delivery. This does not include services associated with premature births or other neonatal care (covered under item 7). 2. Complications of pregnancy and pregnancies that do not result in a delivery due to miscarriage or therapeutic abortion.	80% coverage is provided for inpatient maternity care. 100% coverage is provided after $500 in out-of-pocket expenses per pregnancy. The maximum out-of-pocket expense for inpatient maternity care is separate from/ in addition to other maximums.
B. Hospital Outpatient – Deliveries, Non-Deliveries. This benefit provides for hospital outpatient services for maternity non-delivery procedures. Such services include: 1. Miscarriages. 2. Therapeutic abortions. 3. Testing procedures such as amniocentesis and ultrasound.	Covered in full.
C. Physician – Deliveries. This benefit provides for physician obstetrical care for normal deliveries, caesarean deliveries, and complications of pregnancy that result in normal or caesarean deliveries. Obstetrical care includes delivery care and anesthesia. This benefit exludes prenatal and post-natal visits---covered under item 1A.	Covered in full.
D. Physician – Non-Deliveries. This benefit provides for obstetrical care by physicians or other qualified health professionals for pregnancies that do not result in a delivery due to a complication, miscarriage or therapeutic abortion. Obstetrical care includes surgical care and anesthesia. This benefit exludes prenatal visits---covered under item 1A.	Covered in full.

Benefit Description	Coverage Terms

6. EMERGENCY SERVICES.

A. Hospital – Emergency Room. This benefit provides for services for emergency accident and medical care performed in the emergency area of a hospital outpatient facility or urgent care center.	$50 copayment, waived if admitted to hospital.
B. Physician - Emergency Room. This benefit provides for visits to either a primary care physician or a hospital staff physician in the emergency area of a hospital outpatient facility.	Covered in full.
C. Ambulance. This benefit provides for professional ambulance service. Ambulance service for maternity is not included, nor is service provided by a hospital in connection with the treatment of an illness or accident, except as provided for elsewhere in these benefits.	20% copayment.

7. HOSPITAL INPATIENT AND HOME HEALTH CARE -- GENERAL.

INPATIENT CARE – TERMS OF COVERAGE: 80% coverage is provided for both general inpatient care and inpatient mental health care. 100% coverage is provided after $2,500 in out-of-pocket expenses per household per year, up to a maximum benefit of $70,000 per person per year ($72,500 in total expenses, including out-of-pocket). The maximum out-of-pocket expense for general inpatient care is a combined maximum with inpatient mental health care.

Maternity care and related well-child care are not included in this category---covered under item 5A. Confinements related solely to custodial care are not covered.

All of the services listed in category 7 are subject to the inpatient care terms of coverage.

A. Hospital – Room, Board, Ancillaries. This benefit provides for daily semi-private room and board and ancillary services in short-term community hospitals. Ancillary services include use of surgical and intensive care facilities (charges that are in excess of an average semi-private room), inpatient nursing care, pathology and radiology procedures, drugs, supplies and other hospital-based services (e.g., physical therapy). Ancillary services do not include professional care by hospital-based physicians.	See above.

Benefit Description	Coverage Terms
B. Physician – Surgery. This benefit provides for surgeries by a primary surgeon or assistant surgeon performed on an inpatient basis, including normal pre-surgical and post-surgical encounters with the surgeon. This benefit also provides for services by an anesthesiologist or anesthetist for inpatient surgeries, including normal pre-surgical and post-surgical encounters and usual monitoring procedures.	See above.
C. Physician – Radiology, Pathology. This benefit provides for professional services by a physician when the x-rays or laboratory procedures are performed on an inpatient basis.	See above.
D. Physician – Visits and Consultations. This benefit provides for physician visits to hospitals and approved extended care facilities. The benefit also provides for the care of critically ill patients in a variety of settings that require the constant attention of the physician (e.g., cardiac arrest, shock, bleeding, respiratory failure, etc.) Critical care is usually given in a critical care area, such as the coronary care unit, intensive care unit or respiratory care unit. The benefit also provides for consultations for inpatient care. A consultation includes services rendered by a physician or other appropriate professional for the further evaluation and/or management of the patient.	See above.
E. Extended Care Facility (non-custodial). This benefit provides for daily room, board and ancillary services in an approved extended care facility. The facility may be either the extended care ward of a community hospital or an independent skilled nursing facility. Confinements must be medically necessary, and not related solely to custodial care.	See above.
F. Private Duty Nursing/Home Health Care (non-custodial). This benefit provides for private duty nursing and home health visits by a home health professional if required by the attending physician. This benefit does not include care that is solely custodial.	See above.

8. DENTAL CARE.

A. Preventive Services. This benefits includes oral examinations, x-rays, flouride applications, teeth cleaning and other laboratory and diagnostic tests.	*Children 0-17:* Covered in full. *Adults:* No coverage.

Benefit Description	Coverage Terms
B. Basic Non-Preventive Services. This benefit includes simple extractions, surgical extractions, oral surgery, anesthesia, restorations, emergency treatment, space maintainers, periodontics and endodontics.	*Children 0-17:* 20% copayments. *Adults:* No coverage.
C. Inlays, Crowns, Prosthetics. This benefit includes inlays and crowns, dentures and other removable prosthetics, bridges and other fixed prosthetics, denture and bridge repair (simple), and other prosthetics.	*Children 0-17:* 50% copayments. *Adults:* No coverage.
D. Orthodontic services. Orthodontic services are not covered.	No coverage.
E. TMJ and CMD Treatment. Treatment for temporomandibular joint disorder (TMJ) and craniomandibular disorder (CMD) is not covered.	No coverage.

9. EXCLUDED SERVICES.

The Intermediate Benefit Set does not cover services that are not medically necessary. In addition to those services listed as not covered in sections one through eight of this attachment, the following services will not be covered, regardless of medical necessity:

1. Experimental procedures.
2. Custodial care.
3. Personal comfort or beautification.
4. Treatment for obesity.
5. In vitro fertilization.
6. Artificial insemination.
7. Reversal of voluntary sterilization.
8. Transsexual surgery.

Model standard benefits

Hawaii

Who
Hawaii is the only state with near universal health care coverage. Over the past 20 years, Hawaii's legislature has implemented or adjusted various programs to expand access.

Objective
Hawaii has three unique health reform initiatives.
1. In 1974 Hawaii passed a statute requiring all employers to provide health insurance coverage to (nearly) all employees. This lowered the uninsured rate from 17% to 5%.
2. In 1989 Hawaii passed the State Health Insurance Program (SHIP) to provide coverage for the estimated 5 percent of Hawaii residents who remained uninsured after the 1974 employer mandate.
3. Hawaii's "Health QUEST" is a demonstration project to "transform Hawaii's various public health programs into a single privatized program" that will participate in a competitive managed care system.

Hawaii's overall objective is universal coverage. However, the initiatives define different levels of standard benefits and it is unclear if Hawaii's goal is uniform standard benefits for all private and public plans.

Products
The level of benefits in the 1974 employer mandate are modeled after the 2 plans offered in Hawaii that had the largest number of subscribers. In effect, Hawaii defined standard benefits for privately insured employees in terms of adequacy to the middle class.

Hawaii's 1989 SHIP, on the other hand, provides very basic coverage (a "bare bones" approach). It focuses on outpatient primary and preventive care and significantly restricts other coverage. Inpatient hospital coverage, for instance, is limited to 5 days per year; psychiatric therapy to 3 visits per year.

Benefits under QUEST are, according to Hawaii, "nearly identical to what every person receives via their employer plan." The stated objectives of the benefits package are to "promote cost containment, encourage prudent resource utilization and emphasize preventive care." The package provides for medical, dental, and mental health services--each category covered under separate contracts (e.g., the state will have only one contract for the dental plan, but may have several for the medical plan). (see attached table for QUEST standard benefits).

Considerations

(Unless and until the QUEST demonstration enrolls all public program enrollees) Hawaii will require private health plans to provide more generous 'standard benefits' than what the state itself is willing to provide to its public plan enrollees.

The 1974 statute's "middle class" definition of standard benefits may be a reasonable compromise between the goals of comprehensiveness and affordability.

Without Medicaid as a safety net, SHIP's bare bones benefits package may be unworkable.

Exhibit 2.3: Standard Benefits Package

SERVICE CATEGORY	LIMITS	CO-PAYMENT
Inpatient Hospital [2]		
• Medical	120 Days/Yr	$25/Admission
• Surgical		$25/Admission
• Rehabilitation		None
• Psychiatric [3]	15 Days/Yr	None
• Detox	5 Days/Yr	None
• Maternity	2 Days-Normal 4 Days-Cesarean	None
• Transitional (Subacute) Care	30 Days	None
Outpatient Hospital [4]		
• Emergency Room	None	$25/Visit [5]
• Ambulatory Surgery Center	None	None
• Psychiatric [3]	12 Visits/Yr	None
Preventive [6]	Mandatory EPSDT participation	None
Prescription Drugs [7]	Generic brands - (or equivalent if generic unavailable)	$2-Generic $5-Multi-source brands
Radiology/Lab/Diagnostic	None	None
Physician	25 Office Visits/Yr	$5/Visit
Other Practitioners [8]	None	None
Home Health	None	None
Child Dental	EPSDT coverage only unless emergency condition exists [9]	None
Adult Dental [10]	$250/Year	$5/visit
Managed Mental Health [3]	None	None
EXCLUDED SERVICES		
Chiropractic Infertility and sex transformation procedures	Personal Care Private Duty Nursing	Medical Social Work Residential Treatment for Substance Abuse

1 Applicable to adults only (21 years or older).
2 Unless indicated otherwise, includes all inpatient services presently covered under the Medicaid program.
3 Persons exceeding the limits will be covered under managed mental health program. Service eligibility contingent on pre-screening review for determination of chronic and seriously mentally ill conditions.
4 Unless indicated otherwise, includes all outpatient services presently covered under the Medicaid program.
5 Co-payment waived for emergency situations.
6 Includes physical examinations; immunizations; family planning, Well Baby and MOMI services.
7 Exempts maintenance prescription drugs, prenatal vitamins, birth control pills for adults.
8 Unless indicated otherwise, includes all other practitioner services covered under the Medicaid program.
9 As defined under Medicaid rules and regulations.
10 Limit and co-payment applicable only to non-preventive, non-emergency services.

Table 5.

Ages 19–39

Schedule: Every 1–3 Years*

Leading Causes of Death:
Motor vehicle crashes
Homicide
Suicide
Injuries (nonmotor vehicle)
Heart disease

SCREENING

History
Dietary intake
Physical activity
Tobacco/alcohol/drug use
Sexual practices

Physical Exam
Height and weight
Blood pressure
HIGH-RISK GROUPS
- Complete oral cavity exam (HR1)
- Palpation for thyroid nodules (HR2)
- Clinical breast exam (HR3)
- Clinical testicular exam (HR4)
- Complete skin exam (HR5)

Laboratory/Diagnostic Procedures
Nonfasting total blood cholesterol
Papanicolaou smear[1]
HIGH-RISK GROUPS
- Fasting plasma glucose (HR6)
- Rubella antibodies (HR7)
- VDRL/RPR (HR8)
- Urinalysis for bacteriuria (HR9)
- Chlamydial testing (HR10)
- Gonorrhea culture (HR11)
- Counseling and testing for HIV (HR12)
- Hearing (HR13)
- Tuberculin skin test (PPD) (HR14)
- Electrocardiogram (HR15)
- Mammogram (HR3)
- Colonoscopy (HR16)

COUNSELING

Diet and Exercise
Fat (especially saturated fat), cholesterol, complex carbohydrates, fiber, sodium, iron[2], calcium[2]
Caloric balance
Selection of exercise program

Substance Use
Tobacco: cessation/primary prevention
Alcohol and other drugs:
- Limiting alcohol consumption
- Driving/other dangerous activities while under the influence
- Treatment for abuse

HIGH-RISK GROUPS
- Sharing/using unsterilized needles and syringes (HR18)

Sexual Practices
Sexually transmitted diseases: partner selection, condoms, anal intercourse
Unintended pregnancy and contraceptive options

Injury Prevention
Safety belts
Safety helmets
Violent behavior[3]
Firearms[3]
Smoke detector
Smoking near bedding or upholstery
HIGH-RISK GROUPS
- Back-conditioning exercises (HR19)
- Prevention of childhood injuries (HR20)
- Falls in the elderly (HR21)

Dental Health
Regular tooth brushing, flossing, dental visits

Other Primary Preventive Measures
HIGH-RISK GROUPS
- Discussion of hemoglobin testing (HR22)
- Skin protection from ultraviolet light (HR23)

IMMUNIZATIONS

Tetanus-diphtheria (Td) booster[4]
HIGH-RISK GROUPS
- Hepatitis B vaccine (HR24)
- Pneumococcal vaccine (HR25)
- Influenza vaccine[5] (HR26)
- Measles-mumps-rubella vaccine (HR27)

This list of preventive services is not exhaustive. It reflects only those topics reviewed by the U.S. Preventive Services Task Force. Clinicians may wish to add other preventive services on a routine basis, and after considering the patient's medical history and other individual circumstances. Examples of target conditions not specifically examined by the Task Force include:
- Chronic obstructive pulmonary disease
- Hepatobiliary disease
- Bladder cancer
- Endometrial disease
- Travel-related illness
- Prescription drug abuse
- Occupational illness and injuries

Remain Alert For:
Depressive symptoms
Suicide risk factors (HR17)
Abnormal bereavement
Malignant skin lesions
Tooth decay, gingivitis
Signs of physical abuse

*The recommended schedule applies only to the periodic visit itself. The frequency of the individual preventive services listed in this table is left to clinical discretion, except as indicated in other footnotes.

1. Every 1–3 years. 2. For women. 3. Especially for young males. 4. Every 10 years. 5. Annually.

Table 5. Ages 19–39 — High-Risk Categories

HR1 Persons with exposure to tobacco or excessive amounts of alcohol, or those with suspicious symptoms or lesions detected through self-examination.

HR2 Persons with a history of upper-body irradiation.

HR3 Women aged 35 and older with a family history of premenopausally diagnosed breast cancer in a first-degree relative.

HR4 Men with a history of cryptorchidism, orchiopexy, or testicular atrophy.

HR5 Persons with family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions (e.g., dysplastic nevi, certain congenital nevi).

HR6 The markedly obese, persons with a family history of diabetes, or women with a history of gestational diabetes.

HR7 Women lacking evidence of immunity.

HR8 Prostitutes, persons who engage in sex with multiple partners in areas in which syphilis is prevalent, or contacts of persons with active syphilis.

HR9 Persons with diabetes.

HR10 Persons who attend clinics for sexually transmitted diseases; attend other high-risk health care facilities (e.g., adolescent and family planning clinics); or have other risk factors for chlamydial infection (e.g., multiple sexual partners or a sexual partner with multiple sexual contacts, age less than 20).

HR11 Prostitutes, persons with multiple sexual partners or a sexual partner with multiple contacts, sexual contacts of persons with culture-proven gonorrhea, or persons with a history of repeated episodes of gonorrhea.

HR12 Persons seeking treatment for sexually transmitted diseases; homosexual and bisexual men; past or present intravenous (IV) drug users; persons with a history of prostitution or multiple sexual partners; women whose past or present sexual partners were HIV-infected, bisexual, or IV drug users; persons with long-term residence or birth in an area with high prevalence of HIV infection; or persons with a history of transfusion between 1978 and 1985.

HR13 Persons exposed regularly to excessive noise.

HR14 Household members of persons with tuberculosis or others at risk for close contact with the disease (e.g., staff of tuberculosis clinics, shelters for the homeless, nursing homes, substance abuse treatment facilities, dialysis units, correctional institutions); recent immigrants or refugees from countries in which tuberculosis is common; migrant workers; residents of nursing homes, correctional institutions, or homeless shelters; or persons with certain underlying medical disorders (e.g., HIV infection).

HR15 Men who would endanger public safety were they to experience sudden cardiac events (e.g., commercial airline pilots).

HR16 Persons with a family history of familial polyposis coli or cancer family syndrome.

HR17 Recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illnesses, living alone, or recent bereavement.

HR18 Intravenous drug users.

HR19 Persons at increased risk for low back injury because of past history, body configuration, or type of activities.

HR20 Persons with children in the home or automobile.

HR21 Persons with older adults in the home.

HR22 Young adults of Caribbean, Latin American, Asian, Mediterranean, or African descent.

HR23 Persons with increased exposure to sunlight.

HR24 Homosexually active men, intravenous drug users, recipients of some blood products, or persons in health-related jobs with frequent exposure to blood or blood products.

HR25 Persons with medical conditions that increase the risk of pneumococcal infection (e.g., chronic cardiac or pulmonary disease, sickle cell disease, nephrotic syndrome, Hodgkin's disease, asplenia, diabetes mellitus, alcoholism, cirrhosis, multiple myeloma, renal disease, or conditions associated with immunosuppression).

HR26 Residents of chronic care facilities or persons suffering from chronic cardiopulmonary disorders, metabolic diseases (including diabetes mellitus), hemoglobinopathies, immunosuppression, or renal dysfunction.

HR27 Persons born after 1956 who lack evidence of immunity to measles (receipt of live vaccine on or after first birthday, laboratory evidence of immunity, or a history of physician-diagnosed measles).

Model specific standard benefit

Preventive Services

Who
The U.S. Department of Health and Human services convened the U.S. Preventive Services Task Force in 1984 to systematically review the scientific evidence on the effectiveness of clinical preventive services.

Objective
Based on its review, the Task Force developed "clinical practice recommendations" for preventive services. The recommendations apply only to asymptomatic persons who have no clinical evidence of the target condition.

Product
The Task Force's *Guide to Clinical Preventive Services* lists recommended screening, counseling, and immunization services, organized by age group. The recommended services and their frequency schedules are "provided for general guidance. Clinicians should use individual judgment to determine what is most appropriate for each patient." The Task Force notes that many services are recommended only for members of high risk groups and are not considered appropriate for routine examination of all persons. (The *Guide* offers detailed criteria for identifying individuals at higher risk.)
(See attached table for sample recommended services)

Considerations
It is not clear whether the Task Force recommendations reflect a judgment of a service's effectiveness (i.e., benefits outweigh harms) or a judgment of a service's cost-effectiveness (i.e., that the benefits are worth the cost). Thus, the recommendations may only indicate which preventive services "work", but not which are "worth doing" and therefor should be included in standard benefits.

Potential bias or lack of objectivity may argue against adopting, wholesale, recommendations (e.g., practice guidelines) developed by interest groups.

Interest groups may not develop their recommendations within a context of economic constraints (i.e., affordability may not be a guiding value).

However, recommendations developed by duly constituted expert panels may provide the best judgment of a health care intervention's effectiveness.