Coordinated Health Care Benefits Policy: Services, Cost Sharing and Limits for Macedonia

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# TABLE OF CONTENTS

Overview .................................................................................................................. 1  
Government Policy Priorities ................................................................................. 2  
Ministry of Health Goals and Objectives .............................................................. 2  
HIF Strategies ......................................................................................................... 3  
Suggested Basic Benefits Package and Participation (Cost Share) Policy ........... 4  
Summary and Recommendations ........................................................................... 10  

Appendices:

A. Health Insurance Theory and Practice ............................................................... 13  
B. Definitions of Terms .......................................................................................... 17
OVERVIEW

This report describes the design of a basic benefits package for the health insurance program of Macedonia. This benefits package design is one product of RAND's consultation work with the Macedonian government. While this report provides a specific benefits package option, it serves two other purposes: 1) it makes the policy levers available to the government explicit and 2) serves as the basis for discussion and policy debate before the package is finalized by policymakers.

The benefits package can be divided into three components as shown below in Figure 1. The first is a list of services or covered benefits. These are typically divided into several categories that vary by the level of insurance coverage and participation responsibilities of individuals. Services are generally divided by provider (e.g., doctor, surgeon, dentist) or location of the service (e.g., inpatient versus outpatient) and procedure (e.g., parenteral therapy, biopsies or deliveries). The second component is the participation policy. These are the copayments (fixed denars amount) or coinsurance (percentage rates of total charges) that limit overutilization of services that occur in insurance markets. Annual limits are the third component and further balance participation and services. The limits restrict the amount patients have to pay through participation or the amount of services insurers have to cover. While the list of services is more commonly thought of as the core of a benefits package, all three components—balanced together—form a coordinated benefits package and define the policy options of government.

Figure 1. Components of a Coordinated Health Care Benefits Policy
To achieve more appropriate levels of service use, to expand availability of medically necessary care, and to limit costs, the suggested basic benefits package needs to have the following features:

- Emphasizes primary care services by generalists
- Shifts care from the inpatient to the outpatient settings
- Eliminates the broad list of coinsurance exemptions and uses the national definition of poverty as the basis for exemptions
- Requires preapprovals before coverage can be provided for high cost services
- Provides for a variety of participation levels for insured individuals to influence their use of health care services to promote participation of primary care services and limit the overutilization of tertiary care
- Sets an annual limit on the amount of total participation to protect the poor and the infirm from the costs of prolonged hospitalization.

GOVERNMENT POLICY PRIORITIES

As the Macedonian government is considering changes to its health insurance, it will have to address questions of general policy it wishes to emphasize. These are priorities that can be divided into three general categories and may help simplify the policy debate. Does the government wish to emphasize:

- the most efficient use of its resources to provide the most health care for the most people?
- the most equitable delivery ensuring that everyone has basic care?
- the most social welfare protecting people against catastrophic illnesses?

These priorities are not always in conflict, but because resources are always limited, not all of these goals can be satisfied. The current debate, however, has not specified these goals, although the discussion has already addressed two subsidiary questions:

1. How much insurance coverage should be provided by the government? There appears to be general agreement that the government should continue to provide a fairly comprehensive benefits package. These provisions, however, are subject to the severe budget constraints the government now faces (and detailed in earlier RAND reports) and the likelihood that HIF revenues will not rise in the foreseeable future.

2. How should the participation (cost-sharing) by individuals and annual limitations be structured to ensure that health protection is achieved within the budget constraints? There already exists a set of participation rates for inpatient and outpatient care, a list of exemptions and a preapproval process for foreign care (see Farley and Ponce, 1997). However, there is still a need to make the policy priorities explicit by selecting a list of benefits, participation obligations and annual limits.

MINISTRY OF HEALTH GOALS AND OBJECTIVES

General government policy priorities need to be translated into goals and objectives at the MOH and other levels of operation (such as the Health Insurance Fund). The process of developing a new health insurance plan is no exception and needs to be based on established government policy. The goals and objectives that come from general policies serve as a yardstick for the effectiveness of the governments and as a context for making decisions.
The government has indicated that it wishes to retain many of its long-standing principles regarding people’s right to health protection, even as it is changing some of its previous policies. Table 1 presents goals and objectives that express these priorities. These need to be carefully reviewed as part of the debate on revising the benefits package.

**Table 1**

MOH Goals and Objectives for a Macedonian Health Benefits Package

<table>
<thead>
<tr>
<th>Goals</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure access to basic health care services for every resident</td>
<td>1. Support the attainment of optimal health status for the insured population within the constraints of available financial resources.</td>
</tr>
<tr>
<td>Protect the poor and vulnerable segments of the population.</td>
<td>2. Provide appropriate types and quantities of services for the common health conditions that have effective treatment.</td>
</tr>
<tr>
<td>Ensure financial stability for the Health Insurance Fund.</td>
<td>3. Deliver health care services in the least expensive treatment setting that is clinically appropriate.</td>
</tr>
<tr>
<td></td>
<td>4. Reduce expenditures for treatment abroad and for high cost conditions, treatments, or procedures.</td>
</tr>
<tr>
<td></td>
<td>5. Protect insured individuals' access to health care of their choice within financial constraints.</td>
</tr>
</tbody>
</table>

**HIF STRATEGIES**

We have used several strategies to guide our design of the basic benefits package and these are listed below. The strategies pull together the general policies, goals and objectives listed above, established health principles of prevention and treatment, economic theory of payment incentives, and the availability of regulatory interventions. These strategies are further based on an understanding of health insurance theory and practice¹. The strategies are to:

1. Create four benefit categories for the list of all covered services:
   - primary care
   - outpatient specialty care
   - inpatient medical, surgery and other specialty care
   - long term inpatient and special procedures

2. Within each category, define a default package of services. A shorter list of selected services, which do not fit into the default categories, is also specified.

3. Establish a list of excluded services.

4. Allow shifts from outpatient to inpatient care or shifts out of special procedures and exclusions to be done by an expert committees operating under a fixed budget constraint

5. Reduce the participation payments to 80 denars for primary care outpatient services.

6. Create financial barriers for specialty outpatient and short-term inpatient care set at 15%. Because hospital care is more expensive, there is a disincentive to use hospital care and this will shift patients to the outpatient setting.

7. Discourage long-term inpatient services and specified high cost treatments, which represent a major financial drain, by raising participation rates for these services to 25%.

¹ A solid understanding of health insurance is important to estimate the tradeoffs in any policy choice. (For those that are not familiar with health insurance, please see RAND report by Farley and Ponce, 1997 and refer to Appendix A).
8. Require preapproval for certain expensive procedures performed in inpatient settings as well as for shifts from the outpatient setting to the inpatient setting. This will apply to selected medical treatments, inpatient stays that exceed 15 days, a list of high cost treatments or procedures, and all long-term (chronic care) inpatient stays.

9. Eliminate all coverage for treatment abroad except by approval by an expert committee.

10. Exclude from coverage some services that are currently covered in the basic benefits such as non-preventive dentistry and in-vitro fertilization.

11. As a principle, establish simple procedural rules that can be easily understood by providers, patients and the general populace.

These strategies are summarized in Figure 2 below.

Figure 2--The four basic benefits categories, default services, and corresponding copayment/coinsurance rates with selected examples

SUGGESTED BASIC BENEFITS PACKAGE AND PARTICIPATION (COST SHARE) POLICY

This benefits package is a starting point for establishing new legislation to reform the Health Care Law. It is recognized that final provisions will be determined through debate among Macedonian policymakers. For each coverage component, the set of services covered, any limits on the quantity of services, and

$^2$ RAND's report on Burden of Disease and Cost Effectiveness describes the average length of stay to be 15 days ranging from 3.3 days to 73.5 days.
For each coverage component, the set of services covered, any limits on the quantity of services, and applicable participation policy are described. The estimated effects of the benefits on policy objectives are listed in Table 2, and the benefits and limits are compared in Table 3. Implications for regulation and the rationale for the proposed approach are summarized in Appendix A. Proposed definitions of terms are provided in Appendix B.

Table 2
Estimated Effects of Each Benefit Component on Policy Objectives

<table>
<thead>
<tr>
<th>Goals and Objectives:</th>
<th>Primary Care Services</th>
<th>Specialty Outpatient Services</th>
<th>Short-Term Inpatient Care</th>
<th>Special Procedures and Long-Term Inpatient Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Optimizes health outcomes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>2. Increases use of appropriate services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>3. Increases use of lower cost settings</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4. Decreases use of high cost events</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>5. Improves access and choice</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

The basic health care benefits package described here consists of the four sets of benefits: 1) primary care episodes of care, 2) specialty outpatient services, 3) short-term inpatient care, and 4) unusually high cost services and long term inpatient care requiring special preapproval. Some services routinely should be provided as outpatient services. Under certain clinical circumstances it may be advisable to provide these services in an inpatient setting, but preapproval should be required before the Health Insurance Fund (HIF) covers them as short-term inpatient care. The services to which this limitation applies are listed under the short-term inpatient care benefit.3

Table 3
Summary of Suggested Health Care Benefits

<table>
<thead>
<tr>
<th>Policy Levers and Effects</th>
<th>Primary Care Services</th>
<th>Specialty Outpatient Services</th>
<th>Short-Term Inpatient Care</th>
<th>Special Procedures and Long-Term Inpatient Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service limits</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Preapprovals</td>
<td>None</td>
<td>None</td>
<td>Exceptions for outpatient services done in hospital</td>
<td>For all specified treatments or procedures and hospitals, stays &gt; 15 days</td>
</tr>
<tr>
<td>Participation</td>
<td>80 denars copayment</td>
<td>15% coinsurance</td>
<td>3,200 denars annual deductible; 15% coinsurance</td>
<td>25% coinsurance if approved</td>
</tr>
<tr>
<td>Pharmaceutical participation</td>
<td>40 denars copayment/each prescription</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
<td>100% for non-approved drugs</td>
</tr>
<tr>
<td>Anticipated effects on utilization:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Direction</td>
<td>Higher</td>
<td>Lower</td>
<td>Lower</td>
<td>Lower</td>
</tr>
<tr>
<td>- General size</td>
<td>Medium/large</td>
<td>Small/medium</td>
<td>Large</td>
<td>Medium/large</td>
</tr>
</tbody>
</table>

3 John Peabody, M.D., Ph.D., and Donna Farley, Ph.D., worked with the full set of Current Procedural Terminology (CPT) codes, established by the American Medical Association, to identify the lists of services to which preapproval limitations would apply.
Provisions for Participation and Annual Limits

- Full exemption from participation is only allowed for those qualifying for social welfare. Exemptions provided by current law for specified groups of individuals need to be eliminated. Individuals that need social welfare should qualify on the basis of the national definition of poverty. This will allow a consistent application of all government poverty benefits and thus would include an exemption from health insurance cost sharing (participation).

- A deductible of 3,200 (Macedonian denars) for inpatient care. Although modest, this is to discourage overutilization of hospital services.

- Establish an annual participation limit for each individual of 15,000 denars. This is to protect individuals from the risk of unusually high costs of care during any given year and to mitigate the economic impact on households suffering from a catastrophic illness. This limit is set at a high enough level that it equals a substantial fraction of the national average family income.

- Guidelines should be specified and revised by the MOH. Current specification (on participation limits) should be removed from the current health care law. This will allow for more responsive policy making and faster revisions as the health care situation changes.

Benefit Lists of Services and Exceptions by Category

The following lists specify the general categories for medical care and the selected procedures that do not lie in the default categories. (It is recognized that these lists will be a source of policy debate. To this end they should serve as the basis for discussion and it is fully expected that there will be changes to these lists as a result of these discussions).

1. Primary Care Episodes of Care

All primary care services, defined generally as health interventions that prevent illness or promote health or provide basic curative services, should be covered by the HIF. Payments for primary care services will be based on an episode of care. This will consist of an initial visit, all related diagnostic tests and treatments done at the time of the visit, and one follow-up visit. Care is provided in the outpatient (clinical) setting. Covered primary care services are described as:

- preventive (including screening) health services,
- maternal and child health care,
- well baby care,
- medically necessary primary care curative services for health problems,
- emergency care at a clinic or in the home, and
- prescriptions issued during a primary care visit.

Suggested participation: Individuals should pay a copayment of 80 denars for each primary care episode. Copayment for prescriptions obtained from a primary care visit should be 40 denars per prescription.

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1 This is based on the 1995 household budget health survey that found that the average person spends 655 MKD For a family (average size of 4.2) the expenditures/year would be approximately 2,751 MKD. See Burden of Disease and Cost Effectiveness, 1997 RAND report.

2 HIF data for 1995 shows that the average cost/prescription in the primary care setting is approximately 200 MKD. At current 20% coinsurance, this is 40 denars and is the basis for the proposed flat copay.
2. Specialty Outpatient Services

A. The default category for subspecialty medicine, pediatrics and for psychiatry is outpatient care. The HIF should cover the following subspecialty outpatient services when an insured individual is referred to a specialty physician by a physician providing a primary care episode of care:

- diagnostic tests,
- outpatient medical treatments,
- outpatient pediatric treatments,
- outpatient medical and pediatric subspecialty services,
- outpatient obstetric and gynecologic treatments,
- outpatient psychiatric/mental health therapy and treatments,
- outpatient surgical procedures,
- other outpatient therapy services, and
- outpatient services by non physicians requiring medical supervision.

B. The default category for surgical treatment is inpatient short term care. The following selected surgical procedures, however, should normally be performed in an outpatient setting. In cases where outpatient care is felt to be clinically inappropriate, exceptions can be submitted for preapproval as inpatient care after review and approval by an authorized committee. Approval does not need to be obtained until 48 hours after admission for clinical emergencies.

Selected surgical procedures that normally should be performed in the outpatient clinic.

- Incision and drainages, incision and debridements, and simple excisions
- All dermatological procedures except complex repairs, tissue transfers and flaps, skin grafts, treatment of pressure ulcers, treatment of third degree burns, or mastectomies
- Minor introductions or removals using needles
- Needle aspirations
- Percutaneous biopsies
- Treatment of fractures or dislocations that are not communicated or complex
- Minor repair, revision, or reconstruction of upper and lower extremities
- Arthroscopic procedures
- All procedures on the respiratory system except thoracotomies or mediastinotomies
- Insertion, replacement, repositioning, or repair of pacemakers
- Endoscopic procedures
- Laparoscopic procedures
- Gastrostomy tube placement, change, or reposition
- Renal biopsies
- IVP, manometry, or uroflowmetry diagnostic tests
- Bladder aspirations or cystoscopies
- Circumcisions
- Vasectomies
- Vaginal procedures
- Procedures on the cervix
- Lumbar punctures
- Procedures on the eyelid, cataracts, or conjunctivitis
- Procedures on the exterior ear or eardrum
Suggested participation: Individuals should pay coinsurance of 15 percent of the allowed charges for specialty/subspecialty outpatient services and prescriptions. Cost sharing for pharmaceuticals is also 15%.

3. Short-Term Inpatient Care

A. The default category for surgery, including gynecologic surgery, is inpatient care while medical, pediatric obstetric and psychiatric treatment is outpatient primary or subspecialty care.

B. The following selected medical, pediatric, obstetric and psychiatric treatments normally should be performed in an inpatient setting. These exceptions do not require preapproval for hospital admission. In cases where outpatient care is felt to be clinically inappropriate, exceptions can be submitted for preapproval as inpatient care after review and approval by an authorized committee. Approval does not need to be obtained until 48 hours after admission for clinical emergencies.

C. Selected inpatient medical, pediatric and psychiatric care not requiring preapproval:

- All parenteral (e.g. intravenous) treatments except chemotherapy
- Cardiac monitoring
- Deliveries
- Diagnostic tests requiring a supervised medical environment
- Intensive respiratory therapy
- Initial stabilization and treatment of respiratory tuberculosis
- Invasive diagnostic procedures
- Psychiatric risks (homicidal or suicidal patients)

D. Inpatient stays for respiratory tuberculosis should be reviewed at the end of each month for HIF preapproval of the treatment plan and continuation of the stay, based on the patient’s health status and communicability of the disease.

Suggested participation: Individuals should pay a deductible of the first 3,200 denars in allowed charges for any short-term inpatient services received during a year plus coinsurance of 15 percent of any allowed charges that exceed the deductible.

4. High Cost Services and Long Term Stays Requiring Preapproval

A. All other short-term inpatient stays that exceed a length of fifteen days should be reviewed for HIF preapproval of the treatment plan and continuation of the stay.

B. Coverage for the listed high cost treatments and procedures should be provided only after they are preapproved by the HIF as being medically necessary and the best treatment alternative for an individual’s health problem. Individuals should pay a coinsurance of 25 percent of the allowed charges for high cost treatments or procedures that are approved.

Selected list of high cost procedures:

- Amniocentesis
- Bone marrow transplantation for children age 18 years or younger

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4 The 1995 estimated cost per outpatient visit in health stations was 419 denars. (The cost at other facilities would be higher.) At the current 20% coinsurance, this is equal to 84 denars and is the basis of the 80 denars out-of-pocket charge. More details are available in RAND’s report on Burden of Disease and Cost Effectiveness.

7 The 1996 RAND Health supplement to the October 1996, Republic of Macedonia Statistical Office, Household Expenditure Survey shows that the average out of pocket expenditure for all prescription drugs is 580 denars.
• Chorionic villus sampling
• Computerized tomography (CT) scans
• Diagnostic nuclear medicine
• Grafts and replantations
• Introductions, removals, or reconstructions
• Long-term inpatient care that exceeds 15-30 days length of stay
• Kidney transplantation
• Myelograms
• Nuclear magnetic resonance
• Radiology procedures using contrast materials
• Surgery for spinal deformity

Prescription Drugs

The HIF should cover a more limited list of prescription drugs than it currently offers. Drugs that treat commonly occurring acute illnesses, prevent illness or deterioration of chronic health conditions, treat infectious diseases, and manage pain, should be priorities for retention on the list. Nonessential drugs should not be covered (100% coinsurance).

Suggested participation: Coinsurance should be 15% for all prescriptions on the list of prescription drugs. If the prescriptions are given in the primary care setting and it is on the basic drug list, the copayment is reduced to 40 denars per prescription. For treatment of tuberculosis in adults or children, the HIF should cover 100 percent (no cost sharing) of all allowed charges for antituberculous drugs.

Exceptions and Exclusions From Coverage

Provisions for treatment abroad should be exceptions to the standard benefits package. Proposed exclusions from coverage also are listed.

A. Treatment Abroad

Coverage for treatment abroad should be provided only for (1) emergency health care services required by individuals while traveling abroad; and (2) specialty services that the HIF determines are not available in Macedonia. Preapproval by the HIF should not be required for coverage of emergency treatment abroad, but it is required for coverage of services not available in Macedonia. The HIF should cover a payment amount for treatment abroad equal to what the allowed charges would be for those services if they were provided in Macedonia, and individuals should pay the applicable participation. This coverage provision should be discontinued for services as they become available in Macedonia.

B. Excluded Services from the Benefits Package

The following services are to be excluded from the basic benefits package. Individuals obtaining these services will be required to pay 100% of the charges. Many of these services continue the exclusions in the current law.

• Dental services except preventive and primary dental care for children age 14 years or younger
• Eyeglasses or other corrective devices for vision
• Services provided by primary care physician other than the one chosen by the individual
• Services provided by a specialty care physician without referral from the primary care physician chosen by the insured individual
• In vitro fertilization
• Transplantation of heart, liver, or pancreas
SUMMARY AND RECOMMENDATIONS

This report proposes a concrete benefits package. It builds on previous RAND reports and emphasizes two policy priorities: the efficient use of resources and assurance of equity through universal access to primary care. The benefits package is designed to coordinate three elements: the list of covered services, cost sharing responsibilities and the annual limits. These elements are also the major policy levers--by changing any of the elements, policymakers can shift utilization, improve services or lower costs. To simplify administration, the list of services is divided into four categories where care is usually provided plus any exceptions that do not require preapproval. To implement this plan the MOH will have to carry out specific tasks and change the health care law (see below). It should be emphasized that while this is a specific proposal, it is to serve as the basis for further discussion and revision before being adopted by the government.

Recommendation for the MOH

The government will be managing a variety of policy, regulatory, and administrative issues as it implements a new basic benefits package. Highlighted here are some factors that will be important to address to ensure the policy goals of health care benefit reform are achieved.

1. Actuarially model the final benefits package. The list of services, cost shares and limits use the estimated costs developed in the first actuarial estimates completed in December, 1996. When the final list of services, participation and annual limits are approved by the MOH for implementation in the pilot project, the actuarial model needs to be rerun. This is to insure that the proposed plan remains financially sustainable. (See RAND report Actuarial Analysis of Basic Benefits Package Options of Health Care Reform In Macedonia, by Cahill et al.).

2. Establish Expert Committee to Establish Lists and review Preapprovals and Exceptions. Many of the regulatory provisions require medical and health care administration expertise to be designed effectively. They will advise the HIF on policies that involve clinical issues and resource allocation. The HIF should create an advisory committee(s) with the responsibility to annually:
   - define primary and secondary outpatient services,
   - develop lists of selected services or procedures that are exceptions to the general location of services and thus will not require preapproval,
   - annually determine the list of the high cost procedures subject to 25% coinsurance limits, and
   - annually review/revise the list of excluded services.
Other expert committees need to be established to meet on a regular basis to do preapproval and allow for exceptions. They would:

- evaluate requests for inpatient provision of defined primary and secondary outpatient services,
- approve all high cost procedures,
- allow exceptions for long term care to continue at a lower 15% coinsurance rate, and
- allow for treatment abroad when the service is not provided in Macedonia.

Other criteria should be based on the likelihood that the effectiveness of the therapy is high and that adequate financial resources are available. These committees, charged with approving exceptions, will have to be given a strict budget limit along with their authority.

3. **For the benefits package to be coordinated, the MOH will need to have more flexibility to change the provisions.** The HIF should have the flexibility to establish levels of fixed copayments, deductibles, and annual participation limits each year (see recommendations on the Health Care Law below). This will require that the basic health care law be revised and the specifications be removed from statutory provisions and delegated to the MOH. At the same time, the HIF should establish objective procedures for establishing these amounts, so that all interested parties are given an opportunity to understand and comment on the proposed amounts before they are adopted in regulation.

4. **Training of MOH and HIF staff will be required.** Many of the provisions introduced in this suggested benefits package are new and not currently being used in Macedonia. To ensure an efficient transition to a new system, HIF personnel and health care providers should be provided training on managing health care under the new benefit structure and working with new benefit policies and administrative procedures.

5. **Evaluate the benefit policies and implementation methods through pilot studies.** The first year of a new benefits package and participation policy will yield many lessons on the strengths and weaknesses of the benefit policies and the methods used to implement them. A formal evaluation done by piloting should be performed during the first year, and the benefit system should be refined in succeeding years in response to the evaluation findings. Impacts on service utilization, outcomes for insured individuals, and HIF expenditures also should be monitored on an ongoing basis.

**Recommendations for Revisions of the Health Care Law**

1. **Rewrite 1991 Health Care Law as a broad but flexible legal framework.** Implementation of the suggested basic benefits package will involve actions at three levels of the Macedonian legal and regulatory system: law, regulation, and practice. Legislation will be required to replace the covered benefits and participation policy in the current Health Care Law. The language in the new law should establish the basic policy framework for health care benefits, describing the general scope of covered services, identifying where annual limits or preapprovals are required, and specifying general provisions for participation. For some provisions, the government will want flexibility to change specific aspects, such as the amount of a fixed copayment. These provisions should be published in regulation or sublaws, rather than in the law.

2. **The MOH needs to be given clear authority to use regulation to implement a coordinated policy so that it can adjust benefits, participation and limits on an ongoing basis.** Details and periodic modifications of coverage policy should be written as regulation so that the government can modify the details of the coverage policy to be responsive to changes in medical care practice, the national economy, and government policy priorities. These are summarized in Table 4. Under current law, the Ministry of Health and HIF have only limited discretion in program design and policy. Regulations can be used to define specific lists of services called for by legislation; establish the sizes of limits on services; specify criteria and procedures for preapprovals; and establish levels for fixed
copayments, deductibles, and annual participation limits. By establishing an open process that informs the public and seeks comments on proposed regulations, the government can create a forum for dialogue on policy changes it is considering.

Table 4
Summary of Regulations, Covered Benefits and Committee Responsibilities
Required to Implement the Suggested Health Benefits Package

<table>
<thead>
<tr>
<th>Covered Benefit</th>
<th>Regulatory Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Provisions</td>
<td>An annual participation limit should be developed and published annually</td>
</tr>
<tr>
<td>Primary Care Services</td>
<td>A definition of primary care services should be established</td>
</tr>
<tr>
<td></td>
<td>Provisions should be established for implementing and enforcing the selection of a</td>
</tr>
<tr>
<td></td>
<td>primary care physician by insured individuals and the role of the primary care</td>
</tr>
<tr>
<td></td>
<td>physician in managing the care for these individuals. This regulation should be</td>
</tr>
<tr>
<td></td>
<td>established regardless of the status of implementing a primary care capitation</td>
</tr>
<tr>
<td></td>
<td>payment.</td>
</tr>
<tr>
<td>Specialty Outpatient Services</td>
<td>None</td>
</tr>
<tr>
<td>Short-Term Inpatient Care</td>
<td>The lists of services should be established and updated annually for:</td>
</tr>
<tr>
<td></td>
<td>• Surgical procedures to be performed in an outpatient setting</td>
</tr>
<tr>
<td></td>
<td>• Medical treatments to be performed in an inpatient setting</td>
</tr>
<tr>
<td>Long-Term Inpatient Care</td>
<td>Procedures should be established for obtaining preapproval for listed inpatient</td>
</tr>
<tr>
<td></td>
<td>services, including criteria for determining the appropriateness of proposed uses</td>
</tr>
<tr>
<td>High Cost Treatments and</td>
<td>The list of treatments and procedures subject to this coverage restriction should</td>
</tr>
<tr>
<td>Procedures</td>
<td>be defined and updated annually.</td>
</tr>
<tr>
<td></td>
<td>Procedures should be established for obtaining preapproval of coverage for listed</td>
</tr>
<tr>
<td></td>
<td>services, including criteria for determining the appropriateness of proposed uses.</td>
</tr>
<tr>
<td>Treatment Abroad</td>
<td>Procedures should be established for obtaining preapproval of treatment abroad for</td>
</tr>
<tr>
<td></td>
<td>services not available in Macedonia.</td>
</tr>
</tbody>
</table>

3. **Daily coverage decisions, including preapprovals, should be made by the HIF and/or by appointed review committees.** The last of the three levels is the daily decisions on coverage of benefits and participation requirements, including formal preapprovals of services required by law. This practice is guided by both law and regulation, but decisions on individual cases will require judgments by the HIF and any review committees or commissions that it establishes to serve as its agents. The HIF should review these decisions periodically to ensure that the law and regulations are being interpreted consistently by different reviewers and over time.
APPENDIX A

HEALTH INSURANCE THEORY AND PRACTICE
Appendix A

Health Insurance Theory and Practice

Applying the Economics of Health Insurance

Insurance for health services exists because individuals cannot predict when they will experience health problems, and their costs of care for those problems may be high. Most people prefer to pay regular, predictable premiums to health insurers (private or public) to avoid potentially large, unpredictable costs when they require health care services. The insurer assumes the financial risk for health care needed by the individuals it insures, and it reduces its own net risk by spreading it over a large number of individuals. The premium an insurer charges for insurance coverage is based on the average (or expected) cost of health care for the group of individuals it insures (plus administrative expenses), anticipating that some will have higher costs than average and others will have lower.

The types of insurance that people have, and the structure of their premiums and participation in payment for care, will influence how they use health care services. For example, people who only have insurance for hospital inpatient services are more likely to be admitted to the hospital so that their insurance will pay for their care, even if the care can be provided just as well -- or better -- on an outpatient basis. In addition, people tend to use fewer health care services when they have to pay some of the cost for each service.

The Macedonian government should use both demand-side strategies (benefit design, management of care, and patient cost sharing) and supply-side strategies (payments to providers, monitoring of care) to manage treatment patterns and expenditures. This suggested benefits package and participation policy offers a coordinated policy and strategy to manage the demand side of the health care market in Macedonia. An equally important step will be the development of policies for payments to health care providers, to manage the supply side of the market. The government can use these policies together to achieve more cost effective care for its citizens and greater financial stability for the HIF.

Rationale for the Suggested Health Benefits Package

General Provisions. Elimination of the exemption from participation for specified groups removes financial incentives for them to overuse services because they do not have to contribute to the costs of their care. These groups, like other insured individuals, are protected by the annual participation limit and poverty provisions, which are protections against costs of medical care that exceed individuals' ability to pay.

Primary Care Services. Benefit design should encourage appropriate use of primary care services to enable early treatment of health problems and coordination of care by a primary care physician. Low fixed copayments are suggested as a key aspect of this strategy. All prevention and promotion services included in this provision currently are covered by the HIF. Under this benefits package, the HIF would pay only for services provided to insured individuals. These services also are among the rights that are guaranteed by the Health Care Law for individuals without health insurance coverage, if they receive other government support, to which the HIF contributes payments.

Specialty Outpatient Services. The goal is to achieve a balance between ensuring access to specialty outpatient services and avoiding overuse of these services. The 15% coinsurance rate is suggested as the method to do so. This is the same coinsurance rate as specialist inpatient care (providing administrative simplicity). Nevertheless, this rate should provide an incentive for specialist doctors to shift their services from the hospital to the clinic where the total cost of outpatient care is less.
**Short-Term Inpatient Care.** These provisions are designed to move health care to the outpatient setting by avoiding some hospital stays and shortening the lengths of others. Medical and surgical services have been classified as either outpatient or inpatient services, based on severity of illness or invasiveness of a procedure. HIF preapproval is required to admit a patient to the hospital for any service designated as an outpatient service. In addition, Macedonian hospitals have long average lengths of stay, and shortening the time that patients stay in the hospital will create savings for the HIF. The deductible and coinsurance contribute to this strategy by discouraging individuals from overusing inpatient care.

**Special High Cost Services.** The use of high cost treatments or procedures creates large costs for the HIF for the benefit of a small number of individuals, and these benefits may be small if service use is inappropriate. Preapproval requirements allow the HIF to assess whether proposed services are appropriate and to free funds for use by a larger number of individuals.

**Treatment Abroad.** This provision essentially continues current law for treatment abroad for services not available in Macedonia. It eliminates coverage for services obtained abroad that are available in Macedonia to protect against erosion in utilization of Macedonian medical care that could compromise service quality or availability.
APPENDIX B

DEFINITIONS OF TERMS
Appendix B

DEFINITIONS OF TERMS

Allowed charges -- The total charge per episode of care or other unit of service that health care providers can receive for health care services provided to insured individuals, which is established by the HIF. Individuals pay the portion of the charge that is their participation (for example, 15 percent or 80 denars), up to the annual participation limit, and the HIF pays the balance.

Annual participation limit -- The maximum total participation amount that an insured individual is obligated to pay in a year for covered health services. The HIF pays 100 percent of any allowed charges in excess of the limit.

Coinsurance -- A specified percentage of the allowed charge that an individual is required to pay for each service received. Coinsurance is the type of participation currently required (10 percent for inpatient, 20 percent for outpatient services) under the Macedonian Health Care Law.

Copayment -- A fixed amount that an individual is required to pay (for example, 80 denars) for each service received, regardless of the total allowed charges for the service.

Deductible -- A fixed amount that an individual is required to pay for health services received for a specified category of health services or period of time, before the HIF is required to pay for services. For example, with a deductible of 1000 denars for short-term inpatient care, an individual would pay the first 1000 denars of allowed charges for inpatient services received during a year, and the HIF would pay the remainder.

High cost treatments and procedures -- Major diagnostic procedures or medical or surgical interventions that are unusually costly because they require specialized expertise, sophisticated technology, or long duration of treatment. Examples are nuclear magnetic resonance, cardiac surgery, or cancer treatment.

Long-term inpatient care -- Provision of chronic care or maintenance services to individuals in a specialty hospital or residential facility, involving inpatient stays of long duration because patients are not able to function independently.

Medical necessity -- A determination by a physician or panel of physicians that a particular health care service is needed by a patient to treat a health problem or improve health status.

Preapproval for coverage -- A formal process by which the HIF or its designated agent makes decisions regarding the medical necessity of a service before the service is provided, to ensure that the HIF is paying for appropriate use of services. HIF preapprovals are required for cases that have a high frequency of service use or when a high cost diagnostic or treatment or procedure is to be used.

Primary care episode of care -- The activities undertaken by physicians and other clinical practitioners to manage an individual’s care and diagnose and treat uncomplicated health problems that arise. An episode of care begins when an individual first presents a health problem to a primary care physician and ends when active treatment of the problem is completed, either because the problem has been corrected or the patient’s health status has been stabilized as much as possible. The designated primary care physician provides, orders, and manages all the services in a primary care episode of care, including physical examinations and other procedures; laboratory, radiology, and other diagnostic tests; medical treatment or therapy services, prescription of drugs, and consultations by specialty physicians.
Primary care physician -- A physician who provides general medical care for adults or children, including prevention and promotion services, prenatal and maternity care, child health care, diagnosis and treatment of uncomplicated acute health problems, and management of some chronic health problems.

Short-term inpatient care – Provision of acute care medical or surgical services to individuals in a hospital setting, involving inpatient stays of short duration.

Specialty outpatient services -- The activities undertaken by specialty physicians and other clinical practitioners to diagnose and treat a specific health problem for an individual. Services begin when a primary care physician refers a patient to a specialty physician. The designated specialty physician provides, orders and manages all services, including physical examinations; medical, surgical, and other procedures; and diagnostic tests.

Specialty physician -- A physician who provides medical care for specific health conditions that are complicated or require special training to treat (e.g., heart disease, cancer) or surgical treatment for problems that cannot be treated medically. Specialty physicians have advanced training in particular areas of medicine or surgery, in addition to general medicine training.

Treatment abroad -- Health care services that individuals insured by the HIF obtain outside of the Republic of Macedonia, either for treatment of emergency problems that arise while traveling abroad or for specialty care for specific health conditions.