Health Care Reform

Chairman's Mark

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Subcommittee on Health
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GENERAL SUMMARY

Title I. Health Care Security

I. Universal Coverage and Individual Responsibility

A. Universal Coverage

1. Entitlement to Health Benefits

a. Each eligible individual would be entitled to the guaranteed national benefit package

b. Every eligible individual would be entitled to a health security card

B. Protection of Consumer Choice

1. Nothing in this act would be construed as prohibiting an individual from choosing her or her own health care providers

2. Nothing in this act would be construed as prohibiting an individual from purchasing health care services

3. Nothing in this act would be construed as prohibiting an individual from purchasing supplemental insurance to cover services not included in the guaranteed benefit package

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

C. Individual Responsibilities

1. All individuals would be covered under a private health plan meeting the insurance standards or in a Federal plan, which would be called Medicare Part C

a. The individual responsibility requirements would be enforced through the Internal Revenue Code

b. Individuals could elect to enroll in an employer-sponsored plan, if offered by an employer, or another private health insurance plan

(1) If an employer makes private coverage available to employees, the employees of that firm would not be permitted to enroll in Medicare Part C

(a) An exception would apply to low-income workers who would be permitted to enroll in Medicare Part C

(2) Individuals not connected to the work force could enroll in any private insurance plan, or in Medicare Part C

2. Individuals would be responsible for assuring each family member was covered by the guaranteed national benefit package and for the payment of premiums

a. Individuals would be required to contribute 100 percent of the premium for the guaranteed benefit package, minus the amount contributed on their behalf by employers, as described below

(1) Low-income individuals would also be eligible for a subsidy of the net amount owed, after deducting employer contributions, if any

(2) Such subsidies would be on a sliding-scale basis

b. Individual worker contributions for their net share of the premium would be collected by the employer through payroll deductions

3. An eligible individual would be defined to include any individual who is residing in the United States, and who is:

a. a citizen or national of the United States;

b. an alien permanently residing in the United States under color of law; or

c. a long-term nonimmigrant

4. An individual entitled to benefits under the current Medicare program would continue to be covered under Medicare Parts A and B, as expanded and improved under this Act.

II. Employer Responsibilities

A. In general, employers would be required to contribute toward the cost of health insurance coverage for all employees, enforced through the Internal Revenue Code

1. Employer contributions would cover at least eighty percent of the cost of the guaranteed national benefit package for full-time employees

2. Employer contributions for part-time, seasonal and temporary workers would be based on a pro rata share based on the ratio of the number of hours worked per week to forty hours

3. Employers with more than 100 employees would be required to meet this requirement for their workers, beginning January 1, 1995, through:

a. Coverage under a private health plan, including plans offered through a health alliance, or

b. Coverage under a self-insured plan, if the employer has 1,000 or more full-time employees and elects to self-insure, or

c. Coverage under a qualified State health plan

4. Employers with 100 or fewer employees would be permitted to enroll employees in Medicare Part C

B. To the extent an employer elects to offer any employee coverage under a private health plan, the employer must make such coverage available to all employees, including employees working on a part-time basis (more than 17.5 hours per week)

1. Employers would not be required to offer private coverage under an employer plan to seasonal or temporary employees who work for the employer less than three months in a given year

2. Employer contributions for seasonal and temporary workers, under Medicare Part C or a private plan, would be based on the number of hours worked

C. Employers of a worker who is under age 18 or a full-time student under age 24 would not be required to contribute on behalf of the worker, provided the worker was covered under a parent's health plan and was claimed as a dependent by the parent

D. Employers would be required to allow family members of workers to be covered under the employer plan, if a private health plan is offered by the employer

1. Employers that offer and contribute to family coverage would continue to do so, during the 5-year maintenance-of-effort period

a. Following the maintenance-of-effort period, such employers would be required to offer family coverage, but contributions toward family coverage would be optional to the employer

2. Employers that do not currently offer or contribute to family coverage would be required to offer family coverage, but contributions to family coverage would be optional to the employer

a. If a family with two workers elects to be covered under a private plan offered by one employer, the enrolling employer could charge the family for the difference between the individual and family coverage, and the family could receive a credit for amounts contributed by the non-enrolling employer

b. The non-enrolling employer would, in effect, contribute 80 percent of the Medicare one-adult premium on behalf of the employee to the enrolling employer

E. Employers would be required to report coverage of employees and dependents to the Internal Revenue Service (IRS) and to the Secretary's eligibility verification system

F. Employers providing private insurance would be required to offer employees the choice of a managed care plan and a plan that provides an unlimited choice of providers

G. Employers would be permitted to provide health benefits in addition to the guaranteed national benefit package

   1. A 5-year maintenance of effort requirement would be imposed on employers that currently offer more generous health benefits

   2. To the extent such benefits were provided pursuant to a collectively-bargained agreement, employers would continue to offer the additional benefits pursuant to the agreement

H. COBRA would be amended to require employers with twenty or more employees that provide health insurance coverage to any employee, or the dependents of such employee, to provide such employee and dependents the opportunity to continue coverage under the employer plan, at 102 percent of premium costs

   1. As under current law, this requirement would terminate with coverage of an employee or dependent under an employer-sponsored plan

   2. This requirement would terminate with the establishment of the Medicare Part C plan

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

   1. Employers would be required to provide wrap-around benefits, consistent with contractual retiree health obligations, and to maintain the obligated level of benefits

Title II. Benefits

I. Guaranteed National Benefit Package

A. The guaranteed national benefit package would be defined in statute

B. Eligible individuals would be entitled to coverage under a health plan that covers the guaranteed national benefit package

1. Low income individuals would be entitled to premium subsidies and supplemental benefits

2. All individuals would be able to purchase supplemental Medigap-type policies for coverage of additional benefits and cost-sharing

C. The guaranteed national benefit package would include the benefits currently covered under Medicare Parts A and B, with the following improvements:

1. A single deductible of $500/$750 per individual/family, indexed each year by the annual change in the estimate of health spending in the public and private sectors

2. Coverage of outpatient prescription drugs with a separate $500 deductible, 20 percent cost-sharing, and $1,000 out-of-pocket cap

a. The deductible and out-of-pocket cap would be indexed to the annual change in the estimate of health spending in the public and private sectors

D. Additional services would be covered for children to age 18, with no cost-sharing, including newborn, well-baby and well-child services, including immunizations

E. All pregnancy-related services would be covered

F. Family planning services would be covered

G. Additional preventive benefits would be covered, including Medicare-covered preventive benefits

H. Extra-billing limits would be consistent with current Medicare requirements

I. Supplemental benefits would be provided under Medicare Part C to individuals with income up to 100 percent of poverty, and to the following categories of individuals with income between 100 and 200 percent of poverty:

1. Children to age 18 up to 200 percent of poverty

2. Pregnant women with income up to 200 percent of poverty

3. AFDC and SSI cash recipients with income up to 200 percent of poverty

J. Medicare Part C would provide wrap-around coverage for eligible low-income individuals enrolled in a private plan offered by an employer

II. Coverage of Outpatient Prescription Drugs

A. Outpatient prescription drugs, biological products, insulin, and home infusion drugs would be added to services covered under Medicare Part B and C

B. Payment rules and related requirements for covered outpatient drugs

1. Drug Deductible

a. The deductible would be set at $500 in 1996 and would be indexed to the target rate of increase in all health expenditures

2. Out-of-pocket limit

a. The out-of-pocket limit in 1996 would be $1,000 and for succeeding years, the amount would be indexed to the rate of increase in all health expenditures

3. Payment amounts and administrative allowance

a. Payments would be at 80% of the lesser of the actual charge for the drug or the Medicare payment limit

b. There would be mandatory assignment for all covered outpatient drugs

c. The administrative allowance would be $5 per prescription

4. Payment limits

   a. The bill would provide for the establishment of payment limits for prescription drugs. The limits would vary depending upon whether the drug is a single or multiple source drug with restrictive prescription, or a multiple source drug without a restrictive prescription. The limits would be updated subject to the target rate of increase for the prescription drug sector

5. Rebate requirement

   a. In order for payment to be available under Medicare manufacturers would be required to enter into and have in effect a rebate agreement with the Secretary

C. Pharmacists would submit claims to Medicare carriers through a point-of-sale electronic system

   1. The Secretary would provide technical assistance as the Secretary determines may be necessary for the pharmacy to submit claims electronically

D. Prescription Drug Payment Review Commission

   1. An 11 member Prescription Drug Payment Review Commission would be established

   2. The Commission would submit an annual report to Congress regarding the reasonableness of prices of single source drugs, increases in drug prices, use of covered drugs, and administrative costs relating to covered drugs

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

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

F. As part of the rebate agreement a manufacturer 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 that same price for such drugs as is offered to such other purchaser

G. Adjustment in the Part B Premium

1. The Part B premium would be adjusted to finance 25 percent of the cost of the prescription drug benefit provided under Medicare Part B

H. Only qualified home infusion drug therapy providers, who meet requirements established by the Secretary, would qualify to provide covered home infusion drug therapy services

Title III. State Responsibilities

A. States should, through enactment of appropriate legislation, establish their own health reform systems

B. The Secretary's approval would be granted for two types of authority:

1. State control solely over provider reimbursement, either as a whole or sector by sector

2. State control over the provision of benefits and health financing generally

C. States could establish all-payer provider reimbursement programs

1. Programs could cover hospital services, or physician services, or all services

2. Federal Medicare-type payment rates (described in Title VI) would not apply to providers in a State with an approved all-payer program

3. States would be required to meet a target consistent with the national health spending estimates and meet other requirements for approval by the Secretary

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

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

2. Guarantee of coverage could be through a State single payer or public plan, an employer mandate, a combination of public and private coverage, competing health plans, managed competition, or any other system, provided that it covered all residents

3. Regardless of the type of State program enacted, States would be required to meet the health spending estimates for the State as under State all-payer provider reimbursement programs, and meet other requirements for approval by the Secretary

4. After three years of experience with the State plan, State could apply to integrate coverage under Medicare Parts A, B, and C into a State-based system

E. If requirements were not met by a State

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

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

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

Title IV. Health Alliances

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

B. $150 million in grants for the five year period beginning in fiscal year 1995 would be authorized to assist States in the planning, development, and initial operation of alliances

1. An alliance could only be operated by a non-profit organization or a State agency

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

3. Regional health alliances would enter into agreements with any health plan meeting Federal standards that seeks to offer health insurance through the alliance

4. Alliances would assist eligible individuals in enrolling in Medicare Part C

5. Alliances would offer to enter into agreements to provide services to any employer in the alliance area with fewer than 1,000 full-time employees

6. Regional health alliances would make similar services available to individuals and families that are not employees of participating employers but who reside in the alliance area

C. A State could designate the regional health alliance to enforce a State capital allocation plan for the review of health-care related capital expenditures

Title V. Health Plans

A. Health plans sold to individuals or employers and health plans operated by self-insured groups could not deny coverage to any eligible group or individual

   1. Managed care plans could limit enrollment up to the capacity of the plan to absorb new members

B. Health plans would be required to offer the guaranteed national benefits as a separate package

   1. Benefits would be offered using one of three cost sharing schedules

      a. Fee-for-service

      b. Managed care

      c. Point-of-service (combining fee-for-service and managed care)

   2. State laws that require health plans to offer benefits in addition to the guaranteed national benefit package would be pre-empted

      a. In defining supplemental benefit packages, the Secretary would be directed to take into account current State laws

      b. Laws relating to provision of benefits by specific types of providers would also be pre-empted and Medicare's definitions of providers would be used instead

C. Health plans would be required to provide year-round open enrollment to any individual or employer without a waiting period and to guarantee renewal

D. Plans could not exclude or condition coverage or vary premiums based on a pre-existing health condition of an individual or a member of a group

E. Health plans would be required to sell the guaranteed national benefit package at community-rated premiums for all purchasers

1. Plans would be allowed to phase in community-rated premiums over a three-year period

2. Plans sold through a health alliance or approved association or multiple employer arrangement could provide an administrative discount specified in advance

F. Managed care plans, including those offering a point of service option would be required to meet additional requirements

G. Federal standards for marketing of health plans would be established

H. Limits on self-insurance would be established

1. Employers with 1,000 full-time employees or less and Multiple Employer Welfare Arrangements would be prohibited from self-insuring

I. 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

J. Transitional insurance reforms would be established and effective January 1, 1995 until the Federal standards described above take effect in the State

K. Supplemental policies

1. Supplemental policy benefits would be restricted to standardized supplemental benefit packages defined by the Secretary; benefits could not duplicate benefits in the guaranteed national benefit package

2. Supplemental policies would be required to meet Federal standards for open enrollment and community rating

3. Standardized benefits for Medicare supplemental insurance (Medigap) policies would be conformed to changes in the benefits covered under Medicare Parts A and B

4. Open enrollment requirements would apply to Medicare supplemental insurance policies

5. Disease specific and hospital indemnity policies would be required to meet the same loss ratio standards applied to Medicare supplemental insurance

L. Federal standards for health plans would be established in regulation by the Secretary of Health and Human Services (HHS)

1. With respect to health plans sold to individuals and employers, States would enforce the standards, except in the case of a State the Secretary determined was not in compliance, in which case the Secretary would enforce the standards in that State

2. With respect to self-insured employer plans, the Secretary would certify that plans were in compliance with Federal standards

3. A Federal excise tax penalty would be established for non-compliance by health plans or employers (in the case of self-insured employer plans)

4. States would continue to regulate financial solvency of health insurance

M. Managed care would be encouraged

1. $25 million a year in grants would be made available to support the development and initial operation of non-profit, community-based staff and group model HMOs

Title VI. Cost Containment in the Private Sector

A. A private sector cost containment program using maximum payment rates based on Medicare's methodologies would be established

B. Establishment of national health expenditure estimates

1. The Secretary would estimate total national health expenditures under Medicare, and under private plans, and the baseline rates of growth for future years

2. A target rate of growth would be set by statute for spending by private plans in each year, beginning with 1996

    a. The private sector national health expenditure estimates for each year would be based on the health expenditure estimates for the preceding year, increased by the sum of the five-year moving average of the annual rate of growth in the gross domestic product (GDP) plus an adjustment factors

    b. The adjustment factors would be set such that growth in private health spending would be reduced by two percentage points in the first year, and then by one percentage point per year until growth reached the rate of growth in nominal GDP

2. The estimate of health spending in the private sector would be allocated to specified classes of health services based upon the historic share and growth rates attributable to each class

    a. The Secretary would perform the calculations and allocations

    b. The allocation to each sector within each estimate would then become an overall target attributable to each type of health service, such as hospital or physician services

3. Changes in the allocations and the reimbursement methodologies would be set through legislation, based upon recommendations of ProPAC, PhysPRC, and DrugPAC

C. States and health care providers would not be subject to the system of maximum payment rates for the initial two years (1996 and 1997) and for subsequent years if growth remained within the target

    1. If, in any year, beginning with 1996, health care spending in the private sector is greater than the private sector health spending estimate for that year, then the fall-back Federal cost-containment system would become effective for all payers, beginning in 1998 at the earliest

a. States with approved State cost-containment or health care reform systems whose spending is less than their State targets would retain control over their system

2. Under the Federal fall-back cost containment system, private plans would make payments under maximum payment limits based on Medicare methodologies

a. The Secretary would establish maximum payment rates, using Medicare methodologies, that would result in spending consistent with the private sector spending estimate

b. The rates would be set at the level of spending which have been achieved if the payment rates had been in effect since 1996

3. Annual updates in payment rates would be consistent with keeping expenditures within estimate, subject to declining growth rates over time

Title VII. Public Health Initiatives

I. Health Workforce Priorities

A. The Secretary would develop and implement a national health care workforce plan

1. The Secretary would develop a national health care workforce plan regarding both the number and specialty of physicians that are need to meet national needs

2. The Secretary would develop and implement a system that would designate residency positions as approved and consistent with the goals of the national health care workforce plan

3. Residency positions that are not consistent with and approved by the Secretary would not be used in determining adjustments to payments to hospitals relating to either the direct or indirect costs of graduate medical education

B. Primary care incentives

1. Funding for the National Health Service Corp would be increased

2. Bonus payments under Medicare for primary care services would be redirected and increased

II. Academic Health Centers

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

III. Essential Health Facilities

A. Medicare's Essential Access Community Hospital (EACH) program for rural health networks would be expanded from seven States to all States

1. Authorization for facilities would be increased from $15 million to $40 million per year

2. Authorization for grants to States for creation of rural health networks would be increased from $10 million to $50 million per year

B. An Essential Community Provider (ECP) program would be created to facilitate the organization and delivery of, and access to, primary, preventive and acute care services for medically underserved populations in urban areas by fostering networks of essential community providers

1. The Secretary would make grants to States, local governments and eligible health care facilities

2. Grants could be used for the expansion of primary care sites, development of information, billing and reporting systems, recruitment and training of health professionals, or health promotion and outreach to underserved populations

3. Facilities eligible for designation as essential community providers include certain hospitals that would qualify for a Medicare disproportionate share adjustment, Federally Qualified Health Centers, and nonprofit community health networks

C. Funding of $160 million per year for each of the fiscal years 1995 through 1999 would be available for the Essential Community Provider program

1. A grant made to a hospital or facility could not exceed $200,000 and the total amount of a grant paid to a consortia of hospitals and facilities could not exceed $1 million

E. A Capital Financing Trust Fund would be established through which the Secretary of HHS would provide capital financing assistance to eligible facilities in the form of loan guarantees, interest rate subsidies, direct matching loans, and (in cases of urgent life and safety needs) direct grants

1. Eligible facilities include Essential Access Community Hospitals, Rural Primary Care Hospitals, and facilities eligible for assistance as Essential Community Providers described above

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

Title VIII. Medicare and Medicaid

I. Medicare Part C

A. In general, all eligible individuals not otherwise entitled to benefits under the current Medicare program, or covered under a private health plan, would be entitled to health insurance coverage under Medicare Part C, as of January 1, 1997

1. The Social Security Act would be amended to add Title XXII to establish a new health insurance program

B. Employers with 100 or fewer employees would be required to make contributions, on behalf of employees, to Medicare Part C, unless the employer provided health insurance coverage to employees under a private plan that meets defined Federal standards

1. An employer with 100 or fewer employees that did not provide private health insurance would provide for payments of premiums imposed under Medicare Part C, and would be prohibited from collecting more than twenty percent of the Medicare premium from a full-time worker

2. If an employer with 100 or fewer employees elects to offer employees coverage under a private health plan, employees of the employer would enroll in a plan offered by the employer, and would not be permitted to enroll in Medicare Part C

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

C. Eligible low income employees with income up to 200 percent of the poverty level would be permitted to elect coverage under the employer plan, if offered, or Medicare Part C

D. Medicare Part C benefits would be consistent with benefits provided under the guaranteed national benefit package

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

E. The Secretary would compute premiums for Medicare Part C on a State by State basis

1. The premium would be set to cover the full actuarial cost of benefits covered under the guaranteed national benefit package, plus all administrative costs

a. The Secretary would exclude from such calculations the cost of services provided to the SSI disabled population

F. A new Medicare Part C Trust Fund would be established

1. All premiums would be deposited in the Trust Fund

G. Payments for services provided under Medicare Part C would be based upon Medicare-type fees/rates

1. The Secretary would develop new DRGs and codes where necessary

2. Persons covered under Part C could elect to receive their coverage through an HMO that contracts with Medicare, under existing Medicare policies

II. Low-Income Coverage

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

1. State maintenance-of-effort would be required

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

B. Medicaid would continue to provide long-term care services and other institutional services

1. Medicaid could continue to provide optional benefits, subject to the current Federal matching payment rate

C. Premium subsidies would be provided to low income individuals with income up to 200 percent of the poverty level for the guaranteed national benefit package under Medicare Part C

1. The premium for individuals without an obligation to file taxes would be deemed to be zero

2. The premium for AFDC or SSI recipients would be deemed to be zero

3. A sliding-scale premium would be imposed for individuals with income between 100 and 200 percent of poverty

III. Cost Containment in Medicare

A. Establishment of Medicare health expenditure estimates

1. As for the private sector, the Secretary would estimate total national health expenditures under Medicare, and the baseline rate of growth for future years

2. A national health target rate of growth would be set by statute for spending by Medicare in each year, beginning with 1996

3. The public national health expenditure estimates for each year would be based on the health expenditure estimates for the preceding year, increased by the sum of the five-year moving average of the annual rate of growth in the gross domestic product (GDP) plus an adjustment factors

4. The adjustment factors would be set to reduce growth in Medicare by two percentage points in the initial year, and one percentage point per year thereafter until growth reaches the rate of growth in nominal GDP

5. Spending limits within each component would be slowed at the same rate; that is, the baseline rate of growth in each component would be reduced by one percentage point each year

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

   1. The Secretary would perform the calculations and allocations

   2. The allocation to each sector within each estimate would then become an overall target attributable to each type of health service, such as hospital or physician services

C. The payment rates under Medicare would be set each year such that expenditures under these programs would meet the spending targets for Medicare

D. Changes in the allocations and the reimbursement methodologies would be set through legislation, based upon recommendations of ProPAC, PhysPRC, and DrugPAC

IV. Additional Medicare Savings

(to be added)

Title IX. Premium-based Financing

I. Premiums for Medicare part C

A. The Secretary of HHS would determine the premium amounts to cover the guaranteed national benefit package under Medicare Part C

1. Premiums would be set such that Medicare Part C would be fully financed by the premium

B. The Secretary of the Treasury would calculate, and collect, the hourly contributions required to cover the guaranteed benefit package

1. Employers would provide for payment of the employee share of the premium through payroll withholding

2. Employers would pay the premiums to the IRS in the same fashion as payroll taxes are paid

C. Employers providing private coverage would not collect or contribute the Medicare part C premium for workers covered under private coverage

D. Each taxpayer would be charged for the Medicare part C premium as part of their annual payment of personal income taxes

1. The amounts collected from employers and withheld from employees would be deducted from the Medicare part C premium otherwise payable

2. If the individual filed proof of private coverage, the individual would not be required to pay the Medicare part C premium

Title X. Quality and Consumer Protection

I. Quality Management and Improvement

A. The Secretary would establish standards for a National Quality Management Program and develop a set of national quality and performance measures which would apply to health plans, institutions and health care professionals

1. States would enforce the standards, except in the case of a State the Secretary determined was not in compliance, in which case the Secretary would enforce the standards in that State

a. Funding would be available to States to ensure consumer protection and quality

2. Health plans would be required to meet the standards developed by the Secretary

B. Health plans, institutions and providers would be required to submit information, as provided by the Secretary, in order to enable quality review and outcome analysis

1. The Secretary would develop and approve a standard design for consumer surveys

a. Health plans, institutions and providers would be required to conduct periodic surveys and submit summaries of survey results

2. States would be required to make available to consumers, in a standard format, the performance of health plans, institutions and providers

C. The Secretary would establish a procedure by which individuals and entities would be able to submit guidelines to AHCPR for evaluation and certification

1. The Secretary would direct AHCPR to develop practice guidelines

2. AHCPR would disseminate approved guidelines to States

D. Health plans would be required to establish a grievance and appeal process and to meet additional standards developed by the Secretary relating to quality assurance

E. Privacy of information standards would apply to the disclosure of protected health information

1. Standards would apply to any individual or entity who receives, collects, uses or maintains protected health information

2. Information may only be used for the purpose for which the information was collected or was obtained

3. Health information may be disclosed if a patient has signed a patient authorization form

II. Information Systems and Administrative Simplification

A. Electronic processing of all claims and other provisions related to administrative simplification and reporting would apply

B. Administrative simplification provisions would include eligibility and enrollment verification, electronic remittances, uniform billing forms and coding, and uniform provider numbers

C. Administrative simplification provisions would provide reporting and coordination of benefits between all health insurance plans, including supplemental policies and plans in States that opt out

D. Supplemental plans and plans in States that opt out would also be required to conform to administrative simplification and reporting requirements

III. Medical Malpractice and Physician Recertification

A. Tort reforms would include limiting contingency fees to 33 1/3 percent, collateral source offset, allowing awards to be paid in periodic installments, and requiring all lawsuits to include an affidavit certifying the merits of the complaint

B. Grants would be available to States for the development and implementation of alternative dispute resolution systems for medical malpractice liability claims

C. The Secretary would establish a pilot program applying practice guidelines to medical malpractice liability actions

D. Standards for a physician qualification evaluation program would be established by the Secretary

IV. Fraud and Abuse

A. The Secretary of HHS and the Attorney General would establish and coordinate an all-payer national health care fraud control program

B. The provisions under the Medicare and Medicaid programs which provide for civil monetary penalties and criminal penalties for specified fraud and abuse violations would apply to similar violations for all payers in the national health care system

1. New civil monetary penalties would be established for certain activities, including kickback violations

2. Current civil monetary penalties would be increased from $2,000 to $10,000

C. Modifications would be made to the exclusionary provisions in the fraud and abuse program

D. A portion of the civil money penalties, fines, and damages would be deposited in a fraud and abuse account

1. The funds would be used, in addition to such appropriated amounts, to meet the operating costs of the national health care fraud control program

V. Physician Ownership and Referral

A. The physician ownership and referral ban would be extended to all payers

1. The ban on physician self-referral would be extended to cover additional services

2. The exceptions in current law to the general ban on referrals would be continued with certain modifications

Title XI. Long-Term Care

I. Federal Long-Term Care Insurance Standards

A. The Secretary of HHS would promulgate regulations to implement Federal standards for private long-term care insurance policies

1. States would enforce the standards for all long-term care insurance policies sold to individuals or employers

a. States be required to adopt the Federal standards within one year after they were issued by the Secretary

b. The Secretary of HHS would certify State compliance and would assume responsibility for enforcing the standards in a State that did not comply

2. A Federal excise tax would be imposed for non-compliance

B. Standards would be established to facilitate understanding and comparison of benefits under policies

C. Requirements relating to coverage would be established to clarify appropriate terms for coverage of benefits under policies

1. Pre-existing condition exclusions would not be permitted

2. Restrictions on eligibility for benefits would be limited, and clearly defined

D. Requirements for 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

E. Non-forfeiture benefits would be required for all policies, as specified by the Secretary

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

2. The non-forfeiture benefit would increase proportionately to the amount of premiums paid

F. Requirements relating to sales practices would be established

1. False and misleading representation, inaccurate completion of a medical history by an insurer, undue pressure and cold lead advertising would be prohibited

G. 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 premiums

H. Each individual liable for the premium would have the unconditional right to return the policy within 30 days after the date of issuance, and would be able to obtain a full refund of any premium paid

I. 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

Title XII. Revenue Provisions

I. Revenue Provisions

A. Increase in tax on tobacco products

1. The tax on cigarettes would be increased by $0.75 per pack

B. Limitations on exclusion of contributions for health benefits through cafeteria plans

1. Contributions to cafeteria plans for health coverage would no longer be excludable from income

C. A payroll tax of 0.8 percent would be imposed on employers

D. Qualified long-term care services would be treated as medical care and subject to the 7.5 percent cap

E. Accelerated death benefits under life insurance

1. Benefits paid under a life insurance program under a policy of an individual who is terminally ill would be treated as an amount paid by reason of death.

F. Tax credit for disabled

1. Impaired with earned income would be allowed to take a non-refundable tax credit equal to 50 percent of expenses for certain personal assistance services

G. Long-term care insurance

1. Treatment of reserves for long-term care insurance would be made comparable to treatment under life insurance policies

H. Tax credits for health service shortage areas

1. Physicians who work in areas that are designated as being short of health professionals would be eligible for certain tax benefits and for special tax treatment relating to expenses for medical equipment

I. Tax treatment of certain health care organizations

1. The tax treatment of Blue Cross and Blue Shield plans would be modified to equalize the treatment of these plans and other insurers

2. New standards would be established for determining whether certain health care providers would qualify as tax-exempt

II. Health Insurance Deduction for the Self-employed

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

Specifications for Universal Health Insurance Coverage

DETAILED SPECIFICATIONS

TITLE I. HEALTH CARE SECURITY

1. Universal Coverage and Individual Responsibilities

I. Universal Coverage and Entitlement to Health Benefits

A. Eligible individuals would be entitled to the guaranteed national benefit package

B. Eligible individuals would be entitled to a health security card

C. An eligible individual would be defined to include any individual who is residing in the United States, and who is:

a. a citizen or national of the United States;

b. an alien permanently residing in the United States under color of law; or

c. a long-term nonimmigrant

D. An individual entitled to benefits under the current Medicare program would continue to be covered under Medicare Parts A and B

II. Protection of Consumer Choice

A. Nothing in this act would be construed as prohibiting an individual from choosing his or her own health care providers

B. Nothing in this act would be construed as prohibiting an individual from purchasing health care services

C. Nothing in this act would be construed as prohibiting an individual from purchasing supplemental insurance to cover services not included in the guaranteed benefit package

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. The individual responsibility requirement for health insurance premiums would be enforced through the Internal Revenue Code

2. An employee in a firm that offers private health insurance would not be permitted to enroll in Medicare Part C, with two exceptions:

(a) A low income employee could elect coverage under the employer plan, or under Medicare Part C

(b) A part-time, seasonal or temporary worker could elect coverage under Medicare Part C

3. Individuals not connected to the work-force could enroll in a private health insurance plan, or under Medicare Part C

4. Individuals would be responsible for assuring each dependent child was enrolled in a plan that covered the guaranteed benefit package, and for payment of premiums

a. 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 (i.e., the employee would pay no more than 20 percent)

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

2. 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 more than 100 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 more than 1,000 employees, or

3. Participation in an approved State health reform plan (see Title III on State Responsibilities)

D. Employers with 100 or fewer employees would be required to meet the health insurance obligation for their workers, beginning January 1, 1997

1. Medicare Part C would be available to individuals in firms with 100 or fewer employees by January 1, 1997

E. 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. Effective upon implementation of Medicare Part C, 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

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 or self-insured 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 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 five-year maintenance-of-effort requirement would be imposed on employers that currently offer more generous health benefits

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 such additional benefits for all full-time employees

VII. General requirements 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 provided 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 make available to employees the choice of a managed care plan, if available, and a plan that provides unlimited choice of providers

1. The requirement for employers to provide unlimited choice of providers could be met through a point-of-service plan or a fee-for-service plan

2. The 80 percent employer obligation would be based upon the health plan selected by the employee

C. Employers that self-insure would meet additional insurance reform requirements (see Title V)

D. To assure continuous health coverage, employers would be required to notify the IRS and the HHS eligibility verification system of any change in enrollment of employees or dependents

1. 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. 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. Employer Obligations 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 such 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 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

TITLE II. BENEFITS

1. Guaranteed National Benefit Package

I. The guaranteed national benefit package would be defined in statute

   A. In general, the guaranteed national benefit package would conform with the benefits currently provided under Medicare Parts A and B, with modifications specified below

   B. 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

   C. Individuals and employers would be able to purchase supplemental Medigap-type policies for coverage of additional benefits and cost-sharing

      1. Employers that elect to self-insure could cover supplemental benefits, in addition to the required guaranteed national benefit package

II. The guaranteed national benefit package would include the following additional benefits:

   A. A single deductible of $500 per individual and $750 per family, indexed to the annual change in the estimate of health spending in the public and private sectors

   B. Coverage of outpatient prescription drugs with a separate $500 deductible, a 20 percent co-insurance and a separate $1,000 out-of-pocket limit for prescription drugs, indexed to the annual change in the estimate of health spending in the public and private sectors

   C. Inpatient services, without co-insurance, deductibles, or spell-of-illness restrictions

III. Specific additional services would be covered for children to age 18 without cost-sharing

A. Newborn and well-baby care would be consistent with the services and periodicity schedule would be specified 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, would be specified by the Secretary, in consultation with the American Academy of Pediatrics

C. The Secretary would be permitted to modify the frequency criteria for clinical preventive services

IV. All pregnancy-related services would be covered

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 would also cover 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 every three years thereafter

2. High risk women would be covered on an annual basis

B. Colorectal screening would be added as a benefit to Medicare and would be covered under the national guaranteed benefit package, with coverage of fecal occult blood tests (FOBT) and screening sigmoidoscopies for the early detection of colorectal cancer

1. The FOBT would be covered on an annual basis, with payments under the laboratory fee schedule

2. The screening sigmoidoscopies would be covered every five years, reimbursed under the resource-based relative value scale (RB RVS)

C. 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

D. The Secretary would be permitted to modify the frequency criteria for preventive services

VII. An alternative cost-sharing schedule would be defined for managed care plans and point-of-service plans offered by private health plans

A. No deductible and no copayments, other than the copayments specified below

1. A five dollar copayment would be imposed for physician visits, rather than the 20 percent coinsurance required under Medicare

2. A twenty-five dollar copayment would be imposed for emergency room services for non-emergency treatment, rather than the 20 percent coinsurance required under Medicare

3. A ten dollar copayment would be imposed for hospital outpatient services, rather than the 20 percent coinsurance required under Medicare

4. A twenty-five dollar copayment would be imposed for outpatient psychotherapy visits, rather than the 50 percent coinsurance required under Medicare

5. A copayment would be imposed for outpatient prescription drugs, rather than the 20 percent coinsurance that would be required under Medicare

a. A five dollar copayment, or

b. A ten dollar copayment for brand-name drugs where a generic equivalent is available

B. With respect to a point-of-service plan, the alternative cost-sharing schedule specified above would apply on to services provided within the plan's provider network

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

IX. 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 guaranteed national benefit package, if the professional or facility objects to doing so on the basis of a religious belief or moral conviction

2. Coverage of Outpatient Prescription Drugs

I. Outpatient Prescription Drug Benefit

A. Effective January 1, 1997 "covered outpatient drugs" would be added to services covered under Medicare Part B and Part C

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, or

(b) Was commercially available before the Drug Amendments of 1962 (and similar, related drugs), including "DESI" drugs

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 and an infusion device

(b) Is administered in the individual's home, and

(c) Can be administered safely and effectively in a home setting

C. The Secretary may exclude those drugs listed in 1927(d) of the Social Security Act (with the exception of fertility drugs, benzodiazepines and barbiturates)

D. Under the Medicare drug benefit the term "covered outpatient drug" would not include any product which is furnished as part of, or as incident to, any other item or service for which payment may be made under this title

1. These drugs are, generally, covered under other provision of the Medicare program

2. The existing benefit for immunosuppressives, osteoporosis, erythropoietin (EPO) and oral cancer drugs would be covered under the new benefit

E. 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 carrier determines (with guidance from the Secretary) that such use is medically accepted based on supportive clinical evidence in peer reviewed medical literature identified by the Secretary

II. Payment rules and related requirements for covered outpatient drugs

A. Drug Deductible

1. The deductible would be set at $500 in 1996 and for succeeding years would be indexed to the target rate of increase in all health expenditures under both public and private plans

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 in 1996 would be $1,000 and for succeeding years would be indexed to the target rate of increase in all health expenditures under both public and private plans

C. Payment amounts and administrative allowance

1. Payments would be at 80% of the lesser of the actual charge for the drug or the payment limit if the beneficiary has met the deductible and 100% if the beneficiary has met the deductible and the out-of-pocket-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 Consumer Price Index

   (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. Payment limits would be established under Medicare Parts B and C, effective with the implementation of benefits in 1997

2. In the case that the Secretary imposes maximum payment limits on services covered under private health insurance, maximum payment limits would be established for prescription drugs

3. Payment limits for prescription drugs would be established. The limits would vary depending upon whether the drug is a single source drug or a multiple source drug with restrictive prescription (brand name drug), or a multiple source drug without a restrictive prescription (generic drug). The limits would be updated subject to the target rate of increase for the prescription drug sector

(a) The payment limit for a single source drug, and for a multiple source drug with a restrictive prescription 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

(i) For the initial payment limit, estimated acquisition cost would be determined by the Secretary based on 1994 data, updated to 1997 by the consumer price index

(ii) For subsequent payment periods the payment limit would be updated annually by the consumer price index

(b) The payment limit for a multiple source drug without a restrictive prescription would be the sum of the administrative allowance and the unweighted median of the estimated acquisition cost for the drug

(i) For both the initial payment period and for subsequent payment periods the Secretary would determine the estimated acquisition cost based upon the most recent year for which data is available

(c) Estimated acquisition cost could not be greater than 93 percent of the published average wholesale price for the drug during the period

(i) In determining the estimated acquisition cost, the Secretary could conduct surveys of wholesalers and direct sellers or use published average wholesale prices

(ii) If the wholesalers and direct sellers do not respond to survey requests from the Secretary, they would be subject to civil money penalties

E. Rebate requirement for Medicare

1. In order for payment to be available under Medicare for covered outpatient prescription drugs the manufacturer would be required to enter into and have in effect a rebate agreement with the Secretary

2. A base rebate would only apply to single source and innovator multiple source drugs

   (a) Rebates would be paid on a quarterly basis and calculated for each dosage, form and strength of a drug

   (b) The amount of the base rebate would be the greater of--

      (i) 17 percent of the average manufacturer retail price, or

      (ii) The difference between the average manufacturer retail price and the average manufacturer non-retail price

   (c) Secretary would have the authority to verify the average manufacturer retail and non-retail price. If manufacturers refuse to provide this information or provides false information, civil money penalties may be imposed by the Secretary

3. If the Secretary determines that the launch price of a new drug is excessive, the Secretary would have the option of negotiating a rebate with the manufacturer instead of the base rebate amount

   (a) In determining the amount of the rebate for a new drug, the Secretary could 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, (5) cost information supplied by the manufacturer, and (6) the value of any Federal assistance provided through direct grants or tax subsidies

(b) Proprietary 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) The findings of the Secretary regarding the prices of new drugs would be made public and would include the justification for the Secretary's determination

(e) If the Secretary is unable to negotiate an acceptable rebate amount with the manufacturer within six months, the Secretary may exclude the drug from coverage under Medicare

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

(a) The additional rebate would be equal to the excess increase in price above the Consumer Price Index

III. Pharmacies

A. Pharmacies would be required to obtain supplier numbers from the Secretary.

1. Such supplier numbers would only be provided to pharmacists who met requirements specified by the Secretary

2. Requirements would include patient counseling, maintaining patient records, submitting claims on behalf of beneficiaries and other requirements specified by the Secretary

IV. Limitation on length of prescription under Medicare

A. The Secretary could establish minimum and maximum per prescription as well as limit the number of refills

V. Administrative simplification

A. Pharmacists would submit claims to Medicare carriers through a point-of-sale electronic system

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 that payment is required to be made under the payment cycle established by the Secretary, interest would be paid as of the end of such five day period at the rate of interest used for other Medicare claims

B. The Secretary would provide technical assistance as the Secretary determines may be necessary for the pharmacy to submit claims electronically

VI. 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 and out-of-pocket limits

2. Payment under such contracts would not be limited to cost basis

3. Carriers would process the claims of Railroad Retiree system

VII. 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 the reasonableness of prices of single source drugs, increases in drug prices, use of covered drugs, and administrative costs relating to covered drugs

C. The Commission would be responsible for coordinating the development of comparative-effectiveness and cost-effectiveness guidelines, and guidelines to be used to determine the amount of the rebate for new drugs under Medicare

D. 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

VIII. 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 real-time prospective review of prescriptions on a 24 hour basis and for retrospective review of claims

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 or inappropriate use

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 electronically be drug carriers 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 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 and reported electronically

IX. 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

X. 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 prescription drug benefit provided to individuals enrolled in Part B

XI. Coverage of home infusion drug therapy services

A. Only qualified home infusion drug therapy providers, who meet requirements established by the Secretary, would qualify to provide covered home infusion drug therapy services

1. Home infusion drug therapy services would be required to be provided under a plan established and reviewed by a physician

2. State agencies would certify that home infusion drug therapy providers met the standards established by the Secretary

3. Payment for home infusion drug therapy services would be based on the fee schedule amount established by the Secretary

3. Other Changes in Medicare Benefits

I. Specific additional services would be covered for children to age 18 without co-payment or deductible

A. Newborn and well-baby care would be covered, with the services and periodicity schedule specified 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, would be specified by the Secretary, in consultation with the American Academy of Pediatrics

C. The Secretary would be permitted to modify the frequency criteria for clinical preventive services

II. Additional Preventive Benefits

A. Colorectal screening would be added as a benefit to Medicare, with coverage of fecal occult blood tests (FOBT) and screening sigmoidoscopies for the early detection of colorectal cancer

1. The FOBT would be covered on an annual basis, with payments under the laboratory fee schedule

2. The screening sigmoidoscopies would be covered every five years, reimbursed under the resource-based relative value scale (RB RVS)

B. 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 every three years thereafter

1. High risk women would be covered on an annual basis

C. 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

D. The Secretary would be permitted to modify the frequency criteria for preventive services

III. Pregnancy-related services would be covered

IV. Family planning services, including voluntary planning services and contraceptive drugs and devices, would be covered

TITLE III. 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 (detailed in Title VI) 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. 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 employer plans

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

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

3. Participation by an employer in an approved State plan would be required as a condition of meeting the Federal employer obligation to contribute to the health insurance coverage of employees

C. 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 guaranteed national benefit package

C. Programs would have to assure, to the satisfaction of the Secretary, that services needed to deliver the guaranteed national 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 Secretary 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.

TITLE IV. 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, gender, sexual orientation, language, religion, national origin, socio-economic status, or perceived health status.

IV. Additional standards for State grants for regional health alliances

   A. A regional health alliance could be operated 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

V. 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 health plan meeting Federal standards in the alliance area that seeks an agreement to offer health insurance through the regional alliance

1. Health plans offered 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 would be required to be specified by the health plan in advance in accordance with standards established by the Secretary and would have to be applied uniformly across alliances

B. Alliances would offer to enter into agreements to provide services to any employer in the alliance area with fewer than 1,000 full-time employees

1. Within one year after its establishment, a regional health alliance would be required to seek out and inform all eligible 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 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 health plan of their choice

3. Receive and forward premiums from employers and employees to the 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. States could allow regional health alliances to charge a fee to employers of up to 2 percent 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

VI. 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 Responsibilities outline)

VII. States participating in the grant program could designate regional health alliances as agencies to enforce a State capital allocation plan for the review and approval of capital expenditures in a State

A. Any capital expenditures in a State exceeding $1 million would be subject to review

   1. States may set a lower threshold

   2. Capital expenditures for a project which, in the aggregate, exceed $1,000,000 would be subject to review, even if individual component expenditures did not exceed the threshold

B. A State's capital allocation plan would be designed to assure that the needs of the State's residents for health care services are met

   1. Plan would be required to be consistent with criteria developed by the Secretary, including occupancy targets for hospital facilities and utilization targets for inpatient and outpatient health care services and equipment

   2. An opportunity for formal review and comment would be required to be provided before the plan could become final

   3. Plan would provide for regionalization of services where appropriate

   4. Plan would identify which facilities (or parts of facilities) would be closed in order to reach occupancy and utilization targets for health facilities and services

   5. Plan would address the special needs and circumstances of public and other disproportionate share hospitals and the provision of trauma care

C. The plan would provide, in a manner satisfactory to the Secretary, for such controls as are necessary to ensure that the capital expenditures approved under the capital allocation plan would not result in facility and service capacities in excess of the needs of the population to be served

D. A review of capital expenditures would be required to include consideration of a number of factors

   1. The relationship of a proposed activity to the State's capital allocation plan

2. The extent to which quality of care would be impacted at the facility under review and at other existing facilities

3. The availability of alternative, less costly, or more effective means of providing the services

4. The impact of the project on the utilization of the applicant's capital resources

5. The need to eliminate unnecessary duplication of services

6. The impact on the price of health care services to the population to be served

7. The extent to which the proposed facilities and services will be available to all residents of the area

E. Review of capital expenditure applications would be required to be made in public in accordance with procedures and criteria established by the Secretary

1. If a determination is made by the review agency that there is a need for a proposed activity, other health care providers (in addition to the original applicant) would be allowed to file an application to address the identified need, and the review agency would select the applicant that was determined to best meet the needs of the community

2. States would create a regularized schedule for the review of applications. To the extent possible, applications affecting substantially the same service area would be considered at the same time

3. Projects approved and monitored by a State under the plan could be provided a waiver from Federal antitrust enforcement

F. The capital allocation plan would provide for on-going review of approved activities and provide for the ability of the State to rescind the approval of the terms of the agreement if they are not upheld

G. Enforcement through the Medicare program

1. The Secretary would be directed to enter into agreements pursuant to Section 1122 of the Social Security Act with States operating a capital allocation plan, providing for denial of Medicare capital payments for capital expenditures not approved under the State plan

H. A capital allocation plan need not provide for review of health facilities and services provided in rural areas if the State has developed a rural health plan according to criteria established by the Secretary under the EACH program

TITLE V. 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, religion, gender, sexual orientation, 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. A managed care plan could apply to the State to close enrollment if it demonstrates that it has reached its capacity to absorb new members

IV. Health plans would be required to offer the national guaranteed benefit package as a separate package, using one of three cost sharing schedules:

1. Fee-for-service cost sharing schedule

2. Managed care cost sharing schedule (for plans which meeting additional requirements for managed care plans)

3. Point-of-service cost sharing schedule, which provides for the managed care cost sharing schedule for services provided within the plan's provider network and the fee-for-service cost sharing schedule for services provided outside the plan's provider network (for plans meeting the additional requirements for managed care plans)

V. Health plans would be required to sell coverage at community-rated premiums for all purchasers

A. 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 the cost of children averaged into the adult premuims

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

B. Plans would be allowed to phase in community-rated premiums over a three-year period

1. The range of premiums charged for the guaranteed national 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 guaranteed national 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

C. 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

VI. Additional standards would be developed for managed care plans, including managed care plans providing for a point-of-service option

A. Managed care plans must provide physician services primarily (i) directly through physicians who are employees or partners of such organization, or (ii) through contracts with individual physicians or groups of physicians (organized on a group practice or individual practice basis)

B. A managed care plan's provider network must include a sufficient number and distribution of participating providers to ensure that network services are available and accessible to each enrollee with reasonable promptness and in a manner which assures continuity

C. Managed care plans must ensure that covered items and services are accessible 24 hours a day and seven days a week, and must provide for reimbursement of services provided outside the plan's provider network where medically necessary and immediately required because of an unforeseen illness, injury or condition, and it was not reasonable given the circumstances to obtain the services through the network

D. An individual enrolled in a managed care plan, or an employer on behalf of an employee enrolled in a managed care plan, may withhold payment of premiums to the managed care plan until the plan has established an initial medical record on behalf of the individual, in accordance with Federal standards

VII. 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

1. Managed care plans (including those offering a point-of-service option) would be required to provide the following additional information

a) Restrictions on payment for services provided outside the plan's provider network

b) Process by which services may be obtained through the plan's provider network

c) Coverage for out-of-area services

B. Health plans 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

VIII Plans would be required to disclose utilization review standards to consumers and the State

IX. Plans would be required to meet the following additional standards developed by the Secretary (detailed under Quality Improvement and Consumer Protection):

A. Grievance procedures

B. Quality assurance requirements

C. Confidentiality, data management and reporting requirements

X. 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 (detailed under Administrative Simplification)

XI. 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

XII. All requirements described in sections I through X above would take effect as States adopt the requirements pursuant to the effective dates described in item I above

XIII. Transitional insurance reforms would be established and effective beginning January 1, 1995 and until States adopt the requirements of sections I through X

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 six months for newly insured individuals

   1. Pre-existing condition would be defined as a condition which has been diagnosed or treated during the six 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