APPENDIX A

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The medigap and food labeling examples exhibit two different approaches to increase comparison shopping for consumers and to promote value-based competition. Standardizing benefits increases comparability but restricts the number of choices available to the consumer. Standardizing descriptive information about products and options also increases comparability without limiting product variance. Both approaches may facilitate decisionmaking, but the latter is less invasive, places fewer restrictions on the market, and allows producers to innovate and create better-value products.

The medigap example

The Omnibus Reconciliation Act (OBRA) of 1990 standardized health care policies available to beneficiaries in the Medicare supplemental insurance market. The elderly buy Medicare supplemental insurance or "medigap" policies to fill coverage gaps in traditional fee-for-service Medicare. Medicare beneficiaries faced a vast and confusing array of supplemental insurance options before standardization measures. By standardizing benefits packages into 10 different policies, legislators hoped to give consumers more leverage in choosing their medigap policies. Beneficiaries would be able to make informed decisions by comparing information about standardized benefits instead of sifting through information about an array of available benefit packages.

Need for intervention in the medigap market: historic context

The prestandardization supplemental insurance market was criticized for several reasons, including the prevalence of beneficiary confusion, fraudulent and abusive marketing and financial practices, and inefficiencies in the market.

- Beneficiary confusion: Beneficiaries were confused by the different combinations of available benefits packages and premiums. Beneficiaries' minimal knowledge of Medicare compounded the problem. According to McCall and colleagues, fewer than half of beneficiaries surveyed in 1982 understood that Medicare does not cover hospital stays exceeding 30 days or that it covers all cost, after the deductible is met, for a five-day hospital stay (McCall et al. 1986). As for the medigap market, few had a good grasp of the limitations in maximum coverage and other important characteristics of their policies.
- Fraud and abuse: Certain insurance companies were heavily marketing their medigap policies—sometimes to the point of misrepresenting their products—to convince the elderly to switch policies or to buy multiple policies. Some companies retained excessive profits by maintaining low loss ratios (the ratios of policy payments to premiums).
- Market inefficiencies: Several benefits packages offered specific benefits that might have appeared attractive but held no real value relative to costs. For example, certain policies covered payment for skilled nursing facilities (SNFs) beyond 100 days if Medicare had continued coverage until then. But because Medicare usually stopped SNF payments well before 100 days, this benefit offered little value. Because comparisons were difficult, ill-informed beneficiaries sometimes bought duplicative and unnecessary coverage.

In 1980, the medigap insurance market became the subject of several congressional hearings. Major problems with the market were highlighted by news of fraudulent market practices to lure frail elderly into switching policies or purchasing duplicative coverage.

These hearings led to the passage of the so-called Baucus Amendments, which encouraged state governments to establish minimum standards for medigap policy carriers. These standards, set by the National Association of Insurance Commissioners (NAIC) and the Association of Chief State Insurance Commissioners, required insurers to offer certain minimum benefits, maintain above-the-floor loss ratios, disclose a wide range of information to state officials, and provide accurate consumer guides. According to the General Accounting Office (GAO), the Baucus Amendments met most of their objectives in reducing marketing fraud and providing minimum benefits, but the legislation did not help consumers shop effectively for medigap policies (1986). These problems persisted because the Baucus Amendments did not address the wide array of benefit and premiums combinations available, nor was information on the assortment of policies couched in user-friendly, comparative formats. Also, the Baucus Amendments were not successful in inducing insurers to make minimum benefits payments in relation to premiums (minimum loss ratios) (Fox et al. 1995).

OBRA 1990 moved the medigap private insurance market, which traditionally had been under state jurisdiction, to federal control. The legislation also contained certain key provisions to alter the way medigap polices were sold and purchased after July 1992:

- All supplemental insurance policies, including hospital indemnity and dread disease policies, were standardized into 10 prototypes, named A-J.
- In addition to disclosing earnings and related information, which continued to be required, insurers now were required to provide potential policyholders with accurate information on benefits and premiums.
- Loss-ratio floors were set at 65 percent for individual policies and 75 percent for group policies. Insurers were required to distribute refunds to policyholders if ratios fell below the floors.
- Agents' commissions for policy sales were limited, and agents and insurers who knowingly sold duplicative coverage could face penalties.
- Exclusion periods for pre-existing conditions were limited to minimize adverse selection. Insurers were also required to hold six-month open enrollment periods for new Medicare Part B enrollees.

Has medigap standardization met its objective of facilitating beneficiary choice?

Standardizing medigap has helped improve beneficiary decisionmaking by simplifying options and reducing confusion among the elderly.

Simplified market

Before standardization, beneficiaries faced two general options:

- They could choose one or more supplemental policies that filled specific gaps in Medicare coverage. Because beneficiaries did not receive a list of supplemental insurance options or managed care organizations in their service area, they had difficulty learning about available options. Newly eligible beneficiaries had the dual task of learning how to navigate the Medicare environment and the supplemental market.
- They could leave the traditional fee-for-service setting and enroll in a managed care organization. If beneficiaries chose to leave the fee-for-service environment, they had to forgo access to medigap policies (otherwise, many would have duplicative coverage) (Davidson 1988).

Standardization simplified the decision-making process for supplemental policies. Although standardizing supplemental policy options into 10 medigap packages limited the number of choices available to consumers, it also significantly reduced the number of variables to process. Standardization narrowed the scope and amount of information needed for effective side-by-side comparison (Rice 1997). However, they did not simplify the choice between fee-for-service or managed care settings. Education initiatives about Medicare+Choice could help make this decision easier for beneficiaries.

Reduced beneficiary confusion

A survey of representatives from insurance carriers; consumer advocacy groups; state and federal officials; and state information, counseling, and assistance programs in 1992, 1993, and 1995 found that confusion among policyholders diminished as a result of medigap policy standardization (McCormack et al. 1996). Consumer advocates say that beneficiaries have become accustomed to 10 types of supplemental benefits packages. Researchers found that the number of complaints to state insurance departments decreased after standardization. OBRA regulation of marketing practices might explain some of this downward trend since agents' commission limits create disincentives for overly aggressive marketing (McCormack et al. 1996).

Has OBRA 1990 met its objective to enhance competition among medigap policy carriers?

The legislated standardization measures, coupled with regulations, cut down on fraudulent business practices. They also achieved a level of market stability and helped beneficiaries obtain better value. However, there is concern that risk selection—separation of the sicker, riskier population from the general population—has made the medigap market more expensive. Also, standardization may have prevented the medigap market from innovating to meet the varied needs of the beneficiary population.

Achieving market stability

McCormack and colleagues studied the level of market stability by measuring the number of medigap insurers before and after standardization. They found that the overall number of insurers remained relatively stable and that smaller carriers had left the market immediately after the legislation, although some did reenter the market within two years. Research found consensus among insurers, consumer advocacy groups, and state and federal regulators that the reduction in the number of carriers did not hurt consumer choice. (All 10 benefits options are now available through national carriers: AARP/Prudential and State BC/BS.) In addition, no significant barriers to entry were found.

Obtaining better value

If the medigap standardization measures have achieved the objective of increasing competition among carriers, then consumers should be able to obtain better value. Benefits that are important to beneficiaries should be available at lower premiums, and insurers should be more likely to offer the medigap policies in greatest demand. Three benefits considered to have little value to consumers were dropped during the legislative process: SNF stays exceeding 100 days, vision care coverage, and private duty nursing. Two specific benefits not previously available—at-home recovery coverage and preventive services—were added to a few benefit packages in response to the demands of consumer advocate groups.

According to Rice and colleagues, the choice of benefit options appears to be demand driven. For example, the number of medigap insurance carriers offering a policy that covered prescription drugs (H, I, or J) increased from approximately 30 percent in 1991 to 60 percent in 1995. However, the percentage of beneficiaries purchasing policies with this benefit increased from 13 percent to only 15 percent. Insurers covering the Part B deductible rose from 59 percent in 1991 to 90 percent in 1994, and demand for policies with this benefit increased from about 21 percent to 58 percent over the same period. The benefit of preventive services was not found to be very attractive to consumers even though 55 percent of insurers made it available (Rice et al. 1997).

These findings show that demand for a benefit, not supply, appears to drive consumer choice. In other words, consumers tend to purchase medigap policies based on their preferences instead of marketing pressures. However, whether beneficiaries make the "right" decision—that is, choose the policy that best fits their preferences, health needs, and budget constraints—is another question. Research on the "effectiveness" of consumers' medigap decisions in the prestandardization market showed that vulnerable beneficiaries especially needed help in choosing optimal policies (Rice et al. 1991). Similar research could help determine the effectiveness of consumer decisions in the post-standardization market.

Costs as well as benefits are part of the "better value" paradigm. In a more competitive market, consumers should pay less for similar services than they would otherwise. However, medigap insurers are subject to certain state and federal regulations in the post-standardization market. These regulations affect how they set their premiums (community rated, attained-age rated, or issue-age rated) and the proportion of premiums insurers may retain (by controlling the loss-ratio minimum). Premium prices have, in fact, increased dramatically in the post-standardization market, for example in certain markets premiums for medigap Plan C increased 8.5 percent annually between 1992 and 1996, and between 1995 and1996 the premiums for the same increased 20.6 percent (HCFA 1998).[1] However, the premium ranges have narrowed, indicating more competition due to standardization. A larger proportion of insurers also carries more comprehensive benefit packages, which may explain some premium increases. Finally, researchers have found that carriers that charge higher premiums than others lose market share (Rice et al. 1997).

Risk selection and limited innovation

More recent concerns relate to the high premiums associated with medigap policies that offer prescription drug benefits. Beneficiaries who expect to have high prescription drug costs may be more likely to purchase these policies than those who do not expect high costs. Medigap carriers, unable to spread risk effectively, must charge higher premiums to cover the aggregate higher costs. Because medigap policies are limited to 10 benefit packages, insurance companies have no flexibility to craft benefit packages to meet beneficiary needs. Additionally, carriers unable to compete on the basis of benefit packages also may have limited their ability to constrain increases in medigap premiums.

The food labeling example

To influence dietary patterns positively and reduce the risk of chronic diseases, the Congress passed the Nutritional Labeling and Education Act (NLEA) of 1990. Legislators believed that the NLEA, by requiring valid and reliable consumer information on labels, would foster informed decisionmaking in food purchases.

NLEA measures

The NLEA amended the Food, Drug, and Cosmetic Act of 1938 to require labeling on practically all packaged foods to specify the nutrient content information and the nature of specific health claims. To

1 Plan C includes coverage for basic benefits, parts A and B deductibles, SNF coinsurance and foreign travel emergency. For an explanation of benefits covered by each package, see *Guide to Health Insurance for People With Medicare* issued by HCFA and NAIC in 1998.

standardize the label, the NLEA provided specific statutory requirements on the description of nutritional content, ingredients, and health claims. The NLEA required the Food and Drug Administration (FDA) to regulate the authorization of health claims, especially disease-specific health claims. The agency was also required to undertake a consumer education initiative to increase awareness of the labeling changes and to help consumers incorporate the new information into their overall diet patterns.

In accordance with the measures, the FDA required standard nutritional information on all packaged foods, including information on serving size, saturated fat, cholesterol, dietary fiber, and other nutrients. Serving size standards enabled comparison shopping between similar products. The labels also included nutritional reference values or "% Daily Values" to provide consumers a benchmark to use in their decisionmaking process. Uniform definitions were required for terms that described the foods' nutritional content (such as "low-fat" or "light"). Health claims that relayed information about a specific nutrient and its relationship to a disease (such as calcium reducing the risk of osteoporosis) had to obtain FDA approval. After market research, focus group research, and market analysis, the FDA attempted to include information that consumers both wanted and needed in formats that were user friendly (such as "bolded" headings, minimal fine print, and excluded information on ingredients of negligible amounts). The regulations went into full effect in August 1994.

NLEA objectives

The NLEA's goals were to ensure that consumer information be provided in "a manner which enables the public to readily observe and comprehend such information and understand its relative significance in the context of a total daily diet" (NLEA of 1990, Pub. L. No. 101-535, 104 Stat. 2356). One goal was to help consumers identify and comprehend specific information on the food label. The second and related goal was to aid consumers in putting this information in the context of their total food intake, thereby "either lowering the risk, or forestalling the onset, of a particular chronic disease condition" (FDA 1990). The third goal was to promote value-based competition among food producers and encourage a more healthful food supply.

Consumers can use labeling information to learn about food contents and nutritional characteristics, comparison shop between different products or brands, or manage a special diet (Levy and Derby 1996). Food labels were standardized to facilitate these multiple tasks.

Health claims, which appear on applicable foods, were designed to create a more salient message about the link between specific nutrients or contents and a health condition. To prevent abuses of health claims, the FDA determines the validity of claims on 10 specific diet-disease relationships. Claims must not be misleading and must be "supported by valid reliable and publicly available scientific evidence" and "consistent with generally recognized medical and nutrition principles for sound total dietary patterns" (FDA 1990).

The need for labeling measures: historical context

In the 1980s, two emerging trends contributed to the passage of the NLEA.

First, amassing scientific evidence lent credence to the relationship between dietary habits and the risk of chronic diseases (such as cancer, cardiovascular disease, obesity, and diabetes). Scientific investigation also showed that more consumers were eating excessive amounts of calories, fat, sodium, and cholesterol. As more meals were consumed away from home and as snacking became more prevalent and frequent, Americans' consumption of fats, oils, and sugars increased in terms of total quantity and as a percentage of their daily intake (CNCFL 1990). The food label was considered an important tool in relaying important messages to consumers—a tool that, by current standards, was not adequately or appropriately used.

The second trend that contributed to the passage of the NLEA was the rise in consumer awareness of and interest in food choices. Americans were becoming more conscious about nutrition and health. Consumers also demanded convenient foods that were also healthy, varied, and high in quality. Food manufacturers, in response to these demands and consumer interest, increasingly produced foods for the health conscious. By 1990, 12,000 new food products were introduced annually in the supermarket. About half of all packaged goods came with nutritional information on the label, and many of these carried health claims. Confusion about U.S. Recommended Daily Allowances abounded, and lack of standard serving sizes made comparisons difficult and open to manipulation by the manufacturer (CNCFL 1990).

Has NLEA met its objectives in promoting consumer use of label information?

Thus far, evidence suggests Americans' use of food labels increased after the information standardization measures. To measure consumer, food processor, and manufacturer behavior, the FDA instituted a Food Label and Nutrition Tracking System. The component to track consumer behavior consisted of two nationally representative telephone surveys conducted before and after the full regulations took effect. Researchers found that 30 percent more consumers reported using quantitative information on the label "often" in November 1995 than in March 1994. More consumers also seemed to be aware that the government regulated information on the label (such as serving sizes), and fewer consumers felt that claims on food labels "are more like advertising than anything else" (Levy and Derby 1996).

Consumers seem to use the labeling information primarily to determine nutritional content and to comparison shop (Derby and Fein 1995). A recent study of the ability of consumers to plan diets based on label information indicated labels to be an "inadequate tool." Although consumers can comparison shop across products and brands based on nutritional and ingredient information, they find it difficult to use this information to calculate consumption levels of various components in the context of a total diet. However, the "% Daily Value" information was found to aid in this information process (Levy and Fein 1998).

Research on consumer reaction to risk information reveals that individuals tend to be more responsive to information about negative consequences than benefits (Bettman et al. 1987, Russo et al. 1986). The proliferation of fat-modified products in the market is a response to consumers' tendency to consume less of a "risky" component. Whether consumers are consuming more nutritionally beneficial components is not clear. This is a concern for certain populations, such as those at risk for chronic diseases.

Authorized health claims on labels were designed to increase the salience of information about nutritionally beneficial components. Those who read labels tend to have better knowledge of diet-disease relationships (Derby and Fein 1995). However, claims not diet-disease related (which do not require authorization) may confuse consumers and promote a product rather than inform decisions.

Has the NLEA met its objective in promoting a healthful food supply?

The market surveillance component of the FDA Food Label and Nutrition Tracking System monitored the sale of food products from supermarkets. It also tracked market share to determine if manufacturers were introducing more healthful foods, such as items lower in fat content. Researchers found an increase in market share of fat-modified products and a significant increase in such new products. For example, availability of fat-modified cookies went from about no percent of market share in 1991 to about 15 percent in 1995 (Levy and Derby 1996). ■

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