Revenue Estimate of High Cost Plan Assessment

Assumes Mandate in 2000 (No Premium Caps)

(Fiscal Years; $ Billions)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995–1999	1995–2004
35 Percent High Cost Plan Assessment	0	0	0.6	1.2	2.1	7.5	12.2	16.1	21.9	28.7	3.9	90.3
25 Percent High Cost Plan Assessment	0	0	0.4	0.8	1.4	5.1	8.2	10.8	14.7	19.2	2.6	60.6

Department of the Treasury
Office of Tax Analysis

July 23, 1994

NOTE: Based on initial specifications which assumed that any plan would be subject to the assessment if the premium exceeded target. Does not take i contained in July 21 specification, in which a plan would only be subject to the assessment if, in addition, the weighted average premium for plar exceeded the reference premium for the area.

Insurance Assessments in July 22 Option

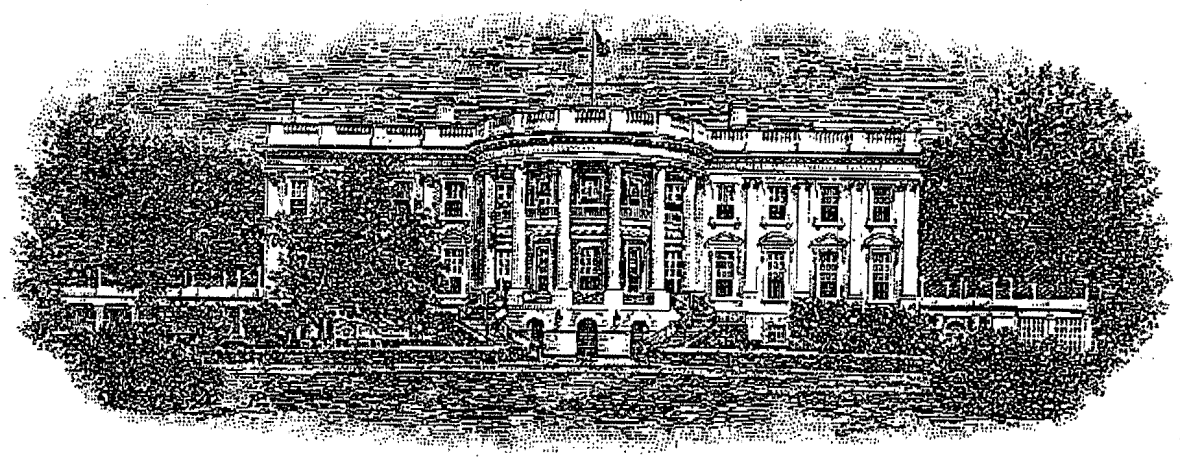
Assessments as Percent of Cost of Average Plan

	2000		2004	
	Community Rated Plans	Experienced Rated Plans	Community Rated Plans	Experienced Rated Plans
Mandate in 2000				
Academic Health Centers	1.75%	1.75%	1.75%	1.75%
Risk Assessment 1/		1.5%		1.5%
25% High Cost Plan Assessment 2/	1.4%	2.0%	3.2%	3.5%
Total	3.2%	5.2%	4.9%	6.7%
% of Plans Subject to High Cost Assessment	99%	71%	100%	100%

1/ Community-rated plans would receive an offsetting payment, equal in the aggregate to the revenues collected by the risk assessment.

2/ Based on initial specifications which assumed that any plan would be subject to the assessment if premium exceeded target. Does not take into account modification contained in July 21 specification, in which a plan would only be subject to the assessment if, in addition, the weighted average premium for plans in a region exceed the reference premium for the area. Ratio is the gross revenue as percent of premiums for taxed plans.

THE WHITE HOUSE
WASHINGTON, DC 20500



FAX COVER SHEET

DATE: _____ TIME: _____

TO: Bob P.

PHONE: _____ FAX #: 5-6148

FROM: Chris Jennings

PHONE: (202) 456-5560 PAGES AFTER COVER: 7

COMMENTS: *Plese clear this ASAP

CHRIS

This is an Administration bill. We cleared in June for Shalala to send to Congress. In addition, Sally Katzen has testified in support of this before House/Senate Committees.

Bob

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

June 8, 1994

The Honorable Albert Gore, Jr.
President of the Senate
Washington, DC 20510

Dear Mr. President:

Enclosed for consideration by the Congress is a draft bill "To make changes in Medicare and Medicaid data collection requirements."

The draft bill would postpone by 18 months the requirement for employers to collect health plan enrollment data for the Medicare and Medicaid Coverage Data Bank. The draft bill would also require Medicare intermediaries and carriers to collect and match data from their private lines of business with Medicare data for the purpose of carrying out the Medicare secondary payer provisions, and would require us to send questionnaires concerning private health plan coverage to individuals shortly before their Medicare coverage begins.

Delaying the implementation of the data bank provisions would allow us to work with Congress and the business community to ensure that the data bank minimizes the burden on employers and is consistent with health care reform. The requirement that Medicare intermediaries and carriers collect and match private data with Medicare data would prevent the inappropriate payment of Medicare funds, would reduce conflict of interest problems, and would lessen the workload for recoveries that utilize matches with Social Security and Internal Revenue Service data. The initial enrollment questionnaire would identify many secondary payer situations before a beneficiary filed claims and would also help to prevent mistaken primary payments.

The 18 month delay in collecting health plan enrollment data would result in an increase of $348 million in entitlement spending over fiscal years 1995 through 1999, but this increase would be offset by savings of $350 million for the same period resulting from intermediary and carrier data collection and matching, producing a net five year savings of $2 million.

The provisions of the draft bill are described in detail in the enclosed section-by-section summary.

We urge the Congress to give the draft bill its prompt and favorable consideration.

Page 2 - The Honorable Albert Gore, Jr.

We are advised by the Office of Management and Budget that enactment of the draft bill would be in accord with the program of the President.

Sincerely,

Donna E. Shalala

SUMMARY OF PROPOSED MEDICARE AND MEDICAID DATA COLLECTION AMENDMENTS OF 1994

Section 1 assigns the draft bill the short title "Medicare and Medicaid Data Collection Amendments of 1994".

Section 2 postpones by 18 months the requirement for employers to collect data for the Medicare and Medicaid Coverage Data Bank.

Section 3 requires Medicare intermediaries and carriers to collect and maintain data (as may be specified by the Secretary) from their private lines of business, and match those data with Medicare data, for the purpose of carrying out the Medicare secondary payer provisions.

Section 4 requires the Secretary to send a questionnaire concerning private health plan coverage to individuals at least two months before they become entitled to Medicare Hospital Insurance (HI) benefits (or at the time of application for Medicare benefits by individuals not entitled to HI coverage).

A B I L L

To make changes in Medicare and Medicaid data collection requirements.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled.

SECTION 1. SHORT TITLE AND REFERENCES IN ACT.

(a) Short Title.--This Act may be cited as the "Medicare and Medicaid Data Collection Amendments of 1994".

(b) References in Act.--The amendments in this Act apply to the Social Security Act.

SEC. 2. DELAY IN IMPLEMENTATION OF MEDICARE AND MEDICAID COVERAGE DATA BANK.

Section 1144(c)(1)(A) is amended--

(1) by striking "1994" and inserting "1996", and

(2) by inserting "for the six month period beginning on July 1, 1995 and" after "paragraph (5)".

SEC. 3. DATA MATCHING BY INTERMEDIARIES AND CARRIERS.

(a) In General.--The last sentence of section 1816(c)(1) and the last sentence of section 1842(b)(2)(A) are each amended--

(1) by striking "may not" and inserting "shall", and

(2) by striking "match data obtained other than in its activities under this part with data used in the administration of this part" and inserting "collect and maintain data (as may be specified by the Secretary) related to its activities (or the activities of any other entity under common ownership or control) other than its activities

under this part, and match those data with data used in the administration of this part,".

(b) Technical Amendment.--The last sentence of section 1816(c)(1) and the last sentence of section 1842(b)(3)(A) are each further amended by striking "1871" and inserting "1874".

(c) Effective Date.--The amendments made by subsection (a) apply to agreements and contracts, entered into or renewed after 30 days after the date of enactment of this Act.

SEC. 4. MEDICARE INITIAL ENROLLMENT QUESTIONNAIRES.

(a) In General.--Section 1862(b)(5) is amended by adding at the end the following:

"(D) Obtaining information from beneficiaries.--At least two months before an individual will become entitled (upon application) to benefits under part A (or when the Secretary is first informed of that entitlement, if later), or at the time an individual applies for enrollment under part B (or applies under section 1818 for enrollment under part A), the Secretary shall provide the individual a questionnaire to obtain information on whether the individual is covered under a primary plan and on the nature of that coverage.".

(b) Effective Date.--The amendment made by subsection (a) applies to entitlements under part A of title XVIII of the Social Security Act that begin after, and to enrollments under that title that occur after, 1994.

Section _____. PARTICIPATION AND LIMITS ON EXTRA-BILLING

(a) PARTICIPATION.--Any physician or supplier may voluntarily enter into an agreement with a plan to become a participating physician or supplier. For purposes of this section, the term "participating physician, supplier or other person" means a physician, supplier or other person who, before the beginning of a year, enters into an agreement with a plan which provides that such physician, supplier or other person will accept assignment for payment for all items and services furnished to individuals enrolled in such plan for such year.

(b) LIMITATION ON ACTUAL CHARGES.--

(1)(A) IN GENERAL.--In the case of a physician, supplier or other person who is not a participating physician, supplier or other person and who does not accept payment on an assignment basis for a service furnished with respect to an individual enrolled in a plan, the following rules apply:

(i) APPLICATION OF LIMITING CHARGE.--No person may bill or collect an actual charge for the service in excess of the limiting charge described in paragraph (2).

(ii) NO LIABILITY FOR EXCESS CHARGES.--No person is liable for payment of any amounts billed for the service in excess of such limiting charge.

(iii) CORRECTION OF EXCESS CHARGES.--If such a physician, supplier or other person bills, but does not collect, any actual charge for a service in violation of clause (i), the physician, supplier, or other person shall reduce on a timely basis the actual charge billed for the service to an amount not to exceed the limiting charge for the service.

(iv) REFUND OF EXCESS COLLECTIONS.--If such a physician, supplier or other person collects an actual charge for a service in violation of clause (i), the physician, supplier, or other person shall provide on a timely basis a refund to the individual charged in an amount by which the amount collected exceeded the limiting charge for the service. The amount of such a refund shall be reduced to the extent the individual has an outstanding balance owed by the individual to the physician.

(B) SANCTIONS.--If a physician, supplier or other person--

(i) knowingly and willfully bills or collects for services in violation of subparagraph (A)(i) on a repeated basis, or

(ii) fails to comply with clause (iii) or (iv) of subparagraph (A) on a timely basis,

the plan may apply sanctions specified by the Secretary of Health and Human Services against the physician, supplier or other person.

(C) TIMELY BASIS.--For purposes of this paragraph, a correction of a bill for an excess charge or refund of an amount with respect to a violation of subparagraph (A)(i) in the case of a service is considered to be provided 'on a timely basis', if the reduction or refund is made not later than 30 days after the date the physician, supplier or other person is notified by the plan of such violation and of the requirements of subparagraph (A).

(2) LIMITING CHARGE DEFINED.--The "limiting charge" shall be 125 percent of the recognized payment amount under the plan for physicians, suppliers or other persons who are not participating physicians, suppliers or other persons. For purposes of the previous sentence, the "recognized payment amount" means the fee schedule amount established by the plan for physicians, suppliers or persons who are not participating physicians, suppliers or other persons for that year.

(c) INCENTIVES FOR PARTICIPATION.--In applying the fee schedule established by a plan in the case of a service furnished by a physician, supplier or other person who is not a participating physician, supplier or other person, the fee schedule amount shall be 95 percent of such amount otherwise applied.

DATE: 7/6/94
TIME: 6:10 pm

Executive Office of the President
Office of Management and Budget
Health Policy

725 17th Street, NW, Room 7021
Washington, DC 20503

FAX: (202) 395-3910 **Voice: (202) 395-3844**

To: Nancy-Ann Min; Chris Jennings; Ken Thorpe

FAX #: 5-7289; 6-7431; 401-7321

Voice #:

From: Linda Blumberg and Len Nichols

Notes:
Following is a second version of 50/50, including transitional measures outlined by Ken. Everything needs to be fleshed out, but we wanted to make sure that this is the general direction everyone is thinking about.

Number of Pages (including cover sheet): 3

- Standard benefit package = HSA-8%

- No mandate until January 1, 1999

- Transition period = January 1, 1997 through January 1, 1999
  Transition policies are as follows:

  - Implement insurance reforms and standard benefit package rules, including non-discrimination rules. No subsidies available to employers.

  - Provide 100% subsidies to households under 75% of poverty without current coverage. Phase-out percentage of premium subsidies between 75% and 150% of poverty. The same subsidies would be available to those losing their jobs that had insurance through their employment.

  - Provide a second year of Medicaid funding for those leaving welfare for work. Coverage continues through separate Medicaid program.

  - Provide constrained growth plan package to employers not currently offering insurance in the small group (< 25) market. Package would be solicited by the federal government from private sector insurers -- plans would agree to limit premium increases to 6-7% per year -- see Florida experience for details of how to do this. If employer contributed at least 50% of premium, worker 50% share would be subsidized on an income-based schedule).

  - 2% free rider assessment

  - Tobacco tax

  - 1% assessment on 500+, if provide (2% if don't provide).

- Mandate period -- January 1, 1999 and forward.

  - As of January 1, 1999, implement 50% employer mandate on firms of >= 20 workers; individual mandate on families. Those firms with fewer than 20 workers have no mandate, but must pay a 2% of payroll assessment if they do not provide 50% coverage to their workers.

  - Employers subsidized according to retreat model 3 (3.5%-7.9%) for 50% share of standard benefit.

  - Community rating for those at or below 500 workers; experience rating above 500 workers. No opt-in to community rate, and 1% assessment on those over 500.

  - Implement a Bradley-esque high cost plan assessment.

Community Rating Pool: Target is adjusted mean in the community rated pool, with growth equal to HSA rates plus 1% (lagged to begin in 1997).

Experience Rated Group: Target is adjusted mean in the experience rated pool, with growth equal to HSA rates plus 1% (lagged to begin in 1997). Plan premium will be adjusted to take the pool's experience into account for firms of < 1000.

Rate is set such that revenue and subsidy losses due to growth in excess of targets is recaptured.

- Household subsidies available for 50% worker share for households up to 200% of poverty. Non-worker/Carve-out subsidies available for other 50% share to households up to 200% of poverty.
- Tax credit expansion for individual premium contributions.
- Tobacco tax
- 1% payroll assesssment on the 500+ firms.

Roger Altman
622-1070

HIGH-COST PLAN ASSESSMENT

DESCRIPTION

The Senate Finance Committee adopted a provision that would place an annual assessment on high cost health plans. In the view of its proponents, the amendment has two purposes: (1) To achieve market-oriented cost containment by dampening demand for high cost health plans; and (2) To finance the cost of the legislation.

The high cost plan assessment would work as follows:

- **The 40% most expensive health plans in each geographic area are subject to an assessment.** The assessment is equal to 25% of the difference between a plan's premium and the average premium in the area.
- **The 25% least expensive health plans *nationwide* (adjusted for cost of living) are exempt from the assessment, even if they are among the most expensive plans in their area.** This provision is intended to help areas that have, in general, kept health care costs down.
- **The assessment applies to supplemental benefits as well as the standard benefits package.**

CONCERNS RAISED

A number of concerns have been raised about this amendment, particularly by organized labor:

- **The assessment would penalize plans with supplemental benefits.** Of particular concern to organized labor is the effect on many self-insured plans offered by large employers (which often have lower deductibles and coinsurance than the standard package).
- **The assessment would penalize plans whose costs are high because of their structure (e.g. self-insured fee for service plans often offered by larger employers).**
- **The assessment would unfairly affect plans whose premiums are high because they serve an older or sicker population.** This is particularly true of self-insured plans offered by large employers in mature industries, because these plans do not draw their membership from a broad community. Many of these plans, for example, have large retiree populations, whose costs tend to be quite high.

POSSIBLE WAYS TO ADDRESS CONCERNS

The amendment could be changed or clarified in relatively minor ways to address some of the concerns that have been raised:

- **The assessment would be applied only after adjustments for the risk of a health plan's participants.** This means that plans would not be penalized for having an older or sicker population.

- **Since self-insured plans offered by larger employers do not participate in risk adjustment, a different assessment mechanism may be appropriate for them.** One approach would be to assess self-insured plans based on their premium increases rather than their actual premium levels. For example, a self-insured plan that had a high premium because its members were old or sick, would be subject to an assessment only if its premium increased faster than the average for other plans.

- **Supplemental benefits could be treated separately.** For example, in the Health Security Act, employer-provided supplemental benefits were treated as taxable income for employees beginning in 2004. Of particular importance to organized labor is the fact that the Health Security Act did not subject employer-provided cost sharing coverage (i.e. supplemental coverage that lowers deductibles or coinsurance) to taxation.

LIST (7/6/94 Revised)

1. **Alabama**
   - Sen. Shelby
   - Sen. Heflin
   - Rep. Bevill
   - Rep. Browder

2. **Virginia**
   - Sen. Robb
   - Rep. Boucher
   - Rep. Byrne
   - Rep. Payne
   - Rep. Pickett
   - Rep. Sisisky

3. **Texas**
   - Rep. Andrews
   - Rep. Bryant
   - Rep. Chapman
   - Rep. Edwards
   - Rep. Geren
   - Rep. Green
   - Rep. Laughlin
   - Rep. Pickle
   - Rep. Sarpalius
   - Rep. Wilson

4. **North Dakota**
   - Sen. Conrad+
   - Sen. Dorgan
   - Rep. Pomeroy

5. **New Jersey**
   - Sen. Lautenberg
   - Sen. Bradley
   - Rep. Pallone

6. **Louisiana**
   - Sen. Breaux
   - Sen. Johnston

7. **Nebraska**
   - Sen. Kerrey
   - Sen. Exon

8. **Kentucky**
   - Sen. Ford
   - Rep. Baesler
   - Rep. Barlow
   - Rep. Mazzoli

9. **Georgia**
   - Sen. Nunn
   - Rep. Bishop
   - Rep. Darden

10. **Missouri**
    Sen. Danforth
    Sen. Bond
    Rep. Skelton

11. **Minnesota**
    Sen. Durenberger
    Rep. Minge+
    Rep. Penny
    Rep. Peterson

12. **South Carolina**
    Sen. Hollings
    Rep. Spratt

13. **Arizona**
    Sen. Deconcini
    Rep. English

14. **California**
    Sen. Feinstein
    Rep. Harman
    Rep. Lehman
    Rep. Schenk

15. **Pennsylvania**
    Sen. Specter
    Rep. Holden
    Rep. Klink
    Rep. Margolies-Mezvinsky
    Rep. McHale

16. **Oklahoma**
    Sen. Boren
    Rep. McCurdy

17. **Wisconsin**
    Sen. Kohl
    Rep. Barca

18. **Colorado**
    Sen. Campbell+
    Sen. Brown

19. **Oregon**
    Sen. Hatfield
    Sen. Packwood

20. **Nevada**
    Sen. Bryan

21. **Connecticut**
    Sen. Leiberman

22. **Delaware**
    Sen. Biden

23. **Rhode Island**
    Sen. Chafee

24. Maine
Sen. Cohen

25. North Carolina
Rep. Lancaster
Rep. Neal
Rep. Valentine

26. Ohio
Rep. S. Brown
Rep. Fingerhut
Rep. Mann

27. Indiana
Rep. Hamilton
Rep. Long+
Rep. Roemer

28. Kansas
Sen. Kassebaum

29. New Mexico
Sen. Domenici

30. Michigan
Rep. Barcia
Rep. Stupak

31. Illinois
Rep. Lipinski
Rep. Sangmeister

32. Washington
Rep. Cantwell
Rep. Inslee

33. Florida
Rep. Hutto

34. Tennessee
Rep. Clement

35. Idaho
Rep. Larocco

36. Arkansas
Rep. Lambert

37. West Virginia
Rep. Mollahan

38. Massachusetts
Rep. Meehan

+ = HSA Cosponsor

Maybe in future if CBO amends Letter 8.

Estimates of the Uninsured (Millions)

CBO now

	DYNAMIC	STATIC
Uninsured ALL YEAR	21	21
Uninsured Part Year	37	15 - 75-80% are in-between jobs.
TOTAL	58	36

NOTE: Most of those uninsured part year are workers in-between jobs.