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Summary

And Detailed Specifications

March 2, 1994

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Universal Health Insurance Coverage

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GENERAL SUMMARY

March 2, 1994

Title I. Health Care Security

I. Universal Coverage and Individual Responsibility

A. Universal Coverage

1. Entitlement to Health Benefits

- a. Each eligible individual would be entitled to the nationally guaranteed benefit package
- b. Every eligible individual would be entitled to a health security card

B. Protection of Consumer Choice

- 1. Nothing in this act would be construed as prohibiting an individual from choosing her or her own health care providers
- 2. Nothing in this act would be construed as prohibiting an individual from purchasing health care services
- 3. Nothing in this act would be construed as prohibiting an individual from purchasing supplemental insurance to cover services not included in the guaranteed benefit package
- 4. Nothing in this act would be construed as prohibiting an employer from providing coverage for benefits in addition to the comprehensive benefit package

C. Individual Responsibilities

1. All individuals would be covered under a private health plan meeting Federal insurance standards or in a Federal plan, which would be called Medicare Part C
 - a. Unless an individual is enrolled in a private health plan meeting the insurance standards, enrollment in Medicare Part C would be automatic
 - b. The individual responsibility requirements would be enforced through the Internal Revenue Code
 - c. Individuals could elect to enroll in an employer-sponsored plan, if offered by an employer, or another private health insurance plan
 - (1) If an employer makes private coverage available to employees, the employees of that firm would not be permitted to enroll in Medicare Part C
 - (a) An exception would apply to low-income workers who would be permitted to enroll in Medicare Part C
 - (2) Individuals not connected to the work force could enroll in any private insurance plan, or in Medicare Part C
2. Individuals would be responsible for assuring each family member was covered by the guaranteed national benefit package and for the payment of premiums
 - a. Individuals would be required to contribute 100 percent of the premium for the guaranteed benefit package, minus the amount contributed on their behalf by employers, as described below

- (1) Low-income individuals would also be eligible for a subsidy of the net amount owed, after deducting employer contributions, if any
 - (2) Such subsidies would be on a sliding-scale basis
- b. Individual worker contributions for their net share of the premium would be collected by the employer through payroll deductions
3. An eligible individual would be defined to include any individual who is residing in the United States, and who is:
 - a. a citizen or national of the United States;
 - b. an alien permanently residing in the United States under color of law; or
 - c. a long-term nonimmigrant.
 4. An individual entitled to benefits under the current Medicare program would continue to be covered under Medicare Parts A and B

II. Employer Responsibilities

- A. In general, employers would be required to contribute toward the cost of health insurance coverage for all employees, enforced through the Internal Revenue Code
 1. Employer contributions would cover at least eighty percent of the cost of the guaranteed national benefit package for full-time employees
 2. Employer contributions for part-time, seasonal and temporary workers would be based on a pro rata share based on the ratio of the number of hours worked per week to forty hours
 3. Employers with 100 or more employees would be required to meet this requirement for their workers, beginning January 1, 1995, through:
 - a. Coverage under a private health plan, including plans offered through a health alliance, or

- b. Coverage under a self-insured plan, if the employer has 1,000 or more full-time employees and elects to self-insure, or
 - c. Coverage under a qualified State health plan
4. Employers with fewer than 100 employees would be permitted to enroll employees in Medicare Part C
- B. To the extent an employer elects to offer any employee coverage under a private health plan, the employer must make such coverage available to all employees, including employees working on a part-time basis (more than 17.5 hours per week)
- 1. Employers would not be required to offer private coverage under an employer plan to seasonal or temporary employees who work for the employer less than three months in a given year
 - 2. Employer contributions for seasonal and temporary workers, under Medicare Part C or a private plan, would be based on the number of hours worked
- C. Employers of a worker who is under age 18 or a full-time student under age 24 would not be required to contribute on behalf of the worker, provided the worker was covered under a parent's health plan and was claimed as a dependent by the parent
- D. Employers would be required to allow family members of workers to be covered under the employer plan, if a private health plan is offered by the employer
- 1. Employers would not be required to pay any share of the family coverage, if family coverage was elected by the employee
 - 2. Employers that offer and contribute to family coverage would continue to do so, during the 5-year maintenance-of-effort period
 - a. Following the maintenance-of-effort period, such employers would be required to offer to family coverage, but contributions toward family coverage would be optional to the employer

3. Employers that do not currently offer or contribute to family coverage would be required to offer family coverage, but contributions to family coverage would be optional to the employer
 - a. If a family with two workers elects to be covered under a private plan offered by one employer, the enrolling employer could charge the family for the difference between the individual and family coverage, and the family could receive a credit for amounts contributed by the non-enrolling employer
 - b. The non-enrolling employer would, in effect, contribute 80 percent of the Medicare one-adult premium on behalf of the employee to the enrolling employer
- E. Employers would be required to report coverage of employees and dependents to the IRS
- F. Employers providing private insurance would be required to offer employees the choice of an HMO plan and a plan that provides an unlimited choice of providers
- G. Employers would be permitted to provide health benefits in addition to the guaranteed national benefit package
 1. A 5-year maintenance of effort requirement would be imposed on employers that currently offer more generous health benefits
 2. To the extent such benefits were provided pursuant to a collectively-bargained agreement, employers would continue to offer the additional benefits pursuant to the agreement
- H. COBRA would be amended to require employers with twenty or more employees that provide health insurance coverage to any employee, or the dependents of such employee, to provide such employee and dependents the opportunity to continue coverage under the employer plan, at 102 percent of premium costs
 1. As under current law, this requirement would terminate with coverage of an employee or dependent under an employer-sponsored plan
 2. This requirement would terminate with the establishment of the Medicare Part C plan

- I. Employers with retiree health obligations as of October 1, 1993 would contribute 80 percent of the Medicare Part C premium for early retirees (ages 55 to 64) who elect to enroll in Medicare Part C, if the employer is otherwise obligated to provide retiree health benefits
 1. Employers would be required to provide wrap-around benefits, consistent with contractual retiree health obligations, and to maintain the obligated level of benefits

III. Benefits

- A. The guaranteed national benefit package would be defined in statute
- B. Individuals and employers would be entitled to coverage under a health plan that covers the guaranteed national benefit package
 1. Low income individuals would be entitled to assistance in meeting plan obligations (see below)
 2. All individuals would be able to purchase supplemental Medigap-type policies for coverage of additional benefits and cost-sharing
- C. The guaranteed national benefit package would include the benefits currently covered under Medicare Parts A and B, with the following improvements, which would also be extended to the current Medicare population:
 1. An out-of-pocket limit of \$2,500 per individual, \$3,000 per family, indexed each year to the allowable rate of growth in Medicare spending
 2. Unlimited inpatient care with no spell of illness restrictions and no separate hospital deductible
 3. A single deductible of \$500/\$750 per individual/family, indexed each year to the allowable rate of growth in Medicare spending
 4. Coverage of outpatient prescription drugs with a separate \$250 deductible, 20 percent cost-sharing, and \$1,000 out-of-pocket deductible (see below)

- D. Specific additional services would be covered for children to age 18, with no cost-sharing, including newborn, well-baby and well-child services, including immunizations
- E. All pregnancy-related services would be covered
- F. Family planning services would be covered
- G. Additional preventive benefits would be covered, including Medicare-covered preventive benefits and colorectal screening
- H. Extra-billing limits would be consistent with Medicare requirements
- I. A supplemental benefit package would be provided to individuals with income below 200 percent of poverty that would include:
 - 1. Deductibles and copayments would be waived and their obligation for the Part C premium would be zero
 - 2. All EPSDT services for children to age 18, not otherwise included in the guaranteed benefit package, would be covered
 - 3. Vision and hearing care
 - 4. Individuals with incomes between 100 and 200 percent of poverty would pay a premium on a sliding scale
- J. Medicare Part C would provide wrap-around coverage for eligible low-income individuals enrolled in a private plan offered by an employer

IV. State Responsibilities

- A. States should, through enactment of appropriate legislation, establish their own health reform systems
- B. The Secretary's approval would be granted for two types of authority:
 - 1. State control solely over provider reimbursement, either as a whole or sector by sector

2. State control over the provision of benefits and health financing generally
- C. States could establish all-payer provider reimbursement programs
1. Programs could cover hospital services, or physician services, or all services
 2. Federal Medicare-type payment rates would not apply to providers in a State with an approved all-payer program
 3. States would be required to meet a target consistent with the national health spending estimates and meet other requirements for approval by the Secretary
- D. States could also apply for authority over all health care benefits provided in the State, including self-insured plans
1. Initially, a State plan would have to guarantee coverage for at least the guaranteed national benefit package for all residents, other than residents covered under Medicare Parts A through C
 2. Guarantee of coverage could be through a State single payer or public plan, an employer mandate, a combination of public and private coverage, competing health plans, managed competition, or any other system, provided that it covered all residents
 3. Regardless of the type of State program enacted, States would be required to meet the health spending estimates for the State as under State all-payer provider reimbursement programs, and meet other requirements for approval by the Secretary
 4. After three years of experience with the State plan, State could apply to integrate coverage under Medicare Parts A, B, and C into a State-based system

- E. If requirements were not met by a State
 - 1. State would be provided with 90-days notice of the intention to re-instate Federal rates in the State
 - 2. To recapture excess payments in previous years, HHS could reduce a State's current annual target or reimpose Federal rates at levels lower than would otherwise be the case

- F. If the Secretary determined that a State program produced savings to the Medicare program over a period of three consecutive years, the Secretary would pay the savings attributable to the first year of that period to the State in the following year, and pay subsequent year's savings in subsequent years.

V. Health Alliances

- A. Regional Health Alliances could be established in each State, at each State's discretion, in which employer participation generally would be voluntary, although participation could be mandatory under an approved State plan as described in the preceding section

- B. \$150 million in grants would be available to States to assist in the planning, development, and initial operation of alliances
 - 1. An alliance could only be run by a non-profit organization or a State agency

 - 2. States could provide for division of the State into more than one area and one or more contiguous States could provide for the establishment of an interstate alliance

3. Regional health alliances would enter into agreements with any qualified health plan (those meeting Federal standards) that seeks to offer health insurance through the alliance
 4. Alliances would assist individuals in enrolling in Medicare Part C
 5. Alliances would offer to enter into agreements to provide services to any small employer in the alliance area (those with fewer than 500 employees)
 6. Regional health alliances would make similar services available to individuals and families that are not employees of participating employers but who reside in the alliance area
- C. A State could designate the regional health alliance to enforce a State capital allocation plan for the review of health-care related capital expenditures

VI. Health Plans

- A. Health plans sold to individuals or employers and health plans operated by self-insured groups could not deny coverage to any eligible group or individual
1. Health Maintenance Organizations (HMOs) could limit enrollment up to the capacity of the plan to absorb new members
- B. Health plans would be required to offer the guaranteed national benefits as a separate package
1. Federally qualified HMOs could offer a more generous package
 2. State benefit mandates would be pre-empted
- C. Health plans would be required to provide open enrollment to any individual without a waiting period and guaranteed renewal
- D. Plans could not exclude or condition coverage or vary premiums based on a pre-existing health condition of an individual or a member of a group

- E. Health plans would be required to sell the guaranteed national benefit package at community-rated premiums for all purchasers
 - 1. Plans would be allowed to phase in community-rated premiums over a three-year period
- F. Federal standards for marketing of health plans would be established
- G. Limits on self-insurance would be established
 - 1. Employers with 1,000 full-time employees or less would be prohibited from self-insuring
 - 2. Multiple Employer Welfare Arrangements (MEWAs) and similar multiple employer plans would be prohibited from self-insuring
- H. The Secretary would be required to study and develop a risk adjustment and/or reinsurance methodology that could be used to reallocate premiums among insurers in a State
- I. Transitional insurance reforms would be established and effective January 1, 1995 until the Federal standards described in A through H take effect in the State
- J. Supplemental policies
 - 1. Supplemental policy benefits would be restricted to standardized supplemental benefit packages defined by the Secretary; benefits could not duplicate benefits in the guaranteed national benefit package
 - a) Secretary would take into account State benefit mandates in developing standardized supplemental benefit plans
 - 2. Supplemental policies would be required to meet Federal standards for open enrollment and community rating
 - 3. Disease-specific and hospital indemnity policies would be required to meet a 75 percent loss ratio standard

4. Standardized benefits for Medicare supplemental insurance (Medigap) policies would be conformed to the standardized supplemental benefit packages
 5. Open enrollment requirements would apply to Medicare supplemental insurance policies
- K. Federal standards for health plans would be established in regulation by the Secretary of Health and Human Services (HHS)
1. States would enforce the standards, except in the case of a State the Secretary determined was not in compliance, in which case the Secretary would enforce the standards in that State
 2. A Federal excise tax penalty would be established for non-compliance by health plans or employers (in the case of self-insured plans)
 3. States would continue to regulate financial solvency of health insurance, with standards at least as stringent as standards established by the National Association of Insurance Commissioners
- L. Managed care would be encouraged
1. \$25 million a year in grants would be made available to support the development and initial operation of non-profit, community-based staff and group model HMOs
 2. Mandatory "dual choice" requirements would be for Federally qualified HMOs would be retained and expanded to "multiple choice"

VI. Federal Responsibilities and Cost Containment

- A. In addition to setting standards for health plans, the Federal government would establish Medicare Part C and would maintain a private sector cost containment program and a public sector cost containment program using maximum payment rates based on Medicare's methodologies
- B. Benefits under Medicare Part C would be the same as the guaranteed national benefit package

C. Cost Containment in Public Sector Plans

1. Establishment of national health expenditure estimates

- a. The Secretary would estimate total national health expenditures under Medicare, and under private plans, and the baseline rate of growth for future years
- b. A national health target rate of growth would be set by statute for spending by Medicare and for private plans in each year, beginning with 1996
- c. The public and private national health expenditure estimates for each year would be based on the health expenditure estimates for the preceding year, increased by the sum of the five-year moving average of the annual rate of growth in the gross domestic product (GDP) plus an adjustment factors
- d. The adjustment factors would be set to reduce by one percentage point per year the rates by which the growth in Medicare and private health spending exceed the rate of growth in nominal GDP, thus phasing the rate of growth in health spending to the rate of growth in the GDP
- e. Spending limits within each component would be slowed at the same rate; that is, the baseline rate of growth in each component would be reduced by one percentage point each year

4. The Medicare and private sector estimates would each be allocated to specified classes of health services based upon the historic share and growth rates attributable to each class

- a. The Secretary would perform the calculations and allocations
- b. The allocation to each sector within each estimate would then become an overall target attributable to each type of health service, such as hospital or physician services

5. The payment rates under Medicare would be set each year such that expenditures under these programs would meet the spending targets for Medicare
6. Changes in the allocations and the reimbursement methodologies would be set through legislation, based upon recommendations of ProPAC, PhysPRC, and DrugPAC

B. Cost Containment in Private Sector

1. States and health care providers would not be subject to the national cost containment system of maximum payment rates for two years (1996 and 1997)
2. If, in any year, beginning with 1996, health care spending in the private sector is greater than the private sector health spending estimate for that year, then the fall-back Federal cost-containment system would become effective for all payers, beginning in 1998 at the earliest
 - a. States with approved State cost-containment or health care reform systems whose spending is less than their State targets would retain control over their system
3. Under the Federal fall-back cost containment system, private plans would make payments under a maximum payment limits based on Medicare methodologies
 - a. The Secretary would establish maximum payment rates, using Medicare methodologies, that would result in spending consistent with the private sector spending estimate
4. Annual updates in payment rates would be consistent with keeping expenditures within estimate, subject to declining growth rates over time

Title II. New Benefits

I. Medicare Outpatient Drug Benefit

- A. Outpatient prescription drugs, biological products, insulin, and home infusion drugs would be added to services covered under Medicare Part B and C
- B. Payment rules and related requirements for covered outpatient drugs
 1. Drug Deductible
 - a. The deductible would be set at \$250 in year one and would be indexed to the rate of growth in the prescription drug sector thereafter
 2. Out-of-pocket limit
 - a. The out-of-pocket limit for the first year would be \$1,000 and for succeeding years, the amount would be indexed to the rate of growth in the prescription drug sector
 3. Payment amounts and administrative allowance
 - a. Payments would be at 80% of the lesser of the actual charge for the drug or the Medicare payment limit
 - b. There would be mandatory assignment for all covered outpatient drugs
 - c. The administrative allowance would be \$5 per prescription
 4. Payment limits
 - a. The bill would provide for the establishment of Medicare payment limits for prescription drugs. The Medicare limits would vary depending upon whether the drug is a single or multiple source drug. The limits would be calculated for 1994, the base year, and then updated under the national health expenditure estimates
 5. Rebate requirement

- a. In order for payment to be available under Medicare manufacturers would be required to enter into and have in effect a rebate agreement with the Secretary
- C. The Secretary would provide for a drug price review program to examine the reasonableness of prices of new drugs and would have the authority to negotiate prices based on specified criteria
- D. The Secretary would establish a point-of-sale electronic system for use by carriers and participating pharmacies to use to submit claims for covered outpatient drugs
 1. An electronic claims processing system would be established
- E. Adjustment in the Part B Premium
 1. The Part B premium would be adjusted to finance 25 percent of the cost of the program
- F. Prescription Drug Payment Review Commission
 1. An 11 member Prescription Drug Payment Review Commission would be established
 2. The Commission would submit an annual report to Congress regarding increases in drug prices, use of covered drugs, and administrative costs relating to covered drugs
 3. The Commission would submit annual recommendations to the Congress regarding payments for prescription drugs, including recommendations on the allocation of the national health estimates to the prescription drug sector

II. Other Changes in Medicare Benefits

- A. Medicare benefits would be improved to include all benefits included in the guaranteed benefit package (see benefit description above)

Title III. Public Health Initiatives

I. Health Workforce Priorities

- A. The Secretary would develop and implement a national health care workforce plan
 - 1. Residency positions that are not consistent with and approved by the Secretary would not be eligible for additional payments
- B. Primary care incentives
 - 1. Funding for the National Health Service Corp would be increased
 - 2. Bonus payments under Medicare for primary care services would be redirected and increased

II. Academic Health Centers

- A. The maximum payment rates would be adjusted to reflect the additional costs related to both direct and indirect graduate medical education

III. Essential Health Facilities

- A. Medicare's Essential Access Community Hospital (EACH) program for rural health networks would be expanded from seven States to all States
 - 1. Authorization would be increased from \$15 million to \$40 million per year
- B. An Essential Community Provider (ECP) program would be created to facilitate the organization and delivery of, and access to, primary, preventive and acute care services for medically underserved populations in urban areas by fostering networks of essential community providers
 - 1. The Secretary would make grants to States, local governments and eligible health care facilities

2. Grants could be used for the expansion of primary care sites, development of information, billing and reporting systems, or health promotion and outreach to underserved populations
 3. Facilities eligible for designation as essential community providers include certain hospitals that would qualify for a Medicare disproportionate share adjustment, Federally Qualified Health Centers, and nonprofit community health networks
- C. Grants to essential community providers would be used to finance the costs including those related to:
1. Development of primary care service sites
 2. Development of information, billing and reporting systems
 3. Recruitment and training of health professionals and administrative staff
 4. Health promotion outreach to underserved populations in the service area
- D. Funding of \$160 million per year for each of the fiscal years 1995 through 1999 would be available for the Essential Community Provider program
1. A grant made to a hospital or facility could not exceed \$200,000 and the total amount of a grant paid to a consortia of hospitals and facilities could not exceed \$1 million
- E. A Capital Financing Trust Fund would be established through which the Secretary of HHS would provide capital financing assistance to eligible facilities in the form of loan guarantees, interest rate subsidies, direct matching loans, and (in cases of urgent life and safety needs) direct grants
1. Eligible facilities include Essential Access Community Hospitals, Rural Primary Care Hospitals, and facilities eligible for assistance as Essential Community Providers described above

2. The Secretary would give preference to assistance needed to bring a facility into compliance with Federal, State or local regulatory standards, improve the provision of essential services, or provide access to otherwise unavailable essential health services

Title IV. Medicare and Medicaid

I. Additional Medicare Savings

(to be added)

II. Medicare Part C

- I. In general, all eligible individuals not otherwise entitled to benefits under Medicare Part A, or covered under a private plan offered by an employer, would be entitled to health insurance coverage under Medicare Part C, as of January 1, 1997.
 - A. The Social Security Act would be amended to add Title XXII to establish a new health insurance program
- II. Employers with 100 or fewer employees would be required to make contributions, on behalf of employees, to Medicare Part C, unless the employer provided health insurance coverage to employees under a private plan that meets defined Federal standards
 - A. An employer with fewer than 100 employees that did not provide private health insurance would provide for payments of premiums imposed under Medicare Part C, and would be prohibited from collecting more than twenty percent of the Medicare premium from a full-time worker
 - B. If an employer with fewer than 100 employees elects to offer employees coverage under a private health plan, employees of the employer would enroll in a plan offered by the employer, and would not be permitted to enroll in Medicare Part C
 1. Low income employees would be permitted to elect coverage under the employer plan, if offered, or Medicare Part C

- C. Any employer with fewer than 100 employees that elects to offer employees the opportunity to enroll in a private health plan, would be required to give employees notification two years prior to the termination of the private health plan

- III. Medicare Part C benefits would be consistent benefits provided under the national guaranteed benefit package

- IV. Additional benefits would be provided under Medicare Part C for low-income individuals

- V. The Secretary would compute premiums for Medicare Part C on a State by State basis
 - A. The premium would be set to cover the full actuarial cost of benefits covered under the national guaranteed benefit package, plus all administrative costs
 - (1) The Secretary would exclude from such calculations the cost of services provided to the SSI disabled population

- VI. A new Medicare Part C Trust Fund would be established
 - A. Premiums collected by the IRS from individuals would be deposited in the Trust Fund

 - B. Additional funds would be appropriated from general revenues to assure that funds are sufficient to cover subsidies under Medicare Part C -- net of State maintenance-of-effort requirements

- VII. Payments for services provided under Medicare Part C would be based upon Medicare-type fees/rates
 - A. The Secretary would develop new DRGs and codes where necessary

 - B. Persons covered under Part C could elect to receive their coverage through a qualified HMO

III. Low-Income Coverage

- A. Medicaid coverage of acute care services would be repealed, effective upon operation of Medicare Part C

1. State maintenance-of-effort would be required
- B. Medicaid would continue to provide long-term care services
- C. Subsidies would be provided to low income individuals with income up to 200 percent of poverty for the national guaranteed benefit package under Medicare Part C
 1. The premium for individuals with income below 100% of poverty would be set to zero
 2. A sliding scale premium would be imposed for individuals with income between 100 and 200 percent of poverty
- D. Low income individuals with income up to 200 percent of poverty would be eligible for wrap-around benefits, covered under Medicare Part C

Title V. Quality and Consumer Protection

I. Quality Management and Improvement

- A. The Secretary would establish standards for a National Quality Management Program and develop a set of national quality and performance measures which would apply to health plans, institutions and health care professionals
 1. States would enforce the standards, except in the case of a State the Secretary determined was not in compliance, in which case the Secretary would enforce the standards in that State
 - a. New State activities would be funded under contract with the Secretary
 2. Health plans would be required to meet the standards developed by the Secretary
- B. Health plans, institutions and providers would be required to submit information, as provided by the Secretary, in order to enable quality review and outcome analysis

1. The Secretary would develop and approve a standard design for consumer surveys
 - a. Health plans, institutions and providers would be required to conduct periodic surveys and submit summaries of survey results
 2. States would be required to make available to consumers, in a standard format, the performance of health plans, institutions and providers
- C. Health plans would be required to meet standards established by the Secretary to ensure the confidentiality of patient information and medical records
- D. Health plans would be required to establish a grievance and appeal process and to meet additional standards developed by the Secretary relating to quality assurance

II. Information Systems, Privacy and Administrative Simplification

- A. Electronic processing of all claims and other provisions related to administrative simplification and reporting would apply
- B. Administrative simplification provisions would include eligibility verification, electronic remittances, uniform billing forms and coding, and uniform provider numbers
- C. Administrative simplification provisions would provide reporting and coordination of benefits between all health insurance plans, including supplemental policies and plans in States that opt out
- D. Supplemental plans and plans in States that opt out would also be required to conform to administrative simplification and reporting requirements
- E. Privacy of information standards would apply to the disclosure of protected health information
1. Standards would apply to any individual or entity who receives, collects, uses or maintains protected health information

2. Information may only be used for the purpose for which the information was collected or was obtained
3. Health information may be disclosed if a patient has signed a patient authorization form

III. Medical Malpractice and Physician Recertification

- A. Tort reforms would include limiting contingency fees to 33 1/3 percent, collateral source offset, allowing awards to be paid in periodic installments, and requiring all lawsuits to include an affidavit certifying the merits of the complaint
- B. Grants would be available to States for the development and implementation of alternative dispute resolution systems for medical malpractice liability claims
- C. The Secretary would establish a pilot program applying practice guidelines to medical malpractice liability actions
- D. Standards for a physician qualification evaluation program would be established by the Secretary

IV. Fraud and Abuse

- A. The physician ownership and referral ban would be extended to all payers
 1. The ban on physician self-referral would be extended to cover additional services
 2. The exceptions in current law to the general ban on referrals would be continued with certain modifications
- B. The Secretary of HHS and the Attorney General would establish and coordinate an all-payer national health care fraud control program
- C. The provisions under the Medicare and Medicaid programs which provide for civil monetary penalties and criminal penalties for specified fraud and abuse violations would apply to similar violations for all payers in the national health care system

1. New civil monetary penalties would be established for certain activities, including kickback violations
 2. Current civil monetary penalties would be increased from \$2,000 to \$10,000
- D. Modifications would be made to the exclusionary provisions in the fraud and abuse program
- E. A portion of the civil money penalties, fines, and damages would be deposited in a fraud and abuse account
1. The funds would be used, in addition to such appropriated amounts, to meet the operating costs of the national health care fraud control program

Title VI. Premium-based Financing

I. Premiums for Medicare part C

- A. The Secretary of HHS would determine the premium amounts to cover the guaranteed national benefit package under Medicare Part C
1. Premiums would be set such that Medicare Part C would be fully financed by the premium
- B. The Secretary of the Treasury would calculate, and collect, the hourly contributions required to cover the guaranteed benefit package
1. Employers would provide for payment of the employee share of the premium through payroll withholding
 2. Employers would pay the premiums to the IRS in the same fashion as payroll taxes are paid
- C. Employers providing private coverage would not collect or contribute the Medicare part C premium for workers covered under private coverage
- D. Each taxpayer would be charged for the Medicare part C premium as part of their annual payment of personal income taxes

1. The amounts collected from employers and withheld from employees would be deducted from the Medicare part C premium otherwise payable
2. If the individual filed proof of private coverage, the individual would not be required to pay the Medicare part C premium

Title VII. Revenue Provisions

I. Financing

(to be added)

II. Health Insurance Deduction for the Self-employed

- A. Self-employed individuals would be permitted to deduct 100 percent of health insurance expenses.

Specifications for Universal Health Insurance Coverage

DRAFT

DETAILED SPECIFICATIONS

TITLE I. HEALTH CARE SECURITY

I. Universal Coverage and Individual Responsibilities

I. Universal Coverage and Entitlement to Health Benefits

- A. Eligible individuals would be entitled to the guaranteed national benefit package
- B. Eligible individuals would be entitled to a health security card
- C. An eligible individual would be defined to include any individual who is residing in the United States, and who is:
 - a. a citizen or national of the United States;
 - b. an alien permanently residing in the United States under color of law; or
 - c. a long-term nonimmigrant
- D. An individual entitled to benefits under the current Medicare program would continue to be covered under Medicare Parts A and B

II. Protection of Consumer Choice

- A. Nothing in this act would be construed as prohibiting an individual from choosing her or her own health care providers
- B. Nothing in this act would be construed as prohibiting an individual from purchasing health care services
- C. Nothing in this act would be construed as prohibiting an individual from purchasing supplemental insurance to cover services not included in the guaranteed benefit package