A Regulated Basic Benefit Package: Conceptual and Practical Issues

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1 Introduction

Although a relatively comprehensive benefit package is available to the poor under the Medical Assistance for the Poor program (MAP), there is no guaranteed minimum basic benefit package available on the market that can be purchased by all citizens of Georgia. The other benefit packages available on the market, both the subsidized voluntary package and the packages offered under corporate health insurance policies, are much more limited, fragmented, and difficult for consumers to understand and compare. The benefit packages currently on the market keep nearly all of the risk with the insured individual, which likely influences the relatively low demand for these products. The subsidized voluntary package has very low benefit ceilings, and the corporate policies have a wide range of exclusions that are directly related to individual risk factors and prior utilization.

The MoLHSA is currently reviewing options for specifying a regulated basic benefit package (BBP) that specifies a minimum set of benefits that must be available in health insurance packages sold by private insurers. This is an important policy decision-- a regulated BBP can do good or harm, and this needs to be a thoughtful process that relates to clear health system goals and the current realities of the system. What does the Government want to achieve with a BBP? Is the main objective to increase insurance coverage, or financial protection for individuals against catastrophic health expenditures? Is the objective to improve fairness and transparency? Clarifying the objectives will help the MoLHSA decide whether and how to go forward with a regulated BBP.

If the Government of Georgia decides to develop a regulated BBP, there are a number of policy decisions that must be made:

1. Will the BBP be regulated for the entire market (government-subsidized and private), or only for the government-subsidized programs?
2. Will the premium/premium-setting for the BBP also be regulated?
3. How will the BBP relate to other (complementary and supplemental) insurance packages?
4. How will the BBP be implemented and supervised?
5. What is the role of insurers in administrating the BBP?

The roles and relationships between the Government and private insurers will need to be clarified. What will be decided policy makers, and how much will insurers have freedom to determine? Specifically, who will determine methods of reimbursement, cost sharing, medical

management, coverage rules, etc.? How will private insurers be allowed to add value to the market by competing against one another?

The purpose of this document is to provide information and a framework for the MoLHSA to address these questions. The document describes the purpose and elements of a BBP, and how different options for design and implementation relate to different objectives, and may have different unintended consequences. Annex 1 provides a framework to develop and assess benefit package components, their characteristics, and estimated utilization, cost, and value. Decision-makers can use this framework to analyze existing benefit packages or construct a new BBP.

2 What is a Regulated Basic Benefit Package?

A regulated basic benefit package is a minimum set of services that must be offered to insurance enrollees. Insurers are free to cover more than the minimum required services. But insurers cannot cover less. A BBP includes at least two components: (1) the list of health care products and services that are covered (positive list), or alternatively, those that are not covered (negative list); and (2) limitations on reimbursement, such as maximum reimbursement levels, cost sharing, and exclusions (e.g. certain covered services may be excluded under certain circumstances). As a policy alternative, it is possible to specify a minimum monetary value of benefits that must be covered by insurers. This allows different insurers to choose to cover varying combinations of services to meet the required monetary value of the benefit. The main value of this regulation is it requires monitoring and measurement of the value of all private insurance packages. This prevents overpriced policies from cluttering the market. It offers insurers greater flexibility and consumers greater variety of coverage options than a BBP. However, it does not guarantee all insured receive selected priority benefits. Of course, it is possible to require both a BBP and minimum monetary benefit, which is similar to the U.S. Medicare system in which insurers must cover certain core components of care and choose other benefits to equate to a specified value

It is tempting to think of a regulated BBP primarily as a requirement for insurers. But this is incorrect. Technically, insurers administer the BBP. However, the real burden of paying for and producing the services specified in the BBP are on the financers and providers of care. A BBP requires all who pay for healthcare insurance, including the Government, employers, and individuals, to pay the amount necessary to cover the designated package. There are no options for anything less. And a BBP requires providers in all areas of the country to be ready to deliver package services.

2.1 What are the policy goals?

Regulated basic benefit packages come in many shapes and sizes and accomplish different objectives in different types of healthcare systems. They are a standard feature in European social health insurance schemes. Typically in these systems, public financing of the BBP is intended to guarantee everyone access to the same minimum of care. The BBP assures public monies provide prioritized healthcare basics before optional services. Under the new U.S. health reform legislation, all new insurance plans have to offer a minimum package of benefits defined by the federal government.

Of course, Georgia does not have a social health insurance system. A BBP implemented outside of a social insurance system is more complicated to design, cost, and enforce (both on the insurer and provider side). In Georgia, a universal BBP would be funded by a combination of public and private monies, would not guarantee everyone access to the same minimum of care because of large variations in service availability and quality and because everyone is not insured, and could improve but not assure prioritized healthcare spending. So why create a BBP in Georgia?

Designing and mandating a BBP should be part of a comprehensive plan for Georgia's health sector. The aggregate need for resources to preserve health and prevent and treat illness is infinite, especially when considering constantly new technological and scientific developments. No country has infinite resources for healthcare, so all must choose what to do and what not to do. This can be a solely political decision typically resulting in shortages, queues, poor quality, and corruption. It can be a purely market allocation to those who can afford to buy care with the consequence that much of the population is deprived of it. Georgia, pulled by history toward the former and driven by reforms toward the latter, must make rationing decisions. A BBP would define common, minimum care for those with insurance coverage.

It is important to understand what a BBP can do and what it cannot. With a BBP, the Government mandates every health insurance policy contain certain benefits. It does not mean everyone will buy insurance. In fact, if requiring a BBP increases the cost of health insurance, it will likely reduce the share of population insured. A BBP does not mean everyone insured will use the covered services they have. This is especially a problem in Georgia where utilization of the existing relatively comprehensive MAP package is low. Thus, a BBP offers all the insured equal access to care, but not equal care because some with access will choose not to use it. Essentially, there are other barriers to care in Georgia besides financial access.

A BBP can increase effective demand for covered services and therefore motivate providers to offer more of those services. However, a BBP does not make the healthcare delivery system capable of producing all its covered services at an acceptable level of quality. The health sector

will continue to be limited by its real capacity of both physical and human capital, which is determined by the resources allocated through provider reimbursement. Unfortunately, much provider financing remains rooted in an inadequate Soviet-style funding model. Insurers are consistently overfunded. Providers are consistently underfunded. The result is a squeezed, uncoordinated delivery system operating without common standards to produce a quality of care most Georgians clearly prefer to avoid.

Benefit design should focus on improving **access and utilization** of necessary services to encourage early diagnosis, appropriate treatment, and chronic disease management through routine care. Benefit design also should provide **financial protection** for individuals against catastrophic health expenditures. These objectives need to be balanced **against financial sustainability and profitability** for financers and insurers.

Some specific policy objectives in the Georgia context may include:

1. Make insurance coverage for a minimum package of essential services available for purchase (or purchased on their behalf) for all Georgian citizens.
2. Improve transparency in the health insurance market by making different plans easier to compare.
3. Make private voluntary insurance coverage more attractive for people who are currently uninsured.
4. Decrease the high level of out-of-pocket payments and catastrophic health expenditures for essential health care services.
5. Improve fairness in the system by decreasing the gap in benefits covered by the MAP program and other subsidized or private plans on the market.
6. Drive changes in the health services delivery system and contracting between insurers and providers that favor expansion and improvement of priority services.

Table 1 presents goals and objectives common to most healthcare systems. It shows a BBP is powerful in offering financial protection for the insured. A BBP's ability to increase the share of the population insured, stimulate desired utilization, and ultimately promote improved health is entirely dependent on its design. A BBP could bring desired or undesired results. Georgia should determine which of the listed goals are most important, and then consider how decision-makers can design a BBP to achieve those most important goals.

Table 1. Possible Outcomes from BBP in Georgia

BBP OUTCOMES	YES	NO	MAYBE
Assures all financial access to prioritized care	For the insured	For the uninsured	
Protect households from catastrophic health expenditures	For the insured (if there are not low coverage limits)	For the uninsured	
Promotes equity in care		Alone it does not	
Removes other barriers to care		Alone it does not	
Assures a standard quality of clinical care		Alone it does not	
Expands consumer choice		It does not	
Makes consumer choice easier by making it simpler to compare plans	Improves transparency in the entire market		
Enhances affordability			Depends on the BBP design and implementation which determine cost.
Increases the share of population insured			
Increases appropriate healthcare utilization			
Assures an adequate supply of covered services			
Produces the services people most want			
Uses fewest resources/ Produces efficiently			
Improves population health			

2.2 Pros and cons of a regulated BBP

2.2.1 Some pros

Greater equity among the insured: every individual who chooses to purchase (or is mandated to purchase in some systems) health insurance is entitled to the same minimum level of coverage.

Simplified consumer choice: standard benefit packages are more transparent and make it easier for individuals to choose insurers/plans

May reduce risk selection: it will be more difficult for insurers to identify high/low risk individuals based on the insurance package they choose, if insurers identify risk in this way.

Less politicization of benefits: when a regulated BBP does not exist, regulation of covered services may evolve in a piecemeal way that leads to fragmented, and at times nonsensical, coverage. In the U.S., for example, every state has a list of mandated benefits that any health insurance policy must cover. All states together have created nearly 1,900 mandated benefits. Mandating benefits in this way has been highly politicized, with medical interest groups spending large amounts of money to lobby politicians to mandate coverage of services that are profitable to them.

Opportunity to strengthen the healthcare system: alone a BBP does not change the delivery system or create standards to improve clinical quality. But a BBP could be a means for prioritizing changes to the healthcare system necessary for its implementation. It would give healthcare financers and deliverers a common prioritized focus. Georgia would need to further develop selected clinical quality standards, standardized definitions and codes, communication and administration information technology, revised reimbursement methods, and delivery system coordination to make a BBP work.

Reorienting healthcare spending: provider reimbursement is inadequate in Georgia while many private insurers earn extraordinarily high profits. Thus, overall healthcare funding might be adequate for delivering quality care if significant amounts of insurer profits can be reallocated to providers. Of course, insurers will not want to give up their profits easily. Depending on the rating methods used to price BBP insurance products and the methods of provider reimbursement, a BBP could reallocate funding from insurer profits to provider payments.

Shared financial risk: insurers should be encouraged to share financial risk with providers through different reimbursement mechanisms including capitation, case rates, target budgets, and withholds. This gives providers the opportunity to earn more through incentives to perform efficiently and effectively, rather than existing incentives to find ways to bill as much as possible because reimbursement is so low.

2.2.2 Some cons

It is critical to anticipate the possible negative consequences of a universal regulated BBP for the public and private sectors.

Reduced equity among the population: a BBP can broaden the gulf between the insured half of the Georgian population and the uninsured half.

Reduced consumer choice and possibly insurance coverage: those employers, individuals, and groups who now buy less expensive, less comprehensive coverage than a BBP would not have that option. Establishing a higher minimum benefit may force on buyers benefits they do not want or understand, and raise the cost of insurance policies. Introducing a BBP can push insurance out of reach for those now buying less generous coverage. A BBP could reduce the share of Georgians insured. This possibly could be addressed by allowing multiple regulated coverage levels, such as different levels of deductible and copayment, without reducing essential services in the package. But higher levels of cost-sharing, even for a lower premium, may not encourage uninsured individuals to buy insurance. If the regulated BBP is anything but most basic, the proportion of insured most likely will not increase, and could even decrease, in Georgia.

Reduce insurer ability to attract uninsured: currently half of Georgians are without health insurance. It is highly unlikely the Government is going to expand public purchasing so it is up to private insurers to attract the uninsured into the market. With a BBP insurers have less flexibility to design benefit policies at different prices that might attract the now uninsured. Since the now uninsured are largely smaller businesses and informal sector workers, it is not likely they can afford comprehensive benefits. If the BBP makes it harder to cover the now uninsured, the aggregate risk pool remains limited and does not allow for the full spreading of risk. Those who buy insurance likely pay more than they would have to if a larger share of the population was insured. On the other hand, the very limited benefit package offered under the subsidized voluntary insurance program ('cheap insurance') was not attractive to the uninsured, even at the very low subsidized premium. It is possible that getting the right minimum BBP that is affordable to the non-poor and perceived to bring real value could increase the share of insured people in Georgia.

May be insufficient to increase desired healthcare utilization: one need only look at MAP to find an example of a comprehensive package of insurance benefits not well used. For a number of reasons, poor Georgians prefer not to use many covered healthcare services. Since covered services are going unused now, it follows that a BBP is not necessarily going to increase use. A BBP can remove the financial barrier to access for those with insurance, but in Georgia, clearly there are other effective non-financial barriers to care a BBP would not remove. It is not at all clear a BBP will increase healthcare utilization.

May increase risk selection: exists because healthy insurance purchasers do not want to subsidize sick ones. Health insurers have many sophisticated ways to estimate medical risk and tools to use to select risk including underwriting, rating, denying or limiting coverage based on pre-existing conditions, developing targeted advertising and marketing campaigns, choosing to

operate in certain regions and not others,… If a goal is to regulate private insurer risk selection, implementing a BBP is a relatively ineffective way to do it.

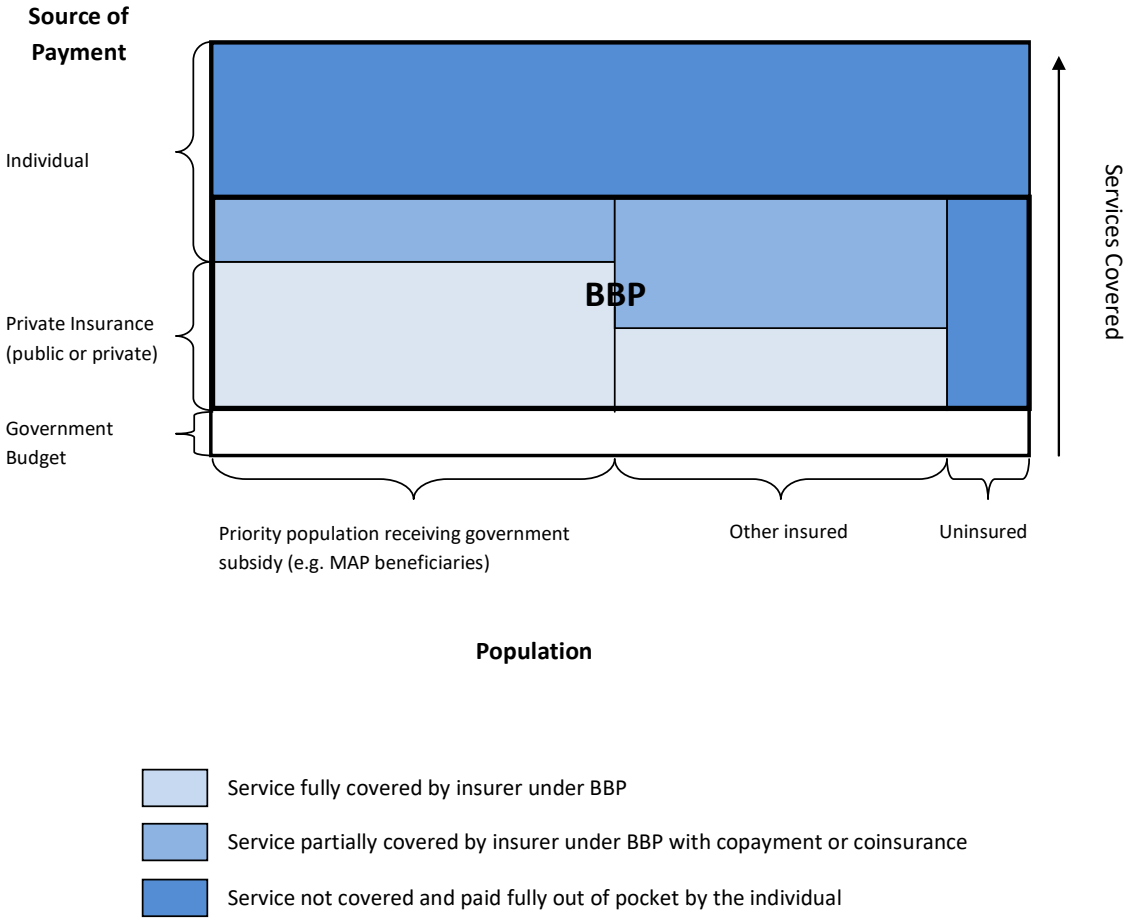
Greater politicization of benefits: the very act of publicly regulating benefits invites politicization of benefits. In Georgia, where insurers, providers, and drug companies can be closely related, the likelihood of politicization of benefits is tremendous.

3 Elements of a BBP

Figure 1 shows the elements of a BBP and how, although all individuals are entitled to coverage for the same services, different services may be covered at different levels for different population groups. For example, the same package of services is offered to all individuals who are insured, but a priority population such as the poor may be entitled to more of those services to be fully covered without cost-sharing. Or the regulated package of services with different levels of cost-sharing can be offered to all enrollees for different premium levels.

The BBP must be defined so that resources (premium revenues, social insurance contributions, and/or government budgets) match the benefits that are promised. The BBP should be aligned with available resources through the right mix of services covered and reimbursement levels/cost-sharing. For example, the packages can be specified to be narrow and deep (fewer services covered but at high percentage of cost covered) or broad and shallower (services are comprehensive, but there are high levels of coinsurance/copayments).

Figure 1. Structure of BBP



3.1 What services/products are covered? Constructing a regulated BBP

When creating a regulated BBP, it is tempting to aim for the highest aspirations of care, selecting services each person in Georgia ideally should be able to access. While this is an excellent approach for creating healthcare system goals, it is a big mistake for designing a BBP. When considering the components of a BBP, it is necessary to take the exact opposite approach, focusing on the minimum quality services deliverable in Georgia's poorest, least resourced areas. For example, it makes no sense to include mammogram breast cancer screening as part of a basic benefit package if the healthcare system does not have adequate screening resources, or if little can be done to intervene when a positive result is found. Decision-makers must consider the ability of the system's resources to provide the minimum benefit, unless there is willingness to cover benefits that could be delivered outside Georgia. Furthermore, since the Government must provide the minimum benefit to all those it covers, in practice, the Government must consider what package it can afford to buy with its limited

budget. To be meaningful, a BBP must be practical, achievable, affordable, and realistic. There must be confidence all package services can be paid for and delivered to all entitled to them.

- Components

What are the possible components of a basic benefit package? Table 2 lists general categories of healthcare services that should be considered when designing a BBP. These categories must have common, standard definitions such that when decision-makers discuss primary care, for example, all think exactly the same thing. Choices will have to be made about covering specific services and procedures within each category. Services and products covered by the BBP can be specified in terms of what is covered (positive list), or what is not covered (negative list). Most countries use negative lists for services and exclude interventions that are not medically necessary or cost-effective (e.g. cosmetic surgery/treatments, fertility treatment). For drugs and other medical products, however, most countries use positive lists. If the BBP is designed as a positive list of services, there can be a tendency to over-specify covered services. Although the intention is to increase transparency, in fact complicated benefit packages are more open to manipulation.[1]

Table 2. BBP Components and Characteristics

Components (Categories of Care)	**Characteristics**					
Category of Care	**Standard Definition**	**Standard Coding**	**Services Included**	**Services Excluded**	**Circumstances/ Limits**	**Provider/Place of Treatment**
			Resources to produce quality			
Primary					When should primary refer to secondary? Avoid dumping patients	
Preventive			Which screenings? Follow-up care? Smoking Cessation?			

[1]Kutzin J, Cashin C, Jakab M, Fidler A, Menabde N (forthcoming). Implementing health financing reform in CE/EECCA countries: synthesis and lessons learned. In Kutzin, J., Cashin, C., and Jakab, M. *Implementing Health Financing Reform: Lessons from Countries in Transition*. London: European Observatory on Health Systems and Policies.

Components (Categories of Care)	Characteristics					
Category of Care	**Standard Definition**	**Standard Coding**	**Services Included**	**Services Excluded**	**Circumstances/ Limits**	**Provider/Place of Treatment**
Secondary					Need a referral from primary?	Need to be a licensed specialist?
Tertiary			Outpatient vs Inpatient Surgery		Consider planned and unplanned	
Diagnostic			MRI, CT when?			
Therapeutic						
Mental Health						
Alcohol and Chemical Dependency						
Vision						
Dental						
Prescription Drug			Generics vs Brand		Step Therapy?	
Emergency Care						
Ambulance	Emergency transport must be different than house calls	Emergency transport must be different than house calls				
Durable Medical Equipment						
Women's Health, Maternity, Family Planning, Infertility						
Long-term care						
Plastic Surgery	What about reconstructive surgeries?					
Out-of-Area Care	Will the BBP cover services provided by out-of-area providers?					

Specific services and procedures also must be clearly defined with standardized coding because the covered service will have to be distinguished from other services for administration and reimbursement. Ambulance services offer a good example in Georgia. Ambulances provide emergency transportation to care facilities, and they also provide home health services. Will the BBP include both types of ambulance services? If so, both should not be reimbursed in the same way. Therefore, they must be distinguished, separately defined, and separately coded.

Practically, it makes sense to begin thinking about BBP components by examining the current MAP package. Which services should be included? Now there are benefit administration problems and ambiguities with some MAP benefits. For example, MAP coverage for all services emergent or urgent has created problems and incentives for abuse of the coverage. A BBP must do a better job of defining genuinely emergent care, what is covered and what is not. Existing problems need to be corrected so they are not transferred to a BBP.

- Circumstances
  When thinking about services to include in a BBP it is important to consider whether a service should be covered always or only in certain circumstances. Generally, a basic package includes only medically necessary care, not elective or optional services. Yet, it is critical to make sure hips and knees are replaced earlier rather than later after more damage has been incurred. How will the BBP make such requirements clear? Will the BBP only cover certain services (drugs, lab tests, radiology exams…) if providers have followed specific steps? For example, will there be prescription requirements to use branded drugs only when cheaper medications have proven less effective in the case or contraindications are present? Will insurers be allowed to pre-authorize benefits that are part of the BBP? Will patient visits to specialists only be covered if patients have a referral from their primary provider? Which circumstances will be defined by BBP decision-makers and which will be defined by insurers? Administrating special circumstances for package basic benefits requires record keeping and communication systems that are not widely in place now in Georgia, and mandates some coordination between primary, secondary, and tertiary levels of care which currently operate largely independently.

- Providers/Places of Treatment
  Must patients receive certain BBP services from particular providers with certain licenses and credentials in order to be covered? Can insureds go to any primary care

provider they choose or are there restrictions? If quality care can be provided in a variety of settings (inpatient hospital, outpatient hospital, or private clinic) how will patients be required or encouraged to get it in the cheapest? Put another way, will there be opportunities for insurers to not cover package benefits if patients do not use certain providers/places of treatment? These kinds of questions about providers and places of treatment must be answered for each service covered.

- Expected Utilization, Expected Cost, Expected Value
  The ideal regulated BBP is comprised of those health services that most improve the health status of the insured population for the money spent. It is necessary to estimate how many individuals will have BBP coverage and what share of them will likely use specific benefits. It is necessary to estimate how much standard quality BBP services and treatments will cost. In Georgia, it is critical to estimate costs based on adequate reimbursement levels and methods, not current ones. Of all medically necessary services available to Georgians, the BBP should include the ones that result in the biggest health improvements.

  Thus, when choosing among alternative medical services to include in the BBP it is necessary to know and compare their expected outcomes. This can be done in highly technical ways, but for practical purposes it is best to rank each service as offering high, medium, low, or no expected outcome. For example, family physicians can give immunizations or write work absence excuses. The first improves health outcomes; the second does not and should not be considered part of a basic benefit package. Combining information about insurance coverage, utilization, reimbursement and outcomes allows decision-makers to compare the relative values of alternative services and choose those that bring the most health for GEL spent. (See Table A2 in Annex 1).

- Updates
  Once selected, the components of a BBP should remain fairly stable over time. From the start, package designers should not include services that would be tempting to cut when times are tough. Included services should not fluctuate with economic highs and lows. The BBP should reflect a long term commitment by funders, insurers, and providers to a package of basic services insured people receive in good times or bad. If this kind of resolve does not exist in the health sector, the BBP should not be implemented.

  However, a BBP is not static. Once the BBP list and rules are created, it needs to be implemented and supervised. It needs to be tended over time. BBP components or rules that result in unintended consequences may need to be revised. In addition, as

advancements in services, treatments, and standards occur, innovations must be incorporated into the BBP to eliminate outdated, ineffective, and obsolete benefits.

3.2 Coverage levels—limits, deductibles, coinsurance and copayments

BBP designers also should consider the required benefit coverage level. Will cost sharing be allowed? It is well known that providing free healthcare services results in overutilization, waste and shortages. Modest cost sharing helps to mitigate these problems and encourage efficient use. Cost-sharing can be introduced into the BBP through a combination of coverage limits, deductibles, coinsurance and copayments (see Figure 2):

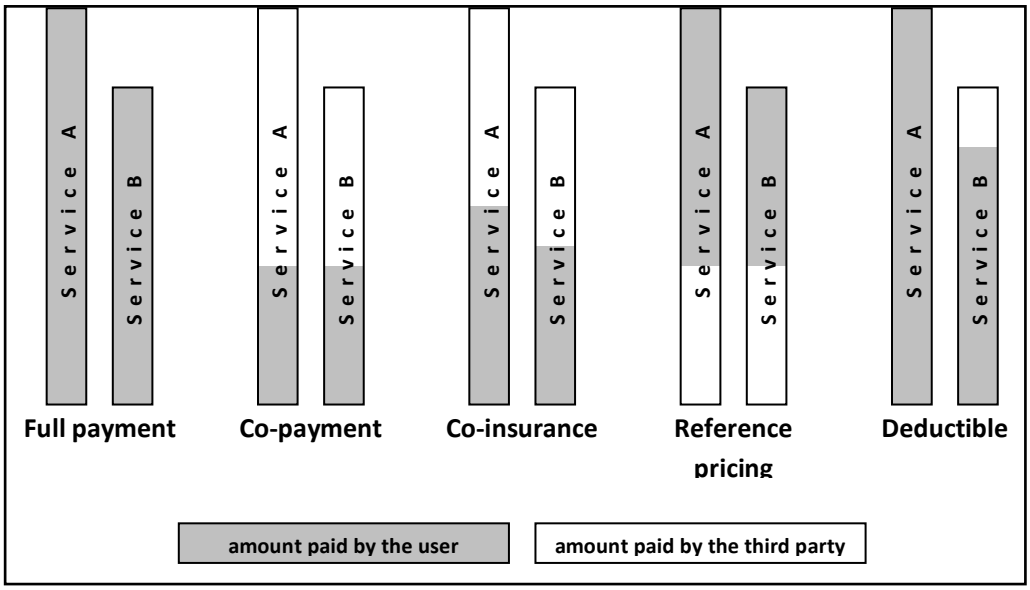
1. Coverage limits--maximum per-episode or per-year reimbursable level for a service or set of services)
2. Deductible—the total amount of money that the insured person must pay out of pocket (for all services) before insurance coverage begins for services that are subject to a deductible.
3. Coinsurance—the percentage of the reimbursed price paid to providers that must be paid by the insured.
4. Copayment—the fixed payment that the insured must pay to the provider for the covered services (unrelated to the price paid to the provider).

Cost-sharing in the context of the BBP serves several important functions:

1. Increases the total revenue available for covering essential services
2. Reduces *moral hazard*—or the possible increase of utilization beyond necessary levels when individuals do not face the full cost of care at the time of access
3. Can influence utilization
    a. Encourage more cost-effective services—e.g. no copayment for preventive services or high copayment for discretionary diagnostic services
    b. Reinforce gatekeeping—no/low copayment with referral and higher copayment without referral
    c. Encourage utilization of the insurer's provider network—no/low copayment for services from providers in the network and higher (or 100%) copayment for providers outside of the network

4. Can introduce choice within regulated BBP--different deductibles, coinsurance and copayments is a way to offer choice of products at different prices without excluding essential services

Figure 2. Cost-sharing Terminology



Source: Gotsadze G and Gaal P (forthcoming). Coverage decisions: benefit decisions and patient cost-sharing. In Kutzin, J., Cashin, C., and Jakab, M. *Implementing Health Financing Reform: Lessons from Countries in Transition*. London: European Observatory on Health Systems and Policies.

Ideally cost sharing fees should be modest yet meaningful, not creating a significant burden on patients. Yet they should not be so small it is of little consequence to the patient or not worth the extra administration to collect. Decision-makers should anticipate the effects charging a fee might have on use. For example, there is usually no cost sharing for preventive services because decision-makers never want to discourage use of preventive care. It is possible to impose a ceiling on the total amount of costs incurred by an individual or family in one year. This stoploss can be adjusted to the insured's income level. Similarly, it is possible to establish criteria for exempting particular insureds from cost sharing entirely.

3.3 Scope—does it include public and private insurance packages?

Typically a BBP is defined for all insurance coverage, public and private. But it does not have to be universal. In Georgia, will the BBP be a requirement for all publicly funded plans, for all privately funded plans, or for both? If it is required for all does it mean only comprehensive health insurance policies will be sold or can insurers offer supplementary and complementary

policies? For example, will there be no opportunity to sell or buy catastrophic plans? Would private insurers be allowed to sell policies that cover cost sharing (deductibles, coinsurance, copays) for comprehensive basic benefits policies?

- Why would the BBP be regulated for private insurance packages? Typically in unregulated packages, insurers try to avoid covering costly services or services likely to attract costly patients because both raise the price of insurance beyond the level purchasers are willing to pay and squeeze insurer profits. This is certainly the case in the corporate insurance market in Georgia.

- What may happen (and is perceived by many to be happening in Georgia) is that the publicly funded/subsidized packages may be more generous than the private packages. This could become a political problem, as well as an equity and access problem. However, it is also possible private sector purchasers may reject a mandated BBP and go without insurance, self insure. The political equity and access problems could persist or even grow with a BBP depending on private market reaction to the regulated package.

3.4 Principles in BBP Design

GOG will have to determine its own approach to BBP design and how to define benefits and coverage in a realistic way to match available resources (both public and private) and the current reality of the delivery system. To summarize the discussion above, there are some ke principles that can guide the definition of the BBP:

1. **Affordability**. The BBP should be affordable for the government and for people (and employers if the BBP will extend to the corporate market) to encourage them to buy insurance.

2. **Financial protection**. People should be protected from the catastrophic costs of serious medical problems. This means that low benefit limits for total coverage or for essential interventions should be avoided.

3. **Benefit exclusions and limitations**. Essential services (including preventive services) that are known to improve health should not be excluded or limited too much (e.g. exclusion of services for sexually transmitted infections in most corporate policies in Georgia).

4. **Improvements in the health delivery system**. The BBP should create incentives for health care providers to shift service delivery to more cost-effective services and modes of providing them.

5. **Chronic disease management**. Patients with serious chronic conditions should have access to services that enable them to manage their conditions and avoid medical

crises. This also should be designed encourage changes in the service delivery system toward more prevention and disease management.

6. **Cost sharing**. Cost-sharing should be included in the BBP in a way that achieves specific objectives (managing utilization, offering choice of levels of coverage) without creating excessive barriers to necessary care.

7. **Transparency**. The benefit package should be easy to understand for the insured and for providers.

8. **Expanded coverage**. People should have the option of buying supplemental/complementary coverage beyond the basic minimum benefit.

4 Other Practical Issues

4.1 Costing of the benefit package

Costing the benefit package and establishing an appropriate premium level is one of the most critical steps in BBP design. In Georgia, there are two main issues related to costing a BBP:

1. The costing should not be based (entirely) on the current actual costs of delivering health services. The current cost structure reflects many imbalances and inefficiencies that need to be corrected, not compensated. Costing the BBP and setting the premium (and ultimately provider payment rates) provides an opportunity to drive more efficient service delivery, as well as better use and more appropriate mix of inputs, including buildings, equipment, different types of personnel, and medicines and supplies.

2. The BBP costing should reflect adequate reimbursement levels and methods, not current ones.

Different approaches to costing the benefit package are available, and each has its strengths and limitations:

1. Actuarial models (can be relatively accurate; high data requirements; may maintain inefficient cost structures or low reimbursement rates)

2. Bottom-up costing (overly complex and inaccurate; based on current inefficient cost structures)

3. Negotiation (may get closer to fair reimbursement rates and improved cost structures; can be highly politicized)

A mix of these costing methods is most likely the best approach in Georgia, given data availability and the need to drive a new cost structure in the health delivery system. To achieve this objective, the costing process needs to be more transparent and systematic, and less politicized than it has been for the government-subsidized insurance programs.

4.2 Premium-setting—risk-rating or community rating

In the absence of regulation, private insurers typically set the premiums for insurance plans related to individual risk, so sicker individuals pay more. Identifying, selecting, and charging individuals for basic insurance based on their risk may make insurance unaffordable for those most in need of health care, and undermine access to necessary services by those with higher health needs. In this situation, over time insurers are likely to compete on their ability to select the lowest-risk individuals, or to identify higher risk individuals and charge them higher premiums. The incentive for insurers to compete on price and quality of services may be diluted.

Governments often regulate the premium-setting (though not always the premium) for regulated BBPs and require "community-rating." With community rating, everyone in a specified group is charged the same premium. The group cannot be defined in a way that is closely linked to health risk. The group may, for example, be defined by income (e.g. MAP beneficiaries) or employer. In some systems, the premium may vary by age and sex, which is related to population health risk, but not individual health risk.

With community rating, some sort of risk equalization scheme is necessary to compensate insurers that have higher than average risk pools. Even under ideal market conditions, some insurers will enroll riskier populations than others. In a well-functioning health insurance market, these risk variations are shared across insurers and not borne by individual consumers.

4.3 Relationship to supplemental/complementary insurance packages

Supplemental or complementary insurance products should be available on the market that are subject to far less regulation, and that have clear boundaries with the BBP without overlap. "Supplemental coverage" refers to coverage of services that are beyond the basic package (e.g. dental services), whereas "complementary coverage" refers to coverage of amenities to the services in the basic package (e.g. greater choice of provider or shorter waiting times) or coverage of copayments for the services in the basic package. The availability of supplemental/complementary insurance coverage keeps choice in the system, can expand the financial risk protection beyond what is possible within the resources available for the BBP, and provide an important way for insurers to distinguish themselves and compete.

Annex 1. Framework for Developing and Assessing Benefit Packages

Table A1. BBP Components and Characteristics

Components (Categories of Care)	Characteristics					
Category of Care	Standard Definition	Standard Coding	Services Included	Services Excluded	Circumstances/ Limits	Provider/Place of Treatment
Primary						
Preventive						
Secondary						
Tertiary						
Diagnostic						
Therapeutic						
Mental Health						
Alcohol and Chemical Dependency						
Vision						
Dental						
Prescription Drug						
Emergency Care						
Ambulance						
Durable Medical Equipment						
Women's Health, Maternity, Family Planning, Infertility						
Long-term care						
Plastic Surgery						
Out-of-Area Care						

Table A2. Estimated Utilization, Estimated Cost, Estimated Value

Category of Care	Number of Covered	Use Rate	Reimbursement Method / Cost Sharing	Cost per Patient per Month/Year	Total Cost	Value proposition: Health Benefit to Cost
Primary						
Preventive						
Secondary						
Tertiary						
Diagnostic						
Therapeutic						
Mental Health						
Alcohol and Chemical Dependency						
Vision						
Dental						
Prescription Drug						
Emergency Care						
Ambulance						
Durable Medical Equipment						
Women's Health Maternity, Family Planning, Infertility						
Long-term care						
Plastic Surgery						
Out-of-Area Services						

Table A3. Benefit Package Assessment

Criterion		Assessment
Affordability	Is the benefit package affordable for the government, the population, employers?	
Financial protection	Does the benefit package limit exposure of insured individuals to catastrophic health expenditures?	
Benefit exclusions and limitations	Are any key essential services that are known to improve health excluded or subject to excessive cost-sharing or coverage limits?	
Improvements in the health delivery system	Does the benefit package create incentives for health care providers to shift service delivery to more cost-effective services and modes of providing them?	
Chronic disease management	Does the benefit package ensure that patients with serious chronic conditions have access to services that enable them to manage their conditions and avoid medical crises? Does the benefit package encourage changes in the service delivery system toward more prevention and disease management?	
Cost-Sharing	Is cost-sharing included in the benefit package in a way that improves utilization management (or achieves other objectives, such as offering choice of levels of coverage) without creating excessive barriers to necessary care?	
Transparency	Is the benefit package easy to understand for the insured and for providers?	
Expanded coverage	Do people have the option of buying supplemental/complementary coverage with clearly defined boundaries between basic coverage and supplementary/complementary coverage?	