

- D. Nothing in this act would be construed as prohibiting an employer from providing coverage for benefits in addition to the comprehensive benefit package

III. Individual Responsibilities

- A. All individuals would be covered under a private health plan meeting Federal insurance standards or in a Federal plan, that would be called Medicare Part C
 - 1. Enrollment in Medicare Part C would be automatic, unless an individual is enrolled in a private health plan meeting Federal insurance standards
 - a. An employee in a firm that offers private health insurance would not be permitted to enroll in Medicare Part C
 - (1) Married employees could elect to be covered with their spouse and children under a plan offered by the employer of either spouse
 - (2) Low income employees could elect coverage under the employer plan, or under Medicare Part C
 - b. Individuals not connected to the work-force could enroll in a private health insurance plan, or under Medicare Part C
 - 2. The individual responsibility requirement for health insurance premiums would be enforced through the Internal Revenue Code
 - 3. Individuals would be responsible for assuring each family member was enrolled in a plan that covered the guaranteed benefit package, and for payment of premiums.

For the purpose of determining coverage under a health insurance policy:

- a. Individuals would be defined as an eligible individual who is not a child
- b. In general, the term family would include:

- (1) the individual's spouse, if the spouse is otherwise eligible, and
 - (2) the individual's children (and, if applicable, the children of the individual's spouse)
- c. In general, the term child is defined to include an eligible individual who
- (1) is under 18 years of age (or under 24 years of age in the case of a full-time student), and
 - (2) is a dependent of an eligible individual
- B. Individuals would be responsible for paying the Medicare Part C premium amount, unless proof of alternative coverage is filed with their annual tax return
1. Individuals would be required to pay 100 percent of the premium for the guaranteed national benefit package, minus the amount contributed on their behalf by employers
 2. The combined contributions of employers and full-time employees would be sufficient to cover 100 percent of the premium for the guaranteed benefit package, so that full-time employee contributions would be capped at twenty percent of the total premium
- C. The employee share of the premium would be collected by the employer through payroll withholding
- D. Individuals that elect to be covered under a spouse's health insurance plan would be obligated to pay the difference between individual and family coverage, in that employers would not be required to contribute to family coverage, unless maintenance-of-effort rules applied
- E. The Secretary of HHS, in consultation with the Secretary of the Treasury, would establish rules for the conversion of compensation to hours of employment, for the purpose of establishing the premium obligations of employees that receive compensation on a salaried basis, or on the basis of a commission (or other

contingent or bonus basis), rather than based on an hourly wage

IV. Premium contributions by part-time, seasonal and temporary workers:

- A. If enrolled in Medicare Part C or enrolled in a private health plan, part-time, seasonal and temporary employees would be responsible for 100 percent of the Medicare Part C, or the private, premium amount, minus any amounts contributed by employer(s)
- B. The employer contribution(s) on behalf of such workers would be credited against the Medicare Part C premium which the employee would otherwise owe
- C. If the employee works on a less than full-time basis for multiple employers, and works more than forty hours per week, the employee share of the premium would be no less than twenty percent
- D. If the employee works for multiple employers, the individual would be entitled to a refund, for the excess share of the premium paid by another employer to the IRS, on behalf of the worker

V. Low-income individuals would be eligible for a subsidy of the net premium amounts owed, after deducting employer contributions, if any (see low income outline)

VI. Health Insurance Coverage for Retirees

- A. In general, premium obligations for early retirees, ages 55 to 64, would be consistent with obligations for non-working individuals of all ages
 - 1. However, retirees who worked for employers with retiree health obligations as of October 1, 1993, would have 80 percent of the Medicare Part C premium paid by their former employer
 - 2. All low income retirees, with income up to 200 percent of the Federal poverty level, would be entitled to premium subsidies
- B. Retirees who worked for employers with retiree health obligations could also be entitled to additional

benefits provided by the former employer, under the maintenance-of-effort requirements

- C. Retirees could be covered under Medicare Part C or a private health plan that meets defined Federal standards
 - 1. Retirees who worked for employers with retiree health obligations as of October 1, 1993, would be covered under the employer plan, if offered by the employer to retirees

VII. Reporting requirements

- A. Upon enrollment in a health plan, including Medicare Part C, individuals would be required to report information to the health plan to coordinate coverage between the public and private plans, in accordance with regulations specified by the Secretary

Specifications for Universal Health Insurance Coverage

II. Employer Responsibilities

- I. In general, employers would be required to contribute toward the cost of health insurance coverage for all employees, enforced through the Internal Revenue Code
 - A. Employer contributions would cover at least eighty percent of the cost of the premium for the guaranteed national benefit package for full-time workers
 1. In general, employer contributions for full-time employees would be based upon a forty hour week, or less based upon the number of hours in the employer's defined work week for full-time employees
 - B. 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
 - C. Employers with 100 or more employees would be required to meet this requirement for their workers, beginning January 1, 1995, through:
 1. Payment of at least 80 percent of the guaranteed national benefit package for employees covered under a private health plan, including plans offered through a health alliance, or
 2. Payment of at least 80 percent of the guaranteed national benefit package for employees covered under a self-insured plan, if employer has 1,000 or more employees and elects to self-insure, or
 3. Payment of at least 80 percent of the guaranteed national benefit package for employees covered under a qualified State health plan

- D. Penalties would be imposed on any employer that fails to comply with the mandate to provide health insurance
 - 1. The employer would be assessed an excise tax equal to \$250 per day for each employee for every day the employer was not in compliance
 - 2. Employees of non-compliant employers would be permitted to enroll in Medicare Part C, and the employer would be obligated to pay 100 percent of the Medicare Part C premium
 - E. Employers with fewer than 100 employees would be permitted to enroll employees in Medicare Part C
 - 1. Medicare Part C would be available to individuals in firms with 100 or fewer employees by January 1, 1997
 - F. Employers would not be required to make premium payments to Medicare Part C on behalf of employees, if such employees are covered under a health plan offered by the employer that meets defined Federal standards
- II. To the extent an employer chooses 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)
- A. 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
 - B. Employer contributions for seasonal and temporary workers, under Medicare or a private plan, would be based on the number of hours worked
- III. Employers of children to age 18 (or children to age 24 in the case of full-time students) would not be required to contribute on behalf of such workers -- provided such worker was covered under a parent's health plan and was claimed as a dependent by the parent

- IV. 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
 - A. Employers that do not currently offer or contribute to family coverage would be required to offer, but not contribute to family coverage
 - 1. Employers that offer and contribute to family coverage would continue to do so, during the 5-year maintenance-of-effort period
 - 2. Following the maintenance of effort period, such employers would only be required to offer family coverage, but could continue to pay for such coverage at the employer's option
 - B. If a dual-worker family elects to be covered under a private plan offered by one employer, the enrolling employer could charge the family for the difference between individual and family coverage, and the family could receive a credit for amounts contributed by the non-enrolling employer
 - 1. The non-enrolling employer would contribute 80 percent of the premium to Medicare on behalf of an employee that elects coverage under the enrolling employer's plan, which would in effect, be transferred to the enrolling employer
 - C. Employers would be required to report information to the health plan to coordinate coverage between the public and private plans, in accordance with regulations specified by the Secretary
- V. Employers would be permitted to provide health benefits in addition to the defined, national guaranteed benefit package
 - A. A maintenance-of-effort requirement would be imposed on employers that currently offer more generous health benefits, through the year 1999
 - B. To the extent such benefits are provided pursuant to a collectively-bargained agreement, employers would continue to offer the additional benefits pursuant to the agreement

- VI. Non-discrimination rules would prohibit employers from paying greater amounts, or from providing more generous benefits, for certain full-time employees
 - A. If an employer pays 80 percent of the 2-adult premium for any full-time employee, such employer would be required to pay 80 percent of the 2-adult premium, or the equivalent dollar amount for all full-time workers that elect family coverage
 - B. If an employer offers and contributes to benefits in excess of the guaranteed national benefit package for any full-time employee, such employer would be required to offer and contribute to more such additional benefits for all full-time employees, or provide equivalent compensation, if the employee does not elect more generous health benefit coverage

- VII. General requirement for employers that offer private health plans to employees
 - A. Employers that elect to offer a private health plan, including employers that self-insure would be required to provide to all employees, at a minimum, the benefits defined under the guaranteed benefit package
 - 1. Employers would be permitted to provide additional health benefits to all employees
 - B. Employers would be required to offer an HMO plan and a plan that provides an unlimited choice of providers
 - C. Employers that self-insure would meet additional insurance reform requirements (see outline on insurance reform)
 - D. To assure continuous health coverage, employers would be required to notify the IRS of any change in enrollment of employees or dependents
 - 1. IRS would notify the Secretary of HHS
 - 2. The Medicare and Medicaid Data Bank would be repealed with implementation of this provision
 - E. 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 program

VIII. Requirements for Employers for Retirees

- A. Employers who, as of October 1, 1993, were paying a portion of the retiree health costs for retirees ages 55 through 64, would be required to make payments to Medicare Part C on behalf of retirees ages 55 to 64, beginning January 1, 1996
 1. Such employers would be required to make payments of not less than 80 percent of the Medicare Part C premium for early retirees
 - a. The required employer contribution to Medicare Part C would be reduced by other employer contributions, if any, for early retirees working for another employer
 2. This requirement would be waived if the eligible retiree elected coverage under another private health plan, including a spouse's health plan
 3. An employer could meet this requirement by payment of at least 80 percent of the premium for the guaranteed national benefit package for coverage of retirees under a private health plan, or if applicable, a self-insured plan,
- B. Employers with obligations to spouses and dependents of retirees, who were paying for a portion of their retiree health costs as of October 1, 1993, would be required to make payments to Medicare Part C on behalf of spouses and dependent of retirees, beginning January 1, 1996

1. Such employers would be required to make payments of not less than 80 percent of the Medicare Part C premium for spouses and dependent children
 2. This requirement would be waived if the eligible spouse or dependent child elected coverage under another private health plan
 3. The required employer contribution to Medicare Part C would be reduced by other employer contributions, if any, for spouses and dependents of retirees working for another employer
 4. An employer could meet this requirement by payment of at least 80 percent of the premium for the guaranteed national benefit package for coverage of spouses and dependents of retirees under a private health plan, or a self-insured plan, if applicable
- C. A maintenance-of-effort requirement would be imposed that would require employers to provide wrap-around benefits, in addition to the nationally guaranteed benefit package under Medicare Part C
1. Employers with contractual retiree health obligations that exceed benefits under the nationally guaranteed benefit package would be required to provide wrap-around benefits to retirees, spouses and dependent spouses consistent with contractual obligations
- D. The obligation of employers would be reduced for retirees at age 65 when they become entitled to benefits under Medicare Part A and B
1. Medicare would be the primary payer for the nationally guaranteed benefit package
 2. Employers would be required to provide wrap-around benefits, as part of maintenance-of-effort requirement

Specifications for Universal Health Insurance Coverage

III. Benefits

- I. The guaranteed national benefit package would be defined in statute
 - A. In general, the national guaranteed benefit package would conform with the benefits currently provided under Medicare Parts A and B, with modifications specified below
 - B. Medicare Parts A and B would be improved to conform with the guaranteed national benefit package
 - C. The guaranteed national benefit package would be covered under Medicare Part C and would be offered by all private health insurers and by employers with self-insured plans
 1. Federally qualified HMOs could offer a more generous benefit package
 - E. Individuals and employers would be able to purchase supplemental Medigap-type policies for coverage of additional benefits and cost-sharing (see health plan requirement outline)
 1. Employers that elect to self-insure could cover supplemental benefits, in addition to the minimum required guaranteed benefit package
- II. In addition to benefits currently covered under Medicare Parts A and B, the national guaranteed benefit package would include the following additional benefits:
 - A. An out-of-pocket limit of \$2,500 per individual, \$3,000 per family, indexed annually to the allowable rate of growth in Medicare spending
 - B. A single deductible of \$500 per individual and \$750 per family, indexed annually to the allowable rate of growth in Medicare spending
 - C. Unlimited inpatient care, with no spell of illness restriction, and no separate hospital deductible

- D. Coverage of outpatient prescription drugs (see outline on Medicare Prescription Drug benefit) with a separate \$250 deductible, a 20 percent co-insurance and a separate \$1,000 out-of-pocket limit for prescription drugs
 - E. Extra billing limitations would be consistent with current Medicare requirements
- III. Specific additional services would be covered for children to age 18 without cost-sharing
- A. Newborn and well-baby care, including pediatrician services for high-risk deliveries, subject to modifications by the Secretary, in consultation with the American Academy of Pediatrics
 - B. Well-child services, including routine office visits, routine immunizations, routine lab tests, and dental care, subject to modifications by the Secretary, in consultation with the American Academy of Pediatrics
- IV. Women would be covered for all pregnancy-related services
- A. Pre-natal services would be covered without cost-sharing requirements
- V. Family planning, including voluntary planning services and contraceptive drugs and devices would be covered
- VI. Additional Preventive Benefits
- A. The guaranteed national benefit package would cover Medicare-covered preventive benefits, including immunizations, mammograms, pap smears and colorectal screening
 - 1. The schedule for pap smears would be modified to cover an annual pap smear for women who have reached childbearing age, until negative results appear for three consecutive years, and would then be covered every three years
 - 2. High risk females would be covered on an annual basis
 - B. The Office of Technology Assessment would continue to examine the efficacy of preventive services and the

appropriate schedule of preventive services for high risk populations

1. The Office of Technology Assessment would make recommendations for modifications to the benefit package to the Congress

VII. Additional benefits would be provided under Medicare Part C for low-income individuals (see low income outline)

VIII. Provision of items or services contrary to religious belief or moral conviction

- A. A health professional or a health facility may not be required to provide an item or service in the national guaranteed benefit package, if the professional or facility objects to doing so on the basis of a religious belief or moral conviction

Specifications for Universal Health Insurance Coverage

IV. State Responsibilities

- I. State flexibility would be encouraged
 - A. States should, through enactment of appropriate legislation, establish their own 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. As under current Medicare law, the Secretary would be required to approve State programs, if all applicable requirements were met
- II. States could establish all-payer provider reimbursement programs
 - A. Programs could cover hospital services, or physician services, or all services
- III. Federal Medicare-type payment rates would not apply to providers in a State with an approved all-payer program
 - A. State programs would meet standards for organization and operation
 - B. States would be required to meet a target consistent with the national health expenditure budget
 - 1. The total costs of covered benefits for State residents not enrolled in Medicare Parts A, B or C could not exceed the projected total costs under the Federal cost containment program
 - 2. Medicare's rates would not apply to Medicare in the State

(a) Total Medicare spending in the State could not exceed the projected total Medicare costs under Medicare's rates

3. State cost determinations would be over 36-month period

4. States could carry savings in any year forward for up to three years

C. Federal rates would not apply in States which created alternative benefit management programs, described below

IV. Requirements for State all-payer provider reimbursement programs:

A. Programs would be required to be publicly administered

B. Programs would be required to provide for equitable treatment of all payers

C. Programs would be required to set rates which would apply to all services for which the State has agreed to set rates and would apply to all payers paying for services in the state

D. Programs would be required to cover all applicable providers such as hospitals or physicians, or all services

E. Programs would be required to make such reports as necessary to monitor the program

F. Programs would be required to insure that total expenditures in the State for services included in the program were no higher than projected expenditures under the Federal payment system

G. The State program could provide for negotiated rates with qualified HMOS

1. If the State program so provided, payments to qualified HMOs would not be counted as part of the State expenditure target

H. States with Medicare waivers

1. States currently holding a waiver under Medicare could continue to operate their program if Medicare expenditures in the State did not exceed the State's target

V. States could also apply for authority over all health care benefits provided in the State, including self-insured plans

A. Initially, a State plan would have to guarantee coverage for at least the minimum benefit package for all residents, other than residents covered under Medicare Parts A through C

1. 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

2. Regardless of the type of program chosen, States would be required to meet the expenditure targets for the State as would State cost containment programs

B. 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

VI. Requirements for State benefit management programs

A. Programs would be required to be publicly administered

B. Programs would be required to assure coverage of at least the nationally guaranteed benefit package

C. Programs would have to assure, to the satisfaction of the Secretary, that services needed to deliver the nationally guaranteed benefit package were reasonably accessible to all the residents of the State

D. Programs would be required to make such reports as necessary to monitor the program

E. Programs would be required to insure that total expenditures in the State for services covered were no higher than projected expenditures under the Federal payment system

1. If Medicare services were included, the State program would be required to insure that total Medicare expenditures were no higher than under Medicare's own payment rules.

- F. To the extent the State proposed to provide benefits directly through a public plan, the public plan would be required to meet the following standards:
1. The portability, open enrollment, guaranteed renewal, and community rating standards that would otherwise be applicable to private plans.
 2. The program would be required to provide for coverage of out-of-state benefits
 3. The program would be required to provide for coordination of benefits with insurers in other States
 4. The program would be required to comply with the national administrative simplification standards

VII. Evaluation of State programs

A. States would file

1. Initial applications
2. Annual reports

B. The aggregate expenditures for covered items and services which would occur for residents of the State if Federal rates were to apply in the state would be projected by HHS

1. Projections would be made prior to the beginning of each year for each State
2. Projections would be based upon prior-year utilization updated to the current year multiplied by the expected Federal rates of payment for covered items and services
3. The first 36-month period would begin with the first month in which the state system applied in a State

VIII. If requirements were not met by a State

A. State would be provided with 90-days notice of the intention to re-instate Federal rates in the State

1. State could request a hearing

- B. To recapture excess payments in previous years, HHS could
 - 1. Reduce a State's current annual target or
 - 2. Reimpose Federal rates at levels lower than would otherwise be the case

IX. Use of Medicare savings

- A. 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.

Specifications for Universal Health Insurance Coverage

V. Health Alliances

- I. Grants would be available to States to assist in the planning, development, and initial operation of regional health alliances
 1. Individual grants would be awarded for a period of up to five years and the total amount of assistance could not exceed \$5 million.
 2. \$150 million would be authorized for the five-year period beginning with fiscal year 1995.

- II. In order to be eligible for a Federal grant, a State would be required to meet requirements established by the Secretary of HHS

- III. States participating in the grant program could establish multiple alliances, but alliances could not overlap and an alliance must be available everywhere in the State
 1. One or more contiguous States could jointly establish an interstate regional health alliance
 2. In establishing alliances, States could not subdivide a Metropolitan Statistical Area (MSA)
 3. In establishing alliance boundaries, a State could not discriminate on the basis of or otherwise take into account race, age, language, religion, national origin, socio-economic status, disability, or perceived health status.

- III. Additional standards for State grants for regional health alliances

- A. A regional health alliance could be run by a non-profit organization or a State agency
 - B. A regional health alliance would be governed by a Board of Directors, who represent employers and consumers, represented in equal numbers
 - 1. The governing board could not include providers or representatives of health plans
 - C. Regional health alliances would have to meet standards established by the Secretary of HHS pertaining to the management of finances, maintenance of records, accounting practices, auditing procedures and financial reporting.
- IV. Responsibilities of Regional Health Alliances in States participating in the Federal grant program
- A. Regional health alliances would be required to enter into an agreement with any qualified health plan (those meeting Federal standards) in the alliance area that seeks an agreement to offer health insurance through the regional alliance
 - 1. Health plans sold through the regional alliance would be sold at the same community rates as health plans sold directly to individuals or employers
 - 2. Health plans offering coverage through a health alliance could provide a volume discount for enrollment and administrative costs
 - a) Administrative discount must be specified by the health plan in advance in accordance with standards established by the Secretary and must be applied uniformly across alliances
 - B. Alliances would offer to enter into agreements to provide services to any small employer in the alliance area (those with fewer than 500 employees)
 - 1. Within one year after its establishment, a regional health alliance would be required to seek out and inform all small employers in the alliance area of the services available through the alliance

- C. Under the agreement with employers, the regional health alliance would provide the following services:
 - 1. Provide information in a uniform format to each employee of participating employers regarding health benefits available from each qualified health plan with which the health alliance has an agreement, as well as Medicare, part C
 - a) Information would include price; identity, location, qualifications and availability of participating providers; and number of members enrolling and disenrolling from the plan.
 - 2. Enroll employees of participating employers into the qualified health plan of their choice
 - 3. Receive and forward premiums from employers and employees to the qualified health plan
 - 4. Coordinate with other health alliances in order to provide health benefits to employees who reside in the alliance area but whose employer's place of business is outside of the area. Such services would be provided in coordination with the health alliance for the area in which the principal place of business of the employer is located
- D. 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
- E. Regional health alliances could charge a fee to employers of up to 2% of premium in exchange for the services provided in accordance with standards established by of the Secretary
- F. Health alliances would conduct an annual open enrollment period on behalf of the participating employers
- G. Health alliances would maintain a grievance hot line, and would investigate each problem with a health plan brought to its attention
- V. States participating in the grant program could provide that alliances would be the exclusive vendor of health plans in

the State, but such application would be governed by the rules for State waivers (see State outline)

Specifications for Universal Health Insurance Coverage

VI. Health Plans

- I. The Secretary of HHS would promulgate regulations to implement federal standards for health plans by July 1, 1995
 - A. States would enforce the standards for all health plans sold to individuals and employers
 1. States would be required to adopt the Federal standards within one year after they were issued by the Secretary
 - (a) States in which the legislature was not scheduled to meet during the year prior to the date by which the State must adopt the Federal standards would be required to adopt the standards by the first quarter after the close of the next scheduled meeting of the State legislature
 2. The Secretary of HHS would certify State compliance and would assume responsibility for enforcing the standards in a State that did not comply
 - B. A Federal excise tax penalty would be established for non-compliance
 1. The excise tax would be equal to 50 percent of the gross premiums received by the issuer of the policy attributed to the time period during which the policy was in violation of the requirements
 - C. States would continue to regulate financial solvency of health insurance using standards at least as stringent as standards established by the National Association of Insurance Commissioners
- II. Non-discrimination and continuation of coverage rules would apply to all health plans sold to individuals or employers

- A. Health plans could not deny coverage to any eligible group or individual due to health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability or medical condition
 - B. Renewal of coverage under a health plan would be guaranteed and coverage could only be terminated or renewal denied due to nonpayment of premiums or to fraud
 - 1. Individuals enrolled in plans for which coverage is terminated would be automatically eligible for enrollment in Medicare Part C
 - C. 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
 - D. No waiting periods for coverage would be permitted
 - E. Plans would be prohibited from engaging directly or indirectly in activities -- including the selection of a service area or selection of a provider network -- that would have the effect of discriminating against an individual on the basis of race, national origin, gender, language, socio-economic status, age, health status or anticipated need for health services
- III. Health plans would be required to provide year-round open enrollment for groups and individuals
- A. Health plans sold through an association or multiple employer arrangement could restrict membership in that plan to the members of the association or arrangement, but only where the Secretary determines that the association or arrangement has been formed for purposes other than selling health insurance and does not exist solely or principally for the purpose of selling insurance
 - B. An HMO could apply to the State to close enrollment if it demonstrates that it has reached capacity
- IV. Health plans would be required to sell coverage at community-rated premiums for all purchasers
- A. All insurers would be required to offer the national guaranteed benefit package as a separate package

1. Federally qualified HMOs could offer a more generous benefit package
- B. Plans would be required to provide the national guaranteed benefit package with premiums differentiated only by enrollment category within a geographic area
1. Separate enrollment categories would be established for families with one adult and families with more than one adult, with no separate charge for coverage of children
 2. Geographic areas could not be smaller than an MSA and non-MSA areas could not be divided within a State
 - a) States could define alternative boundaries for non-MSA areas within a State for the purposes of community rating
- C. Plans would be allowed to phase in community-rated premiums over a three-year period.
1. The range of premiums charged for the nationally guaranteed benefit package in the first year of the transition could not be greater than 2/3 of the range of premiums charged for similar benefits in the previous year
 2. The range of premiums charged for the nationally guaranteed benefit package in the second year of the transition could not be greater than 1/3 of the range of premiums charged in the previous year
- D. Health plans offering coverage through a health alliance could offer a volume discount for enrollment and administrative costs
1. The discount would be required to be specified by the health plan in advance in accordance with standards established by the Secretary, and would be required to be applied uniformly by the plan to all alliances through which the plan was sold
 2. The same discount would be available to insurance sold to an association or multiple employer arrangement, but only where the Secretary determines that the association or arrangement has been formed for purposes other than selling health

insurance and does not exist solely or principally for the purpose of selling insurance

- V. Federal standards for marketing of health plans would be established to prevent plans from attracting or limiting enrollees on the basis of personal characteristics or anticipated need for health services
 - A. The State would be required to update annually and make available to consumers, in a uniform format, information on approved health plans sold in the State, including information on price; on identity, location, qualifications and availability of participating providers; and on number of members enrolling and disenrolling from the plan
 - B. Insurers and brokers would be required to provide to consumers the information developed under item A
 - C. The State would also make available to the public information on procedures used by each approved health plan to control utilization of services and expenditures, procedures for assuring quality of care, and rights and responsibilities of enrollees
 - D. Marketing materials used by health plans would have to be approved in advance, made available uniformly throughout the State, and could not be used to attract or limit enrollment of certain individuals or groups
 - E. A plan could not pay commissions to agents based upon the actual or expected claims experience of a group or individual

- VI. Plans would be required to disclose utilization review standards to consumers and the State

- VII. Plans would be required to meet the following additional standards developed by the Secretary (detailed in Quality Improvement and Consumer Protection outline):
 - A. Grievance procedures
 - B. Quality assurance requirements
 - C. Confidentiality, data management and reporting requirements

- VIII. Health plans would be required to issue health cards, conform to requirements of administrative simplification and perform other functions needed to coordinate coverage between public and private plans, in accordance with regulations developed by the Secretary (see outline on Administrative Simplification)
- IX.. 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
- A. The risk adjustment or reinsurance system could take into account factors such as age, sex, other demographic characteristics, health status, geographic area of residence, socio-economic status, proportion of SSI and AFDC recipients, other factors
 - B. States could use alternative systems if the Secretary determines that the systems meet the goal of spreading risk among all health plans
 - C. All health plans sold to individuals and employers in a State could be required to participate in any risk adjustment or reinsurance system operated within the State
- X. All requirements described in sections I through IX above would take effect as States adopt the requirements pursuant to the effective dates described in item I above
- XI. Transitional insurance reforms would be established and effective beginning January 1, 1996 and until States adopt the requirements of sections I through IX
- A. Health plans would be required to maintain coverage in force and to accept new members in a group plan without respect to health status
 - B. Pre-existing condition exclusions would be prohibited for individuals with previous coverage and would be limited to 6 months for newly insured individuals
 - 1. Pre-existing condition would be defined as a condition which has been diagnosed or treated during the 6 month period prior to coverage

2. Plans that did not apply any pre-existing condition exclusion prior to enactment of this limitation would not be allowed to apply one
- C. Insurers would have to apply consistent rating policies with respect to demographic characteristics and changes in benefit design across all covered individuals and groups
- D. Premium increases for individual plans and small group plans (less than 100 employees) could not vary based on claims experience
- E. Health plans would be required to file a certification with the Secretary or the State indicating that they are in compliance with the transitional insurance reform requirements
- F. Requirements would be enforced by the Secretary of HHS, subject to a civil monetary penalty up to \$25,000 for each violation
 1. The Secretary may enter into agreements with States to enforce the transitional requirements
 2. Secretary would be authorized to issue interim final regulations to implement the requirements
- G. Requirements would not pre-empt any existing State law that is more stringent
- H. Self-insured employer plans would be prohibited from reducing or limiting coverage with respect to any medical condition for which the cost of treatment is expected to exceed \$5,000 a year

XII. Limits on self-insurance would be established

- A. Employers with 1,000 full-time employees or less would be prohibited from self-insuring
- B. Multiple Employer Welfare Arrangements (MEWAs) and similar multiple employer plans would be prohibited from self-insuring. Such groups could provide health insurance, but only to the extent that they met all applicable standards as health insurers in each State, including financial solvency requirements

XIII. Federal standards for self-insured employer plans would be established in regulation by the Secretary of Health and Human Services (HHS) and enforced by sanctions applied by the Department of the Treasury, based upon determinations of the Secretary of HHS

- A. Plans would be certified annually by the Secretary of HHS
- B. A Federal excise tax penalty would be established for non-compliance
 - 1. Tax would be equal to 50 percent of the expenditures of the plan during the period for which the plan was in violation of the requirements
- C. Self-insured employer plans would be required to provide the nationally guaranteed benefit package
 - 1. Plans may provide additional benefits
- D. Self-insured employer health plans could not deny coverage to any eligible individual due to health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability or medical condition
- E. Self-insured employer plans could not exclude or condition coverage or vary premium contributions charged to employees based on a pre-existing health condition
- F. No waiting periods for coverage would be permitted
- G. Self-insured plans would be required to meet additional requirements specified by the Secretary in the following areas:
 - 1. Grievance procedures
 - 2. Quality assurance requirements
 - 3. Confidentiality, data management and reporting requirements
- H. Self-insured plans would be required to disclose utilization review standards to enrollees

- I. Self-insured employer plans would be required to issue health cards, comply with requirements of administrative simplification and perform other functions needed to coordinate coverage between public and private health plans, in accordance with regulations developed by the Secretary

XIV. Supplemental policies

- A. Supplemental policy benefits would be restricted to those provided in up to ten supplemental benefit packages defined by the Secretary
 1. Benefits could not duplicate benefits in the national guaranteed benefit package
 2. The Secretary would be required to take into account current State benefit mandates in determining benefits to be included in the standardized supplemental benefit packages
- B. Supplemental policies would be required to meet Federal standards and could not be sold unless certified by the State
- C. Federal standards for supplemental policies would include:
 1. Non-discrimination based upon health status, occupational status or claims history of applicant, and open enrollment
 2. Community rating, with price differences between supplemental benefit packages based only on differences in the actuarial value of benefits, not claims experience or health status, consistent with standards established by the Secretary
 3. Prohibition on tying sale of supplemental policy to purchase of basic insurance or any other policy
 4. Marketing materials for supplemental policies would be approved in advance, be made available uniformly throughout the State, and could not be used to attract or limit enrollment of certain individuals or groups
- D. Disease-specific and hospital indemnity policies would be required to meet a 75 percent loss-ratio standard.

- E. Standardized benefit packages for Medicare supplemental insurance plans would be conformed to the standardized supplemental benefits defined by the Secretary
- F. Medicare supplemental insurance policies could not deny coverage to any eligible individual due to health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability or medical condition

XV. Managed Care Provisions

- A. \$25 million a year in grants would be authorized to support the development and initial operation of staff and group model HMOs in underserved areas, for fiscal years 1995 through 1999
 - 1. Grants could be used for market surveys, initial enrollment activities, working capital, physician recruitment, and acquisition of buildings and equipment
 - 2. Grants would be made to public or non-profit organizations
- B. Incentives for Expansion of Federally Qualified HMOs
 - 1. Mandatory "dual choice" requirements would be retained and expanded to "multiple choice." If requested by an HMO serving an area, an employer that offers enrollment in any health plan would be required to make the HMO available to employees as an option under the employer's health benefits
 - 2. Employers offering a health plan would be required make available the approved marketing materials for all available HMOs to each employee

XVI. State laws that mandate benefits to be included in all private health insurance plans would be pre-empted by the requirements of the nationally guaranteed benefit package

Specifications for Universal Health Insurance Coverage

VII. Federal Long-Term Care Insurance Standards

- I. The Secretary of HHS would promulgate regulations to implement federal standards of compliance within 12 months following the date of enactment.
 - A. States would enforce the standards for all health plans sold to individuals and employers
 1. States would be required to adopt the Federal standards within one year after they were issued by the Secretary
 - a. States in which the legislature was not scheduled to meet during the year prior to the date by which the State must adopt the Federal standards would be required to adopt the standards by the first quarter after the close of the next scheduled meeting of the State legislature
 2. The Secretary of HHS would certify State compliance and would assume responsibility for enforcing the standards in a State that did not comply
 - B. A Federal excise tax penalty would be established for non-compliance
 1. The excise tax would be equal to 50 percent of the gross premiums received by the issuer of the policy attributed to the time period during which the policy was in violation of the requirements
- II. Federal Standards and Requirements
 - A. Requirements to facilitate understanding and comparison of benefits would be established
 1. The Secretary would develop and propose standardized formats and terminology to be used in long-term care insurance policies

2. Insurers would be required to provide to customers and beneficiaries information on the range of public and private long-term care coverage available
 3. The Secretary would establish other requirements to promote consumer understanding and facilitate comparison of benefits
- B. Uniform terms, definitions, and formats would be defined
1. Insurers would be required to use uniform terminology, definition of terms, and formats, in accordance with regulations promulgated by the Secretary
- C. A standard outline of coverage would be required for all long-term care insurance policies
1. Insurers would be required to develop an outline of coverage in a uniform format for each long-term care insurance policy sold or issued, and make available to each potential purchaser
 2. The contents of the outline of coverage would include a description of:
 - a. Benefits
 - (1) A description of all benefits covered, including the extent to which benefits would be furnished in residential care facilities
 - (2) The principal exclusions from and limitations on coverage
 - (3) The terms and conditions, if any, upon which the insured individual may obtain upgraded benefits, and
 - (4) The conditions for entitlement to receive benefits
 - b. Continuation, renewal and conversion requirements
 - (1) A statement of the terms under which a policy may be returned (with premium

refunded), continued or renewed, or converted to an individual policy

c. Cancellation limitations

- (1) The outline would include a statement of the circumstances in which a policy may be terminated, and the refund or nonforfeiture benefits applicable in each circumstance, including
 - (a) Death of the insured individual
 - (b) Non-payment of premium
 - (c) Election by the insured individual not to renew
 - (d) Any other circumstances

d. Premiums

- (1) A statement of the total premium, and the portion of such premium attributable to each covered benefit
- (2) Any reservation by the insurer of a right to change premiums
- (3) Any limit on annual premium increases
- (4) Any expected premium increases associated with automatic or optional benefit increases, including inflation protection
- (5) Any circumstances under which the payment of the premium would be waived

e. A cost/value comparison

- (1) The outline would include information on average costs (and variations in such costs) for nursing facility care and other covered benefits
- (2) A comparison of benefits, over a period of 20 years for policies with and without inflation protection

- (3) A declaration stating whether the amount of benefits will increase over time, and any limitations on and any premium increases for such benefit increases
 3. Reporting to State insurance commissioners would be required of all insurers
 - a. Each insurer would be required to report at least annually to the State insurance commissioners in any State in which a policy is sold or issued, in a manner specified by the Secretary
 - b. Information to be reported would include:
 - (1) the standard outline of coverage
 - (2) lapse rates and replacement rates
 - (3) the ratio of premiums collected to benefits
 - (4) reserves
 - (5) written materials used in the sale or promotion of policies
 4. Comparison of long-term care coverage alternatives would be provided to prospective purchasers
 - a. Each insurer would be required to furnish to prospective purchasers of a policy the conditions of eligibility for, and benefits under other policies sold by the insurers, and benefits covered under public programs, including but not limited to Medicare and Medicaid
- D. Requirements relating to coverage would be established
1. The Secretary would promulgate regulations establishing requirements with respect to the terms of and benefits under long-term care insurance policies
 2. Pre-existing condition exclusions would not be permitted

3. A long-term care insurance policy would not be permitted to condition eligibility for benefits:
 - a. on the need for another type of service (such as prior hospitalization), or a higher level of care
 - b. on any particular medical diagnosis, including any acute condition, or on one of the group of diagnoses
 - c. on services furnished by licensed or certified providers on compliance by such providers with conditions not required by Federal or State law
 - d. on the provision of such services by a provider, or in a setting, providing a higher level of care than that required by an insured individual
4. A long-term care insurance policy that provides benefits for home and community-based services provided in a setting other than a residential care facility:
 - a. may not limit benefits to services provided by registered nurses or licensed practical nurses
 - b. may not limit benefits to services provided by entities participating in Medicare and Medicaid
 - c. must provide, at a minimum, benefits for personal assistance with activities of daily living, home health care, adult day care and respite care
5. A long-term care insurance policy that provides benefits for services in nursing facilities must provide benefits for services provided by all types of nursing facilities licensed by the State, and may provide benefits for care in other residential facilities
6. Long-term care insurance policies would not be permitted to discriminate with respect to eligibility for benefits or amount of benefits under the policy in the treatment of: Alzheimer's

disease or other progressive degenerative dementia, any organic or inorganic mental illness, mental retardation or any other cognitive or mental impairment, or HIV infection or AIDS

E. Requirements pertaining to inflation protection would be established

1. An insurer would be required to offer the purchaser the option to obtain coverage under the policy for annual increases in benefits
2. The benefits under a policy would increase by not less than 5 percent per year compounded
3. Inflation protection would be excluded from the coverage only if the insured individual rejected in writing the option to obtain such coverage

F. Non-forfeiture benefits would be required for all policies

1. The Secretary would be required to promulgate regulations for an appropriate non-forfeiture benefit for policies that lapse -- including policies that lapse for nonpayment of premiums and non-renewal but excluding for reason of death, which could include:
 - a. Reduced paid-up benefits where indemnity level is reduced by a specific amount
 - b. Extended term benefits, where a policy remains in effect for an abbreviated period of time after policy lapses
2. The non-forfeiture benefit would increase proportionately to the amount of premiums paid
3. All long-term care insurance policies would be required to include defined non-forfeiture benefits, as specified by the Secretary

G. Requirements relating to premiums would be established

1. The Secretary would promulgate regulations with respect to State procedure for review and approval of premium rates and rate increases or decreases

2. The Secretary would promulgate regulations with respect to limitations on the amount of initial premiums, or on the rate or amount of premium increases
3. The Secretary would promulgate regulations with respect to the factors to be taken into consideration by an insurer in proposing, and by a State, in approving or disapproving premium rates and increases
4. Adjustments in premiums would be required, if a change in law is enacted that provides long-term care benefits to policy-holders
 - a. The policy would provide a rebate that is actuarially equivalent to the benefits which would be provided under the new law

H. Requirements relating to sales practices would be established

1. Any insurer offering a long-term care policy would meet such requirements pertaining to content, format and use of application forms
2. Any insurer that sells or offers a policy could not offer such a policy through an agent who does not comply with the minimum standards with respect to training and certification established by the Secretary
3. Agent commissions for sales would be limited to 200 percent of second year commissions
4. The following sales practices would be prohibited:
 - a. false and misleading representation
 - b. inaccurate completion of medical history by insurer
 - c. undue pressure
 - d. cold lead advertising
5. The sale of duplicate benefits would be prohibited
 - a. An insurer or agent would be prohibited from selling a policy that the insurer or agent

know duplicates coverage already provided to an individual under another long-term care insurance policy, unless the policy is intended to replace the other policy

- I. Continuation, renewal, replacement, conversion and cancellation rules would be defined
 1. In general, insurers would not be permitted to cancel, or refuse to renew any long-term care insurance policy for any reason other than for fraud, material misrepresentation, or for non-payment of premium, effective 6 months after date of enactment
 2. Each policy would contain a provision that states the duration of the policy, the right of the insured individual to renewal, the date by which the option to renew must be exercised, and applicable restrictions, effective 6 months after date of enactment
 3. Continuation and conversion rights would be established with respect to group policies
 - a. Individuals would be permitted to continue or convert policies
 - b. A group policy would meet the conversion requirements if it entitles individuals covered under the group policy to be issued a replacement policy providing benefits substantially equivalent to the benefits, or greater than the benefits, without requiring evidence of insurability, and at premium rates no higher than would apply if the individual had obtained under a replacement policy
 4. Each individual liable for the premium would have the unconditional right to return the policy within 30 days after the date of its issuance, and would be able to obtain a full refund of any premium paid, effective six months after date of enactment
 5. Any insurer would have the right to cancel a policy, or to refuse to pay a claim, based on evidence that the insured made false representations or knowingly failed to disclose information on the application

6. Insurers have the right to cancel policies for non-payment of premiums, subject to non-forfeiture requirements
 7. The insurers would be required to reinstate full coverage of an individual canceled due to non-payment of premiums, retroactive to the effective date of cancellation, if the insurer receives evidence, from a representative of the individual, that the individual was incapacitated, and receives payment of all premiums due and past due, and charges for late payment, effective 6 months after date of enactment
 - a. At the time of sale, the issuer would require the insured individuals to designate a representative to communicate with the insurer, in the event the individual cannot be located or is incapacitated
- J. Requirements relating to payments of benefits would be established
1. The Secretary would promulgate regulations establishing requirements with respect to claims for and payment of benefits under a policy
 2. Each policy would specify the threshold for "triggering" eligibility for benefits, including levels of functional or cognitive status
 3. The policy would provide for a procedure to determine whether threshold conditions have been met, which is based upon uniform assessment standards, procedures and formats
 4. The policy would allow for an independent assessment selected by the insured individuals, as to whether the threshold conditions have been met
 - a. The insurer would have the option for a re-evaluation by an independent assessor
 - b. In the event of a disagreement or inconsistencies, final resolution would be provided by a State agency or other impartial third party

5. Insurers would be required to provide an explanation in writing of the reasons for payment, partial payment or denial of such claims
7. Insurers would be required to provide an administrative procedure under which an individual may appeal any denial of a claim

III. Relation to State Law

- A. States would be permitted to impose standards that are more protective of individuals, except that State standards may not be inconsistent with the specified Federal standards

Specifications for Universal Health Coverage

VIII. Cost Containment

I. National Health Expenditure Estimates

A. National health expenditure targets would be set by statute for total spending for health services for private and public plans

1. The Secretary would make separate estimates would be made for expenditures for services covered under Medicare (including Part C) and under private plans, beginning for 1996
 - a. Estimates would be published by October 1 of each year for the following year, beginning in 1995
2. For each category (public and private) of spending, annual growth limits would be set beginning in 1996 at the current trend minus one percentage point and phase down by an additional 1 percentage point each year until growth is limited to the increase in the nominal gross domestic product (GDP)
 - a. The initial limits would be based on the most recent actual data (1993) inflated forward at the baseline rate of growth to 1995, and at the target rate of growth thereafter.
 - i. The estimates would be measured on a per capita basis to reflect and adjust for changes in enrollment between the public and private plans
 - b. The initial estimates would reflect current spending patterns; estimates for years beginning after 1996 would be adjusted to reflect:
 - i. Changes in enrollment between public and private insurers
 - ii. Any net increase in health spending related to implementation of universal coverage; and

- iii. Reductions in spending under private insurance related to (1) the elimination of uncompensated care, and (2) the increase in payments for services that would have been covered under Medicaid in the absence of Part C
 - c. Subsequent per capita limits would be adjusted to reflect changes in the mix of enrollments across public and private plans, and to correct errors in estimation of initial spending relative to the estimated baseline levels of inflation in 1994 and 1995, baseline levels of spending for services within each category, and errors in estimation of volume responses relating to universal coverage
3. The target rates of increase in the limits for each category of spending (public and private) would be based on the five-year moving average rate of growth in the GDP, plus a growth adjustment
- a. The growth adjustment would be set such that the limit on growth in spending would decrease one percentage point in 1996, two percentage points in 1997, three percentage points in 1998, and so on until the growth limit is equal to the growth in the GDP in each subsequent year
 - b. Secretary would estimate and publish the growth targets for a year by October 1 of the preceding year, beginning in 1995
4. Public sector estimates and limits would apply to the current Medicare plan, to services covered under the new Medicare Part C, and to wrap-around benefits under the supplemental benefit program for low-income persons
5. The public and private sector estimates would include all payments made for the types of services covered under the nationally guaranteed benefit package, including:
- a. Inpatient and outpatient hospital services
 - b. Physician services
 - c. Diagnostic testing services, including laboratory and x-ray services

- d. Prescription drugs
 - e. Home health, durable medical equipment, orthotics and prosthesis
 - f. Mental health services, including inpatient and outpatient drug and alcohol treatment
 - g. Rehabilitation services
6. Expenditures for services provided in qualified HMOs would be included within the estimates

B. Monitoring Health Spending

- 1. All providers who submit claims to either the public plan or to private payers would be required to submit annual reports to the Secretary of DHHS to be used in monitoring and enforcing compliance with the national health spending targets
 - a. Hospitals and other institutions would provide cost and revenue data; other providers would submit only revenue data
 - b. Reports would be submitted by April 15 of each year for the preceding calendar year
 - i. The initial report, covering payments made for services provided in 1996, would be due on April 15, 1997.
 - c. The reports would include information on all revenues received during the preceding calendar year relating to medical services provided to all patients, broken down separately by type of payer (Medicare A, B and C, Medicaid, CHAMPUS, private insurance plans, and direct patient out-of-pocket costs)
 - d. Revenues for activities not related to the provision of direct patient care, such as teaching or research, would be reported separately
- 2. Hospitals' reports for inpatient and outpatient services would be part of the uniform hospital reporting system
- 3. Physicians and other providers would submit reports in a form to be specified by the Secretary

II. Allocation of National Health Spending to States

- A. State level estimates of health spending would be used to monitor the States' success in controlling costs
- B. The Secretary of HHS would estimate the amount of health spending for each State without regard to the implementation of a State plan
 - 1. The estimate would be based on prices in the State as determined under maximum payment rate system (see description below)
 - 2. The estimate would be based on utilization patterns within each State
 - 3. States' spending would be permitted to grow at the same rate as the national health estimates
 - 4. In estimating the initial targets, the Secretary would adjust the data to reflect use of services by out-of-State residents, and use of out-of-State services by in-State residents
- C. The initial allocation for each State would be estimated for 1995, based on the most recent data available
 - 1. The estimate of the 1995 spending would be adjusted for estimation errors when actual data become available.
- D. Each State's allocation for 1996 would be equal to the 1995 allocation, increased by the national target rate of growth in health spending
 - 1. States could apply to the Secretary to exclude certain health care spending from being considered in determining whether a State is within its growth limits in the case of cost related to demands of a sudden and temporary nature, such as epidemics or natural disasters

III. Cost Containment

- A. Beginning for calendar year 1996, HHS would set maximum rates of payment under Medicare, at levels estimated to keep public health spending within the national targets
1. The maximum payment rates would not be binding on providers with regard to payments for services covered by private insurers during 1996 and 1997
 2. The maximum payment rates would first apply to services covered by private insurers beginning with the first year (and all subsequent years) following 1996 that, as determined by the Secretary, health spending in the private sector during the preceding year is greater than the target amount of spending for such year
 3. The maximum payment rates would be used to establish and limit growth in payment rates and spending under Medicare beginning in 1996
 4. HHS would separately allocate each of the initial national health spending estimates among health sectors (hospitals, physicians, etc.)
 - a. Initial sector allocations would be based on baseline spending patterns; projected changes in sector allocations would also be based on baseline patterns of change
 - i. Public and private spending estimates would each have their own sector allocations
 - ii. For Medicare, these allocations would serve as expenditure target type limits for prospectively setting reimbursement rates to keep spending within the target
 - b. Once established, the sector allocations could not be changed without specific authorizing legislation
 - c. PropAC, PhysPRC, and DrugPAC would jointly study and recommend changes in sector definitions and allocations to Congressional Committees
 5. The maximum allowable payment rates for private payers would be set based on Medicare methodologies

- a. The national maximum payment rates would be adjusted between types of providers and geographic areas in the same manner as under the Medicare program
- b. Providers would be required to accept the maximum payment rates as payment in full; private insurers would be prohibited from paying more than these amounts, adjusted for cost-sharing
- c. ProPAC, PhysPRC, and DrugPAC would study and recommend any necessary changes in provider payment policies to the Congressional Committees
 - (i) Recommendations would include the allocation of national expenditures between public and private payers, and among hospitals, physicians and other sectors of the health care system, as well as updates for hospital and physician payment under Medicare to assure that Medicare expenditures are within the national health spending limits

IV. Maximum Payment Rates

- A. Maximum provider payments would be based on Medicare methodologies
 1. Specific rates of payment for providers would be set by HHS at levels estimated to meet the expenditure targets for each sector of the health care system
 2. The rates would not apply in States which opted to operate their own provider payment or cost containment systems, and would not initially apply to services covered by private insurers
 - a. States electing to operate their own systems would be required to keep spending within their own target for health spending
 3. If the private sector limits are triggered and apply to private sector payers, the rates would be the maximum rates which providers could be paid for a service, including extra-billing
 - a. Payers could negotiate lower payment amounts

4. Rates would be set separately for Medicare and for all other payers

B. Adjusted Medicare-type DRG rates for hospitals

1. Initial level of payment amounts

- a. Maximum payment rates, including all adjustments, would be set initially at the average level currently paid by private insurers in serving the under-65 population
 - i. Costs would be determined using Medicare's definition of allowable costs, adjusted for necessary differences in the scope of services
 - ii. The maximum payment rates would include an average allowance for bad debt associated with nonpayment of co-payments and deductibles
- b. Rates would be updated taking the following factors into account:
 - i. Adjustments for changes in case mix and case mix coding
 - ii. Changes in the volume of hospital services
- c. Updates would be limited such that total payments would not exceed the target amount allocated to hospitals under the national health spending estimates
- d. Rates would be published each October 1 and would be effective the following January 1

2. Benefits included in the base payment amounts

- a. Base payment rates would be based upon the nationally guaranteed hospital benefit package
- b. Specific percentage adjustments to the base payment rates to reflect benefits covered by the supplemental policies would be defined by HHS
- c. Hospitals would be prohibited from charging patients any additional amounts, except for the following:

- i. Deductibles and co-payments defined in the nationally guaranteed benefit package
 - ii. Private room charges
 - iii. Convenience items such as telephone and television rentals
 - iv. Experimental procedures not included in the standard benefit package
3. General adjustments to the base maximum payment amounts
 - a. Base maximum payment amounts would be adjusted as needed to reflect any new DRGs and new DRG weights established for an under-65 population
 - b. Base maximum payment amounts would be adjusted by geographic area for wages and for non-labor input prices
 - i. A separate cost-of-living adjustment would not be used, except in the case of hospitals in Hawaii and Alaska, as under Medicare
 - c. Separate maximum payment amounts would be set for large urban and for all other hospitals
 - d. Additional payments would be made for cases with exceptionally high costs or long stays
 - e. Transfer cases would be paid using Medicare's methodology for transfer payments
 - f. Maximum payment rates to all hospitals would be adjusted for the indirect costs of graduate medical education, as described in the outline on Academic Health Centers based on Medicare's policy as amended by this proposal
 - g. Base payments would be adjusted for the costs of serving a disproportionate share of uncovered patients, using Medicare's formula as amended by this proposal
4. Capital adjustment

- a. Capital costs would be paid as part of the DRG payment rates, as under Medicare policy
 - b. Hospitals would receive a hospital-specific capital payment adjustment during the current transition to fully-prospective capital payment
5. Adjustment for direct costs of graduate medical education would be made, as described in the outline on Academic Health Centers
6. Maintenance-of-effort by State and local governments during transition period
- a. States could not reduce Medicaid payments to hospitals below the level paid in 1992
 - i. Test would be on a state-wide average basis
 - ii. Test would compare actual Medicaid payments against amount which would have been paid using the Medicare-level DRG payment method expressed as a percentage
 - b. Local governments could not reduce support for public and non-profit hospitals serving the indigent below the level paid in 1992
 - i. Payment under the uncompensated care adjustment would be reduced dollar-for-dollar for reductions in local support
 - ii. Time-limited grants initially granted prior to 1992 would be excluded from the test
7. Payments to hospitals and units currently exempt from the PPS system
- a. Hospitals and units currently exempt from the PPS payment system would be subject to a rate of increase limit similar to the TEFRA limits
 - i. Hospitals and units currently exempt are children's hospitals, long-term hospitals, cancer hospitals, rehabilitation hospitals, and psychiatric hospitals

- b. For purposes of determining payment in the first year, 1993 revenues would be updated to 1996 using baseline growth in spending for exempt hospitals and units
- c. Growth thereafter would be constrained based upon a limit determined to be consistent with the target growth in national health spending estimates
- d. The rate of growth limit would be replaced with prospective methodologies as new methodologies were developed
- e. With respect to children's hospitals, the prospective method would be hospital-specific and would be based on the resource requirements of pediatric populations and would be developed using pediatric-specific inpatient data

C. Physician services

- 1. Adjusted Medicare-type RB RVS rates for physicians
 - a. The Secretary of HHS would define new procedure codes and estimate RB RVS units as necessary for under-65 patients
 - b. Definitions and payment policies necessary for private payers to adopt RB RVS payment system would be published by HHS
 - c. Rates would be published each October 1 and effective January 1
 - d. The maximum payment rate RB RVS fees would be geographically adjusted in the same manner as under Medicare
- 2. Initial rates for private payers would be set at the level that would provide the same aggregate amount of payments to physicians from private payers as under current payment systems
 - a. The rates would be adjusted to reflect patient out-of-pocket payments and to keep total payments within the sector allocations
 - b. Based on current estimates, the initial private sector maximum payment rates would be approximately 135% of the fully-phased-in RB RVS rates, exclusive of extra-billing limits

3. Updates to initial conversion factor would be determined such that expenditures would be consistent with the national health spending estimates

D. Other ambulatory services

1. Adjusted Medicare-type rates for other services
 - a. Laboratories fees would be set at Medicare rates, and all services would be required to be directly billed to insurers, as provided under Medicare
 - b. Fees for rental and purchase of durable medical equipment would be based on Medicare reimbursement rates
 - c. Fees would be published each October 1 and effective January 1
2. Hospital outpatient services would be subject to a rate of increase limit similar to the TEFRA limits
 - a. For purposes of determining payment in the first year, 1993 revenues would be updated to 1995 using average growth rates for hospital outpatient services
 - b. Growth thereafter would be constrained based upon a limit which is determined to be consistent with the national health expenditure estimates
 - c. The rate of growth limit would be replaced with a prospective payment methodology as soon as current work to develop one is complete.

E. Prescription drugs

1. Maximum rates of payment for each drug would be set, consistent with the allocation to the drug sector within the national health spending estimates by HHS
2. Annual increases in maximum payment rates would be determined so that total payments would be consistent with the national health spending growth targets
3. See outline on drug benefits for detailed description of methodology

F Medicare limits on extra-billing to patients

1. Extra-billing limits would follow current law Medicare policies
 - a. No extra-billing by hospitals, nursing homes, ambulatory surgery centers, and other facilities
 - b. 15% limit on extra-billing by physicians
 - c. Other services would have the same limits as provided under Medicare
 - d. Health insurance plans, and self-insuring employers, could negotiate assignment agreements with physicians that would prohibit extra-billing

G. Limits on payments to qualified HMOs

1. Risk contracting payments under Medicare Part C
 - a. Rates would be established using the same methodologies as under current law
 - (1) Separate adjustments would be estimated for computing the AAPCC
 - (2) The Secretary of HHS would establish interim rates, which would be retrospectively adjusted to reflect actual spending outside of risk contracts, when such data become available
2. Premium growth limits for qualified HMOs
 - a. The maximum allowable per capita premium charged by each HMO would be subject to a national average rate of growth, consistent with spending under the national health spending estimates
 - b. The rate of growth limit would be applied to a 1994 base year average per capita premium, averaged across all enrollees in the HMO during the base year, and adjusted to reflect the actuarial value of the benefits included in the nationally guaranteed benefit package
 - c. The Secretary would establish age and sex ratings adjustments for HMOs

- d. The maximum allowable per capita premium amount would be adjusted to reflect changes in the age and sex of an HMOs enrollees, as compared to the demographics of their enrollees in the base year

IV. Reference to Limitation on Administrative and Judicial Review of Certain Determinations

A. There would be no administrative or judicial review of:

1. Maximum payment rates
2. DRG or RB RVS values established for services
3. Estimates of initial national health spending estimates or the allocation of such estimates to health sectors or States

Specifications for Universal Health Insurance Coverage

TITLE II. NEW BENEFITS**I. Coverage of Outpatient Prescription Drugs****I. Outpatient Prescription Drug Benefit**

- A. Effective January 1, 19** "covered outpatient drugs" would be added to services covered under Medicare Part B
- B. A "covered outpatient drug" means any of the following products used for a medically accepted indication:
 - 1. Is dispensed only upon a prescription, and-
 - (a) Is approved for safety and effectiveness under the Federal Food, Drug, and Cosmetic Act
 - (b) Is commercially used or sold in the U.S. before the date of the enactment of the Drug Amendments of 1962, or
 - (c) Is a drug that is identical, or similar, to a drug used or sold prior to the Drug Amendments of 1962
 - 2. A biological product which-
 - (a) Is dispensed only upon prescription
 - (b) Is licensed under the Public Health Service Act, and
 - (c) Is produced at an establishment licensed to produce such product
 - 3. Insulin
 - 4. Covered home infusion drug that-
 - (a) Is administered intravenously, subcutaneously, epidurally or through other

means determined by the Secretary, using an access device that is inserted into the body

- (b) Is administered in the individual's home, and
- (c) Can be administered safely and effectively in a home setting

5. Coverage of home infusion drug therapy services

- (a) Only qualified home infusion drug therapy providers', who meets requirements established by the Secretary, would qualify to provide covered home infusion items and services

C. Drugs provided as part of, or incident to hospital, nursing home, hospice and physician services, dialysis supplies, vaccinations, and certain other services, would not be covered under Medicare

- 1. These drugs are, generally, covered under other provision of the Medicare program
- 2. Immunosuppressives and oral cancer drugs would be covered under the new benefit

D. The term "medically accepted indication" includes any use that has been approved by the FDA and includes another use of the drug if-

- 1. The drug has been approved by the FDA, and
- 2. Such use is supported by specified compendia, unless the Secretary has determined that the use is not medically appropriate or if use is not indicated in one or more such compendia, or
- 3. The Secretary determines that such use is medically accepted based on supportive clinical evidence in peer reviewed medical literature

II. Payment rules and related requirements for covered outpatient drugs

A. Drug Deductible

- 1. The deductible would be set at \$250 in the first year and for succeeding years would be set at an

amount to ensure the same percentage as the previous year

2. No payment would be made until the enrollee has met the annual drug benefit deductible

B. Out-of-pocket limit

1. The out-of-pocket limit for the first year would be \$1,000 and for succeeding years would be set at an amount to ensure the same percentage as the previous year

C. Payment amounts and administrative allowance

1. Payments would be at 80% of the lesser of the actual charge for the drug and the payment limit
2. There would be mandatory assignment for all covered outpatient drugs
3. The Administrative allowance would be \$5 per prescription
 - (a) The administrative allowance would be updated annually by the GNP deflator
 - (b) The Secretary would be able to adjust the administrative allowance for any covered outpatient drug dispensed by a mail order pharmacy

D. Payment limits

1. The bill would provide for the establishment of payment limits for prescription drugs. The limits would vary depending upon whether the drug is a single or multiple source drug. The limits would be calculated for 1993, the base year, and then updated according to the allowable limits in the prescription drug sector
 - (a) The payment limit for single source drugs, and for multiple source drugs with restrictive prescriptions, would be the lesser of: (1) the 90th percentile of actual charges for the drug within a geographic area, or (2) the sum of an administrative allowance plus the estimated acquisition cost
 - (b) The payment for multiple source drugs without a restrictive prescription, would be the administrative allowance plus the unweighted median of the estimated acquisition cost for the drug
 - (c) Estimated acquisition cost could not be greater than 93 percent of the published average wholesale price for the drug during the period
2. The Secretary could conduct surveys to determine the average wholesale prices of both single and multiple source drugs in the most recent year for which data are available. These data would then be updated to the base year

E. Rebate requirement

1. In order for payment to be available under Medicare for covered prescription drugs the manufacturer would be required to enter into and have in effect a rebate agreement with the Secretary
 - (a) The amount of the rebate with respect to single source and innovator multiple source drugs, would be the greater of--
 - (i) 17 percent of the average manufacturer price, or

- (ii) The difference between the average manufacturer retail price and the average manufacturer non-retail price
2. For any new drugs, the Secretary would negotiate a rebate amount with the manufacturer
- (a) In determining the reasonableness of a launch price, the Secretary would consider: (1) prices of other drugs in the same therapeutic class, (2) cost-effectiveness, (3) prices charged for the drug in countries specified in section 802(b)(4)(A) of the Federal Food, Drug and Cosmetic Act, (4) projected prescription volume, economies of scale, product stability, manufacturing requirements, research costs and product availability, and (5) the value of any Federal assistance provided through direct grants or tax subsidies
 - (b) Information disclosed to the Secretary could only be used in carrying out this section
 - (c) The Secretary would be able to request from other Federal agencies information on the amount of Federal assistance provided in the research, development or manufacturer of the product
 - (d) If the Secretary is unable to negotiate with the manufacturer, the Secretary may exclude such drug
3. An additional rebate would be remitted to the Secretary if the average manufacturer retail price for a covered drug of the manufacturer exceeds the average manufacturer retail price for the base period, increased by the percentage increase in the Consumer Price Index

IV. Pharmacies

- A. Pharmacies participating in Medicare would be required to keep appropriate records, provide Medicare beneficiaries with information on drugs, and advise beneficiaries on the availability of therapeutically equivalent covered outpatient drugs

V. Limitation on length of prescription under Medicare

- A. Payment for covered outpatient drugs would be prohibited when the drug is dispensed in a quantity exceeding a 30-day supply
- B. The Secretary may, in exceptional cases, authorize payments for a quantity of up to a 90-day supply

VI. Administrative simplification

- A. The claims would be processed through a point-of-sale electronic system for use by carriers and pharmacies to use to submit claims for covered outpatient drugs
 - 1. The Secretary would establish a monthly payment cycle for each pharmacy providing benefits under the program
 - 2. If claims are not paid within five days of the day payment is required to be made under the contract with the Secretary, interest would be paid on the same basis as interest is paid for other Medicare claims
- B. The Secretary would provide each participating pharmacy with a distinctive emblem, and technical assistance as the Secretary determines may be necessary for the pharmacy to submit claims electronically

VII. Use of Carriers, Fiscal Intermediaries, and other entities under Medicare

- A. The use of contracts with entities other than carriers and fiscal intermediaries to process claims for covered outpatient drugs would be authorized
 - 1. Carriers would provide information to pharmacies as to whether an individual has met the annual deductible

VIII. Prescription Drug Payment Review Commission

- A. An eleven-member Prescription Drug Payment Review Commission would be established within one year of enactment
- B. 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

- C. The Commission would submit annual recommendations to the Congress regarding payments for prescription drugs under the national health expenditure estimates, including recommendations on the allocation of the national expenditure estimates to the prescription drug sector

IX. Assuring Appropriate Prescribing and Dispensing Practices

- A. The Secretary would establish a program to assure appropriate prescribing and dispensing practices under Medicare

- 1. The program would provide for on-line prospective review of prescriptions on a 24 hour basis
- 2. The program would identify inappropriate prescribing and dispensing practices, substandard care and potential adverse reactions
- 3. The program may require advance approval for a drug if a more cost-effective therapeutically equivalent drug is available or the drug is subject to misuse
- 4. The program would establish requirements for pharmacies regarding counseling individuals

- B. Information on the prescribing of scheduled II through V controlled substances would be reported to the State health agency by pharmacists, physicians and others dispensing these substances

- 1. Information on potential illegal use or diversion of prescription drugs would be reported to the prescribing physician, or the the State law enforcement agencies, as appropriate

- C. Reports to the Secretary of death or serious injury resulting from prescribing, dispensing, or administering a drug under Medicare would be mandated

X. Discounts

- A. As part of the rebate agreement a manufacture would be required to guarantee that the manufacturer would offer, to each wholesaler or retailer that purchases

such drugs on substantially the same terms as any other purchaser the same price for such drugs as is offered to such other purchaser

1. In determining compliance there shall not be taken into account terms offered to the Department of Veterans Affairs, the Department of Defense or any public program

XI. Adjustment in the Part B Premium

- A. A special add-on to the Part B premiums would be made to finance 25 percent of the costs of the program

Specifications for Universal Health Insurance Coverage

II. Other Changes in Medicare Benefits**I. Benefit changes for all beneficiaries**

The following benefits would be added to Medicare for all beneficiaries:

- A. An out-of-pocket limit of \$2,500 per individual, \$3,000 per family, indexed annually to the allowable rate of growth in Medicare spending
- B. A single deductible of \$500 per individual and \$750 per family, indexed annually to the allowable rate of growth in Medicare spending
- C. Unlimited hospital care, with no spell of illness restriction
- D. Coverage of outpatient prescription drugs (see outline on Medicare Prescription Drug benefit) with a \$250 deductible, a 20 percent co-insurance and a \$1,000 out-of-pocket limit for prescription drugs

II. Specific additional services would be covered for children to age 22 without co-payment or deductible

- A. Newborn and well-baby care, including pediatrician services for high-risk deliveries, subject to modifications by the Secretary, in consultation with the American Academy of Pediatrics
- B. Well-child services, including routine office visits, routine immunizations, routine lab tests, and dental care, subject to modifications by the Secretary, in consultation with the American Academy of Pediatrics

III. Women would be covered for all pregnancy-related services, including

- A. Prenatal care, and all complications of pregnancy
- B. Inpatient labor and delivery services
- C. Postnatal care

- D. Family planning, including voluntary planning services and contraceptive devices

IV. Additional Preventive Benefits

- A. Colorectal screening would be added as a benefit to Medicare
- B. The Office of Technology Assessment would continue to examine the efficacy of preventive services, and the appropriate schedule of preventive services, and make recommendations to the Congress

Specifications for Universal Health Coverage

TITLE III. PUBLIC HEALTH INITIATIVES**I. Health Workforce Priorities**

- I. The Secretary would develop a national healthcare workforce plan.
 - A. The plan would specify the total number of physicians that should be trained, and how this total should be allocated among specialties
 1. The plan would provide that at least 53 percent of all residents beginning training on or after July 1, 1998 would be in primary care specialties, including obsetrics and gynecology
 - B. The Secretary would submit a report to Congress on the plan by December 31, 1995.
 - C. In developing the plan, the Secretary would consult with consumers, experts in health workforce needs, teaching physicians, physicians in private practice, representatives of health insurers, including HMOs and other manaed care plans, and other organizations representating physician
- II. The Secretary would develop a methodology for a national program to accredit or otherwise limit the number of residency positions.in a specialty that would be considered for the purpose of determining adjustments in payments or maximum payment rates under Medicare and private health plans
 - A. The methodology would include specific criteria that would be used to "accredit" such positions
 1. The criteria should include consideration of the geographic distribution of physicians and assure the training of minority physicians

- B. The methodology developed would include a method for limiting, or reducing, the number of residency positions that would be considered for the purpose of payment adjustments, consistent with the national healthcare workforce plan develop above.
- C. The Secretary would submit a report, and detailed legislative proposal regarding the implementation of this methology to the Congress by December 31, 1995.
 - 1. The report would include an analysis of the impact on teaching hospitals and other training programs of limiting support for training, consistent with the national healthcare workforce plan.
- D. In developing the methodology, the Secretary shall consult with experts in graduate training and education, including the Accreditation Council for Graduate Medical Education, and other organizations involve in the accreditation of residency positions

III. The Secretary would implement a program to limit the number of training positions in accordance with the national health care workforce plan

- A. Beginning with residents whose training begins on or after July 1, 1998, Medicare payments and adjustments under the national payment limit system would be based on those approved residency slots designated by the Secretary
- B. Teaching hospitals that lose residency slots would be eligible for transition payments, as provided under H.R. 3600

IV. Primary Care Incentives

- A. Bonuses for providing primary care services in medically underserved areas under Medicare (including Part C) would be increased, consistent with H.R. 3600 (see Medicare outline)
- B. Consistent with H.R. 3600, the authorization of funding for the National Health Service Corp would be increased to \$200 million per year by the year 1997

Specifications for Universal Health Coverage

II. Academic Health Centers

- I. The maximum payment rates to all hospitals would be adjusted for the indirect costs of graduate medical education (IME), based on Medicare's policy as amended by this proposal
 - A. The number of residents that would be used in computing the adjustment for IME would include only those residents in positions approved by the Secretary as consistent with the national health care workforce objectives
- II. Adjustment for direct costs of graduate medical education
 - A. The maximum payment rate per case would be adjusted on a hospital-specific basis for the direct costs of medical education based on the number of FTE residents times the allowable costs per resident determined for Medicare in the base year, updated to the current year
 1. The number of FTE residents would be determined using a weighted count of residents
 2. The payment adjustment per admission for each FTE resident would be based on the rates and adjustments used by Medicare, but paid on a per admission basis
 3. The number of residents that would be used in computing the adjustment for the direct costs of graduate medical education would include only those residents in positions approved by the Secretary as consistent with the national health care workforce objectives