DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

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Number of Pages (Including Cover): _____

Comments:

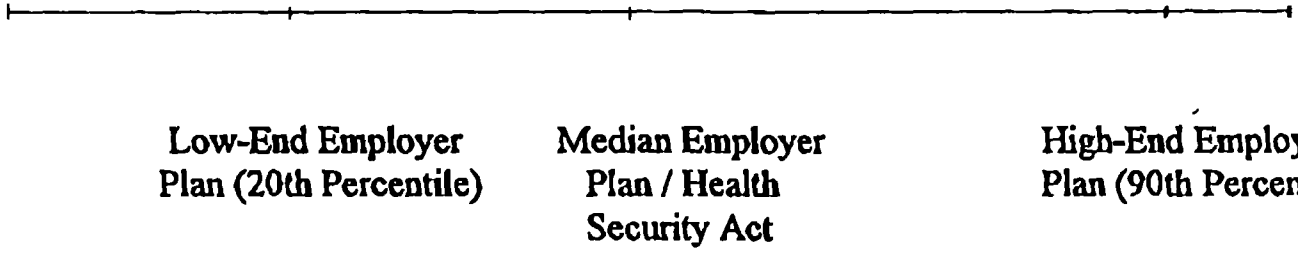
COMPARISION OF BENEFIT PLANS
(Administration Premium Estimates)

- The HSA benefit package is at about the midpoint of benefit packages offered by large corporations.
- Using Administration premium estimates for the single adult premium, the premium for the HSA benefit package would be about $215 per year, or 12%, more than the comparable premium for the lower-end of the benefit plans offered by Fortune 500 companies.*
- The HSA benefit package is about $270 per year, or 12%, less espensive than the premium for an upper-end of benefit plans offered by Fortune 500 companies.*

* Estimates from Actuarial Research Corporation

BENEFIT PLANS

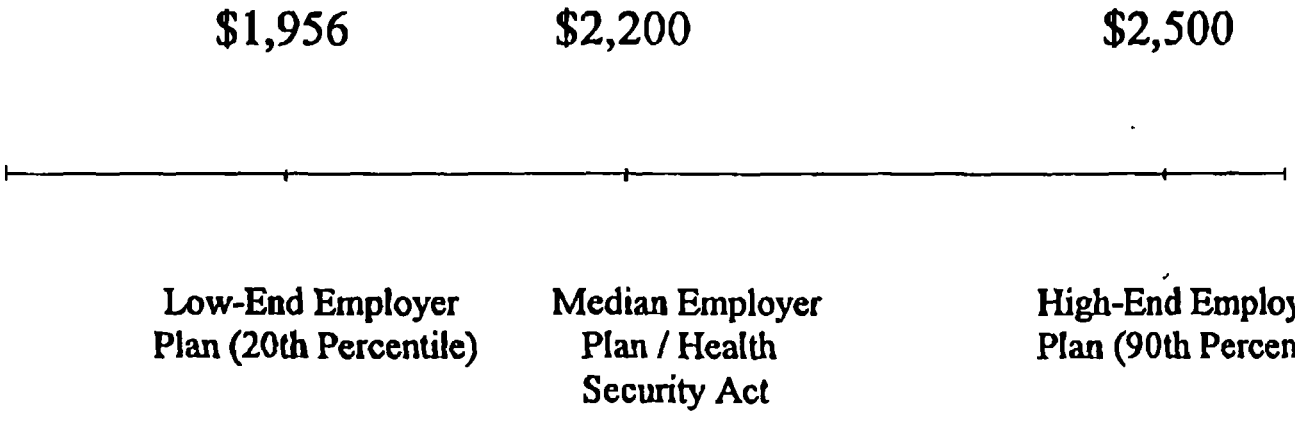
Comparison to Plans Offered By Fortune 500 Firms



* Administration estimates for single premium.

BENEFIT PLANS

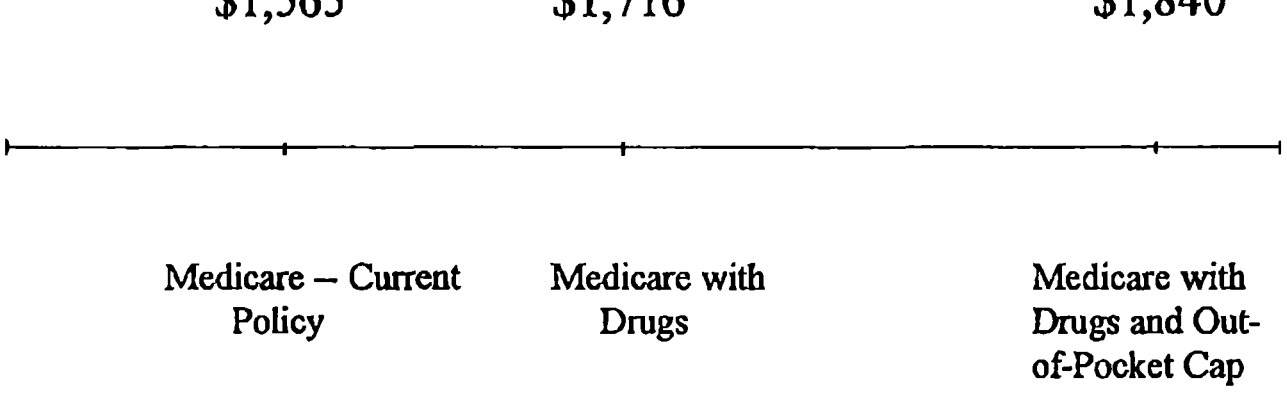
Comparison to Plans Offered By Fortune 500 Firms



* CBO-like estimates for single premium.

MEDICARE BENEFIT PLANS

Comparison of Alternative Benefits for Individuals Enrolled in Regional Alliance



* Administration estimates for those enrolled in regional alliance.

FEDERAL DISCOUNTS

- Reducing benefits for fee-for-service plans to the lower-end level offered by Fortune 500 companies would lower premium discounts by about $32 billion over five years (assuming Administration premium estimates).

- If HMO and PPO cost-sharing remains at the level proposed by the HSA, federal discounts for cost sharing provided to the poor and near poor would increase by about $25 billion over five years.

  - Under HSA, cost-sharing discounts are not provided to people who enroll in HMOs or PPOs because the level of cost-sharing is low (AFDC and SSI recipients pay a lower level of cost-sharing).

  - If no HMO or PPO is available below the average premium, however, federal discounts are provided to people with incomes below 150% of poverty. The discount brings the level of cost-sharing down to the HMO/PPO level (a reduced level for AFDC and SSI recipients, but with no additional payment).

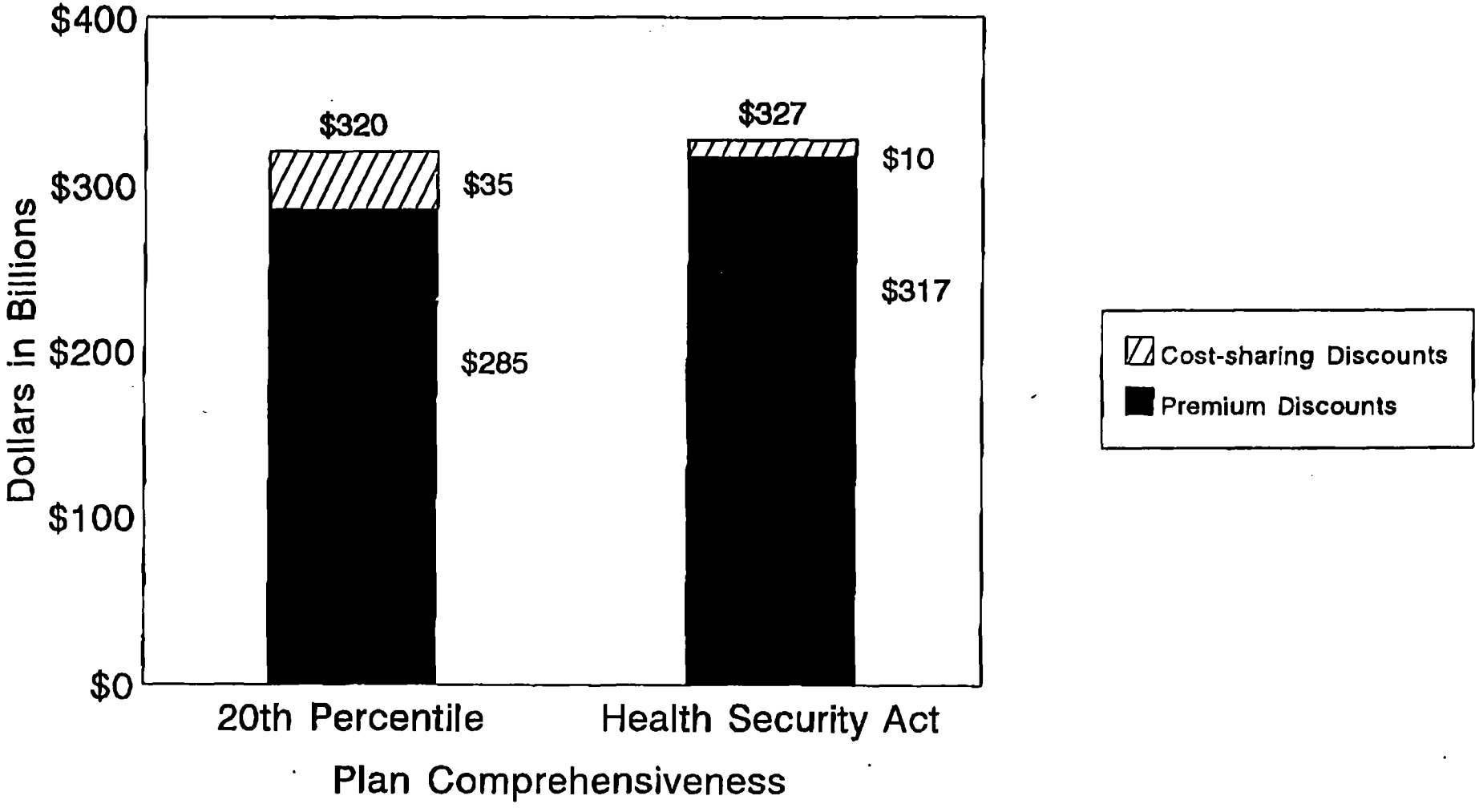
  - Reducing the premium for fee-for-service plans but not for HMOs would mean that there would be far fewer HMO plans below the average premium, and therefore higher cost sharing discounts.

- The net effect on federal discounts would be a decrease of about $7 billion over five years.

FEDERAL DISCOUNTS

Premiums* & Cost-sharing Discounts: 1996 - 2000

Assumes HMO/PPO cost sharing does not change

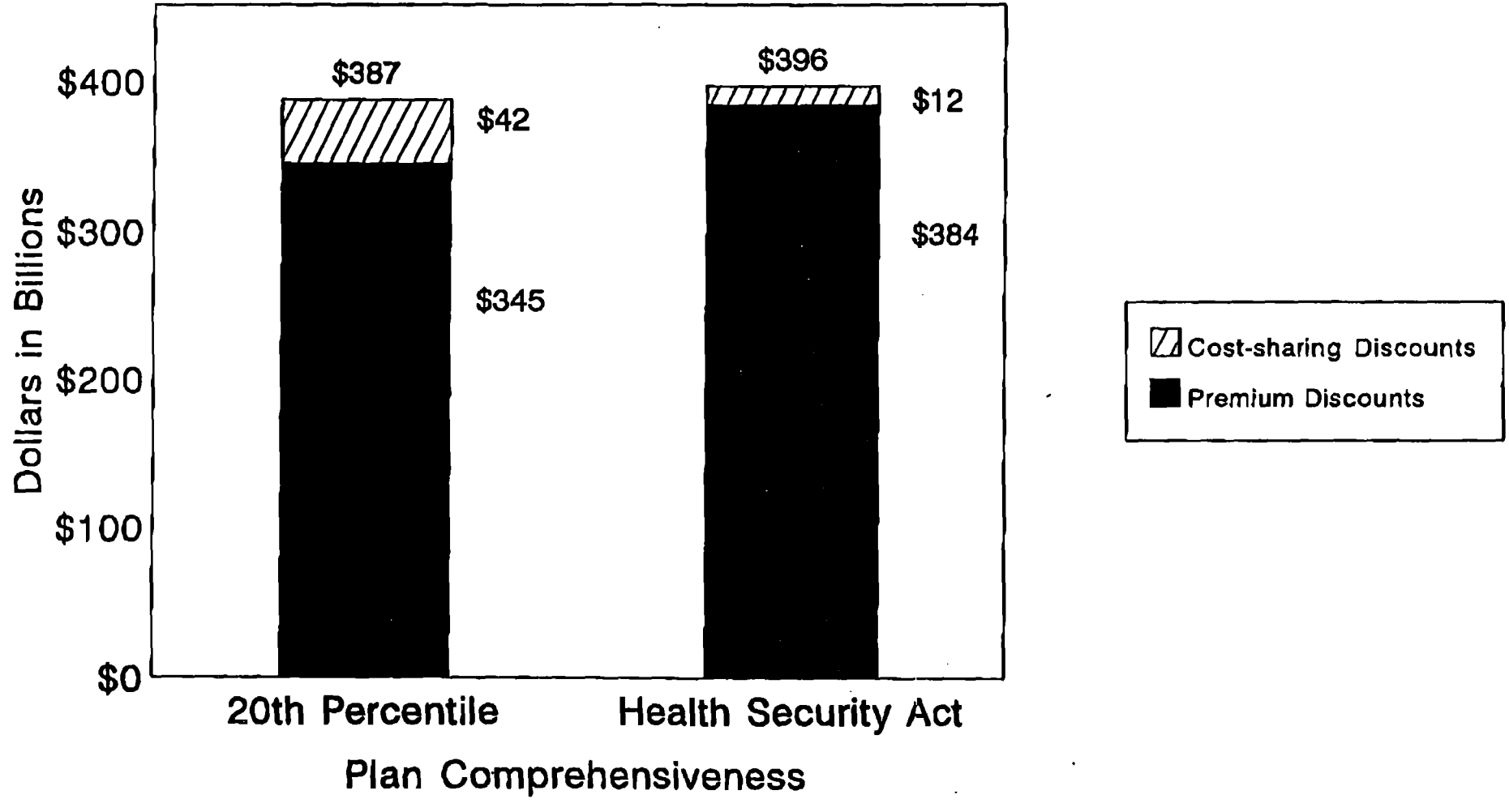


*Administration premiums.

FEDERAL DISCOUNTS

Premiums* & Cost-sharing Discounts: 1996 - 2000

Assumes HMO/PPO cost sharing does not change

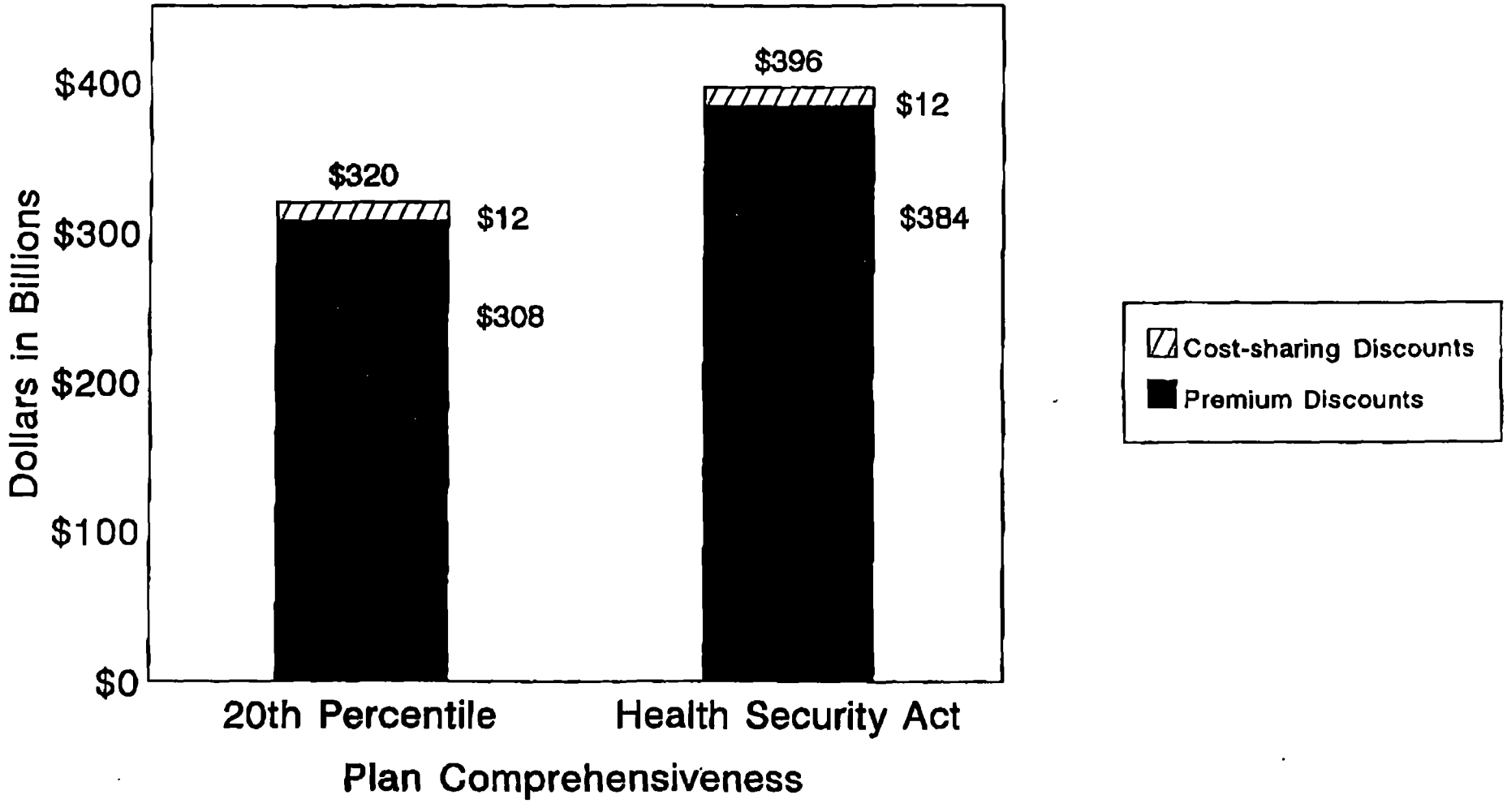


* CBO-like premiums.

FEDERAL DISCOUNTS

Premiums* & Cost-sharing Discounts: 1996 - 2000

Assumes HMO/PPO cost sharing increases

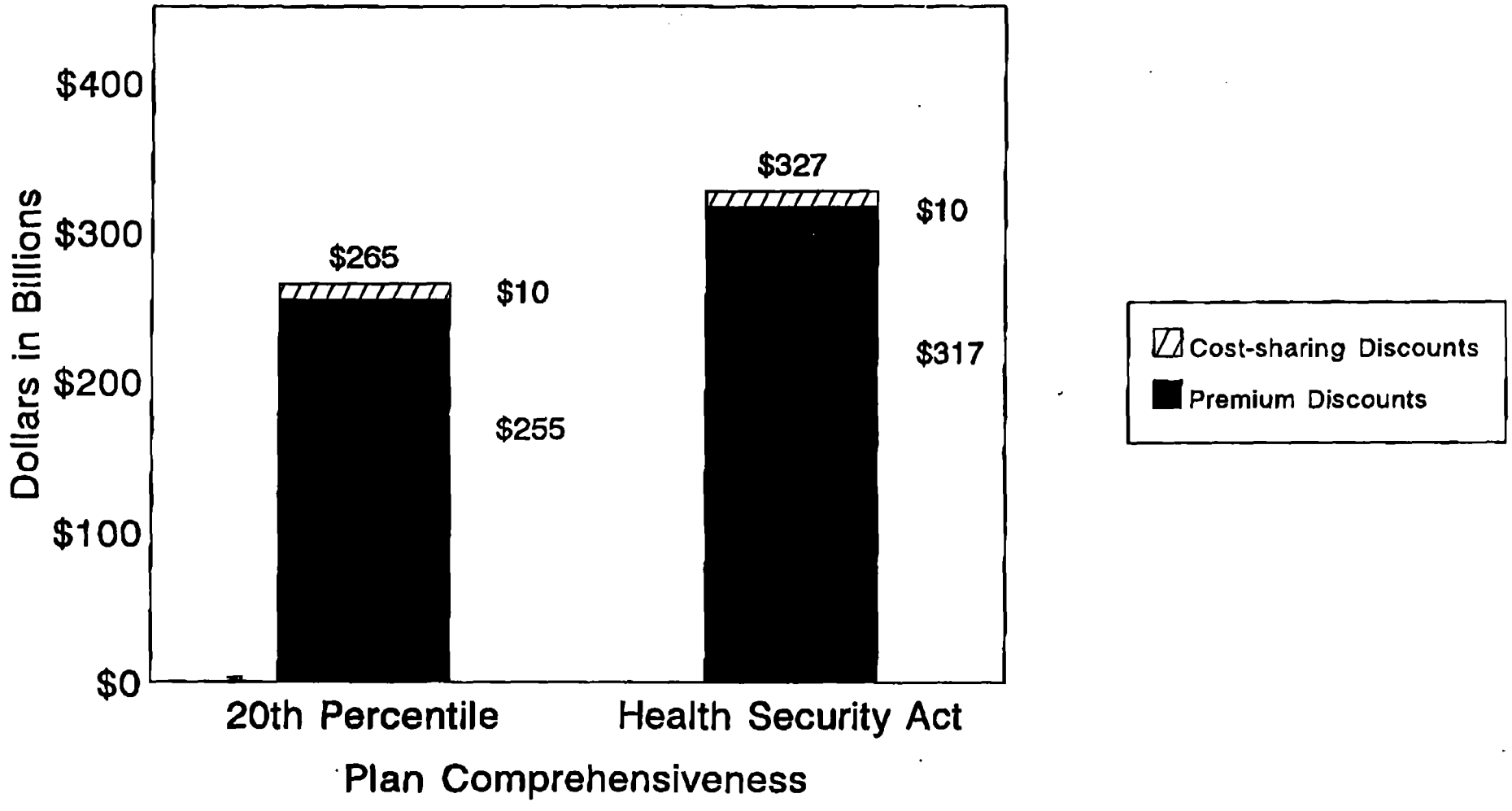


* CBO-like premiums.

FEDERAL DISCOUNTS

Premiums* & Cost-sharing Discounts: 1996 - 2000

Assumes HMO/PPO cost sharing increases



* Administration premiums.

Differences between HSA Premium and BC/BS Standard

Dollar impact of differences on HSA single premium ($1,932)

HSA Premium Above BC/BS Standard		
(1)	Mental Health	$ 97
(2)	Preventative	90
(3)	Coinsurance	116
(4)	Cost-sharing maximum	114
(5)	Other differences	87
Total of benefits above BC/BS		$504
HSA Premium Below BC/BS Standard		
(1)	Hospital cost sharing	$147
(2)	Prescription drug cost sharing	143
Total of benefits below BC/BS		$290
Net difference between HSA and BC/BS standard		$214

Cost-Sharing to Reduce HMO Premiums

	Health Security Act	10% Reduction	7.5% Reduction
Per Admission Ded.	$0	$250	$125
Emer. Rm. Copayment	$10	$100	$50
Inpatient Surgery	$10	$100	$50
Delivery	$10	$100	$50
Outpatient Visits	$10	$15	$15
Outpatient Surg.	$10	$50	$25
Ambulance	$0	$50	$50
Prescriptions	$5	$10	$10

BENEFITS: THE HEALTH SECURITY PLAN COMPARED WITH CURRENTLY OFFERED PLANS

BENEFITS	HEALTH SECURITY ACT PLAN MEDIAN FORTUNE 500 PLAN		BLUE CROSS STANDARD, FEHBP/ LOW-END FORTUNE 500 PLAN	HIGH-END/ "CADILLAC" PLAN	MEDICARE UNDER CURRENT LAW
	LOW COST SHARING (HMO)	HIGH COST SHARING (FFS)[1]			
Medical Plan Maximum	No lifetime dollar maximum limit	No lifetime dollar maximum limit	Lifetime maximum for organ/ tissue transplants, mental health and substance abuse	Lifetime maximum for inpatient substance abuse	No lifetime dollar maximum limit
Out-of-Pocket[2]	$1500 / individual $3000 / family maximum	$1500 / individual $3000 / family maximum	$3000 / individual $3000 / family	$1,000 per covered individuals - does not include deductibles	
Deductibles	None	$200 / individual $400 / family	$200 / individual $400 / family	$100 / individual $200 / family	Part A: $696 in 1994 Part B: $100 in 1994 Blood: No payment for first 3 pints
Inpatient Hospital[3]	Full coverage, no coinsurance No dollar or day maximum	20% coinsurance No dollar or day maximum	$250 per admission deductible No dollar or day maximum	Full coverage in-network; 20% coinsurance out-of-network	Coinsurance: $0 for days 1-60 and $174/day for days 61-90 per benefit period 60 Lifetime reserve days with coinsurance of $348/day

1. FFS - fee for service.

2. Deductibles counted toward out-of-pocket limits.

3. Mental health and substance abuse have separate provisions, see below.

BENEFITS	HEALTH SECURITY ACT/ MEDIAN FORTUNE 500 PLAN		BLUE CROSS STANDARD, FEHBP/ LOW-END FORTUNE 500 PLAN	HIGH-END/ "CADILLAC" PLAN	MEDICARE UNDER CURRENT LAW
	LOW COST SHARING (HMO)	HIGH COST SHARING (FFS)			
Doctors Office Visits, Hospital Outpatient	$10 copay per visit No dollar or visit maximum	20% coinsurance No dollar or visit maximum	25% coinsurance	20% coinsurance	Doctors coinsurance: 20% of Medicare approved amount Outpatient services coinsurance: 20% of billed amount No balance billing allowed
Outpatient Laboratory, iology, and Diagnostic Servi s	Full coverage	20% coinsurance	25% coinsurance	Full coverage in-network 20% coinsurance out-of-network	
rgency	$25 copay per visit, waived in emergency	20% coinsurance	Full coverage within 72 hrs. of accident	Full coverage - required plan notification within 48 hours	Covered the same as nonemergency (see Doctors/hospital outpatient above)
Preventive Servi s[4]	Full coverage, based on periodicity schedule	Full coverage, based on periodicity schedule	25% coinsurance 100% well childcare	100% well-baby; prenatal	Only specific services covered: influenza, hepatitis B and pneumococcal vaccines, mammography and pap smears. Heptatis B, mammography and pap smears subject to Part B deductible plus 20% coinsurance.

4. Including well-child and prenatal care, periodic health exams, targeted tests and vaccines.

BENEFITS	HEALTH SECURITY ACT/ MEDIAN FORTUNE 500 PLAN		BLUE CROSS STANDARD, FEHBP/ LOW-END FORTUNE 500 PLAN	HIGH-END/ "CADILLAC" PLAN	MEDICARE UNDER CURRENT LAW
	LOW COST SHARING (HMO)	HIGH COST SHARING (FFS)			
Prescription Drugs	$5 per prescription	$250/year deductible 20% coinsurance	$50 deductible 40% coinsurance	20% coinsurance 50% coinsurance for drugs for treatment of mental or nervous conditions	
Inpatient Mental Health (MH) and Substance Abuse (SA)[5]	Full coverage 30 day annual limit with 30 additional days available under certain circumstances	1 day deductible 20% coinsurance 30 day annual limit with 30 additional days available under certain circumstances	$250 per admission deductible; 40% coinsurance Unlimited days $3,000 maximum for substance abuse treatment program - 28 day max. $50,000 lifetime maximum	20% coinsurance precertification required Substance abuse: Full coverage in-network 20% coinsurance out-of-network; 30 days per stay; 2 stays maximum	190 days lifetime limit in Medicare participating psychiatric hospitals Psychiatric treatment in general hospitals same as inpatient hospital benefit above

5. In 2001, inpatient and outpatient MH/SA limitations and higher cost sharing are phased out.

BENEFITS	HEALTH SECURITY ACT/ MEDIAN FORTUNE 500 PLAN		BLUE CROSS STANDARD, FEHBP/ LOW-END FORTUNE 500 PLAN	HIGH-END/ "CADILLAC" PLAN	MEDICARE UNDER CURRENT LAW
	LOW COST SHARING (HMO)	HIGH COST SHARING (FFS)			
Outpatient Mental Health	All outpatient except psychotherapy - $10 / visit Psychotherapy - $25 / visit; 30 visits annual maximum; with additional days available as a substitute for inpatient days Hospital alternatives - full coverage for first 60 days (available only as a substitute for inpatient days); 60 additional days under certain circumstances)	All outpatient except psychotherapy - 20% coinsurance Psychotherapy - 50% coinsurance; 30 visits annual maximum; with addional days available as a substitute for inpatient days Hospital alternatives - 1 day deductible; 20% coinsurance for first 60 days (available only as a substitute for inpatient days); 60 additional days under certain circumstances.	40% coinsurance; 25 visits annual maximum - includes partial hospitalization and visits for outpatient substance abuse $50,000 lifetime maximum	20% coinsurance for employee 20% coinsurance for dependent	50% coinsurance of Medicare allowed amount Medication management 20% coinsurance
Outpatient Substance Abuse	30 group therapy visits subsequent to treatment in inpatient or intensive nonresidential settings For individuals not initially treated on an inpatient or intensive nonresidential basis, 4 visits for 1 inpatient day trade	30 group therapy visits subsequent to treatment in inpatient or intensive nonresidential settings For individuals not initially treated on an inpatient or intensive nonresidential basis, 4 visits for 1 inpatient day trade	Subject to mental health limits	20% coinsurance; 30 visit maximum	50% coinsurance of Medicare allowed amount Medication management 20% coinsurance

BENEFITS	HEALTH SECURITY ACT/ MEDIAN FORTUNE 500 PLAN		BLUE CROSS STANDARD, FEHBP/ LOW-END FORTUNE 500 PLAN	HIGH-END/ "CADILLAC" PLAN	MEDICARE UNDER CURRENT LAW
	LOW COST SHARING (HMO)	HIGH COST SHARING (FFS)			
Hospice	Full coverage	20% coinsurance	100% coverage for home hospice; $250 per admission for inpatient hospice with 5 consecutive day limit	Full coverage	Medicare pays all but limited costs for inpatient respite care as long as doctor certifies need
H Health (HH) / Extended Care (ECF - and Rehab Hospitals)	Full coverage as inpatient alternative 100 day annual limit extended care facilities	20% coinsurance as inpatient alternative 100 day annual limit extended care facilities	25% coinsurance Covers 25 visits home nursing care	20% coinsurance	Part B: 10% copayment on all visits except those received within the first 30 days of an inpatient hospital discharge. SNF: No coinsurance first 20 days; days 21-100, $87/day; no coverage beyond 100th day
Routine Eye Exams, Eyeglasses	$10 per exam, 1 set of eyeglasses Glasses limited to children <18	20% coinsurance Glasses limited to children <18	Not covered	Not specified	No coverage for routine eye exams or eye glasses except conventional lenses after cataract surgery
Preventive and rgency Dental [6]	$10 / visit Preventive services limited to children <18	20% coinsurance; $50/year deductible on minor restorative Preventive services limited to children <18	Covered at fee schedule	No deductible; no coinsurance; minor restorative; 50% coinsurance on major restorative	No coverage for dental care or dentures
Prenatal Care	Full Coverage	Full Coverage	25% coinsurance	20% coinsurance	Part A and Part B coverage same as all other Medicare services

6. In 2001, adult prevention and treatment, and orthodontia for severe malocclusion in children are added.

BENEFITS	HEALTH SECURITY ACT/ MEDIAN FORTUNE 500 PLAN		BLUE CROSS STANDARD, FEHBP/ LOW-END FORTUNE 500 PLAN	HIGH-END/ "CADILLAC" PLAN	MEDICARE UNDER CURRENT LAW
	LOW COST SHARING (HMO)	HIGH COST SHARING (FFS)			
Outpatient Rehabilitation	$10 copay per visit; reassessed at 60 days for continuing improvement	20% coinsurance; reassessed at 60 days for continuing improvement	25% coinsurance 25 visit limit	20% coinsurance	Short-term restorative rehabilitation and establishment of maintenance program subject to Part B deductible and coinsurance Outpatient physical therapy and occupational therapy limited to $900/year furnished by independent therapists
Durable Medical Equipment	Full coverage	20% coinsurance	25% coinsurance	Not specified	Coinsurance: 20% of Medicare amount. No balance billing allowed.

SUMMARY OF MODELS PRESENTED TO S.L. as of 5/2/94	**UI Model 139: HSA** (Note: Marginal rates for House-Hold Subsidies are smoother than specified in HSA) (assumes MOE)	**UI Model 138: 12% Ind. Wage Cap with 5.5%-12% for firms < 75; CBO Premiums** [Retreat Model 1] (assumes MOE)	**WH Model 138A:** Same as UI Model 138 but **with 2.8%-12% for <10 firms.** [Scenario A] May Understate Outsourcing (assumes MOE)	**WH Model 138B:** Same as UI Model 138 but **with 2.8%-12% for <25 firms.** May Understate Outsourcing (assumes MOE)	**UI Model 142:** Same as UI **Model 138 but employer mandate is 50% instead of 80%** [Scenario C] (assumes MOE)	**UI Model 140:** Same as UI **Model 142 but premium is 5% below CBO scoring of HSA.** (assumes MOE)	**UI Model 131: 7.9% Ind. Wage Cap with 3.5%-7.9% for firms < 75; 50% 'er mandate; CBO Premiums-5%** [Retreat Model 3] (assumes MOE)	**UI Model 132: 12% Ind. Wage Cap with 5.5%-12% for firms < 75; CBO Premiums-5%** [Retreat Model 2] (assumes MOE)
Total Employer Payments 1 Year (1994) ($m)	225,245	226,847	221,292	217,573	189,798	183,331	187,771	218,242
Average Employer Payments per Family	2,176	2,192	2,138	2,102	1,834	1,771	1,814	2,108
Total Family Payments 1 Year (1994) ($m)	58,357	60,398	60,398	60,398	103,757	98,384	86,015	57,430
Average Family Direct Premium Payments	564	584	584	584	1,002	951	831	555
Government Subsidies:								
1 Year (1994) ($m)	88,170	82,096	87,651	91,370	75,522	69,448	76,905	75,567
employer	40,082	34,489	40,044	43,763	10,182	8,879	17,955	30,800
household	48,088	47,607	47,607	47,607	65,340	60,569	58,950	44,767
Government Subsidies:								
5 Years ($m)	396,000	359,906	383,293	398,950	337,550	310,547	341,455	331,567
employer	179,000	145,199	168,585	184,242	42,866	37,381	75,591	129,668
household	217,000	214,708	214,708	214,708	294,683	273,166	265,865	201,899
Government Subsidies:								
10 Years ($m)	1,082,000	962,004	1,028,387	1,072,829	876,352	805,676	895,435	885,119
employer	521,000	412,144	478,526	522,968	121,675	106,104	214,562	368,060
household	561,000	549,861	549,861	549,861	754,677	699,572	680,873	517,059
Select Revenue Estimates: *								
Corporate Assessment	7,600	40,600	40,600	40,600	41,600	41,600	41,000	41,000
Other Revenue	19,300	24,600	29,400	33,800	45,700	58,400	58,000	27,000
Total (5 Years)	26,900	65,200	70,000	74,400	87,300	100,000	99,000	68,000
Select Revenue Estimates: *								
Corporate Assessment	15,200	81,200	81,200	81,200	83,200	83,200	82,000	82,000
Other Revenue	38,600	49,200	58,800	67,600	91,400	116,800	116,000	54,000
Total (10 Years)	53,800	130,400	140,000	148,800	174,600	200,000	198,000	136,000
Net Effect on Deficit * (5 Years)	74,000	(394)	18,193	29,450	(44,850)	(84,553)	(52,645)	(31,533)
Net Effect on Deficit * (10 Years)	126,000	(70,596)	(13,813)	21,829	(200,448)	(296,524)	(204,765)	(153,081)

* Revenue estimates are for those components that differ from HSA. Deficit effects are relative to current system.

** May Understate Outsourcing

Fiscal Analysis of Some Alternatives

	1 year fully phased-in, billions			
	HSA (#239)	Staff Draft (#242)	219 (#235)	253 (#253) = 219 with Kennedy income cap
Total Subsidies	101.9	90.7	86.2	90.9
Household	50.7	58.0	55.4	60.1
Employer	51.2	32.7	30.8	30.8
5 year subsidy savings vs. HSA	na	32	50	30
5 year revenue gains vs. HSA	na	44	43	43
5 year net deficit effect vs. HSA	na	76	93	73

Source: AHCPR

Staff Draft: ≤ 10 exempt, 3.9% cap for exempt workers
219: ≤ 20 exempt, no extra cap for exempt workers
253: ≤ 20 exempt, 4-6% caps for exempt workers

ESTIMATES ARE PRELIMINARY, ROUGH BALLPARKS, ESPECIALLY THE MULTIYEAR ESTIMATES, AND THEY MAY UNDERSTATE THE EFFECTS OF OUTSOURCING.

Household Premium Payments

by exempt workers, per household

	Staff Draft	219	253	Kennedy Mark (#241b)
All	$847	$1630 (7.3%)	$991 (4.5%)	$870
≤ 100% of poverty	$239	$502 (8.3%)	$243 (4.0%)	$256
100-200%	$511	$1401 (10.6%)	$607 (4.6%)	$575
200-300%	$868	$2232 (10.3%)	$1238 (5.7%)	$1014
300%+	$1989	$2571 (5.1%)	$2057 (4.0%)	$2095

Source: AHCPR, preliminary estimates. Numbers in parentheses are average percentages of AGI paid for premiums by exempt households in the relevant income class. Dollar figures are for 1994 fully phased-in.

Schedule of extra income caps for exempt workers:

≤ 150% of poverty	pays no more than	4.0%
150-175% of poverty	"	4.5%
175-225% of poverty	"	5.0%
225%+ "	"	6.0%

BENEFIT SCENARIOS

CBO-like Premiums, Subsidies

Scenario	Single Premium	Richness Percentile for Fortune 500 Co's.[1]	5-Year Premium Subsidies (Billion $)	5-Year Cost-Sharing Subsidies (Billion $)	Total	(HMO Premium) (with MC)[2]
Base - Health Security Act (HSA)	$2,200	Median	$384	$12	$396	$2,200
1. .25/$2,000	$2,051	30th	$357	$25	$383	$2,200
2. .25/$2,000 BCSO mental health	$1,948	15th	$327	$24	$351	$2,098
3. HSA w/o mental health	$1,980	20th	$332	$12	$344	$2,090
4. .25/$2,000, trimmed other benefits by $100	$1,937	15th	$324	$24	$348	$2,086
5. .25/$1,500 or .20/$2500	$2,101	35th	$355	$12	$367	$2,101
6. .25/$2,000 w/o mental, w/o prev, and w/o drugs	$1,541	5th	$194	$12	$206	$1,585

Includes Δs to HMO benefit
$250 inpatient
$10 drugs

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[1] Relative generosity of plan compared to all Fortune 500 Companies.

[2] HMO premium assuming 20% savings from "management".

BENEFIT SCENARIOS

Adminstration's Premiums, Subsidies

Scenario	Single Premium	Richness Percentile for Fortune 500 Co's.[1]	5-Year Premium Subsidies (Billion $)	5-Year Cost-Sharing Subsidies (Billion $)	Total	(HMO Premium) (with MC)[2]
Base - Health Security Act (HSA)	$1,932	Median	$317	$10	$327	$1,932
1. .25/$2,000	$1,801	30th	$295	$21	$316	$1,932
2. .25/$2,000 BCSO mental health	$1,711	15th	$270	$20	$290	$1,842
3. HSA w/o mental health	$1,739	20th	$274	$10	$284	$1,836
4. .25/$2,000, trimmed other benefits by $100	$1,701	15th	$267	$20	$287	$1,832
5. .25/$1,500	$1,845	35th	$293	$10	$303	$1,845
6. .25/$2,000 w/o mental, w/o prev, and w/o drugs	$1,353	5th	$160	$10	$170	$1,392

[1] Relative generosity of plan compared to all Fortune 500 Companies.

[2] HMO premium assuming 20% savings from "management".

TRIM:

1. BC/BC MH
2. No preventive
3. Drop kids dental, drugs don't apply to OOP Max, preventive through age of 2

REDUCING THE HSA BENEFIT PACKAGE BY 30%

Ranking

- HSA benefit package ranking is lowered from a 50th percentile plan to a 5th percentile plan among those offered by Fortune 500 companies.

Benefits

- Preventive services are not covered.
- Outpatient prescription drugs are not covered.
- Mental health and substance abuse services are not covered.

Cost-Sharing

High cost-sharing plan:

- Individual copay increases from 20% to 25% for selected services.

Low cost-sharing plan:

Inpatient services:	per admission deductible increases from $0 to $250
Emergency Services:	copay increases from $10 to $100
Hospital Surgery:	copay increases from $10 to $100
Delivery of Babies:	copay increases from $10 to $100
Outpatient visits:	copay increases from $10 to $15
Outpatient Surgery:	copay increases from $10 to $50
Ambulance:	copay increases from $0 to $50

Cap on Annual Out-of-Pocket Expenses

- The annual out-of-pocket limit for an individual increases from $1,500 to $2,000.

Premiums

- Single person premium (for high cost sharing plan) decreases from $2,200 to $1,541.

Subsidies

- Total 5 year subsidies for premiums and cost-sharing decrease from $395 billion to $206 billion.

MEMORANDUM

To : Ken Thorpe

From : Jim Mays JM

Subject : Additional Benefit Tables

The attached tables give some of the additional detail discussed at the February 7 meeting. Table 1 shows the preventive services percentage of the current benefit package, and the increases associated with the specific benefits discussed (from Rose Chu). Table 2 shows the coverages which would correspond to 10th and 90th percentile coverages, respectively, consistent with the benefits distribution table from last week (from Cathi Callahan). Table 3 shows the prevalence of particular service coverages by small employer plans versus those of medium and large employers.

Gordon looked at the question of what fraction of the approximately 15% of total benefit costs associated with mental health and substance abuse services could be cut out by alternative benefit structures. Explicit exclusion of all but "stabilizing" services could reduce that by perhaps a half. Requiring all services to be approved by a capitated gatekeeper could generate about a one-third reduction. If there is interest in more detail, Gordon will be happy to discuss the issues any time.

cnat1
/a/c

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To Jennifer Klein	From Jim Mays
Co.	Co.
Dept.	Phone # 703-941-7400
Fax # 202-456-2878	Fax #

Table 1

Preventive Services without coinsurance

I. Base costs for preventive package in HSA	4.38%
II. Mammograms	
A. Add mammogram every 2 years for women 50-64 to make annual	0.24%
B. Add mammogram every 2 years for women 40-49	0.29%
III. Prostate cancer screening for men (PSA every 3 yrs 50-64)	0.13%
IV. Colorectal screening	
A. Occult blood every year 50-64	0.13%
B. sigmoidoscopy every 3 years after 3 annual for 50-64)	0.76%
V. Genetic screening (MAFP, PKU, T4, galactasemia, sickle cell) Waiving the 20% coinsurance only, assume 80% covered already	0.06%
VI. Family Planning Waiving the 20% coinsurance on visits	0.11%
VII. In vitro fertilization (Estimate could vary widely depending on utilization)	1.11%

Table 2

Alternative Plans in the Distribution of Fee for Service Plans - CY 1994

10th Percentile Plan:

Starting Point: National Guaranteed Benefit Plan

Cost Sharing: Deductible $450/$900, cost-sharing maximum $4,000/$8,000

Add: Prescription drugs covered as all other services

Subtract:

No dental
Eliminate payment in full for prenatal and well baby care
No home health, physical therapy, oxygen, prosthetics, ambulance

90th percentile Plan:

Starting Point: National Guaranteed Benefit Plan

Cost Sharing: Deductibles $100/$200, cost-sharing maximum $1,500/3,000

Add: Preventive and restorative dental for adults, prescription drugs covered as all other services

Table 3

Medical Care Benefits by Employer Size

Small establishments from 1990 BLS Employee Benefit Survey (EBS
Medium and Large establishments from 1991 BLS EBS

Category of Benefit	Small	Medium and Large
Hospital room and board	100	100
Hospital misc.	100	100
Extended care facility	63	80
Home health care	79	81
Hospice	51	55
Surgery	100	100
Physician visits		
in hospital	100	100
office	100	98
Diagnostic x-ray and lab	100	100
Prescription drugs - nonhospital	96	96
Mental health care		
in hospital	98	98
outpatient	96	97
Alcohol abuse treatment		
inpatient detox	97	97
inpatient rehab	78	77
outpatient rehab	72	77
Drug abuse treatment		
inpatient detox	94	96
inpatient rehab	73	76
outpatient rehab	68	75
Dental	30	60

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(703) 941-7400
FAX (703) 941-3951

Date: 3/22/94

----------*Please Deliver Immediately*----------

To: Jennifer Klein

From: Jim Mays

Re: Limited Sigmoidoscopy Expansion (age 50 on time)

Memo: Sorry about the delay. Rose's numbers translate into a 0.14% premium add-on (vs. 0.76% we had in the "every 3 years" benefit)

We are transmitting ___ pages (including this transmittal sheet).

bbsp3
h / jwm
3 March 94
wgted avg prem

Benefit Scenarios

1. Administration's Premiums, Subsidies

Scenario	Single Premium	Richness Percentile	5-year Premium Subsidies (bil.$)	5-year Cost-sharing Subsidies (bil.$)	Total	(HMO Premium) (w/ MC)
Base - Health Security Act (HSA)	$1,932	60th	317	10	327	$1,932
1. .25/$2,000	$1,801	40th	295	21	316	$1,932
2. .25/$2,000, BCSO mental health	$1,711	25th	270	20	290	$1,842
3. HSA w/o mental health	$1,739	30th	274	10	284	$1,836
4. .25/$2,000, trimmed other benefits by $100	$1,701	25th	267	20	287	$1,832

•25 + Δ in HMO cost sharing

2. CBO-like Premiums and Subsidies

Scenario	Single Premium	Richness Percentile	5-year Premium Subsidies (bil.$)	5-year Cost-sharing Subsidies (bil.$)	Total	(HMO Premium) (w/ MC)
Base - Health Security Act (HSA)	$2,200	60th	384	12	396	$2,200
1. .25/$2,000	$2,051	40th	357	25	383	$2,200
2. .25/$2,000, BCSO mental health	$1,948	25th	327	24	351	$2,098
3. HSA w/o mental health	$1,980	30th	332	12	343	$2,090
4. .25/$2,000, trimmed other	$1,937	25th	324	24	348	$2,086

IMPLICATIONS OF RAISING COST SHARING FOR FEE FOR SERVICE PLANS

♦ Premiums are less comparable between HMOs and fee for service (FFS) plans, which makes the weighted average premium a less appropriate measure on which to base:

- Premium caps
- Required employer contributions and alliance credit
- Premium and cost sharing subsidies

If FFS cost sharing and benefits are adjusted so that the actuarial difference between FFS benefits and HMO benefits increases from 15% to 25%, it is unlikely that management savings in HMOs can eliminate the full 25% premium differential. FFS plans would, therefore, likely have lower premiums than HMO plans.

With higher FFS cost sharing, premiums may tend to cluster around two levels (a "FFS average" and a higher "HMO average"), with the overall weighted average premium falling in between these two levels.

♦ PREMIUM CAPS

- Premium cap enforcement is complicated because caps affect premiums and not cost sharing, and therefore apply to a greater percentage of the total costs associated with HMOs than with FFS plans. As the cost sharing differential increases, it becomes more difficult for HMOs to compensate for the difference through management savings. HMOs are therefore far less likely to be able to bid at or below the premium target.

- Enrollment in HMOs raises average premium, and therefore increases the likelihood that an alliance would reach its premium cap. This would be true even if HMOs were operating quite efficiently.

- FFS plans (with higher cost sharing) would have an actuarial value below the average premium, and would therefore have a greater opportunity to shadow price at 80% of the alliance's premium target. Shadow pricing would tend to raise the average premium.

♦ REQUIRED EMPLOYER CONTRIBUTIONS AND ALLIANCE CREDIT

- The weighted average premium is likely to exceed FFS premiums, creating an opportunity for FFS plans to shadow price at 80% of the average.

- The lowest premium HMOs may substantially exceed 80% of the average premium. This gap may seem larger than it is to people, since it requires that they assess the combined effect of premiums and anticipated cost sharing.

♦ PREMIUM AND COST SHARING SUBSIDIES

- Fewer HMOs are likely to have premiums at of below the average premium, so cost sharing subsidies will have to be provided to far more low-income people, raising the overall cost of these subsidies.

- Direct subsidies for low-income families (for premiums and cost sharing) are likely to rise because these families would end up receiving the same benefits, but in a FFS environment rather than an HMO environment.

- Low-income families (including AFDC and SSI recipients) would not likely be able to enroll in HMOs because there are not likely to be HMO plans at or below the average premium.

Table 1

Premium Impact of Alternative Deductibles

Cost-sharing Maximum = $1,500 single, $3,000 family

Deductibles		Premiums			
		Single	Couple	1 Adult Family	2 Adult Family
$100 /	$200	$1,965	$3,930	$3,968	$4,444
150 /	300	$1,948	$3,896	$3,930	$4,401
→200 /	400	$1,933	$3,866	$3,894	$4,361
250 /	500	$1,918	$3,836	$3,863	$4,326
300 /	600	$1,906	$3,811	$3,837	$4,297
500 /	1000	$1,858	$3,715	$3,745	$4,194

Notes:
Deductibles expressed as individual, then family maximum.
Premiums derived from NMES expenditure distributions adjusted to 1994, calibrated to SPAM premiums.

Table 2

Premium Impact of Alternative Deductibles

Cost-sharing Maximum = $1,000 single, $2,000 family

Deductibles		Premiums			
		Single	Couple	1 Adult Family	2 Adult Family
$100 /	$200	$1,999	$3,998	$4,036	$4,520
150 /	300	$1,983	$3,966	$4,000	$4,479
200 /	400	$1,970	$3,939	$3,965	$4,441
250 /	500	$1,956	$3,912	$3,937	$4,409
300 /	600	$1,943	$3,887	$3,913	$4,382
500 /	1000	$1,901	$3,802	$3,834	$4,293

Notes:
Deductibles expressed as individual, then family maximum.
Premiums derived from NMES expenditure distributions adjusted to 1994, calibrated to SPAM premiums.

Table 3

Premium Impact of Alternative Deductibles

Cost-sharing Maximum = $2,000 single, $4,000 family

Deductibles		Premiums			
		Single	Couple	1 Adult Family	2 Adult Family
$100 /	$200	$1,939	$3,877	$3,919	$4,389
150 /	300	$1,922	$3,843	$3,880	$4,345
200 /	400	$1,907	$3,813	$3,842	$4,303
250 /	500	$1,891	$3,782	$3,810	$4,267
300 /	600	$1,877	$3,754	$3,783	$4,237
500 /	1000	$1,827	$3,654	$3,684	$4,126

Notes:

Deductibles expressed as individual, then family maximum.
Premiums derived from NMES expenditure distributions adjusted to 1994, calibrated to SPAM premiums.

Table 4

Premium Impact of Alternative Cost-Sharing
Based on Medicare Benefit Structure

Deductibles	Premiums			
	Single	Couple	1 Adult Family	2 Adult Family
$200 / $400	$1,933	$3,866	$3,894	$4,361
Current Medicare	$1,731	$3,431	$3,584	$3,980
Add prescription drug coverage	$1,841	$3,617	$3,684	$4,077
Also add cost-sharing maximum	$1,932	$3,841	$3,875	$4,271

Notes:
Drug coverage has $250 deductible, $1,000 cost-sharing maximum in second option. Cost-sharing maximum of $1,500 per person for all services added in third option.
Premiums derived from NMES expenditure distributions adjusted to 1994, calibrated to SPAM premiums.

Table 5

Contribution of Specific Service Categories to Total Premium

Service	Percent
Hospital	38.8%
Physician	29.0%
Other Professional	7.2%
Prescription Drugs	7.0%
Dental	2.1%
Mental health	14.9%
Other	1.0%
Total	100.0%

Note: benefit allocations reflect distributions of covered charges derived from NMES, adjusted to 1994, and calibrated to SPAM.

cnsst1
/a/c

MEMORANDUM

To : Linda Blumberg

From : Jim Mays JM

Subject : Revised Actuarial Value Distribution

Cathi Callahan has completed a revised distribution of health insurance actuarial values for medium and large firms for 1994. The changes in the attached table compared to earlier versions are:

- rebased average benefits to be consistent with average single coverage cost of $1,870, family coverage cost of $4,218, and

- refined projection of expected benefit rates for 1994, using published BLS results from 1991 EBS.

The proposed standard package is close to the 60th percentile in richness. As we have discussed before, the thin dental benefits are largely offset by the richer-than-typical medical coverages, especially the modest cost-sharing and fully-paid preventive services.

Also attached is a short description of the logic of the placement and a histogram of benefit rates (rather than deciles) which shows the standard package landing in the modal benefit rate interval. The picture is more suggestive of the plan's richness compared to all coverages, but explaining average benefit rate may be harder than explaining average benefits.

cnrbd4
/4 /a/d

Distribution of Actuarial Values of Health Insurance, 1994 dollars

Based on BLS Employee Benefit Survey, 1988
of Medium and Large Firms, projected to 1994

Percentile	Average Benefit Payments	
	Single	Family
10	$1,372	$3,096
20	$1,457	$3,287
30	$1,535	$3,464
40	$1,592	$3,593
50	$1,648	$3,717
60	$1,688	$3,808
70	$1,736	$3,916
80	$1,814	$4,092
90	$1,915	$4,320
average	$1,626	$3,668

→ + 15% = our premium

Note: Population controlled to average cost for typical plan of $1,870 for single coverage, $4,218 for family coverage, including loading factor of 15%.

Actuarial Research Corporation
cmc/jwm 11/10/93

Relative Richness of the Clinton Plan

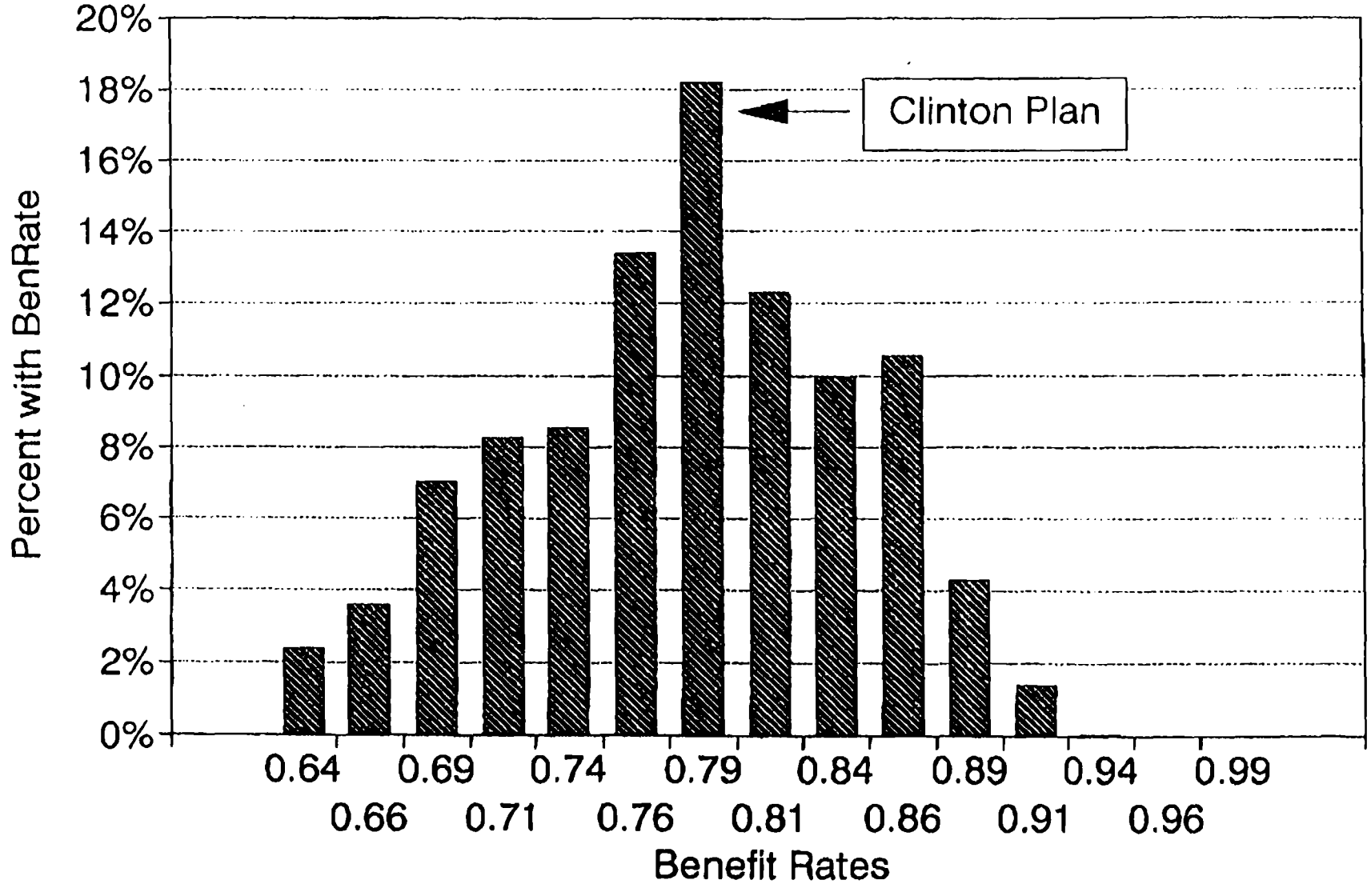
The relative richness of the Clinton plan was compared to plans existing in medium and large firms, and was found to be at the 60th percentile of richness (i.e., only 40 percent of persons covered by these plans have better coverage than the Clinton plan).

The data used was the 1988 BLS Employee Benefits Survey: a survey of medium and large firms that offer health insurance to their employees. The survey data was brought to 1994, and the plans were evaluated using a uniform rating method (each plan rated on the same basis). Plans which were Health Maintenance Organizations (HMOs) were excluded from the comparison. Each plan was run through an automated rate-book in order to calculate a benefit rate, which is an index value between 0 and 1. The benefit rate is defined as the percent of covered charges likely to be paid by this plan, when the plan parameters were applied to a uniform population. For example, a benefit rate of 0.85 would indicate that the plan would, on average, pay 85% of covered charges. Included in covered charges were hospital, physician, other professional services, and prescription drugs, as well as dental.

The Clinton plan was then evaluated using the same rating method as used for the BLS plans. The benefit rate assigned to the Clinton plan (approximately 0.80) was found to place the plan at the 60th percentile of the distribution of fee for service (non-HMO) plans.

1994 Benefit Rate Distribution

Fee for Service Plans, Including Dental



MEMORANDUM

To : Ken Thorpe

From : Jim Mays

Subject : "Bare-bones" Premium Estimates

The attached table walks through the premium savings associated with moving from the Health Security Act benefit package to a "bare-bones" package. The overall reduction ought to be pretty close to what HCFA would generate with a full SPAM analysis, although the pieces may not be fully in sync. Dollars shown are marginal reductions, as if the line item is the only change made from HSA. The bottom line, labeled cumulative change, takes out interactions (crudely).

CBO + Admin

① 2, 3, 4

② 2, 3, 5

③ 2-7

④ NO DENTAL (2-7)

① Actuarial Value

② Subsidies

	Marginal Reduction
1. Base - Health Security Act, single premium =	$1,932
2. Raise coinsurance from .20 to .25 =	-$87
3. Raise cost-sharing maximum to $2,000 per individual, $3,000 per family =	-$46
4. Cut mental health benefit to Blue Cross Standard Option level =	-$97
5. Eliminate mental health benefit =	-$193
6. Eliminate prescription drug benefit =	-$218
7. Eliminate preventive care package =	-$85
Cumulative reduction (with interactions)	-$579

cnbb1
/a/c

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To Ken Thorpe	From Jim Mays
Co.	Co.
Dept.	Phone # 703-941-7400
Fax # 202-401-7321	Fax # 703-941-7951

Jim -
Do 1 pager to back this up.

Differences between HSA Premium and BC/BS Standard

Dollar impact of differences on HSA single premium ($1,932)

HSA Premium Above BC/BS Standard

(1)	**Mental Health**	**$ 97** → Look at limiting this? (*)
(2)	**Preventative**	**90** → What about doing this only for low-income?
(3)	**Coinsurance**	**116** Just kids & prenatal? 20% → 25% (*)
(4)	**Cost-sharing maximum**	**114** Go from $1500 to 2000 (*) for individuals
(5)	**Other differences**	**87**
Total of benefits above BC/BS		**$504**

What about postponing benefits?
Other changes to bring subsidy costs down?

HSA Premium Below BC/BS Standard

(1)	**Hospital cost sharing**	**$147**
(2)	**Prescription drug cost sharing**	**143** → Take out prescription drugs?
Total of benefits below BC/BS		**$290**

Net difference between HSA and BC/BS standard	**$214**

Two steps
(1) Premiums
(2) What impact on subsidies

(1) together [
(1) Coinsurance 20 → 25 %
(2) Cost-sharing maximum 1500 → 2000

(2) This + no MH + no drugs + targeted preventive [Davidsons]
(3) Mental health → (1) No MH
(2) MH - BC/BS

(4) Targeting preventive
: by population
: by income
kids and prenatal mammography → Prevention w/ new cost sharing scheme

(3) This + (6) Δ MH Δ Drugs (5) Drugs
: decrease FFS package $
→ What if allow HMOs figure out how to conform to this?
• risk selection problems

KT

BENEFITS

4 scenarios:

- determine subsidy impact, -determine where on distribution new benefit packages sit

1.
- Raise coinsurance from .20 to .25
- Raise cost-sharing maximum to $2,000 per individual, $3,000 per family

2.
- Raise coinsurance from .20 to .25
- Raise cost-sharing maximum to $2,000 per individual, $3,000 per family
- Cut mental health benefit to Blue Cross standard option level

3. Eliminate mental health benefit

4.
- Raise coinsurance from .20 to .25
- Raise cost-sharing maximum to $2,000 per individual, $3,000 per family
- Reduce (do not eliminate) mental health, prescription drug, preventive care, dental benefit by $100 (total)

(4)

(1) OPTION 2

(2) NO PREVENTIVE

(3) $250 / 40% / NO OVP CAP

MH → 30/60 INPT.

MEMORANDUM

To : Ken Thorpe

From : Jim Mays

Subject : Additional Benefit Tables

The attached tables give some of the additional detail discussed at the February 7 meeting. Table 1 shows the preventive services percentage of the current benefit package, and the increases associated with the specific benefits discussed (from Rose Chu). Table 2 shows the coverages which would correspond to 10th and 90th percentile coverages, respectively, consistent with the benefits distribution table from last week (from Cathi Callahan). Table 3 shows the prevalence of particular service coverages by small employer plans versus those of medium and large employers.

Gordon looked at the question of what fraction of the approximately 15% of total benefit costs associated with mental health and substance abuse services could be cut out by alternative benefit structures. Explicit exclusion of all but "stabilizing" services could reduce that by perhaps a half. Requiring all services to be approved by a capitated gatekeeper could generate about a one-third reduction. If there is interest in more detail, Gordon will be happy to discuss the issues any time.

cnat1
/a/c

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To Jennifer Klein	From Jim Mays
Co.	Co.
Dept.	Phone # 703-941-7400
Fax # 202-456-2878	Fax #

Table 1

Preventive Services without coinsurance

I. Base costs for preventive package in HSA	4.38%
II. Mammograms	
A. Add mammogram every 2 years for women 50-64 to make annual	0.24%
B. Add mammogram every 2 years for women 40-49	0.29%
III. Prostate cancer screening for men (PSA every 3 yrs 50-64)	0.13%
IV. Colorectal screening	
A. Occult blood every year 50-64	0.13%
B. sigmoidoscopy every 3 years after 3 annual for 50-64)	0.76%
V. Genetic screening (MAFP, PKU, T4, galactasemia, sickle cell) Waiving the 20% coinsurance only, assume 80% covered already	0.06%
VI. Family Planning Waiving the 20% coinsurance on visits	0.11%
VII. In vitro fertilization (Estimate could vary widely depending on utilization)	1.11%

Table 2

Alternative Plans in the Distribution of Fee for Service Plans - CY 1994

10th Percentile Plan:

Starting Point: National Guaranteed Benefit Plan

Cost Sharing: Deductible $450/$900, cost-sharing maximum $4,000/$8,000

Add: Prescription drugs covered as all other services

Subtract:

No dental
Eliminate payment in full for prenatal and well baby care
No home health, physical therapy, oxygen, prosthetics, ambulance

90th percentile Plan:

Starting Point: National Guaranteed Benefit Plan

Cost Sharing: Deductibles $100/$200, cost-sharing maximum $1,500/3,000

Add: Preventive and restorative dental for adults, prescription drugs covered as all other services

Table 3

Medical Care Benefits by Employer Size

Small establishments from 1990 BLS Employee Benefit Survey (EBS
Medium and Large establishments from 1991 BLS EBS

Category of Benefit	Small	Medium and Large
Hospital room and board	100	100
Hospital misc.	100	100
Extended care facility	63	80
Home health care	79	81
Hospice	51	55
Surgery	100	100
Physician visits		
in hospital	100	100
office	100	98
Diagnostic x-ray and lab	100	100
Prescription drugs - nonhospital	96	96
Mental health care		
in hospital	98	98
outpatient	96	97
Alcohol abuse treatment		
inpatient detox	97	97
inpatient rehab	78	77
outpatient rehab	72	77
Drug abuse treatment		
inpatient detox	94	96
inpatient rehab	73	76
outpatient rehab	68	75
Dental	30	60

Memorandum

To: Ken Thorpe, Ph.D.

From: Gordon R. Trapnell

Date: March 16, 1994 [Revised]

Re: The Effect on the Average Premium Rate for Alliance Coverage of Benefit Changes proposed by a Senate Committee

A. Objective

The purpose of this note is to provide an estimate of the impact on the premium rates charged in the public alliances of expanding certain benefits in the uniform benefit package in H.R. 3600.

B. Benefit Changes

1. In Vitro Fertilization

The specific change would be to add "in vitro fertilization services" to family planning services and remove the exclusion of same. Coverage would be subject to the outpatient copayments in the low cost sharing schedule and the deductible and coinsurance in the high cost sharing schedule. The change proposed would apparently not cover GIFT (Gamete Intrafallopian Transfer), since fertilization does not occur "in vitro" (i.e. in a "dish" or test tube) but in the fallopian tubes (although with extracted and duplicated eggs and extracted sperm, perhaps donated, inserted back artificially). It is not clear whether certain other modifications of in vitro fertilization technology such as "ZIFT" would be covered.

Coverage would apparently be unlimited, both as to episodes (attempts to produce a normal embryo) and menstrual cycles (corresponding to implantations). Patients typically prepare for three to six or more "cycles" using eggs extracted and multiplied beforehand in one episode or attempt to become pregnant.

We have data from the U.S., Canada and France, in which the number of cycles varies from 116 per million population in the

U.S., where there are religious and cultural inhibitions to the technique and 70% of the costs are paid by the patients (average of $54,000 per baby produced) to 588 per million population in France, where the cost is paid almost entirely by the national health insurance. (The French figures are inflated somewhat by France serving as a center of excellence that attracts infertile women from other countries, especially those that were part of the French African empire.) Data is also available for the Canadian province of Ontario, where utilization is 333 cycles per million population, where the average patient share was documented to be 28.8% in a cost effectiveness study. Given the huge costs of raising a child and the complete change in life style that accompanies having children, the variation in utilization is much greater than I would expect on the basis of the difference in patient shares of the costs (although there is no valid data on which to base such an expectation). On the other hand, the capacity to raise the $25,000 or so needed to try at least three cycles is not within the immediate means of many couples and a large proportion of those may not be willing to risk such sums on the chance of having a baby. (From an emotional perspective, there may be many couples who prefer to pay $50,000 to adopt a child, and have the certainty of having the child. Thus risk aversion may distort the relationship between cost sharing and demand.)

Coverage with nominal copayments through HMOs and POS plans (into which couples desiring fertilization assistance would presumably enroll) would lead to a much higher utilization level in the U.S. The increase would probably occur over some period of years, however, as the technology becomes better known and more widely accepted. There may also be some initial supply restraints as well, although many of the existing centers can expand services substantially and there would appear to be few constraints on capacity over a five to ten year horizon. The level of utilization in the early years of coverage would also be affected to some extent by an initial pent up demand from those unable to afford the technology.

Whether to use the Ontario or French levels as a base as to what to expect in the longer run in the U.S. is open to debate. What will matter over the first few years of Health Security, however, is how private insurers set premiums for a service that may grown very rapidly and be very expensive. The French data obviously provides a more "conservative" base.

Based on the French level of utilization, we project a fully implemented utilization level in 1994 of $1.3 billion for in vitro fertilization alone. If this cost is spread over all two parent families, the increase in family premium would be $26.94 before loading for administrative expenses and other margins. The latter should be less than the average loadings attributed to the premium rates, since there would be a relatively minor

additional administrative cost to include this benefit. Using a marginal loading of 5%, the increase in two adult premiums would be $28.29.

If coverage is only for couples who have no normally impregnated children, it may be appropriate to charge the cost of this service only to couples without children. If this were done, the increase in benefits would be around $67 and with a 5% loading, $69.98.

It is also possible that some single women or women with female partners will seek this service. I have not included any of this potential demand in my estimate. (They may be included anyway. The cost of marriages and no-fault divorces is low compared to the cost of artificial procreation, if problems related to liability for paternity payments could be solved, which would appear feasible given the current capacity of genetic identification to disprove paternity of a non-father husband.)

There are currently around 5,000 GIFT cycles and 2,000 ZIFT cycles in the U.S. If in vitro is fully covered, it is unlikely that there would be much utilization of these alternatives. If covered, expenditures would thus only be increased by the difference in the cost of the procedures. Such expansion would increase overall expenditures by the difference in costs, multiplied by the share of patients choosing the alternatives.

2. Hearing Aids for Children Under Age 18

Hearing aids would be covered for children under age 18 according to a periodicity schedule established by the Board. As with all services under the HSA, payment would be limited by fee schedules established by each state alliance.

According to "Advance Data" from the Health Interview Survey, there were 152,000 persons in the U.S. under age 25 using a hearing aid or other audio assistive device. This number can be projected to 1992 by 1% per year and increased 10% for population undercount and underreporting.

Assuming an average payment of $1500 and an average frequency of replacement of four years, the implied expenditure would be around $183 million in 1994, or about $.68 per child under age 18.

Since the expense is very high for relatively few patients, the administrative costs to add this benefit should be a much lower proportion of the additional benefit costs than the case with the services already included. For this reason, the benefit cost per child is loaded by 5%. This produces family premiums of $1.36 for one adult families and $1.50 for two adult families with children. There is also a small increase in the premiums

for single adults and couples to allow for those under age 18 for whom these premiums are payable.

3. Care for Congenital Conditions

a. Remove 100 day limit for extended facility care and the restriction that it follow an accident or illness if it provides a cost effective alternative to inpatient hospital confinement

If the specification is met literally, there would be a cost reduction. In practice there would be a cost increase, but it would be very small unless grossly mismanaged.

To avoid the impression that there is a free lunch anywhere, however, I will estimate that there would be an increase in the premium rates for families with children of 0.01% for these changes.

b. Remove the restriction on home health services that they follow an accident or illness

Coverage would be for the home health services covered by Medicare when it is an alternative to inpatient care in a hospital, skilled nursing facility or rehabilitation facility. Skilled nursing facilities and rehabilitation facilities are defined in a more comprehensive manner than in the Social Security Act. The change would be to remove the restriction that the care follow an accident or illness.

A key consideration is whether to interpret H.R. 3600 literally or according to the intent of the drafters. The intent of this section was to cover home health care that is a substitute for <u>covered</u> confinements in other facilities. As drafted, however, it would cover home health care that is a substitute for <u>uncovered</u> confinements in skilled nursing and rehabilitation facilities.

If we follow the intention of the bill, the cost would be minimal for the reasons already given. Again, to emphasize the principle that there is no free lunch (there would be some expansion of coverage, or at least that is the expected value over the possible scenarios), I estimate the impact as 0.01%.

If, however, the bill is interpreted as written, the cost could be many times higher. Since what would appear to be important in discussions with Congress is the bill as intended, I am not estimating the cost of offering the expanded coverage.

4. Include all Preventive Care Procedures Recommended by AAP

ARC has estimated that expanding the preventive care

schedule to include all of the services on "Attachment C" would increase the premiums of families with children by $17.97 per child, including a 15% loading. This produces increases of $34.14 in the one adult family premium rate and $37.74 in that for full families. (The increase would be $24 if charged to all family units including couples). The cost of administration for these services, even on a marginal basis, would be comparable to the overall loading.

5. Medical Costs Associated with a Clinical Trial

I do not have data on the number of persons in clinical trials and expenditures that are not paid by insurance (some are), or the offset to other payments (some are buried in teaching hospital charges). It is hard to believe they could be a significant proportion of overall expenses. Consequently I will estimate the cost as a minimal .01% of premiums.

6. Outpatient Rehabilitation Services

The proposal would (i) explicitly cover rehabilitation therapies for all patients with congenital conditions and (ii) expand the coverage to include "periodic oversight of the patient's needs" and "reevaluations" by the professional therapists of maintenance or prevention programs set up them. (Designing maintenance programs and training parents are already covered by the health security program.)

There is also the question of whether payment could be made under the bill as modified for services now provided under school based programs for rehabilitation services if the "accident and illness" restriction is dropped.

a. Explicit Coverage of All Children with Birth Defects

The explicit coverage of congenital conditions may not increase the premium rate at all, since the most likely interpretation of the Act in regulations by the National Health Board would consider nearly all birth defects to be accidents. This would appear to have been the intention of the drafters. In addition, the fact that in some states the courts have already found some birth defects to be the result of accidents should push the national regulations in this direction. Further, any other interpretation would probably be followed by legislation that had this effect.

On the other hand, the current interpretation of the courts in most states of the accident and illness limitation in the bill permits insurers to deny claims related to birth defects on the grounds that they are not either accidents or illnesses. Thus adding the phrase "other health condition" does expand the

coverage, and in recognition of this fact, I will estimate the change as adding 0.01% to the premium rates for families with children. This will increase the cost of the coverage by about $.19 per child per year, which will add $.36 to the one adult family premium and $.43 to the two adult and children family premium.

b. Coverage of School Based Services

Under Federal mandates, public schools are required to provide a number of rehabilitation services including those of skilled therapists for children with disabilities that interfere with learning. Approximately 13% of the state and local expenditures pursuant to the federal mandates are for services which would be covered if provided by independent or other covered providers (e.g. home health agencies). The estimate above in effect assumes that these services would not be billed to health plans.

c. Oversight and Evaluation Benefit

Adding professional oversight and evaluation to the outpatient rehabilitation services that will be covered should involve a relatively small increase in plan outlays, especially for the integrated care plans. As with other minimal, but positive, increases in the premium rates, I am estimating this one to add 0.01% to the premium rates for families with children.

7. Treat Family Planning Services as Preventive Care

This change would not apply deductibles, copayments or coinsurance to family planning services, drugs and supplies. The increase in overall premiums would be around 0.2%. When this is charged to the premium rates for families with children, the cost per child of $8.19 produces increases of $15.57 for one parent families and $17.21 for two parent families with children. There is also a minimal cost for persons paying single adult or couple premium rates who are under age 18.

8. Allow Children to Buy Into Medicaid Wrap Program

This change would open up the Medicaid program treatment services for children to provide care for any condition found during EPSDT. This would obviously incur a non-trivial expense. I need more detailed specifications to attempt an estimate.

9. Open Up the HCB Care Program to Virtually All Children with Disabilities

The cost of the HCB program in H.R. 3600 is constrained by two factors: (i) limiting care to most frail elderly persons to those who have problems with three of five relatively difficult

to meet ADLs, which in practice would mean they would have to have problems with one of the following: toileting, eating, or transferring to or from chairs or beds and (ii) caps on federal funding. Coverage is potentially already relatively comprehensive for children, including all children who have "severe cognitive or mental impairments and can not perform at least one ADL or IADL (there is no age limitation), have "severe or profound mental retardation" or "are severely disabled" and under age 6.

Since the proposal apparently would not increase federal funding, it would have no cost. (If it increases federal funding, the increase in cost is the proposed federal funding.)

Table 2-A

Effect on Premium Rate of Specified Benefit Changes

Item	Single	Couple	1 Adlt Fam	2 Adl Fam
Administration Estimates				
HS Premium Rate	$1932.00	$3165.00	$3893.00	$4360.00
Proposed benefit changes				
In vitro fertilization	0	28.29	0	28.29
Hearing aids under age 18	.01	.02	1.36	1.50
Care for congenital conditions:				
ECF - No 100 day limit or accident/illness restricts	0	0	.39	.43
HHA - No accident/illness restricts	0	0	.39A/	.43A/
AAP preventive care	.18	.36	34.14	37.74
Medical costs in clinical trials	.19	.39	.39	.43
Outpatient rehabilitation				
Cover all congenital condns	0	0	.39	.43
Oversight and evaluation	0	0	.39	.43
No cost sharing on family plan	.08	.16	15.21	17.21
Total:	1932.46	3194.22	3945.66	4446.89

A/ Assumes coverage only in lieu of either a short term hospital stay or ECF stay that is a substitute for a short term hospital stay.

Table 2-B

CBO Premium Rates

HS Premium Rate	$2200.00	$4400.00	$4095.00	$5017.00
Proposed benefit changes				
In vitro fertilization	0.00	28.29	0.00	28.29
Hearing aids under age 18	.01	.02	1.36	1.50
Care for congenital conditions:				
ECF - No 100 day limit or accident/illness restricts	0	0	.39	.43
HHA - No accident/illness restricts	0	0	.39A/	.43A/
AAP preventive care	.18	.36	34.14	37.74
Medical costs in clinical trials	.19	.39	.39	.43
Outpatient rehabilitation				
Cover all congenital condns	0	0	.39	.43
Oversight and evaluation	0	0	.39	.43
No cost sharing on family plan	.08	.16	15.21	17.21
Total:	2200.46	4429.22	4147.66	5103.89

A/ Assumes coverage only in lieu of either a short term hospital stay or ECF stay that is a substitute for a short term hospital stay.

March 9, 1994

To: Guy King

From: Bill London

Subject: Proposal To Expand HSA Mammography Screening Coverage

The current HSA benefit does not cover women who are 40 to 49 years old. For women over age 50, coverage is for one screening every two years.

This proposal adds one screening every two years for women between 40 and 49. It increases the coverage to every year for women over age 50.

The applicable female population aged 40 to 49 is 16 million. The applicable over 50 population is 16 million.

The payment per case is assumed to be the same as Medicare's, except without the 20% coinsurance. This would probably be about $63 in 1995.

The cost of the current HSA mammography screenings is estimated to be $178 million. This represents about 0.07% of benefits. The cost of the expanded benefit is estimated to be $435 million, or 0.17% of the total. The additional benefits would therefore add 0.1% to the $3,129 premium. This represents a premium increase of about $3.

SUMMARY OF STAFF DRAFT OF NEW HEALTH BILL

Introduction

This is a new proposal. It is designed to achieve the following goals:

- ensure affordable private health insurance coverage for all Americans that can't be taken away;
- protect federal taxpayers from the crippling burdens of deficit spending; and
- retain desirable elements of current system while expanding health care choices to employers and individuals.

Major Elements of Bill:

- Individuals are required to pay a greater share of out-of-pocket expenditures than under the President's bill.
- Employers are generally required to pay a smaller share of health costs than under the President's bill.
- There is enormous relief for small business. More than 75% of all American businesses --namely, small businesses-- are exempt from paying the required employer share. Those small businesses not covering them are required only to make a modest contribution to partially covering the costs of their employees' coverage.
- Concerns over a compulsory, bureaucratic, and monopolistic system are addressed directly there are no mandatory alliances.
- The private insurance market continues and is subject to genuine insurance reforms.
- Individuals and employers may continue to buy directly from insurers or, if desired, through voluntary alliances. In either case, insurance can be bought through agents.
- The bill is designed so that there is no increase in the federal deficit.
- The bill is designed to remove the $70 billion deficit shortfall in the President's bill.
- Federal spending is explicitly capped and specific provision is made for automatic reductions in federal spending if caps would be breached so that there is no deficit spending.

ENERGY AND COMMERCE COMMITTEE STAFF DRAFT

MAJOR ELEMENTS OF NEW HEALTH BILL

EMPLOYER RESPONSIBILITY

Employers With 10 or Fewer Employees:

Employers with 10 or fewer employees are exempt from the required employer share.

Some employers may still choose to pay the required employer share for all their employees. For those employers:

- The employer is subject to all of the provisions (below) applicable to employers with 11 to 75 employees, including the special subsidies; and
- Employees do not pay more than 3.9 percent of income for their share of the premium.

Other employers may choose not to pay the required employer share for all their employees. For those employers:

- There is a minimum employer contribution of 1 percent of payroll for firms with 1-5 employees;
- For employers with 6-10 employees, the amount would gradually increase to 2 percent over time; and
- Employees must purchase standard benefits package but are subsidized for the foregone employer share with monies which would have been directed to the exempt employers.

Employers with 10 or fewer employees who don't fully contribute to employer share, but who do contribute more than 1 percent of payroll, receive no direct subsidies, but retain tax deductibility.

Special Rule for Small Family Farmers:

Farmers with 10 or fewer employees would have special protections and a simplified method for making employer contributions:

- Seasonal employees (up to a maximum of 75 employees) are not counted for purpose of determining the "10 or fewer employees" test;
- The Secretary of Health and Human Services (HHS)

will provide for a simplified method of meeting the minimum employer contribution -- taking into account non-hourly, piecework payments; and

- The Secretary of HHS will establish a fund to use payments for migrant and seasonal workers to support county governments and migrant and rural clinics in geographic areas where payments are made.

Employers With 11 to 75 Employees:

- Must provide community-rated standard benefit package to employees.
- Receive special subsidies which are greatest for small firms with low average wages; subsidies occur through a reduction in the required portion of the premium that the employer must pay, ranging from a cap of approximately 20 percent of premium for smallest, low-wage firms to the cap that applies to employers with 76 to 1000 employees (see below).
- Employers may provide for coverage for all employees either inside or outside the alliance:
  - If inside the alliance, employees may choose from among all available alliance plans.
  - If outside the alliance, the employer must provide employees a choice from among at least 3 plans, including a fee-for-service plan.
- Required employee contribution is generally 20 percent with subsidies for low-income employees.

Employers with 76 to 1000 Employees:

- Must provide community-rated standard benefit package to employees.
- May not self-insure.
- Employer pays no more than 7.9 percent of an average premium taking into account all workers in the payroll system.
- Required employer share is limited to 80 percent of an average premium, but <u>is reduced</u> by the following:
  (1) credit for other employer contributions for 2-worker families (which generally reduces

contribution to approximately 66 percent); and

(2) subsidy resulting from a 7.9 percent payroll cap limitation.

- Employers may provide for coverage for all employees either inside or outside the alliance--
  - If inside the alliance, employees may choose from among all available alliance plans.
  - If outside the alliance, the employer must provide employees a choice from among at least 3 plans, including a fee-for-service plan.
- Required employee contribution is generally 20 percent with subsidies for low-income employees.

Employers with more than 1000 Employees:

- Must provide at least the standard benefit package.
- Must provide employees with choice of at least 3 plans, including a fee-for-service plan.
- Responsible for 80 percent of the premium (may contribute more).
- Must cover all employees and subsidize low-income employees as in H.R. 3600.
- May self-insure or buy insurance privately.
- May not participate in the voluntary alliances described below until 8 years after full implementation of the bill in all states.
- Must contribute 1 percent of payroll to carry fair share of responsibilities.
- Bill retains appropriate ERISA protections.

BENEFITS PLAN

- Reduce standard benefits package contained in H.R. 3600:
  - Increase cost-sharing to reduce actuarial value of benefits to approximately federal Blue Cross standard option (plus preventive services). This reduces value of package from 60th percentile of all group plans as in H.R. 3600 to 35th percentile).
  - Specifically, increase individual catastrophic limit from $1,500 to $2,500.

STRUCTURE OF SYSTEM FOR OBTAINING INSURANCE COVERAGE

- There are no mandatory alliances.
- There will be no competition over risk selection.
- There are basic reforms for all insurance, including portability, no pre-existing condition limitations, guaranteed issue and renewal, solvency and reinsurance requirements, and improved consumer protections, etc.
- Community rating required for all individuals and employers of 1000 employees or less.
- States arrange for Voluntary Alliances to make insurance products available to individuals and employers, collect premiums and enroll individuals and employers:
  - Single alliance available in every area;
  - No alliance competes with another;
  - Alliances will establish reasonable limitations on which qualified plans may offer through the alliance;
  - All three types of plans, including fee-for-service, will be available through the alliance;
  - Individuals may purchase inside the alliance or outside the alliance;
  - Employers may purchase inside the alliance or outside the alliance;
  - No requirement for insurers selling inside the alliance to sell outside the alliance;

- No requirement for insurer that sells outside the alliance to sell inside the alliance, but state may require that insurers selling outside the alliance must also offer to sell inside the alliance;
- Insurers selling outside the alliance must make all products available to individuals as well as groups;
- Insurers that sell both inside and outside the alliance use the same community rate, but may provide a limited administrative-only discount provided in statute for plans sold inside the alliance; and
- Agents may sell insurance outside the alliance; states may also provide an option for individuals and employers to purchase, through agents, insurance which is sold inside the alliance.

- For insurance sold outside the alliance, information and enrollment for all products are made available to individuals and employers through a method of central enrollment (as well as through existing mechanisms).

Requirements for Health Plans:

- Qualified health plans are required to:
  - Offer a standard benefit package.
  - Report outcome, quality measures and other data for consumer report card.
  - Contract with essential community providers and academic health centers (as required under H.R. 3600).
  - Market broadly and without discrimination.
  - Adhere to required grievance procedures.

Administration:

- Pursuant to federal rules, states are responsible for:
  - Coordination of premiums in two-worker families, including credits to employers to reduce employer share.

- Risk-adjusting premiums across health plans.

- Continued funding for Graduate Medical Education through assessments.

- Costs of Medicaid beneficiaries and non-workers spread among all qualified plans.

COST CONTAINMENT

- The plan continues to have cost containment elements essential to make it affordable and deficit neutral through managed competition and a backstop mechanism.

- States are encouraged to establish a process for negotiation between purchasers (both employer and consumer), and providers and insurers to achieve the limitations on growth in health care costs in most broadly acceptable manner.

- States are ultimately responsible for administering the cost containment plan --

  - States must approve and establish premiums to assure prospectively that the overall increase in premiums is within the allowed level of growth under H.R. 3600. There is provision for automatic reductions in payments to plan providers to protect individuals, employers and insurers; and, provision for state responsibility for any excess subsidy costs resulting from excess growth.

- Federal government would have these responsibilities only if states do not carry them out.

FEDERAL BUDGET

- Federal spending is reduced in the bill to achieve budget neutrality.

- Federal spending is capped at levels specified in the bill.

- An explicit mechanism is included for defining automatic reductions in new spending equal to the shortfall.

PUBLIC HEALTH

- Dedicate portion of the 1 percent payroll assessment to targeted public health programs.

OTHER PROVISIONS

- Clarify that definitions in the bill (e.g. employer/employee/contractor) will not affect definitions under any other law unless specified.

[Note: Provisions in H.R. 3600 not specifically addressed above are generally retained.]

*[For purposes of determining firm size, references to "employees" are to full-time equivalent employees and include part-time employees.]