U.S. DEPARTMENT OF LABOR

Pension and Welfare Benefits Administration
Office of the Assistant Secretary

October 9, 1992

MEMORANDUM TO HANS KUTTNER
GREGORY HUBBARD
STEVE BANDEIAN

FROM: ANN L. COMBS

Attached is summary of Rep. Bill Ford's (D-MI) health care proposal. His staffer has been talking to the Clinton campaign. It may give us a better handle on some of Clinton's rhetoric. I have bill language if you are interested.

Attachment

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992

CONGRESSMAN WILLIAM D. FORD (MICHIGAN)
CHAIRMAN, COMMITTEE ON EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES

Overview/Summary

A single unified system providing universal access to health insurance for all Americans through 3 component parts -- an employer mandate (MediWorkers), coverage for children (MediKids), and an element to cover adults not connected to the workforce (MediWrap).

MediWorkers

An employer mandate covering full-time adult employees (and spouses who do not work full-time). Employees pay no more than 20% of premium.

Basic benefits (including preventive services), with a $250 individual deductible, 20 percent coinsurance, and $2,500 stop-loss, but with first-dollar coverage for pregnancy-related and preventive services.

Process for premium/benefit equalization that assures employer premiums are related to payroll and health plan receipts are related to risk.

Additional insurance reform (including guaranteed availability, acceptance of actuarially based premium rate, no preexisting condition exclusion) to ensure availability to all.

MediKids

Provides health benefits to all children under 22 years of age, regardless of familial, employment, educational, or economic status.

Same benefits as in MediWorker, plus early, periodic, screening, and diagnostic services and increased mental health benefits. No deductible for kids under age 18, $150 annual deductible thereafter. No copayment for kids under 3 or for pregnancy-related or preventive services. Minimal copayment schedule for ages 3-11, 20 percent copayment ages 12-21, and $1,500 stop-loss per child.

MediWrap

Provides health benefits to all individuals 22 years of age or older who are not covered under MediWorker or Medicare. There would be a national-rated premium.

Notwithstanding the national-rated premium, no individual's

liability could exceed the premium percentage established under the MediWorker component of UniMed times the individual's gross income. Part-time and seasonal workers would receive a credit toward this income-related cap for payments credited through employment.

Same benefits as in MediWorker.

Cost Containment

Under MediWorkers, (1) maximum charge limits, (2) encouraged use of managed and coordinated care (through network plans, utilization review, use of practice guidelines and outcomes research), (3) local quality review boards, (4) use of uniform claims forms and electronic billing, uniform health plan cards, etc., (5) limitation on capital expenditures, and (6) initiatives toward medical malpractice reform.

Under MediKids and MediWrap, (1) mandatory assignment and use of specific payment rates, (2) managed and coordinated care initiatives, (3) use of uniform claims forms and electronic billing, etc., and (4) demonstrations on medical malpractice reform.

Low-Income Assistance

Premiums - Employee/employer premiums related to wages (viz., lower for low-income workers). Premiums for non-worker coverage capped at a percentage of gross income.

Deductible and Coinsurance - Reduction/rebate of deductibles and coinsurance for individuals with income below poverty level, with phase-out in assistance through 200 percent of poverty level.

Financing

MediWorker - Financed entirely through payroll-related premiums, with employees paying no more than 20% of the premium.

MediKids - Financed through MediWorker payroll premium, premium on child employees, State medicaid maintenance of effort payment (with additional Federal matching revenues), and other revenue sources.

MediWrap - National-rated premium (subject to income cap), (non-worker self-employment taxes), and Medicaid maintenance of effort payments.

Low Income Assistance - (1) Income tax on gross income (other than wages, self-employment, and other income subject to premium or taxes under the three programs) at flat rate (of 1/5 of premium percentage), and (2) other Federal general revenues.

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992
Short Overview/Summary

Title/Program	Summary of Policy	Notes
Short Title	Universal Medical Care Act of 1992 or "UniMed".	
UniMed Program	Program administered by an independent Health Benefits Administration (HBA), to ensure that basic, affordable medical care is available to all citizens, under a unified, coordinated program. The MediWorker component imposes an employer mandate to provide basic insurance benefits to employees and their spouses. The MediKids component ensures that the same basic benefits (with modifications to take into account the medical needs peculiar to children) are extended to the children of workers and nonworkers. The MediWrap component extends basic benefits to adults who are not in the workforce. Effective: January 1, 1995.	
MediWorker Component	An employer mandate covering full-time adult employees (and spouses who do not work full-time). Basic benefits (including preventive services), with a $250 individual deductible, 20 percent coinsurance, and $2,500 stop-loss, but with first-dollar coverage for pregnancy-related and preventive services. Funded by premiums paid by employers and (through withholding) by employees at a prescribed "MediWorkers national premium percentage" (MNPP) of payroll, except that employees pay no more than 20% of premium. Process for premium/benefit equalization that assures that employer and employee premiums are related to payroll and group health plan receipts are related to actuarial risk.	MediWorker Component of UniMed will be set forth in new title V of ERISA.
MediKids Component	Provides health benefits to all children under 22 years of age, regardless of familial, employment, educational, or economic status.	
MediWrap Component	Provides health benefits to all individuals 22 years of age or older who are not covered under MediWorker component or Medicare.	
Medicare Changes	Reduction in age of initial eligibility from 65 to 60.	

MEDIWORKERS COMPONENT OF UNIMED [TITLE I]

Issue/Topic	Policy	Notes
A. EMPLOYER MANDATE		MediWorker Component of UniMed will be set forth in new title V of ERISA.
Enrollment Requirement	All employers are required to enroll full-time employees (and spouses who are not full-time employees) who are not children under a qualified group health plan. U.S. companies employing U.S. nationals abroad would have to meet this requirement. These plans can be insured or self-insured. Self-employed individuals (with or without employees) would be covered under MediWrap component of UniMed.	
B. GROUP HEALTH PLAN REQUIREMENTS		
Summary of Requirements for All Group Health Plans	To be qualified, a group health plan must meet specified requirements, including— (1) providing required core benefits [see C1. below]; (2) limiting deductibles, coinsurance, and total cost-sharing [see C.2-4. below]; (3) providing consumer protection (including maximum employee premiums, no preexisting condition limits, "portability" of benefits, and solvency protection); and (4) providing for equalization of premiums and capitation rates for core benefits.	
C. REQUIRED "CORE" BENEFITS		
C1. "Core" Services:	Employers can supplement core benefits.	
C1. (a) Inpatient hospital services	Unlimited; except limited to 45 days of inpatient mental health services in any year.	
C1. (b) Physicians' services	Unlimited inpatient and outpatient physicians' services and community health clinic services (except for limit on mental health services, see below).	
C1. (c) Mental health services	Limited to 45 days of inpatient care per year and 20 outpatient visits per year. Would treat as qualified providers (for outpatient services) psychologists and clinical social workers.	

C1. (d) Alcohol and drug abuse treatment services	Limited specified dollar value (viz., $5,000) in any 3-year period.
C1. (e) Pregnancy-Related Services	Coverage of prenatal, labor, delivery, and postnatal services, including services of certified registered nurse midwives.
C1. (f) Preventive Services	Coverage of-- Screening mammography and screening pap smears (at frequency to be specified by HBA), Family planning services, & Adult immunizations. HBA to establish an advisory committee to make recommendations on additional preventive benefits; HBA can add new preventive benefits if appropriate, taking into account cost, but only after providing at least 2 years' notice.
C1. (g) Laboratory and Diagnostic tests	Diagnostic and laboratory tests are covered.
C1. (h) Case management services	To be covered for people diagnosed with certain ailments, specified by HBA.
C2. Deductible	
C2. (a) Amount	Single, per person annual deductible.
C2. (b) Exceptions	$250, indexed by inflation-related increases in SSA wage base (viz., § 230 contribution and benefit base).
	Does not apply to pregnancy-related services or preventive services
C3. Coinsurance/Copayments	
C3. (a) Percentage	20 percent.
C3. (b) Exceptions	Does not apply to pregnancy-related services or preventive services. Can be greater in the case of provision of services by nonparticipating providers under qualified network plans.
C4. Limit on Cost-Sharing	$2,500 per person. Amount indexed by increases in SSA wage base.
D. MAXIMUM CHARGE LIMITS AND MINIMUM PAYMENT RATES	

MEDIWORKERS COMPONENT OF UNIMED [TITLE I]—Continued

Issue/Topic	Policy	Notes
D1. Establishment of Reference Payment Rates	In connection with the periodic establishment of the MediWorkers national premium percentage (MNPP) [see G2 below] and using medicare payment methodology or similar prospectively determined payment methodology, HBA will set reference payment rates. HBA may, upon application by a State, permit substitution of State-based rates, if (1) the rates will apply to all payors (including the MediKids and MediWrap components), (2) the rates will not result in total expenditures greater than those otherwise permitted under all the programs, and (3) will not result in a significant shifting of costs among the different components.	
D2. Maximum Charge Limits	*Institutional services.*—For institutional services (viz., other than professional services), the reference payment rates are the maximum charges that can be imposed by providers for covered services for individuals under qualified group health plans. *Professional services.*—For physician and other professional services, the maximum charges are the same proportion above the reference payment rates as the limiting charge permitted under the medicare RB-RVS payment system. *Enforcement.*—Violation of the charge limits would subject providers to civil money penalties and exclusion under MediKids and MediWrap components of UniMed.	Maximum charge limits consistent with medicare model.
D3. Controls on Capital Expenditures for Hospitals	—Hospitals required to report annually to HBA on expenditures for capital. HBA will require justification for rates of increase in capital costs identified as excessive. The HBA will reduce, prospectively, the maximum charge limits for hospital services to the extent the identified excessive rate of increase in capital expenditures has not been justified.	

E. EMPLOYEE & CONSUMER PROTECTIONS	These would include (1) limiting employee premiums to 20% of MNPP, (2) prohibiting use of preexisting condition restriction on basic benefits, (3) enrollee protection against plan insolvency, (4) standardization of health plans cards and health claims forms, and (5) protections for emergency out-of-plan coverage in the case of network plans (such as HMO's).	
F. ADDITIONAL REQUIREMENTS FOR INSURED PLANS	Also, *insured* plans must also meet requirements relating to (1) guaranteed availability of basic benefit plans for all employers (without regard to size) in a State, (2) guaranteed renewability (except for cause), (3) requiring the offering of basic benefit plans (with preemption of State benefit mandates), & (4) limitation on premium to the MNPP of wages.	
G. PREMIUM EQUALIZATION PROCESS		
G1. Summary/Overview	—(1) Employers effectively pay premiums based on a percent of payroll. [This provides inter-employer equity.] —(2) Group health plans, after "equalization", effectively receive a netted "actuarial" premium based on the demographic characteristics of individuals enrolled. [This provides inter-insurer equity and provides opportunity (and therefore incentive) for health plans to contain costs.] Since health plans are not paid based on actual cost, employees, employers, and plans may "profit" from containing costs (either through managed care or preferred provider arrangements or through employer/employee wellness programs, or other means).	
G2. Specification of Employer Premiums (MediWorkers National Premium Percentage (MNPP))		

MEDIWORKERS COMPONENT OF UNIMED [TITLE I]—Continued

Issue/Topic	Policy	Notes
G2. (a) In general	Employers (other than those that are meeting mandate through self-insurance), pay a premium for basic benefits equal to a percentage (periodically adjusted by HBA) of payroll to the qualified plan. This percentage is referred to as the MediWorkers National Premium Percentage or "MNPP". Plans of self-insured employers are treated the same as insured plans for purposes of "equalization" of payable premiums to benefits to be provided. Payroll subject to MNPP would be capped for each worker at twice the maximum wages subject to the Social Security tax.	
G2. (b) Computation of MediWorkers National Premium Percentage (MNPP)	-*Establishment of initial MNPP.* The MediWorkers National Premium Percentage (MNPP) of payroll for 1st year only (viz., 1995) will be specified in the statute. *Subsequent MNPP.*—HBA will adjust the MNPP each year to reflect changes in health care costs relative to payroll. HBA must set the MNPP high enough to cover all expenses. HBA will take into account efficiencies resulting from medical care innovations as well as new technologies.	

G3. Requirement of Equalization

-*Equalization Premiums Payable to FHBEC.*—Each qualified group health plan (including self-insured employers and Taft-Hartley plans) must pay to the Federal Health Benefits Equalization Corporation (FHBEC, which is within the Health Benefits Administration) an amount equal to the amount by which (A) the employer premiums (viz., computed as an HBA-specified percent of payroll) *exceed* (B) the "capitation amount" [see G4 below] for all individuals covered under the plan.

Equalization Rebates Paid by FHBEC—FHBEC must pay each group health plan (including self-insured employers and Taft-Hartley plans) an amount equal to the amount by which (A) the employer premiums (viz., percent of payroll) [see G3 below] *are less than* (B) the "capitation amount" [see G4 below] for all individuals covered under the plan.

G4. Computation of Capitation Amounts

G4. (a) Summary

The capitation amount, which is used by FHBEC as a reference rate for the amount employer plans should have received for basic benefits, for an individual is equal to the product of a base rate (common to all individuals) and the weighting factors (for the actuarial class to which the individual is assigned). The base rate and weighting factors (as well as actuarial classes) are established by the HBA under the process described below.

G4. (b) Establishment of Actuarial Classes

The HBA shall assign individuals covered under qualified group health plans to "actuarial classes". These classes are established by the HBA, based on a combination of age, sex, disability status, area of residence, and other appropriate factors, and would be actuarially sound. The HBA shall establish the minimum number of actuarial classes and shall not provide for disease-specific or condition-specific classifications.

MEDIWORKERS COMPONENT OF UNIMED [TITLE I]—Continued

Issue/Topic	Policy	Notes
G4. (c) Computation of Relative Weight for Each Actuarial Class	Using sample data supplied by FHBEC in its work, the HBA computes "weighting factors" that reflect the relative costs of each actuarial class compared to the average for all the classes. HBA would obtain information, on covered individuals by social security number only, on plan enrollment, age, sex, and other relevant actuarial characteristics necessary to assign accurate weighting factors for each individual. Privacy Act protections would apply to restrict use and disclosure of the information. There would be a one-time collection of information, with periodic adjustment. The information would only be used for purposes of capitation payment computations.	
G4. (d) Computation of National Average Expenditures (Base Rate)	The FHBEC would compute each year, based on the MediWorkers national payroll percentage (MNPP), a national average per capita amount of expenditures ("base rate") for basic health care services under all qualified group health plans (including self-insured plans). This base rate would be based on formula: (A) total projected payroll for MediWorkers covered individuals subject to MediWorkers premiums, times (B) MNPP, divided by (C) average number of covered individuals under MediWorkers component of UniMed.	
G4. (e) Computation of Capitation Amount	For each individual in an actuarial class, the "capitation amount" would be the product of the national average expenditures and the weighting factor for the class.	
G5. Transitional Premium Subsidy for Small Business	Businesses with 25 or fewer employees would be eligible for a subsidy to reduce the employer share of MediWorker premiums. The subsidy would begin at 50% of the employer share in 1995, and be phased down to be 37.5%, 25%, & 12.5% in 1996, 1997, & 1998.	
H. ENFORCEMENT AND RELATED ADMINISTRATIVE ISSUES		

Enforcement of employee's rights under group health plans through Special Counsel and Group Health Plan Review Board	—After exhausting plan's own claims review procedures, employees may bring complaints to a Special Counsel of HBA, who will attempt to resolve disputes in Early Resolution Program (ERP). —Under the ERP process there will be facilitators to eliminate misunderstandings, clarify issues, and identify settlement options and assist in encouraging settlement of disputes. However, neither party waives the right to further adjudication of issues at conclusion of ERP process. —Special Counsel or employee may bring disputes left unresolved by ERP to administrative review before ALJ of the Group Health Plan Review Board (GHPRB), subject to court review in Federal Circuit Court of Appeals of appropriate Circuit.	
I. MISCELLANEOUS		
I1. Preemption of State provisions		
I1. (a) Preemption of State Benefits Mandates	State law cannot require benefits other than the basic required benefits.	
I1. (b) Preemption of State Restrictions on Managed Care	State cannot impose certain restrictions on bona fide network plans nor on proper utilization review programs.	
I2. Repeal of COBRA continuation requirements	COBRA continuation coverage requirements are superceded by UniMed and are therefore repealed.	
I3. Increase Deduction for expenses for self-employed	Would extend current 25% deduction through 1/1/95; as of that date would increase to 100%, but limit to expenses for required health benefits only.	

MEDIKIDS COMPONENT OF UNIMED [TITLE II]

Issue/Topic	Policy	Notes
A. ELIGIBILITY/ENTITLEMENT	Extension of MediWorkers component, providing coverage to all children residing in the U.S. who are under 22 years of age, regardless of employment or education status. Enrollment at birth or time of immigration; enrollment not prerequisite to receive services or benefits.	
B. REQUIRED BENEFITS	Employer's group health plan can supplement benefits; but benefits under MediKids component are primary.	
B1. Services		
B1. (a) Basic Services	Except as specified, would include the MediWorkers "core" service package, including— —inpatient hospital services (subject to 45 day annual limit for inpatient mental health services), except that preadmission authorization would be required for inpatient mental health services and no admission would be approved if could adequately treat as an outpatient; —physicians services and community health clinic services; —mental health services (but with outpatient limit of 40 visits per year, rather than 20 under MediWorkers component of UniMed); —alcohol and drug abuse treatment services; —pregnancy-related services; —laboratory and diagnostic tests; & —case management services.	

B1. (b) Additional MediKids Services	Would include the following additional services (subject to a periodicity schedule established by HBA in consultation with the American Academy of Pediatrics): —periodic screening services, including comprehensive physical examinations, age appropriate immunizations, laboratory tests, and health education; —vision services, including screening and corrective eyeglasses or lenses; —dental services, including screening and preventive dental and corrective dental services; and —hearing services, including screening and hearing aids. Would also include prescription drugs, including insulin and medically appropriate nutritional supplements. Would also include the following (if part of plan of care prescribed by a physician): —treatment of developmental and learning disabilities (other than the educational component); and —speech, occupational, and physical therapy. HBA would examine (and report to Congress) concerning the appropriateness of providing coverage for long-term care services under the MediKids component of UniMed.
B2. Deductible	Under age 18, none would apply. At age 18, there would be a deductible of $150, indexed to SSA wage base (as with MediWorkers' deductible)
B3. Coinsurance	None for children under 3 or for pregnancy-related services or preventive services. For other services, copayment schedule for children 3-11 (i.e., $5 per outpatient visit) and 20 percent coinsurance for children 12 and older.
B4. Limit on Cost-Sharing	$1,500 per kid, indexed by increases in SSA wage base.
C. PAYMENTS FOR SERVICES	Single payor-model (like medicare).

MEDIKIDS COMPONENT OF UNIMED [TITLE II]—Continued

Issue/Topic	Policy	Notes
C1. Payment Rates	HBA to establish payment rates based on reference payment rates established under MediWorkers component of UniMed, with appropriate modifications to reflect children-only coverage under the MediKids component. For services not covered, will establish appropriate schedule based on concepts used in establishing MediWorkers reference payment rates.	
C2. Payment Method	Assignment is mandatory.	
D. MISCELLANEOUS		
D1. Funding	Financing for MediWorkers children through MediWorkers premiums. (See B1 under Financing [Title VI]) and for MediWrap children through addition to MediWrap premiums (see C1 under Financing [Title VI]).	
D2. Use of Intermediaries	As in medicare, except HBA would do the contracting for fiscal administration. Would permit States to administer.	
D3. Treatment of HMO's and Capitation	HBA would be authorized to contract with HMO's under a capitation contract in manner similar to authority of HHS to contract on a risk basis with HMO's under the medicare program.	
D4. Relation to Medicare & Medicaid Programs	Primary payor to medicare and medicaid programs. States would be required to maintain effort in terms of eligibility and benefits for children (above those provided under MediKids component of UniMed). This would not duplicate low-income assistance.	

MEDIWRAP COMPONENT OF UNIMED [TITLE III]

Issue/Topic	Policy	Notes
A. ELIGIBILITY/ENTITLEMENT	All legal permanent residents aged 22 through 59 who cannot establish coverage under medicare (as disabled) or under a qualified employer health plan (as a full-time employee or spouse).	
B. BENEFITS (including deductibles, coinsurance, etc.)	[Same as basic services under MediWorkers component]	Employers can supplement benefits for part-time and seasonal workers.
C. PAYMENTS FOR SERVICES	Single payor model (like medicare).	
C1. Payment Rates	HBA to establish payment rates based on reference payment rates established under MediWorker component of UniMed, with appropriate modifications to reflect population covered under the MediWrap component.	
C2. Payment Method	Assignment is mandatory.	
D. MISCELLANEOUS		
D1. Premiums	There would be a monthly actuarially determined national community-rated premium subject to an income related cap. Part-time and seasonal employees would receive credit for both the employer and employee amounts of the UniMed part-time/seasonal payroll tax paid, as well as any part of the Health Care equalization self-employment tax paid.	
D2. Use of Intermediaries	As in medicare, except HBA would do the contracting for fiscal administration. Would permit States to administer.	
D3. Treatment of HMO's	HBA would be authorized to contract with HMO's under risk-based contract in manner comparable to authority of HHS to contract with HMO's under medicare program.	
D4. Relation to Medicaid Program	Primary payor to medicaid. Medicaid could supplement these benefits.	

COST CONTAINMENT AND QUALITY CONTROL [TITLE IV]

Issue/Topic	Policy	Notes
A. COST CONTROL MECHANISMS	Costs to employers are controlled through premiums based on the MNPP of UniMed wages and capitation payments to qualified group health plans.	
A1. Prices & Capital Expenditures	Payment levels to providers are restricted through use of maximum charge levels under the MediWorker component and through mandatory assignment under the MediKids and MediWrap components. Control over capital expenditures through reduction in maximum charges to reflect excessive increases in capital expenditures by hospitals.	
A2. Encouraging "Managed" or "Coordinated" Care	Encouraging the use of "managed" or "coordinated" care through MediWorker payments to plans based on capitation, preemption of State anti-manged care laws, payments to network plans under MediKids and MediWrap components, and increasing Federal funding for outcomes research.	
B. QUALITY CONTROL MECHANISMS		
B1. National Standards	To counter-balance the significant incentives that capitation provides for cutting costs, HBA would establish national quality standards, including standards to monitor the use of preauthorization review and other utilization review and network controls, and financial solvency standards.	
B2. Local Quality Review Advisory Bodies	HBA would provide for establishment of local quality review monitoring advisory bodies, with representation of employers, labor organizations, and individuals, to obtain locality-specific, non-individually-specific information on utilization and quality of services under different plans in a community or service area, and to provide feedback to plan sponsors, the HBA, employers, and labor organizations.	
C.IMPROVEMENTS IN ADMINISTRATIVE EFFICIENCY		

C1. Uniform Claims Forms & Electronic Billing	All plans would have to use a uniform claims form and, as may be required by the HBA, uniform electronic billing standards.	
C2. Uniform Health Care Cards	Health care enrollment cards would have to be electronically coded for uniform input, as prescribed by HBA.	
D. MEDICAL MALPRACTICE REFORM		
	HBA would report to Congress on specific steps (such as the use of early resolution process under the MediWorker program as a means of alternative dispute resolution) that could be taken to improve system.	

LOW-INCOME ASSISTANCE [TITLE V]

Issue/Topic	Policy	Notes
DEDUCTIBLES AND COINSURANCE ASSISTANCE	Throughout the UniMed Program (comprising MediWorkers, MediKids, and MediWrap components), assistance for deductibles and coinsurance for required services would be based on adjusted gross income (including joint income for couple). There would be no deductibles and coinsurance for those with income below 100 percent of poverty line; the deductibles and coinsurance would be phased out until there is no low-income assistance for individuals with income above 200 percent of the poverty level.	

FINANCING [TITLE VI]

Issue/Topic	Policy	Notes
A. MEDIWORKERS COMPONENT OF UNIMED: Use of Payroll-Based premium	**Employer pays a total premium to health plan based on the MediWorkers National Premium Percentage (MNPP) of total payroll computed by HBA. However, the wages counted cannot exceed twice the maximum wage level subject to Social Security taxes (approx. $125,000).** **Employer may charge the employee based on a percentage of wages (but percentage may not be greater than ⅛ of the MNPP specified by HBA).**	**The funding of the transitional premium subsidy for small business, would come from other Federal revenues.**
B1. MediKids Element of the MediWorkers National Premium Percentage (MNPP)	**In recognition of coverage to be provided under UniMed to workers' children, the MNPP paid to group health plans under the MediWorkers component would include a portion to be directed to funding the MediKids component.**	
B1. (a) Determination of Aggregate Amount to be Collected Through Premium	**HBA would estimate the total cost for the year under the MediKids component for children of adults covered under MediWorker component.**	
B1. (b) Payment of MediWorkers National Premium Percentage under MediWorkers Component as Element of Funding for MediKids Component	**In setting the appropriate level of the MNPP, the HBA would add a percentage determined to be required to raise the MediWorkers element of funding MediKids computed under B1.(a) above.** **In applying the MNPP so computed under the MediWorkers component, this additional element of funding for the MediKids component would automatically be shared 80/20 between the employer and employees.**	
B2. MediKids Element of MediWrap Premium		**This element would not apply to children whose parents are full-time workers because the parents pay premiums for their children through the MediWorker program.**

FINANCING [TITLE VI]—Continued

Issue/Topic	Policy	Notes
B2. (a) Amount of Flat Monthly Premium Element	As part of the MediWrap premium for individuals who are not covered through the MediWorker component and who have a child covered under MediKids, there would be a MediKids premium element equal to a nationally specified community-rated actuarial premium to be established by HBA for each child under the MediKids component of UniMed. There would be no variation by age, sex, marital status, etc. The premium component would be computed on a monthly basis (as is the case for the MediWrap premium for adults).	
B2. (b) Payment of Premium Element	Parents would be required to pay the premium element each year in conjunction with the payment of the MediWrap premium. As with the MediWrap premium, parents would receive a credit for employer/employee equalization premiums paid and low-income assistance would be available to eliminate or reduce the premium element.	
B3. State Medicaid "Maintenance of Effort" Payment	States are required to pay the MediKids component a "maintenance of effort" amount.	
B4. Treatment of Workers under Age 22	There would be a payroll-based "equalization" tax computed for workers under age 22 equal to the MediWorkers National Premium Percentage (MNPP) of their wages. The tax would have a ceiling of twice the maximum level of wages subject to the Social Security tax.	This would treat wages of child workers the same as the wages of adult workers.
B5. Additional Federal Funds	Additional Federal funds would come from previous general revenues dedicated to medicaid and from other taxes (to be specified).	
C. MEDIWRAP COMPONENT OF UNIMED		
C1. Actuarial Premium Collected Through Income-Tax System		

C1. (a) Amount of Premiums	Nationally specified community-rated monthly actuarial premium to be established for each individual (no family premium). There would be no variation by age, sex, marital status, etc.	In the case of MediWrap beneficiaries with children, the amount of the premium would be increased to include a MediKids element. See B2(a) above.
C1. (b) Limit on Amount of Premium to MNPP of Total, Gross Income	In order to provide protection to low-income individuals, the MediWrap premium (including any MediKids element) could not exceed the MediWorkers National Premium Percentage (MNPP) of total, gross income (including joint income for a married couple and any children's income).	
C1. (c) Crediting MediKids and MediWrap Equalization Employment Taxes and MediWrap Self-Employment Taxes	There would be credited against MediWrap premium amount (including any MediKids element), total MediWrap and MediKids equalization taxes paid (including both employer and employee shares).	
C1. (d) Collection	To be paid with income taxes (including provision in estimated taxes).	
C2. State Medicaid "Maintenance of Effort" Payment	States are required to pay the MediWrap component of UniMed a "maintenance of effort" amount.	
C3. MediWrap Employment Equalization Tax for Part-Time and Seasonal Workers	There would be a payroll-based "equalization" tax computed for part-time and seasonal workers, equal to the MediWorkers National Premium Percentage (MNPP), including the MediKids element, of their wages. The tax would have a ceiling of twice the maximum level of wages subject to the Social Security tax (approx. $125,000).	This would treat wages of part-time and seasonal workers the same as the wages of adult workers. An employer may pay all or a portion of the employee's share of the payroll-based tax, and (as under the MediWorker component) this payment would not be included in income of the employee.
C4. MediWrap Tax on Self-Employment Income	Tax on self-employment income, equal to the MediWorkers National Premium Percentage (MNPP) (up to twice the maximum wages subject to Social Security taxes, viz., approx. $125,000). This is non-refundable.	This assures that self-employment income is not treated more favorably than wage income.
C5. Source of Additional Federal Funds	Remaining Federal funds would come from previous general revenues dedicated to medicaid and from other sources (to be specified).	
D. MEDICARE PROGRAM ELIGIBILITY EXPANSION	Increase cap on HI part of FICA & SECA tax to extent necessary to fund expenses for expanded eligibility.	

FINANCING [TITLE VI]—Continued

Issue/Topic	Policy	Notes
E. LOW-INCOME ASSISTANCE (COVERING LOW-INCOME EMPLOYEES, CHILDREN, AND OTHERS)	Addition to income tax at flat rate of 1/5 of the MediWorkers National Premium Percentage (MNPP). However, wages, self-employment income and other income, to the extent a UniMed premium has been computed based on such income, would not be subject to this additional tax.	

OVERALL ADMINISTRATION [TITLE VII]

Issue/Topic	Policy	Notes
Health Benefits Administration (HBA)	Health Benefits Administration (HBA), headed by 15-member bipartisan board appointed from private sector by President with Senate confirmation, 6-year staggered terms. 3 appointed from each of the following: labor; employers; medical community, insurance community, consumer representatives. The HBA would administer UniMed through a variety of entities: —The Federal Health Benefits Equalization Corporation (FHBEC), a corporate entity established in the HBA and with structure and powers similar to the Pension Benefit Guaranty Corporation (PBGC), would be responsible for assessment, collection, and distribution of premium equalization payments from and to qualified group health plans. An Office of the Special Counsel, appointed by the President subject to Senate confirmation, with responsibility for encouraging early resolution of disputes and enforcement of the Act. An Early Resolution Program (ERP) Office to develop program procedures, conduct case intake, maintain roster of "facilitators", and otherwise carry out the ERP program. A Group Health Plan Review Board (GHPRB), consisting of 9 members appointed by President with Senate confirmation and similar to OSHRC, to appoint ALJ's to hear complaints of participants and beneficiaries not resolved through ERP.	

MEDICARE REVISIONS & MISCELLANEOUS PROVISIONS [TITLES VIII & IX]

Issue/Topic	Policy	Notes
A. REDUCTION IN AGE OF MEDICARE ELIGIBILITY	Reduce, as of January 1, 1995, age of initial eligibility to 60.	
B. MISCELLANEOUS PROVISIONS		
1. Repeal of COBRA Continuation Provisions	Effective January 1, 1995, repeal the COBRA continuation requirements contained in ERISA, the IRC, and the PHSA.	
2. Grant Program for Expansion of Federally Qualified Health Centers	Provide an authorization of appropriations of an additional $400, $800, $1200, $1600, and $1,600 millions in fiscal years 1993 through 1997 for expansion of services to medically underserved individuals by Federally qualified health centers.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992
Overview/Summary

Title/Program	Summary of Policy	Notes
Short Title	Universal Medical Care Act of 1992 or "UniMed".	
UniMed Program	Program administered by an independent Health Benefits Administration (HBA), to ensure that basic, affordable medical care is available to all citizens, under a unified, coordinated program. The MediWorker component imposes an employer mandate to provide basic insurance benefits to employees and their spouses. The MediKids component ensures that the same basic benefits (with modifications to take into account the medical needs peculiar to children) are extended to the children of workers and nonworkers. the MediWrap component extends basic benefits to adults who are not in the workforce.	
Title I. MediWorker Component	An employer mandate covering full-time adult employees (and spouses who do not work full-time). Basic benefits (including preventive services), with a $250 individual deductible, 20 percent coinsurance, and $2,500 stop-loss, but with first-dollar coverage for pregnancy-related and preventive services. Funded by premiums paid by employers and (through withholding) by employees at a prescribed "MediWorkers national premium percentage" (MNPP) of payroll, except that employees pay no more than 20% of premium. Process for premium/benefit equalization that assures that employer and employee premiums are related to payroll and health plan receipts are related to actuarial risk. Additional insurance reform (including guaranteed availability, acceptance of actuarially based premium rate, no preexisting condition exclusion) to promote availability to all employers and employees. Effective: January 1, 1995.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued
Overview/Summary

Title/Program	Summary of Policy	Notes
Title II. MediKids Component	Extension of the MediWorker component, providing health benefits not only to workers' children, but to all children under 22 years of age, regardless of familial, employment, educational, or economic status. Same benefits as under MediWorker component, but adding additional preventive benefits, prescription drugs, and certain therapeutic services, increasing outpatient mental health benefits, and decreasing cost-sharing for the youngest. Funding for MediKids component of UniMed derived substantially through premium payments integrated under MediWorker component, to the extent that HBA determines such integration necessary for maintenance of effort in relation to existing practices in the workplace. Remainder of funding derived from States under maintenance of effort determined in relation to existing medicaid assistance, from payroll taxes on workers under age 22 (and who therefore do not qualify for coverage under MediWorkers component), and from additional general revenues, including Federal funds from previous general revenues dedicated to medicaid. Effective: January 1, 1995.	
Title III. MediWrap Component	Further extension of MediWorkers component, providing health benefits to all individuals 22 years of age or older who are not covered under MediWorker component or Medicare. Same benefits as in MediWorkers component. Funded through a national community-related premium, subject to a low-income assistance cap set at a percent of income. Effective: January 1, 1995.	

Title IV. Cost Containment

Cost containment features integrated throughout UniMed Program, such as (1) encouraging use of "managed" or "coordinated" care (through HMO's, utilization review, use of practice guidelines and outcomes research), (2) use of uniform claims forms and uniform health plan cards, and (3) initiatives toward medical malpractice reform.

Based in the MediWorkers component, UniMed Program will provide for (1) payment of health plans based on actuarial capitation, thus fostering competition, (2) maximum charge limits (based on medicare payment methodology), and (3) locally-based quality monitoring to ensure full availability of services and providers.

Under MediKids and MediWrap components, UniMed Program will also provide for mandatory assignment and use of specific payment rates.

Title V. Low-Income Assistance

Premiums.—MediWorkers component employee premiums related to wages (viz., lower for low-income workers). MediKids component funded in part through MediWorkers premiums. Additional premiums for MediKids component and premiums for MediWrap component capped at the percent of income applied under the MediWorkers component.

Deductible and Coinsurance.—Throughout the UniMed Program, reduction/rebate of cost-sharing for individuals with income below poverty level, with phase-out in low-income assistance until there is no assistance for those with income exceeding 200 percent of poverty level.

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued
Overview/Summary

Title/Program	Summary of Policy	Notes
Title VI. Financing	UniMed Program generally keyed to funding based on the MediWorkers National Premium Percentage, as prescribed by HBA. *MediWorkers Component.*—Financed entirely through payroll-related premiums, with employees paying no more than 20%. No Federal funding component. *MediKids Component.*—Financed for MediWorkers children entirely through MediWorkers premiums. Financed for MediWrap children through an addition to the MediWrap community-based premiums, "equalized" payroll taxes on employees under 22, and State medicaid maintenance of effort payment (with additional Federal revenues). *MediWrap Component.*—Community-rated premium (subject to income cap), UniMed self-employment taxes, "equalized" payroll taxes on part-time and seasonal employees, and Medicaid maintenance-of-effort payments. *Low-Income Assistance.*—(1) Income tax on gross income (other than wages and self-employment income subject to premium or taxes under MediWorkers, MediKids, or MediWrap components of UniMed) at flat rate (of approx. 1.5%), and (2) other revenue sources. *Small employer transitional subsidy.*—Other revenue sources. *Medicare program expansion.*—Increase in cap on HI part of FICA and SECA (adjusted annually) to finance Medicare changes described below (see title VIII).	

Title VII. Overall Administration	Establishment of independent Health Benefits Administration (HBA) headed by a 15-member board. HBA controls a Federal Health Benefits Equalization Corporation (FHBEC), with data collection functions and special function under the MediWorker component relating to "equalizing" premiums paid by employers and "equalizing" premiums received by plans. Additional special provisions with respect to enforcement (including an early resolution program to settle grievances andadministrative review procedures). Several specified advisory committees, to deal with benefits and coverage, rates, etc.	
Title VIII. Medicare Changes	Reduction in age of initial eligibility from 65 to 60, effective January 1, 1995.	
Title XIX. Miscellaneous	Repeal of COBRA Continuation Grants program to expand services of Federally qualified health centers. Conforming Medicaid program to earlier changes.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992
Table of Contents of Provisions

	Subtitle H. Enforcement and Related Administrative Issues	H1. Enforcement of employee's rights under group health plans through Special Counsel an Group Health Plan Review Board H2. Additional enforcement actions H3. Effect of enforcement provision H4. Miscellaneous enforcement and administrative provisions.
	Subtitle I. Miscellaneous	I1. Preemption of State provisions I2. Repeal of COBRA Continuation Requirements I3. Increase Deduction for Expenses for Self-Employed
TITLE II. MEDIKIDS COMPONENT OF UNIMED	Subtitle A. Eligibility/Entitlement Subtitle B. Required Benefits	B1. Services B2. Deductible B3. Coinsurance B4. Limit on Cos-Sharing
	Subtitle C. Payments for Services	C1. Payment Rates C2. Payment Method
	Subtitle D. Miscellaneous	D1. Premiums D2. Use o Intermediaries D3. Treatment of HMO's and Capitation D4. Raation to Medicare and Medicaid Programs D5. Enforcement
TITLE III. MEDIWRAP COMPONENT OF UNIMED	Subtitle A. Eligibility/Entitlement Subtitle B. Benefits Subtitle C. Payments for Services	C1. Payment Rates C2. Payment Method
	Subtitle D. Miscellaneous	D1. Premiums D2. Use of Intermediaries D3. Treatment of HMO's D4. Relation to Medicaid Program D5. Enforcement
TITLE IV—COST CONTAINMENT AND QUALITY CONTROL	Subtitle A. Determination of Premiums Based on Mediworkers National Premium Percentage (MNPP); Use of Capitation Rates Subtitle B. Payment Levels Subtitle C. Controls on Capital Expenditures	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued

Table of Contents of Provisions

	Subtitle C. MediWrap Component of UniMed	C1. Actuarial Premium Collected Through Income-Tax System C2. State Medicaid "Maintenance of Effort" Payment C3. MediWrap Employment Equalization Tax for Part-Time and Seasonal Workers C4. MediWrap Tax on Self-Employment Income C5. Source of Additional Federal Funds
	Subtitle D. Medicare Program Eligibility Expansion Subtitle E. Low-Income Assistance	
TITLE VII—OVERALL ADMINISTRATION		A. Health Benefits Administration (HBA); basic structure B. Federal Health Benefits Equalization Corporation (FHBEC) C. Office of Special Counsel D. Early Resolution Program (ERP) Office E. Group Health Plan Review Board (GHPRB)
TITLE VIII—MEDICARE REVISIONS		A. Reduction in Age of Medicare Eligibility
TITLE IX—MISCELLANEOUS PROVISIONS		A. Repeal of COBRA Continuation Requirements B. Grant Program for Expansion of Federally Qualified Health Centers

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992
MediWorkers Component of UniMed [title I]—Employer Mandate

Issue/Topic	Policy	Notes
A. EMPLOYER MANDATE [subtitle A of title I (new subtitle A of title V of ERISA)]	MediWorkers component of UniMed will be set forth in new title V of ERISA. Title I of ERISA will be amended so as to restrict its applicability with respect to group health plans to the fiduciary provisions of part 4 of subtitle B. Reporting requirements for group health plans will be part of new title V of ERISA. The enforcement and court review provisions of part 5 of subtitle B of title I will continue to relate to group health plans, but only with respect to rules contained in part 4 of subtitle B (fiduciary duties). New enforcement provisions in title V of ERISA will relate to all other aspects of ERISA regulation of group health plans. Necessary amendments will be made to ensure that preemption of State law with regard to matters not covered under title I will be provided in new title V. Preemption will be maintained under title V with respect to group health plans in the same manner and extent as currently provided under title I.	
A1. Enrollment Requirement	-All employers are required to enroll full-time employees (and spouses who are not full-time employees) who are not children under an employee welfare benefit plan (as defined in title I of ERISA) that is a qualified group health plan (as defined below). U.S. companies employing U.S. nationals abroad would have to meet this requirement. These plans can be insured or self-insured. Self-employed individuals (with or without employees) would be covered under MediWrap component of UniMed. Coverage would begin with the month following the month in which became a full-time employee (or spouse). *Effective Date.*—Requirement becomes effective as of January 1, 1995; except not apply to workers (and family) receiving any health care coverage under the terms of a current collective bargaining agreement.	

A2. Certifi of Employer Coverage Under Plan		
A2. (a) Requirement	Each employer must provide to the Health Benefits Administration (HBA) at such times (not less often than annually) as HBA specifies a certification from a qualified group health plan of coverage of full-time employees (and related spouses) of the employer under the plan. The plan could charge the employer premium in advance (but not for more than 3 months in advance) to make the certification. The plan would assume the risk of collection for premiums during the period of certification.	
A2. (b) Enforcement	—IRS shall provide HBA requested information on employer identification numbers issued; these would be matched up against HBA records to find out about employers not reporting. —If employer failed to meet requirement (viz., failed to provide required coverage or certification thereof) after warning from the HBA, the HBA through an order (which is enforceable in court)— (1) would assign full-time employees (and spouses) to a qualified group health plan, (2) would assess the employer the amount of premium otherwise due, plus 50 percent, (but the employer would be prohibited from charging employees any more) during a 3 month period, and (3) would require the employer to provide information on payroll for employees. An employer's failure to pay the premium (and penalty) assessed would create a lien (which would have priority in bankruptcy proceedings).	
A3. Coverage Based on Employment in Previous Month	Group health plan is liable for those employed full-time during the *previous* month for that employer [this would, effectively, require a week's worth of work before you take responsibility]. If an employee left one job and started another job during a month, in the following month the last full-time employer would assume responsibility. The group health plan must continue to provide coverage to individuals until they leave employment or establish evidence of other full-time employment.	This would also be used as model for portability under the UniMed program.

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992

MediWorkers Component of UniMed [title I]—Group Health Plan Requirements

Issue/Topic	Policy	Notes
B. GROUP HEALTH PLAN REQUIREMENTS [subtitle A of title I (new subtitle B of title V of ERISA)]		
Summary of Requirements for All Group Health Plans [Part I of new Subtitle B]	To be qualified, a group health plan must meet specified requirements (detailed below): (1) provide required core benefits [see C1. below]; (2) limits on deductibles, and coinsurance, and a limit on cost-sharing [see C.2-4. below]; (3) consumer protection provisions (including maximum employee premiums, no preexisting condition limits, "portability" of benefits, and solvency protection) [see E. below; provisions may be incorporated by reference from general provisions in title VII]; (4) adequate payment rates [see D3. below]; (5) meets plan requirements of § 402 of ERISA, trust requirements of § 403 of ERISA [no exceptions], and claims procedures of § 503 of ERISA; and (6) provide for equalization of premiums and capitation rates for core benefits, including related information reporting (in accordance with subsequent subtitle) [see F. below].	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992
MediWorkers Component of UniMed [title I]—Required Benefits

Issue/Topic	Policy	Notes
C. REQUIRED "CORE" BENEFITS **[Part II of new Subtitle B]**		
C1. "Core" Services:	**Employers can supplement core benefits.**	**Details on definitions to be filled in by HBA.** **Plans could offer additional benefits (such as hospice care) if desired (particularly if plans found that additional benefits resulted in no increase in total costs).**
C1. (a) Inpatient hospital services	**Unlimited; except limited to 45 days of inpatient mental health services in any year.**	
C1. (b) Physicians' services	**Unlimited inpatient and outpatient physicians' services and community health clinic services (except for limit on mental health services, see below).**	**[See title IX for grant program to expand community health centers.]**
C1. (c) Mental health services	**Limited to 45 days of inpatient care per year and 20 outpatient visits per year. Would treat as qualified providers (for outpatient services) psychologists and clinical social workers.**	**Would be 40 outpatient visits per year under MediKids component**
C1. (d) Alcohol and drug abuse treatment services	**Limited specified dollar value (viz., $5,000) in any 3-year period.** **HBA to review dollar limit and is authorized to update. HBA to specify who are qualified providers.**	
C1. (e) Pregnancy-Related Services	**Coverage of prenatal, labor, delivery, and postnatal services, including services of certified registered nurse midwives.**	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued
MediWorkers Component of UniMed [title I]—Required Benefits

Issue/Topic	Policy	Notes
C1. (f) Preventive Services	Coverage of-- Screening mammography and screening pap smears (at frequency to be specified by HBA), Family planning services, & Adult immunizations. HBA to establish an advisory committee (which would include doctors and repre. of employers, employees, and employer health plans) to make recommendations on additional preventive benefits. HBA can add new preventive benefits (for all or for populations at risk) if appropriate, taking into account cost, but only after providing at least 2 years' notice (so Congress has time to respond and so employers and plans can adjust to the new benefits).	
C1. (g) Laboratory and Diagnostic tests	Diagnostic and laboratory tests are covered.	
C1. (h) Case management services	To be covered for people diagnosed with certain ailments, specified by HBA. HBA to provide minimum standards of qualifications for case managers.	
C1. (i) Determinations of Covered Services	Benefits are required only for medically necessary and reasonable services, or, in the case of preventive services, in accordance with periodicity schedules. HBA would establish an advisory committee for reviewing medical necessity. In particular, the Committee would review determinations with respect to experimental treatments.	
C1. (j). Demonstrations of New Benefits	The HBA may provide for a set aside, through the Federal Health Benefits Equalization Corporation (FHBEC) in an amount not to exceed 1/10th of 1 percent of total MNPP premiums, in order to conduct demonstration projects for new benefits and for central funding of experimental treatments (which individual plans are not required to pay for).	
C2. Deductible	Single, per person annual deductible.	No "family" deductible.

C2. (a) Amount	$250, indexed by inflation-related increases in SSA wage base (viz., § 230 contribution and benefit base).	
C2. (b) Exceptions	Does not apply to pregnancy-related services or preventive services	
C3. Coinsurance/Copayments		—
C3. (a) Percentage	20 percent.	
C3. (b) Exceptions	Does not apply to pregnancy-related services or preventive services. Can be greater in the case of provision of services by nonparticipating providers under qualified network plans.	
C4. Limit on Cost-Sharing	$2,500 per person. Amount indexed by increases in SSA wage base.	Same index as for deductible. "Family" limit is sum of limits for family members.

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992

MediWorkers Component of UniMed [title I]—Payment Rates & Consumer Protection

Issue/Topic	Policy	Notes
D. MAXIMUM CHARGE LIMITS AND MINIMUM PAYMENT RATES [Part III of new Subtitle B]		
D1. Establishment of Reference Payment Rates	In connection with the periodic establishment of the MediWorkers national premium percentage (MNPP) and using medicare payment methodology or similar prospectively determined payment methodology, HBA will set reference payment rates. HBA may, upon application by a State, permit substitution of State-based rates, if (1) the rates will apply to all payors (including the MediKids and MediWrap components), (2) the rates will not result in total expenditures greater than those otherwise permitted under all the programs, and (3) will not result in a significant shifting of costs among the different components.	
D2. Maximum Charge Limits	*Institutional services.*—For institutional services (viz., other than professional services), the reference payment rates are the maximum charges that can be imposed by providers for covered services for individuals under qualified group health plans. *Professional services.*—For physician and other professional services, the maximum charges are the same proportion above the reference payment rates as the limiting charge permitted under the medicare RB-RVS payment system. *Enforcement.*—Violation of the charge limits would subject providers to civil money penalties and exclusion under MediKids and MediWrap components of UniMed.	Maximum charge limits consistent with medicare model.

D3. Minimum Plan Payment Rates	QGHPs must provide payment either of at least 95 percent of the reference payment rates or establish to the satisfaction of HBA that the rates provide for access to all required benefits without beneficiaries incurring additional out-of-pocket expenses. To avoid cost-shifting for direct medical education expenses, HBA may require that payment for hospital services for a teaching hospital include an appropriate additional percentage which reflects, in the aggregate, an appropriate percentage to provide for direct medical education costs. HBA will monitor impact of payment rates on capital expenditures and medical education, particularly for disproportionate share hospitals.
D4. Payment Methodologies	Plans must make payment using medicare payment methodologies (e.g., DRG-based system for inpatient hospital services, RB-RVS for physician services, etc.). Payment for hospital services would include, as under medicare, payment for costs of capital and indirect medical education.

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued
MediWorkers Component of UniMed [title I]—Payment Rates & Consumer Protection

Issue/Topic	Policy	Notes
D5. Controls on Capital Expenditures for Hospitals	—Hospitals required to report annually to HBA on expenditures for capital. —HBA will require justification for rates of increase in capital costs identified as excessive. In identifying rates of increase that are excessive, HBA will take into account— 1. allowable rates of increase in maximum charge limits for hospital services (viz., general rate of increase in payments for hospital services); 2. average rate of increase in capital expenditures for hospital services generally; 3. rate of increases in unit costs of capital (e.g., based on an index of costs of construction); and 4. percentage of the hospital's budget devoted to capital expenditures (in comparison with the average hospital) (viz., so that hospitals with historically low capital expenditures are permitted to rise to the average). —HBA would establish standards (like those used under certificate of need laws) for finding that a higher rate of increase in hospital capital expenditures is justified. In order to provide for predicability, HBA will provide a process under which a hospital could apply, before making capital expenditures that otherwise might result in an excessive rate of increase in capital expenditures, for "pre-approval" of the additional expenditures. —The HBA will reduce, prospectively, the maximum charge limits for hospital services to the extent the identified excessive rate of increase in capital expenditures has not been justified. This is an effective "disallowance" of excessive, unjustified capital expenditures.	
E. EMPLOYEE & CONSUMER PROTECTIONS [Part IV of new Subtitle B]		

E1. Limit on Employee Premiums	Employee premiums cannot exceed 20% of MediWorkers National Premium Percentage (MNPP) established by HBA.	Employer can pay employee's share, and remains tax-free to employee.
E2. Treatment of Pre-Existing Conditions	There may be no preexisting condition restrictions for basic benefits.	
E3. Consumer Protections	—Physician incentive plans (viz., plans that provide direct incentives for physicians to reduce or limit services to individuals) must meet medicare requirements. —Insured plans must have satisfactory protection of enrollees with respect to potential insolvency and self-insured plans must maintain an adequate escrow reserve. —In case of plan insolvency, enrollees will not be liable to providers for more than cost-sharing which would have been required in the absence of insolvency. HBA to establish the solvency standards taking into account those standards required by OPM of plans under the Federal Employees Health Benefits Program (FEHBP).	
E4. Standardization and Benefit Portability	Plans would issue health plan cards in a standard form. Plans would process claims using standard forms and processes established by HBA. In order to assure the continuity and "portability" of benefits and providing additional protection against "job-lock", QGHP's would have to provide notice to the HBA of individuals enrolled and disenrolled under plans and coordinate (in accordance with HBA standards) the accounting, reporting, and crediting of deductibles and cost-sharing previously incurred.	
E5. Additional Requirements for Network Plans [viz., HMOs, PPOs]	Network plans (viz., plans with provider restrictions or additional cost-sharing for nonparticipating providers beyond 20 percent) must meet additional requirements relating to— —full disclosure of conditions, & —providing for out-of-plan coverage in cases of emergencies.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992
MediWorkers Component of UniMed [title I]—Insurance Reform

Issue/Topic	Policy	Notes
F. ADDITIONAL REQUIREMENTS FOR INSURED PLANS [Part V of new Subtitle B]	**Also, *insured* plans must also meet the following requirements:**	These effectively are the elements of 'insurance reform' included in the proposal.
F1. Guaranteed Availability	**Guaranteed availability of basic benefit package for all employers (without regard to size) in any State in which the insurer does business; except that HMO's and similar limited enrollment plans can limit enrollment on a 1st-come-1st served basis and may limit to those employers in their service delivery area (which area must be reasonable, as determined by the HBA).** **The insurer must agree to take employers assigned to the plan by HBA under A2. above. The HBA would establish a method for reassignment and would pay over to plan 100 percent of premium otherwise due.** **If HBA believes that reinsurance was not generally available to help small insurers who might otherwise be at risk (because they can no longer underwrite and must depend upon capitation-related income) and that such reinsurance is necessary to carry out the MediWorkers component of UniMed, the HBA is authorized to establish a reinsurance program (and to charge appropriate premiums for this purpose).**	
F2. Guaranteed Renewability	**Policies must be guaranteed renewable (viz., no cancellation by insurer due to health status), unless terminated for cause or unless terminates all group health plans in a State (and, in such case, makes financial provision for claims previously incurred).**	
F3. Offering of Minimum Benefit Plan	**Must offer qualified group health plans that are only basic plans (viz., no additional benefits beyond the minimum), if offer other plans.**	States cannot require offering of other benefits or other types of plans; see H1. below.

F4. Premiums/Rating	Cannot charge (for basic plans) more than the MediWorkers National Premium Percentage (MNPP) specified by the HBA. Plans may not require employers to pay for more than 3 months of premium in advance.	Risk for insurers will be adjusted through "equalization" process. However, there are no price controls on supplemental plans; for such plans insurers can underwrite groups and charge unequal premiums for additional benefits.
F5. Plan Certification for Employers	Will provide for certification to HBA of employers enrolled under plan.	
F6. Enforcement of Requirements for Insured Plans	Noncomplying insurer subject to administrative enforcement, including administrative order of specific performance plus a penalty of up to $1,000 for each employer for each day of noncompliance or, in egregious cases, loss of status as a qualified health plan.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992
MediWorkers Component of UniMed [title I]—Premium Equalization Process

Issue/Topic	Policy	Notes
G. PREMIUM EQUALIZATION PROCESS [Subtitle A of Title I (new subtitle C of title V of ERISA)]		
G1. Summary/Overview		
G1. (a) Principles of System	—(1) Employers effectively pay premiums based on a percent of payroll. [This provides inter-employer equity.] —(2) Group health plans, after "equalization", effectively receive a netted "actuarial" premium based on the demographic characteristics of individuals enrolled. [This provides inter-insurer equity and provides opportunity (and therefore incentive) for health plans to contain costs.] Since health plans are not paid based on actual cost, employees, employers, and plans may "profit" from holding down utilization (either through managed or coordinated care or preferred provider arrangements or through employer/employee wellness programs, or other means).	
G1. (b) Approach to Enforcement of Principles	The system will guard against 2 financial risks for group health plans: (1) Plans must collect payroll-based premiums (particularly in the case of employers that go bankrupt in a month) in an effective manner. This is to be accomplished through plans being permitted to charge premiums for months in advance. To provide for predictability, the premium for a month is related to the payroll of covered employees for the previous month. (2) Plans must provide for payment for health benefits accrued during periods of coverage. This would be assured through requiring, of all qualified group health plans, adequate protection against insolvency or, in the case of self-insured plans, some type of escrow account or other means found satisfactory by HBA.	
G2. Specification of Employer Premiums (MediWorkers National Premium Percentage (MNPP))		

G2. (a) In genera.	Employers (other than those that ar. .eeting mandate through self-insurance), pay a premium for basic benefits equal to a percentage (periodically adjusted by HBA) of payroll to the qualified plan. This percentage is referred to as the MediWorkers National Premium Percentage or "MNPP". Plans of self-insured employers are treated the same as insured plans for purposes of "equalization" of payable premiums to benefits to be provided. Payroll subject to MNPP would be capped for each worker at twice the maximum wages subject to the Social Security tax.	
G2. (b) Computation of MediWorkers National Premium Percentage (MNPP)		
G2. (b)(1) In general	*-Establishment of initial MNPP.* The MediWorkers National Premium Percentage (MNPP) of payroll for the 1st year only (viz., 1995) will be specified in the statute. *Subsequent MNPP.*—HBA will adjust the MNPP each year to reflect changes in health care costs relative to payroll. HBA must set the MNPP high enough to cover all expenses. HBA can provide for a contingency margin and can set up a reserve (to stabilize rates during recessionary times or for epidemics). The HBA would adjust the MNPP each year based on errors in projections of utilization and total wages in previous years.	The MNPP specified for the first year will be sufficient to fund the entire MediWorkers component (not including any low-income assistance under title V). For timing and process (including use of advisory committees), see below.
G2. (b)(2) Determination of Trend in Health Care Costs (Numerator) for MNPP and In Determining Reference Payment Rates	Health care costs (including administrative costs) to be trended (based on costs in 1991), taking into account the following:	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued

MediWorkers Component of UniMed [title I]—Premium Equalization Process

Issue/Topic	Policy	Notes
(A) Unit health care costs inflation factor (e.g., reflecting update in conversion factor for physician services or change in marketbasket for hospital services)	In determining appropriate unit cost inflation, the HBA would have to consider the 2 different factors which must be reconciled: (1) increases in wages per covered individual [which is the increase in the revenue stream for the MediWorkers component] and (ii) increases in inputs which drive costs of providing services [namely, the types of factors used in medicare "marketbasket"-type increases]. The unit health care inflation factor derived in this process would be used by HBA in determining the reference payment rates for employer plans (and in establishing payment rates under MediKids and MediWrap components of UniMed). The HBA would establish an advisory committee on health care unit costs.	
(B) Changes from Medical Care Improvements	This would include new procedures, as well as devices and new benefits (including preventive benefits). This would take into account efficiencies resulting from medical care innovations. The HBA would use the technology advisory committee (established for purposes of making coverage recommendations on experimental procedures) for purposes of reviewing this component.	

(C) Trends in demographics and utilization	This would take into account changes in number of covered individuals and changes in age composition in covered individuals, as well as any changes in required benefits under the MediWorkers component of UniMed. Also, HBA would evaluate efficiencies which have resulted or could result from applications of practice guidelines and any evidence of inappropriate utilization of services, as well as evidence of lack of access to or use of necessary services. This factor would also take into account the use of health maintenance organization and other incentives towards managed or coordinated care. HBA obtains from FHBEC data on utilization of different services during the past (to detect trends). The HBA would establish a separate advisory committee to review these demographic and utilization changes. In addition, the views of the advisory committee on quality would be taken into account in the review of utilization.	
(D) Changes in Administrative Costs	This reflects administrative costs as a relative percent of other expenditures. This would take into account costs for administration of medicare program and costs for administration of private health plans. This would also take into account any need to implement data collection systems and utilization/peer review systems, and any new administrative mandates established by HBA. It would assume implementation of electronic billing systems (in conjunction with uniform claims).	
(E) Changes in Contingency margin/reserve	This is optional and could serve to buffer percentage fluctuations from year to year in the economy as well as to help buffer cash flow fluctuations.	
(F) Adjustment for previous year over/under estimates.	In outyears, an adjustment factor to compensate for over and under-estimations on utilization and other factors from those assumed.	
(G) Change in Demonstration Allowance	This would reflect any change in the optional demonstration allowance (not to exceed 1/10 of 1 percent).	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued
MediWorkers Component of UniMed [title I]—Premium Equalization Process

Issue/Topic	Policy	Notes
G2. (c) Projection of Wages (Denominator)	(1) HBA would determine projected total wages subject to the MediWorkers premium calculation during the subsequent year. The Federal Health Benefits Equalization Corporation would provide data on structural changes in workforce (e.g., shift from manufacturing to service) and other useful historical data. Like the Social Security Boards of Trustees, the HBA would make 3 projections: optimistic, neutral, and pessimistic. The HBA could provide for a contingency reserve for wage shortfalls to deal with possibility of economic downturn (to prevent the need to cut benefits or to provide for massive changes in the MNPP during recessions); this would be achieved by assuring full funding under the most pessimistic assumptions. The middle would be used to make the computation, but there would have to be a sufficient reserve to assure funding if the most pessimistic assumption were to come true. The HBA would establish a wage advisory committee to review	
G2. (d) Process	The MNPP to be established annually by HBA by regulation. MNPP (and additional information, such as payment rates) for a year to be published in proposed form by August 1 of previous year, with a 60 day comment period; final regulation to be published by November 15 of that previous year. Process will begin in 1994 for 1/1/95 effective date.	

G2. (e). Computation of Employer Premium	Employer premiums for a month would be total payroll (for full-time, as well as part-time and children) employees during the *previous* month. In order to "capture" wages for employers going out of business, in group health plans equalizing premiums with capitation with FHBEC, the group health plan is assumed, with respect to an employer, to have collected the same amount for a month as the amount for the previous month; this would be to take into account employers that go out of business and don't provide information on wages for the month in which they go out of business.	This principle reflects coverage under plan based on employment during previous month. The lag permits the system to use more accurate data and provide for greater predictability and stability.
G2. (f) Collection of Employer Premiums	Generally, the timing of collection of premiums is left up to negotiation between employers and plans. However (in order to deal with problems of small employers)— (1) a qualified plan cannot require payment for more than 3 months of premiums; (2) in estimating amount of premiums, the plan cannot base estimated premiums for future periods on amounts exceeding the MNPP of the most recent actual payroll; and (3) the plan must provide for adjustment, not less often than quarterly, of any estimated premiums based on actual payroll.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued
MediWorkers Component of UniMed [title I]—Premium Equalization Process

Issue/Topic	Policy	Notes
G3. Requirement of Equalization	*-Equalization Premiums Payable to FHBEC.*—Each qualified group health plan (including self-insured employers and Taft-Hartley plans) must pay to the Federal Health Benefits Equalization Corporation (FHBEC, which is within the Health Benefits Administration) an amount equal to the amount by which (A) the employer premiums (viz., computed as an HBA-specified percent of payroll) *exceed* (B) the "capitation amount" [see G4 below] for all individuals covered under the plan. *Equalization Rebates Paid by FHBEC*—FHBEC must pay each group health plan (including self-insured employers and Taft-Hartley plans) an amount equal to the amount by which (A) the employer premiums (viz., percent of payroll) [see G3 below] *are less than* (B) the "capitation amount" [see G4 below] for all individuals covered under the plan. Payments and rebates would be made, not less often than quarterly, accordingly to schedule established by FHBEC.	
G4. Computation of Capitation Amounts		
G4. (a) Summary	The capitation amount, which is used by FHBEC as a reference rate for the amount employer plans should have received for basic benefits, for an individual is equal to the product of a base rate (common to all individuals) and the weighting factors (for the actuarial class to which the individual is assigned). The base rate and weighting factors (as well as actuarial classes) are established by the HBA under the process described below.	

G4. (b) Establishment of Actuarial Classes	The HBA shall assign individuals covered under qualified group health plans to "actuarial classes". These classes are established by the HBA, based on a combination of age, sex, disability status, area of residence, and other appropriate factors, and would be actuarially sound. The HBA shall establish the minimum number of actuarial classes and shall not provide for disease-specific or condition-specific classifications. Within each class, insurers can reasonably anticipate that individuals will use similar amounts of basic health benefits.	
G4. (c) Computation of Relative Weight for Each Actuarial Class	Using sample data supplied by FHBEC in its work, the HBA computes "weighting factors" that reflect the relative costs of each actuarial class compared to the average for all the classes. So a weight of "1.0" represents an average risk or average amount of anticipated health care expenditures. A weight of "2.0" represents a group that is likely to have health care expenses for basic services that are twice the national average. The weights would be subject to annual adjustment. FHBEC would obtain information, on covered individuals by social security number only, on plan enrollment, age, sex, and other relevant actuarial characteristics necessary to assign accurate weighting factors for each individual. Privacy Act protections would apply to restrict use and disclosure of the information. There would be a one-time collection of information; information would be periodically audited (in conjunction, say, with the auditing of how much spent for different classes of individuals) and individuals would have access to verify or change information. The information would only be used for purposes of capitation payment computations. Qualified group health plans would be required to report to FHBEC information on "medical events affecting capitation" [things that would affect, prospectively, payments to be made to plans], by social security number only. In the equalization process, QGHPs would submit the social security number of covered individuals and would receive payment for all individuals on an aggregate (viz., there would be no individual specific payment).	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued
MediWorkers Component of UniMed [title I]—Premium Equalization Process

Issue/Topic	Policy	Notes
G4. (d) Computation of National Average Expenditures (Base Rate)	The FHBEC would compute each year, based on the MediWorkers national payroll percentage (MNPP), a national average per capita amount of expenditures ("base rate") for basic health care services under all qualified group health plans (including self-insured plans). This base rate would be based on formula: (A) total projected payroll for MediWorkers covered individuals subject to MediWorkers premiums, times (B) MNPP, divided by (C) average number of covered individuals under MediWorkers component of UniMed. The base rate would not take into account discounting from the payment rates. The HBA may ask the FHBEC to examine historical information on utilization to recommend appropriate weighting factors to be applied.	
G4. (e) Computation of Capitation Amount	For each individual in an actuarial class, the "capitation amount" would be the product of the national average expenditures and the weighting factor for the class.	
G5. Information Reporting	Qualified group health plan must report quarterly to the FHBEC information on (1) case (viz., demographic/actuarial) characteristics of enrollees, including information on "medical events affecting weighting factors" and (2) payroll for covered enrollees. Qualified group health plans must report to GAO and FHBEC (and HBA) information (not in individually identifiable form) required to audit expenditures for core benefits.	Information to be used (1) to check appropriateness of the MediWorkers National Premium Percentage (MNPP) and the capitation amounts are appropriate and (2) to identify patterns of under-utilization.

G6. Transitional Premium Subsidy for Small Business	**Businesses with 25 or fewer employees would be eligible for a subsidy to reduce the employer share of MediWorker premiums.** **The subsidy would begin at 50% of the employer share in 1995, and be phased down to be 37.5%, 25%, & 12.5% in 1996, 1997, & 1998.** **Employers would apply to the HBA for the subsidy. The subsidy would be available as a direct reduction of the premium required of the employer (and charged by an insurer against the employer).**	Taking into account the subsidy, for small employers, the employer share of the premiums would increase from 40% to 80% of the MNPP.

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992

MediWorkers Component of UniMed [Title I]—Enforcement and Related Administrative Issues

Issue/Topic	Policy	Notes
H. ENFORCEMENT AND RELATED ADMINISTRATIVE ISSUES *[subtitle A of title I (new subtitle D of title V of ERISA)]*		
H1. Enforcement of employee's rights under group health plans through Special Counsel and Group Health Plan Review Board		
H1. (a) In general	—After exhausting plan's own claims review procedures (see H4. (a) below), employees may bring complaints to Special Counsel of HBA, who will attempt to resolve disputes in Early Resolution Program (ERP). —Special Counsel or employee may bring disputes left unresolved by ERP to administrative review before ALJ of the Group Health Plan Review Board (GHPRB), subject to court review in Federal Circuit Court of Appeals of appropriate Circuit.	
H1. (b) Special Counsel process	—Exclusive avenue for actions against group health plans is by means of complaint filed with local office of Special Counsel (SC) —Complaint must be brought within 1 year after notification of plan. —Complainant informs SC of desire to use ERP at time of complaint. —Within 10 days, SC notifies plan of complaint and of election (if any) of complainant for ERP. —If ERP is not elected, SC decides within 75 days after date of complaint whether the SC has reasonable cause to bring the complaint as a charge before an ALJ of the GHPRB. —If ERP is not elected, upon the earlier of 75 days or finding of no reasonable cause, SC must issue right to proceed letter to complainant. Upon receipt of right to proceed letter, complainant may bring charge to an ALJ of the GHPRB independently of the SC.	

H1. (c)(1) Early Resolution Program	—Plan must submit to ERP upon election by complainant. Process runs for 120 days after notification of plan by SC. Otherwise applicable administrative review process is held in abeyance during ERP. —1. A Director of the ERP and staff will develop program procedures, conduct case intake, maintain roster of "facilitators", coordinate facilitator selection process, provide meeting sites, maintain records, and provide facilitators with legal assistance and administrative support staff. —2. HBA Board administers program through the Director of the ERP. In acting as administrator of ERP, Board will include 2 additional experts in mediation and reconciliation of disputes, one representing plan interests and one representing employee interests. —3. Board will establish lawyer referral panels, legal specialty panels, and health benefits consultants panel to serve as resources for assistance to facilitators and the parties involved in ERP.	
H1. (c)(2) Requirements for referral to ERP	—1. Dispute involves participant's assertion of— —(A) claim for health benefits (which may be accompanied by claims such as age discrimination, unjust termination, etc.); —(B) plan's failure or refusal to comply with participant's request for information or documents; or —(C) plan's failure otherwise to comply with requirements of applicable law. —2. Plan has issued final determination under plan's claim procedure under same standards required under § 503 (picked up in title V) and participant elects to participate in process. —3. All parties have opportunity to obtain independent legal advice to determine whether to enter process, obtain legal representation, basic legal and factual issues involved.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued

MediWorkers Component of UniMed [Title I]—Enforcement and Related Administrative Issues

Issue/Topic	Policy	Notes
H1. (c)(3) Certain parties excluded.	—Certain cases excluded— —(A) case in which complainant is unable to have a basic understanding of the ERP process, unless they are represented by a legal guardian or other court-appointed representative; —(B) matters within 90 days of court filing dates under limitation statutes.	
H1. (c)(4) Role of facilitators	—Facilitators in the process will do the following: —1. Facilitate discussions between parties to assist them in: —(a) eliminating simple misunderstandings and disputes arising from ill feelings or lack of communication, —(b) gaining a better understanding of opponent's position, —(c) identifying settlement options and undisputed issues. —2. Clarify legal and factual issues involved. —3. Identify additional key information and documents for assessing parties' positions and predicting outcome of further adjudication. —4. Encourage settlement by suggesting areas of consensus. —5. Assist in drafting of settlement agreements. —6. Present the parties with assessment of respective positions and likely outcome of further adjudication.	

H1. (c)(5) Entry into ERP proceedings	Neither party waives right to further adjudication of issues at conclusion of process. —1. Plan must inform participants of ERP when responding to benefit claims. —2. SC will encourage referrals by organizations and agencies. —3. SC presents participants with written description of program and requests signed contract to participate under rules. Contract forwarded to plan for signature. $100 filing fees filed by both sides (with waiver authority for participants)	
H1. (c)(6) Selection, impartiality, assignment of facilitators	1. Facilitators recruited by Board from among qualified professionals who have demonstrated— —(a) expertise in the law governing employee benefits, —(b) health plan experience —(c) ability to act impartially, —(d) ability to perform quick evaluations and to present them in nontechnical terms, and —(e) ability to foster communication between parties and encourage settlement in an informal setting. —2. To ensure impartiality, the Board shall— —(a) require disclosure upon application for position of facilitator situations where conflicts of interest might be anticipated, —(b) assess impartiality during training by Board, —(c) request facilitator to identify any possible conflict at time of case assignment, —(d) ask evaluation by parties. —3. Facilitators will be assigned on blind, random basis, with opportunity on both sides to strike unacceptable selections.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued

MediWorkers Component of UniMed [Title I]—Enforcement and Related Administrative Issues

Issue/Topic	Policy	Notes
H1. (c)(7) 120-day process—Timetable	—1. Plan notified within 10 days of complainant's election to enter program. —2. Facilitator selected within 30 days after notification of plan —3. Analysis stage lasts 45 days —4. Evaluation stage lasts until end of 120-day period following notification of plan —5. Process may be suspended to permit agency ruling or to permit second conference upon consent of complainant and plan.	

Issue/Topic	Policy	Notes
H1. (c)(8) 120-day process—Analysis Stage	—1. IN GENERAL.—In the commencement of the conference proceedings of the Early Resolution Program with respect to any dispute, the facilitator assigned to the dispute shall— —(A) identify the necessary parties, —(B) confirm that the case is eligible for the Program, —(C) ensure that the requirements of (c)(2) and (c)(3) are met and that each party is informed that, while legal representation is not necessary, there is legal representation available, (D) set a conference date, —(E) at the option of the facilitator, request position papers from the parties of not more than 10 pages in length, if the facilitator determines that such papers are needed to clarify the parties' positions and issues in dispute, —(F) with appropriate legal assistance provided by the SC, analyze the record of the claims procedure conducted pursuant to plan's internal claims review procedure and any position papers submitted by the parties to determine if further case development is needed to clarify the legal and factual issues in dispute, and whether there is any need for additional information and documents.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued

MediWorkers Component of UniMed [Title I]—Enforcement and Related Administrative Issues

Issue/Topic	Policy	Notes
	—2. POSITION PAPER REQUIREMENTS.—Any position paper referred to in paragraph (1)(E) which is submitted by a party shall include a brief, informal statement of the facts, the issues, and the arguments in support of the party's position, together with any additional information or documents which the party would like to have considered. The parties may attach to such papers any relevant documents or other evidence. Copies of each position paper will be sent to the other party. —3. FURTHER CASE DEVELOPMENT.—Further case development pursuant to paragraph (1)(F) shall be accomplished by directing parties to clarify legal issues and to produce additional information and documents, identifying the need for any agency rulings, consulting with experts, and conducting brief legal research as needed. —4. COORDINATION OF COMMUNICATIONS.—Any communications with the parties pursuant to this subsection shall be made through letters addressed to both parties or conference calls. Copies of any correspondence to or from a party will be provided to the other.	

H1. (c)(9) 120-Day Process—Evaluation stage

—EVALUATION STAGE.—Conference proceeds as follows:

—1. The facilitator convenes conference between the parties, designed to last between 2 and 4 hours.

—2. At the outset of the conference, the facilitator reiterates objectives and groundrules.

—3. The facilitator asks each party additional questions as determined necessary by the facilitator. If written position papers were not required by the facilitator, each party shall be given the opportunity to make a statement summarizing the facts, issues, and arguments in support of such party's position, and present, or inform the facilitator of, any additional evidence such party considers to be relevant to the evaluation.

—4. The facilitator maintains neutral stance between the parties.

—5. The facilitator encourages parties to discuss positions openly, with the goal of identifying undisputed issues and exploring settlement.

—6. If settlement is reached, facilitator assists in the preparation of a written settlement agreement (which shall remain confidential at the option of the parties) and shall explain the terms of the settlement to parties.

—7. If no settlement is reached, the facilitator presents evaluation, including an assessment of the parties' positions and the likely outcome of litigation. The evaluation may also include suggestions for narrowing the issues in dispute (through agency rulings, additional discovery, or other means).

—8. The facilitator encourages parties to discuss settlement again, or to enter into partial agreement on as many issues as possible.

—9. A second conference may be scheduled at the suggestion of the facilitator or a party if it is likely to lead to settlement or a substantial narrowing of the issues.

—10. The facilitator not to meet separately with either party. All parties are present at any conferences held during the proceedings.

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued

MediWorkers Component of UniMed [Title I]—Enforcement and Related Administrative Issues

Issue/Topic	Policy	Notes
H1. (c)(10) 120-day proceeding—expert assistance to facilitator	—1. INDEPENDENT PROFESSIONALS.—The facilitator may, with respect to any dispute to which the facilitator is assigned, appoint not more than 2 independent professionals to assist in mediation and conciliation on issues with respect to which such professionals have special expertise. —2. LEGAL AND ADMINISTRATIVE SUPPORT.—Each facilitator may be assisted by one or more Employee Benefit Specialists assigned by the Board, consisting of an attorneys employed in the HBA specializing in benefit issues under this Act.	

H1. (c)(11) ERP—Misc.	—1. Facilitators compensated on hourly basis and receive travel and out-of-pocket reimbursement. Allowed to serve pro bono. —2. Facilitators shielded from liability to parties. —3. Parties may be represented. Board will ensure that parties are referred to experienced lawyers with expertise. —4. Legal Effect.—Facilitator may assist in drawing up binding settlement agreement between parties. Procedings completely non-binding if no settlement is reached. If settlement is reached, non-binding and non-precedential with respect to those not party to the proceedings. Settlement agreements are filed in Federal district court and enforceable by the court upon application of any party. Neither party to waive rights as part of agreement. Parties may withdraw at any time before settlement. —5. Procedural rules.—No formal rules of evidence. All statements and evidence admissible. Oaths not required for submission of evidence. —6. Confidentiality.—Oral and written communications generated within the contest of ERP not subject to discovery in any subsequent legal proceeding, except— —(a) the settlement agreement itself (if any), —(b) facilitator's final case report indicating no settlement reached. Parties may agree in settlement to provide for confidentiality of settlement. No transcripts or recordings made. Facilitator's evaluation is oral. Outside expert's testimony oral.	—Costs.—No additional fees on complainants. Annual user fee on plans at $.05 a head (with special rules for smaller plans). Costs of ERP to be covered by $100 entry
H1. (d) Review by Group Health Plan Review Board (GHPRB)	—SC, or complainant with right to proceed letter from SC, appeals to GHPRB if matter not resolved in ERP.	
H1. (d)(1) Hearings, etc	Every official act of GHPRB entered of record, hearings subject to § 554 of APA, and hearings and records open to public. May make rules for proceedings, but unless other rule adopted, Federal Rules of Civil Procedure apply.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued

MediWorkers Component of UniMed [Title I]—Enforcement and Related Administrative Issues

Issue/Topic	Policy	Notes
H1. (d)(2) Depositions, evidence, fees	GHBRB may order testimony by deposition. Persons may be compelled to appear and depose, produce evidence.	
H1. (d)(3) Investigatory powers	Same powers as NLRB	
H1. (d)(4) ALJ determinations; final order of Board	An ALJ appointed by Board will hear and make determinations upon any proceeding before the Board assigned by the Board to the ALJ. ALJ makes a report of final disposition to the Board. Report of ALJ becomes final order of Board within 30 days unless a party appeals to the Board or a Board member directs that matter come before the Board.	
H1. (e) Circuit Court review	"Any person" aggrieved by final order of GHPRB may obtain review in U.S. court of appeals for the circuit in which "violation occurred or employer resides or transacts business". Action must be filed within 60 days of date of GHPRB's final order (or upon expiration of 30-day review period). Copies of petition filed with court, GHPRB, other parties. GHPRB files hearing record with court. Court has jurisdiction to affirm, modify, or set aside, in whole or in part, order of the Board and power to enforce the order. Order may be modified or set aside only to extent order is determined to be "arbitrary or capricious".	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992

MediWorkers Component of UniMed [Title I]—Enforcement and Related Administrative Issues

Issue/Topic	Policy	Notes
. Additional enforcement actions		
(a) Civil enforcement actions by HBA, FHBEC, etc.	—Brought by HBA to enjoin any act or practice which violates any provision of title V of ERISA or to obtain any other appropriate legal or equitable relief to redress such violations or to enforce any provisions of title V. —HBA may assess civil penalties against plans (including self-insured employers) of up to $1,000 a day from date of plan failure or refusal to meet prescribed reporting requirements (including under A2.(b)). HBA may bring civil action to collect. Amounts collected used exclusively for ERP. —The Federal district courts have *exclusive* jurisdiction of civil actions under title V. Cases may be brought in district where plan is administered, breach took place, or defendant resides or may be found. No amount in controversy requirement. —Reasonable attorney's fees to prevailing party. —Authority to sue to be delegated to FHBEC, SC, etc. with respect to matters within their jurisdiction.	—Note that actions are brought against "insurers" here and not "plans". Also, A2 provides for administrative enforcement of employer mandate itself.
(b) Actions against HBA, etc. by employees, employ-, and plans	Suits by employees and beneficiaries, by employers, and by plans to review final orders of HBA, FHBEC, etc., restrain HBA, FHBEC, etc. from taking any action contrary to title, compel HBA, FHBEC, etc. to take action required under title, brought in the distict court for district where plan has principal office or DC	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued

MediWorkers Component of UniMed [Title I]—Enforcement and Related Administrative Issues

Issue/Topic	Policy	Notes
H2. (c) Actions between employers and insurers	Federal cause of action in Federal district court by insurer against employer and by employer against insurer to enforce contractual terms. Insurer's plan may terminate coverage of employer's employees for cause, such as nonpayment of premiums in accordance with permitted terms of plan. The ERP under the Special Counsel of the HBA is available for settlement out of court. Settlement agreements obtained under ERP enforceable in Federal district court (see H1. (c)(11) —4.). State causes of action are preempted.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992

MediWorkers Component of UniMed [Title I]—Enforcement and Related Administrative Issues

Issue/Topic	Policy	Notes
13. Effect of enforcement provisions.		
13. (a) HBA and Group Health Plans	—Plan (or self-insured employer) must provide HBA a certification of insurance for each contracting employer on timely basis on behalf of employer. —Certification of insurance (1) demonstrates that plan continues to meet qualification requirements during the reporting period, and (2) sets forth identity of employers who either have made payments—or assumed obligations to a plan to make payments—necessary to provide required coverage to employees during reporting period, or have developed reserves to provide for such coverage —HBA must issue to qualified plan a qualification letter upon demonstrating meeting of qualification requirements. —HBA may assess fines for failure to comply with reporting requirements of title. —In the case of an insured plan that failed to meet B2. requirements or to cover an employer that has tendered (or offered to tender) premiums, HBA can seek specific performance and impose a fine (of up to $1,000 per day). —HBA may sue group health plan in Federal district court for appropriate legal or equitable relief to enforce requirements of title. —Plan may sue HBA for qualification letter and for other appropriate legal or equitable relief to enforce requirements of title.	
13. (b). HBA and employers	—Premium surcharge of 50% payable to HBA by employer (or by plan on behalf of employer) for failure to provide timely certification of insurance to HBA —HBA may sue employer in Federal district court for appropriate legal or equitable relief to enforce requirements of title.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued

MediWorkers Component of UniMed [Title I]—Enforcement and Related Administrative Issues

Issue/Topic	Policy	Notes
13. (c) HBA and employees	—Employees have right of action against HBA to carry out responsibilities under title, similar to action allowed under § 502(k) of ERISA.	[Review this provision]
13. (d) FHBEC and group health plans (and employers in the case of self-insured plans)	—Qualified plans must provide FHBEC timely information concerning the payroll of the employer, including information defining the fulltime workforce and other data relevant to determination of applicable capitation rates. Together with such data, the plan must provide data necessary to determine extent to which payments for services under the plan have or have not exceeded capitation rates. —FHBEC may sue plans (including employers providing self-insured plans) in district court for failure to provide relevant data on covered employees (and spouses). Fines may be assessed. —FHBEC may sue plans (including employers providing self-insured plans) in district court for unpaid equalization payments based on capitation rates. Equalization payments treated same as tax liens (in establishing priority in bankruptcy and for purposes of collection). —Plans (including self-insured employers) may sue FHBEC in district court for unpaid equalization rebates.	
13. (e) Plans and employers	—Insured plan must provide the employer at least annually a certification that the plan is qualified. Employers held harmless for reliance on such certification. —Federal cause of action in Federal district court by insurer against employer and by employer against insurer to enforce contractual terms. Insurer's plan may terminate coverage of employer's employees for cause, such as nonpayment of premiums in accordance with permitted terms of plan. Settlement agreements obtained in ERP enforceable in Federal district court. State causes of action are preempted.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992

MediWorkers Component of UniMed [Title I]—Enforcement and Related Administrative Issues

Issue/Topic	Policy	Notes
. Miscellaneous enforcement and administrative ›visions.		
(a) Plan claims procedures	A counterpart to ERISA § 503 will appear in title V, requiring mimimum standards for procedures under the plan for reviewing benefit claims. The provision will be strenghened to allow a maximum of 60 days for initial determinations by the plan, and a maximum of 60 days to respond to appeals of such determinations. Failure to respond within the time limit will be deemed a denial of the claim.	
(b) Investigative authority in HBA	Investigative authority will be granted to HBA, subject to delegation to FHBEC, etc. Authority similar to § 504 of ERISA.	
(c) Regulatory authority	HBA will have broad regulatory authority, similar to § 505 of ERISA, subject to delegation to FHBEC, etc.	
(d) Coordination with other agencies	Provision similar to § 506 of ERISA	
(e) General applicability of APA	Provision similar to § 507(a) of ERISA applicable where appropriate.	
(f) Conflict of interest in Govt. employees prohibited	Provision similar to § 507(b) of ERISA	
(g) Authorization of appropriations	Provision similar to § 508 of ERISA	
(h) Interference with rights protected under title	Provision similar to § 510 of ERISA	
(i) Coercive interference	Provision similar to § 511 of ERISA, including prohibition of discrimination based on health status	
(j) Research, studies, annual report	Provisions similar to § 513 of ERISA	
(k) Lien for liability	Rules governing lien for liability should be patterned after § 4068 of ERISA, while ensuring proper treatment in bankruptcy.	
(l) Limitations on causes of action	Follow rules generally applicable under ERISA (6 year/3 year limitation)	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued

MediWorkers Component of UniMed [Title I]—Enforcement and Related Administrative Issues

Issue/Topic	Policy	Notes
H4. (m) Criminal provisions	Criminal code provisions currently applicable to ERISA violations expanded to include references to new title V provisions.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992
MediWorkers Component of UniMed [title I]—Miscellaneous

Issue/Topic	Policy	Notes
I. MISCELLANEOUS [subtitle B of title I]		
I1. Preemption of State provisions		
1. (a) Preemption of State Benefits Mandates	State law cannot require benefits other than the basic required benefits.	The term "State" includes all States and territories.
1. (b) Preemption of State Restrictions on Managed or Coordinated Care	State cannot impose certain restrictions on bona fide network plans nor on proper utilization review programs.	—
2. Repeal of COBRA continuation requirements		—[Cross-reference only here; repeal of ERISA, IRC, and PHSA provisions would be in title IX]
3. Increase Deduction for expenses for self-employed	[Would extend current 25% deduction through 1/1/95; as of that date would increase to 100%, but limit to expenses for required health benefits only.]	[Cross-reference only here; provision to appear in title VI (Financing).]

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992
MediKids Component of UniMed [title II]

Issue/Topic	Policy	Notes
A. ELIGIBILITY/ENTITLEMENT [Subtitle A]	Extension of MediWorkers component, providing coverage to all children residing in the U.S. who are under 22 years of age, regardless of employment or education status. Enrollment at birth or time of immigration; enrollment not prerequisite to receive services or benefits. In order to provide for initial enrollment, would require schools and Head Start programs and (under medicare) hospitals to enroll individuals beginning September 1, 1994. Births on or after 1/1/95 in medicare hospitals would be automatically recorded. All children immigrating to the U.S. would be enrolled at time of entry or adjustment of status. However, children covered under current collective bargaining agreements would not be covered until agreement expired (not counting any extensions).	Disabled children may also be eligible for benefits under the medicare program, but medicare benefits would be secondary to MediKids benefits.
B. REQUIRED BENEFITS [Subtitle B]		Employer's group health plan can supplement benefits; but benefits under MediKids component are primary.
B1. Services		

1. (a) Basic Services	Except as specified, would include the MediWorkers "core" service package, including— —inpatient hospital services (subject to 45 day annual limit for inpatient mental health services), except that preadmission authorization would be required for inpatient mental health services and no admission would be approved if could adequately treat as an outpatient; —physicians services and community health clinic services; —mental health services (but with outpatient limit of 40 visits per year, rather than 20 under MediWorkers component of UniMed); —alcohol and drug abuse treatment services; —pregnancy-related services; —laboratory and diagnostic tests; & —case management services.	
1. (b) Additional MediKids Services	Would include the following additional services (subject to a periodicity schedule established by HBA in consultation with the American Academy of Pediatrics): —periodic screening services, including comprehensive physical examinations, age appropriate immunizations, laboratory tests, and health education; —vision services, including screening and corrective eyeglasses or lenses; —dental services, including screening and preventive dental and corrective dental services; and —hearing services, including screening and hearing aids. Would also include prescription drugs, including insulin and medically appropriate nutritional supplements. Would also include the following (if part of plan of care prescribed by a physician): —treatment of developmental and learning disabilities (other than the educational component); and —speech, occupational, and physical therapy. HBA would examine (and report to Congress) concerning the appropriateness of providing coverage for long-term care services under the MediKids component of UniMed.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued
MediKids Component of UniMed [title II]

Issue/Topic	Policy	Notes
B2. Deductible	Under age 18, none would apply. At age 18, there would be a deductible of $150, indexed to SSA wage base (as with MediWorkers' deductible)	
B3. Coinsurance	None for children under 3 or for pregnancy-related services or preventive services. For other services, copayment schedule for children 3-11 (like $5 per outpatient visit) and 20 percent coinsurance for children 12 and older.	
B4. Limit on Cost-Sharing	$1,500 per kid, indexed by increases in SSA wage base.	
C. PAYMENTS FOR SERVICES [Subtitle C]	Single payor model (like medicare).	
C1. Payment Rates	HBA to establish payment rates based on reference payment rates established under MediWorkers component of UniMed, with appropriate modifications to reflect children-only coverage under the MediKids component. For services not covered, will establish appropriate schedule based on concepts used in establishing MediWorkers reference payment rates. HBA to establish such additional, special advisory committee or committees as may be appropriate to establish these rates. Payment methodology will be similar to medicare program.	
C2. Payment Method	Assignment is mandatory. Violations subject to exclusion under MediKids and UniMed components of UniMed, as well as civil monetary penalties.	
D. MISCELLANEOUS [Subtitle D]		For Cost-Containment features, see below.
D1. Funding	Financing for MediWorkers children through MediWorkers premiums. (See B1 under Financing [Title VI]) and for MediWrap children through addition to MediWrap premiums (see C1 under Financing [Title VI]).	These financing methods take into account ability to pay.

D2. Use of Intermediaries	As in medicare, except HBA would do the contracting for fiscal administration. Would permit States to administer.	
D3. Treatment of HMO's and Capitation	HBA would be authorized to contract with HMO's under a capitation contract in manner comparable to authority of HHS to contract on a risk basis with HMO's under the medicare program, except that— —payment rate would be 100 percent (rather than 95 percent) of the adjusted average per capita cost (or AAPCC) for children, —plans could be "kids-only" plans (e.g., school-based programs), and —plans have an affirmative obligation to follow up on conditions detected through screening. In addition, HBA would establish an optional primary care capitation payment methodology under pediatric group practice arrangements (and for pediatricians in other cases specified by HBA).	
D4. Relation to Medicare & Medicaid Programs	Primary payor to medicare and medicaid programs. States would be required to maintain effort in terms of eligibility and benefits for children (above those provided under MediKids component of UniMed). This would not duplicate low-income assistance.	[For State financial maintenance of effort requirement, see title VI (Financing).]
D5. Enforcement	Covered individuals have access to Early Resolution Program (ERP) and claims review procedures established as part of MediWorkers component of UniMed.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992
MediWrap Component of UniMed [title III]

Issue/Topic	Policy	Notes
A. ELIGIBILITY/ENTITLEMENT [Subtitle A]	All legal permanent residents aged 22 through 59 who cannot establish coverage under medicare (as disabled) or under a qualified employer health plan (as a full-time employee or spouse). Eligible individuals aged 22 through 59 will be deemed enrolled unless can establish other coverage. Medicare is secondary payor for disabled and ESRD individuals. Effective January 1, 1995, except will not apply to individuals provided health coverage under a current collective bargaining agreement until such agreement expires.	
B. BENEFITS (including deductibles, coinsurance, etc.) Subtitle B]	[Same as basic services under MediWorkers component]	Employers can supplement benefits for part-time and seasonal workers.
C. PAYMENTS FOR SERVICES [Subtitle C]	Single payor model (like medicare).	
C1. Payment Rates	HBA to establish payment rates based on reference payment rates established under MediWorker component of UniMed, with appropriate modifications to reflect population covered under the MediWrap component. HBA to establish such additional, special advisory committee or committees as may be appropriate to establish these rates. Payment methodology will be similar to medicare program.	
C2. Payment Method	Assignment is mandatory. Violations subject to exclusion under MediWrap and MediKids components of UniMed, as well as civil monetary penalties.	
D. MISCELLANEOUS [Subtitle D]		

01. [Premiums]	[There would be a monthly actuarially determined national community-rated premium subject to an income related cap. Part-time and seasonal employees would receive credit for both the employer and employee amounts of the UniMed part-time/seasonal payroll tax paid, as well as any part of the Health Care equalization self-employment tax paid.]	—[For details, see financing title, as the premium would be collected through income tax system.]
02. Use of Intermediaries	As in medicare, except HBA would do the contracting for fiscal administration. Would permit States to administer.	
03. Treatment of HMO's	HBA would be authorized to contract with HMO's under risk-based contract in manner comparable to authority of HHS to contract with HMO's under medicare program, except that— —payment rate would be 100 percent (rather than 90 percent) of AAPCC (adjusted average per capita cost), and —plans could be 100 percent MediWrap.	
04. Relation to Medicaid Program	Primary payor to medicaid. Medicaid could supplement these benefits.	[For State financial maintenance of effort requirement, see title VI (Financing).]
05. Enforcement	Covered individuals have access to Early Resolution Program (ERP) and claims review procedures established as part of MediWorkers component of UniMed.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992

Cost Containment and Quality Control [title IV]—MediWorkers Component of UniMed

Issue/Topic	Policy	Notes
A. DETERMINATION OF PREMIUMS BASED ON MEDIWORKERS NATIONAL PREMIUM PERCENTAGE (MNPP); USE OF CAPITATION RATES		[This is specified in title I and is cross-referenced here for informational purposes.]
B. PAYMENT LEVELS	[HBA establishes maximum charge levels.]	[This is specified in title I and is cross-referenced here for informational purposes.]
C. CONTROLS ON CAPITAL EXPENDITURES	[HBA can reduce maximum charge levels to reflect excessive increases in capital expenditures by hospitals.]	[This is specified in title I and is cross-referenced here for informational purposes.]
D. ENCOURAGING USE OF "MANAGED" OR "COORDINATED" CARE		
D1. Encouraging Use of "Network" Plans	[Payment based on capitation and preemption of State anti-managed care laws.]	[This is specified in title I and cross-referenced here for informational purposes.]
D2. Encouraging Use of Utilization Review.	[Preemption of State anti-managed care laws.]	[This is specified in title I and cross-referenced here for informational purposes.]
D3. Use of practice guidelines & Outcomes research	Current Federal outcomes-related research, through the Agency for Health Care Policy and Research, would be expanded to cover employer health plans. FHBEC would set aside an appropriate percentage of MediWorkers premiums to fund an appropriate share of expenses for outcomes research. Plans could deny benefits for services that are not provided in accordance with practice guidelines which HBA has recognized for application. Any practice guidelines would be adjusted over time, taking into account feedback from local quality monitoring boards (see below).	
D4. Quality Control Mechanisms	*Policy.*—The concept here is to provide for a dynamic process of locally-driven, consumer-oriented information, to serve as a counter-balance to the significant incentives that capitation provides for cutting costs.	

D4. (a) National Quality Advisory Board	HBA would establish a national advisory committee on quality standards, to advise HBA concerning substandard plans and to provide guidance and technical assistance to local advisory boards. HBA would establish national quality standards, including standards to monitor the use of preauthorization review and other utilization review and network controls. HBA could establish additional requirements that network plans and utilization review programs would have to meet in order to be exempt from any State anti-managed care laws.	
D4. (b) Use of Local Quality Review Boards	HBA would provide for establishment of local quality review monitoring advisory bodies, with representation of employers, labor organizations, and individuals. The bodies would be provided locality-specific information (collected by FHBEC) on a non-individually-identifiable basis on utilization and quality of services under different plans in a community or service area. These bodies would— (1) provide feedback to plan sponsors (in order to improve performance), (2) provide feedback to HBA (in order to take appropriate actions in the case of substandard performance), and (3) provide information to employers (and labor organizations) that is useful in improving marketplace decisionmaking by taking into account quality measures in the selection of a qualified group health plan. Local advisory boards would have access to quarterly reports supplied by plans to FHBEC.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued
Cost Containment and Quality Control [title IV]—MediWorkers Component of UniMed

Issue/Topic	Policy	Notes
D4. (c) Financial Monitoring	In order to protect beneficiaries and the FHBEC system, as a condition of qualification plans would be required to have adequate reserves or otherwise meet financial solvency standards specified by HBA. There would be quarterly financial reports by each plan (in order to catch plans before they become insolvent). Beneficiaries are held harmless for bad debts resulting from failure of plans to make payment for services; providers must look to plan for most payment. Once a plan is declared insolvent, HBA would establish procedure for temporary assignment of individuals to another plan [which could be MediWrap] pending employer selection of a new plan.	
E.IMPROVEMENTS IN ADMINISTRATIVE EFFICIENCY		['These would also apply under the MediKids and UniMed components of UniMed.]
E1. Uniform Claims Forms & Electronic Billing	All plans would have to use a uniform claims form and, as may be required by the HBA, uniform electronic billing standards.	
E2. Uniform Health Care Cards	Health care enrollment cards would have to be electronically coded for uniform input, as prescribed by HBA.	
F. MEDICAL MALPRACTICE REFORM	HBA would report to Congress on specific steps that could be taken to improve system. More specifically, under the MediWorkers component of UniMed HBA would examine the feasibility of using the ERP (early resolution process) as a means of alternative dispute resolution.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992
Cost Containment [title IV]—MediKids and MediWrap Components of UniMed

Issue/Topic	Policy	Notes
G1. Payment Rates	[Under MediKids and MediWrap components of UniMed, mandatory rates are established using medicare payment methodology.]	[Provisions to be in titles II and III and cross-referenced here for informational purposes.]
G2. Encouraging Use of "Managed" or "Coordinated" Care		
G2. (a) Encouraging Use of "Network" Plans	[Permit enrollment in HMO's and similar prepayment plans (under capitation-like conditions, such as under medicare).] [In addition, under the MediKids component of UniMed, there would be demonstrations of use of school-based networks as well as primary care capitation demonstration projects.]	[Provisions to be in titles II and III and cross-referenced here for informational purposes.]
G2. (b) Encouraging Use of Utilization Review.	Under MediKids and UniMed components of UniMed, HBA would be authorized to contract with PRO's in manner similar to how medicare operates if it determines it to be cost-effective.	
G2. (c) Use of Practice Guidelines & Outcomes Research	Expand current Federal outcomes research, through the Agency for Health Care Policy and Research, to cover MediKids and MediWrap components of UniMed. MediKid and MediWrap trust funds would pay their fair share (based on the proportion of national health care expenditures made under the programs). HBA is authorized to deny benefits for services that are not provided in accordance with practice guidelines which HBA has recognized may be applied.	
G3. Improvements in Administrative Efficiency		[These are the same as under MediWorkers component.]
G3. (a) Uniform Claims Forms & Electronic Billing	MediKids and MediWrap components of UniMed would have to use a uniform claims form and any uniform electronic billing standards that are used under employer plans.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued
Cost Containment [title IV]—MediKids and MediWrap Components of UniMed

Issue/Topic	Policy	Notes
G3. (b) Uniform Health Care Cards	MediKids and MediWrap components would have health care enrollment cards which meet MediWorkers component standards.	
G4. Medical Malpractice Reform	In addition to study provided under MediWorkers component of UniMed [namely study of alternatives and improvements], HBA would establish the use of ERP (early resolution process) as a means of alternative dispute resultion under the MediKids and MediWrap components.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992
Low-Income Assistance [title V]

Issue/Topic	Policy	Notes
. PREMIUM ASSISTANCE		
1. MediWorkers Component of UniMed	No Federal subsidy.	[Program is progressively financed, with at least 80 percent of premium paid by employer; no additional subsidy required.]
2. MediKids Component of UniMed	[See Financing: certain premiums limited to percent of income.] $100 fee for entering the Early Resolution Program is waived.	There are no direct premiums (so no explicit low-income assistance needed)
3. MediWrap Component of UniMed	[See Financing: premium is limited to a percent of income.] $100 fee for entering the Early Resolution Program is waived.	
. DEDUCTIBLES AND COINSURANCE ASSISTNCE	Throughout the UniMed Program (comprising MediWorkers, MediKids, and MediWrap components), assistance for deductibles and coinsurance for required services would be based on adjusted gross income (including joint income for couple). There would be no deductibles and coinsurance for those with income below 100 percent of poverty line; the deductibles and coinsurance would be phased out until there is no low-income assistance for individuals with income above 200 percent of the poverty level.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued

Low-Income Assistance [title V]

Issue/Topic	Policy	Notes
APPLICATION PROCESS	Upon application, an individual may obtain a reduction of deductibles and coinsurance during a year. The individual could submit a 1040-like estimated income statement. Based on the statement, assistance to reduce the deductibles and coinsurance could be provided. Falsification of the statement would be subject to penalty. Anyone provided assistance based on an estimate would be required to file an income tax return (or 1040-like information return) for the year in which assistance provided. The amount of assistance would be adjusted based on the final income for the year with the individual making restitution (or being provided additional assistance) based on the return. Instead of receiving a direct reduction of deductibles and coinsurance, an individual may apply at the end of the year, through the filing of a 1040 tax return (or 1040-like information return) for a rebate of excess deductibles and coinsurance based on income during the year.	[This process would be similar to low-income assistance process provided under S. 1177.] [The program of financial assistance to qualified medicare beneficiaries would continue under the medicaid program.]

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992
Financing [title VI]—MediWorkers Component of UniMed

Issue/Topic	Policy	Notes
MEDIWORKERS COMPONENT OF UNIMED	Use of Payroll-Based premium	[These provisions will be in ERISA provisions and would merely be referenced here]
A1. Employer/ee share	Employer pays a total premium to health plan based on the MediWorkers National Premium Percentage (MNPP) of total payroll computed by HBA. However, the wages counted cannot exceed twice the maximum wage level subject to Social Security taxes (approx. $125,000). Employer may charge the employee based on a percentage of wages (but percentage may not be greater than ⅓ of the MNPP specified by HBA). [If employer pays share, would be treated the same as payment for health insurance benefits now. Probably no specific provision needed, if this is clearly a premium.]	
A2. Treatment of Self-Employed	[See MediWrap component, C3 below.]	
A3. Treatment of Children and Part-Time and Seasonal Workers	For treatment of children, see MediKids component at B4 below. For treatment of part-time and seasonal workers, see MediWrap component at C4 below.	
A4. Effective Date and Maintenance of Employer Effort	MediWorkers premium would be paid in each month (beginning with January 1995) based on remuneration paid during previous month (viz., beginning with December 1994). MAINTENANCE OF EFFORT.—The premiums would not be required for remuneration of individuals provided health care coverage under a collective bargaining agreement entered into before date of enactment.	Note that employees will receive benefits in January 1995 based on employment status in December 1994.
B. Funding Early Resolution Program and Administrative Review Process	Annual user fee charged to insurers (including self-insurers) at $0.05 per insured person, to be used exclusively for funding ERP and administrative review process. There is also $100 fee per party under the ERP.	
C. Funding Transitional Premium Subsidy for Small Business	Other Federal revenues.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992
Financing [title VI]—MediKids Component of UniMed

Issue/Topic	Policy	Notes
B1. MediKids Element of the MediWorkers National Premium Percentage (MNPP)	In recognition of coverage to be provided under UniMed to workers' children, the MNPP paid to group health plans under the MediWorkers component would include a portion to be directed to funding the MediKids component. This would be provided in the terms of group health plans as a requirement for a qualified group health plan (QGHP).	In essence, a QGHP provides benefits for the children of covered workers through payment of a MediKids employment-based premium to FHBEC. A QGHP cannot elect to cover children directly under the plan, rather than paying the MediKids premium. A QGHP could supplement benefits available to children of workers, just as it can supplement basic benefits for workers.
B1. (a) Determination of Aggregate Amount to be Collected Through Premium	HBA would estimate the total cost for the year under the MediKids component for children of adults covered under MediWorker component. This would be done by multiplying (1) the average number of children under the MediKids component in the year who are the children of workers (or spouses) covered under the MediWorker component, by (2) the estimated average per capita cost under MediKids.	
B1. (b) Payment of MediWorkers National Premium Percentage under MediWorkers Component as Element of Funding for MediKids Component	In setting the appropriate level of the MNPP, the HBA would add a percentage determined to be required to raise the MediWorkers element of funding MediKids computed under B1.(a) above. In applying the MNPP so computed under the MediWorkers component, this additional element of funding for the MediKids component would automatically be shared 80/20 between the employer and employees. As under MediWorkers, an employer's payment of the employee share of the MediKids component would not be considered taxable income to the employee.	This augmented MNPP would also be applied in computing the additional taxes to finance low-income assistance under title VI.E.
B1. (c) Collection by Group Health Plans and Allocation to MediKids through Equalization Process	By incorporation as part of the MNPP, this element of funding for the MediKids component is collected in due course through payment to qualified health benefit plans and then forwarding to FHBEC (through the equalization process). FHBEC would then forward the portion of the MNPP attributable to the MediKids element to the MediKids trust fund.	

B2. MediKids Element of MediWrap Premium		This element would not apply to children whose parents are full-time workers because the parents pay premiums for their children through the MediWorker program.
B2. (a) Amount of Flat Monthly Premium Element	As part of the MediWrap premium for individuals who are not covered through the MediWorker component and who have a child covered under MediKids, there would be a MediKids premium element equal to a nationally specified community-rated actuarial premium to be established by HBA for each child under the MediKids component of UniMed. There would be no variation by age, sex, marital status, etc. The premium component would be computed on a monthly basis (as is the case for the MediWrap premium for adults).	The monthly premium element is basically the average monthly per child cost of MediKids for the year.
B2. (b) Payment of Premium Element	Parents would be required to pay the premium element each year in conjunction with the payment of the MediWrap premium. Insofar as it is included as part of a MediWrap premium— (1) in the case of children of part-time and seasonal workers, parents would receive a credit against the premium in the amount of the employer/employee equalization tax paid (but there would be no refund for excess employer/employee taxes paid), and (2) in order to provide protection to low-income individuals, a family's premium (including MediWrap and MediKids elements) could not exceed the MNPP of total, gross income (including joint income of married couple) for members of the family.	Low-income assistance would be available to eliminate or reduce the premium element, in the same manner as for the MediWrap premium for the parent.
B2. (c) Collection of Premiums	Premiums would be collected in the same manner as premiums under the MediWrap component.	
B3. State Medicaid "Maintenance of Effort" Payment	States are required to pay the MediKids component a "maintenance of effort" amount.	Effective for calendar quarters beginning on or after January 1, 1995.

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued

Financing [title VI]—MediKids Component of UniMed

Issue/Topic	Policy	Notes
B3. (a) Computation	(1) *Medicaid Eligibles.*—HBA would determine, based on the law as of January 1, 1992 (including changes in eligibility scheduled to occur after that date) and for each calendar quarter beginning on or after January 1, 1995, the average number of individuals in the State who are entitled to MediKids and who would have been entitled to medicaid assistance in the quarter. (2) *Per capita MediKids payments.*—For each quarter, the Secretary would estimate the average per child expenditures to be made in the quarter in the State under the MediKids component. (3) *Maintenance of Effort Amount.*—The maintenance of effort amount is the product of (1) and (2) multiplied by 1 minus the Federal Medical Assistance Percentage (FMAP) under the medicaid program.	
B3. (b) How Paid	States required, as a condition of receiving funds under the Elementary and Secondary Education Act for each calendar quarter beginning on or after January 1, 1995, to pay the maintenance of effort amount.	

B4. Treatment of Workers under Age 22	There would be a payroll-based tax computed for workers under age 22 equal to the MediWorkers National Premium Percentage (MNPP) of their wages. The tax would have a ceiling of twice the maximum level of wages subject to the Social Security tax. Payroll-related taxes paid in for wages of children (regardless of whether they are full-time, part-time, or seasonal), [viz., who are not covered under employer plan,] would be credited to MediKids Trust Fund. An employer may pay all or a portion of the employee's share of the payroll-based tax, and this payment would not be included in income of the employee [so would treat payroll tax the same way as health care premiums are currently treated]. Effective for remuneration paid on or after January 1, 1995.	This tax is in the nature of an "equalization" tax so that, taking also into account the similar tax for part-time and seasonal employees, from an employer's perspective, wages of all employees (whether full-time adult, child, or part-time or seasonal) are effectively subject to a premium or tax or similar amount. There would be a need for coordination between the IRS (collecting this tax) and FHBEC (which has information on health care enrollment for everyone). Payroll would have to be reported with some indication or other method of identifying those individuals who are covered under the 3 different components of UniMed. This would be important in assuring individuals receive appropriate credits under the MediWrap component.
B5. Additional Federal Funds	Additional Federal funds would come from previous general revenues dedicated to medicaid and from other taxes (to be specified).	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992
Financing [title VI]—MediWrap Component of UniMed

Issue/Topic	Policy	Notes
C. MEDIWRAP COMPONENT OF UNIMED		
C1. Actuarial Premium Collected Through Income-Tax System		
C1. (a) Amount of Premiums	Nationally specified community-rated monthly actuarial premium to be established for each individual (no family premium). There would be no variation by age, sex, marital status, etc.	In the case of MediWrap beneficiaries with children, the amount of the premium would be increased to include a MediKids element. See B2(a) above.
C1. (b) Limit on Amount of Premium to MNPP of Total, Gross Income	In order to provide protection to low-income individuals, the MediWrap premium (including any MediKids element) could not exceed the MediWorkers National Premium Percentage (MNPP) of total, gross income (including joint income for a married couple and any children's income). In case of coverage during part of a year, the total, gross income would be prorated based on number of months of coverage.	For low-income workers, practical net effect of this limit (and crediting for employment equalization taxes paid) would be to limit premium to the MNPP of non-wage income (viz., interest and dividends), which is usually small.
C1. (c) Crediting MediKids and MediWrap Equalization Employment Taxes and MediWrap Self-Employment Taxes	There would be credited against MediWrap premium amount (including any MediKids element), total MediWrap and MediKids equalization taxes paid (including both employer and employee shares), see C4 below, and self-employment taxes, see C3 below. However, if the amount of taxes exceeds the amount of the premium, the taxes would not be refunded.	
C1. (d) Collection	To be paid with income taxes (including provision in estimated taxes).	Effectively, low-income individuals not now required to file a tax return will be required to file information return to obtain relief from full MediWrap premium (including any MediKids element). Would be payable for months in which individuals covered under MediWrap component of UniMed beginning with January 1995.
State Medicaid "Maintenance of Effort" Pay-	States are required to pay the MediWrap component of UniMed a "maintenance of effort" amount.	Effective for calendar quarters beginning on or after January 1, 1995.

C2. (a) Computation	(1) *Medicaid Base Payment.*—HBA would determine the average quarterly amount expended under the State medicaid plan (including Federal and State share) for individuals eligible for MediWrap component of UniMed during a base year (probably 1992) for services covered under that component. (2) *Updating for trend in expenses.*—The base payment under (1) would be trended forward to reflect (for periods before January 1, 1995), average, per capita medicaid expenditures for the population and types of services described in (1) and, for subsequent periods, by the average per capita growth in program expenditures under the MediWrap component of UniMed in the State up to the quarter involved. (3) *Maintenance of Effort Amount.*—The maintenance of effort amount is the amount determined under (2) multiplied by 1 minus the Federal Medical Assistance Percentage (FMAP) used under the medicaid program.	
C2. (b) How Paid	States required, as a condition of receiving funds under the Job Training Partnership Act for each calendar quarter beginning on or after January 1, 1995, to pay the maintenance of effort amount.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992—Continued

Financing [title VI]—MediWrap Component of UniMed

Issue/Topic	Policy	Notes
C3. MediWrap Employment Equalization Tax for Part-Time and Seasonal Workers	There would be a payroll-based tax computed for part-time and seasonal workers, equal to the MediWorkers National Premium Percentage (MNPP), including the MediKids element, of their wages. The tax would have a ceiling of twice the maximum level of wages subject to the Social Security tax (approx. $125,000). Payroll-related taxes paid in for part-time and seasonal workers (other than children) would be credited to MediWrap and MediKids trust funds for premiums of those workers (allocated in proportion to the amounts of the MNPP attributable to the MediWorkers and MediKids components); except that (1) IRS would identify the social security number of those workers who are covered under the MediWorkers component of UniMed and will transfer such taxes to the FHBEC for equalization purposes, and (2) for workers without children, the MediKids trust fund would only receive its allocation if the combined MNPP exceeds the MediWrap premium. An employer may pay all or a portion of the employee's share of the payroll-based tax, and (as under the MediWorker component) this payment would not be included in income of the employee. *Effective:* For remuneration paid on or after January 1, 1995.	This tax is in the nature of an "equalization" tax so that, taking into account the similar tax for workers under age 22, from an employer's perspective, wages of all employees (whether full-time adult, child, or part-time or seasonal) are effectively subject to a premium or tax or similar amount. There would be a need for coordination between the IRS (collecting this tax) and FHBEC (which has information on health care enrollment for everyone). Payroll would have to be reported with some indication or other method of identifying those individuals who are covered under the 3 different components of UniMed. This would be important in assuring individuals receive appropriate credits under the MediWrap component.
C4. MediWrap Tax on Self-Employment Income	Tax on self-employment income, equal to the MediWorkers National Premium Percentage (MNPP) (up to twice the maximum wages subject to Social Security taxes, viz., approx. $125,000). This is non-refundable. Funds are credited against MediWrap premium (including any MediKids element). This tax is non-refundable. *Effective*: Taxable years ending after December 31, 1994; except would pro-rate to reduce tax so as to make it not applicable for portions of tax years beginning before January 1, 1995	This is similar to MediWrap employment equalization tax so that self-employment income and wages are treated similarly.

C5. Source of Additional Federal Funds	
	Remaining Federal funds would come from previous general revenues dedicated to medicaid and from other sources (to be specified).

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992
Financing [title VI]—Medicare Eligibility Expansion

Issue/Topic	Policy	Notes
D. Medicare Program Eligibility Expansion	Increase cap on HI part of FICA & SECA tax to extent necessary to fund expenses for expanded eligibility.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992
Financing [title VI]—Low-Income Assistance

Issue/Topic	Policy	Notes
E. Low-Income Assistance (covering low-income employees, children, and others)	Addition to income tax at flat rate of 1/5 of the MediWorkers National Premium Percentage (MNPP). However, wages, self-employment income and other income, to the extent a UniMed premium has been computed based on such income, would not be subject to this additional tax.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992
Overall Administration [title VII]

Issue/Topic	Policy	Notes
A. Health Benefits Administration (HBA); basic structure	Health Benefits Administration (HBA), headed by 15-member board appointed from private sector by President with Senate confirmation, 6-year staggered terms. (Board also includes 2 additional members solely for purposes of administering the ERP process. See, under title I, H1. (c)(1) —2.) Would be established by not later than March 1, 1993. Paid at Executive Level II. No more than 8 of same political party. 3 appointed from each of the following: labor; employers; medical community, insurance community, consumer representatives. Chair elected by board. Will include: —the Federal Health Benefits Equalization Corporation (FHBEC) (see below); —the Group Health Plan Review Board (GHPRB) (see below); —an Office of Special Counsel (SC) (see below); —an Early Resolution Program Office, headed by Chief Facilitator (see below); —an Office of Executive Director, appointed by and serving at pleasure of the board; —a MediWorkers Office; —a MediKids Office; and —a MediWrap Office. HBA will also include 4 Advisory Committees with regard to discrete coverage issues. HBA will administer the entire program, through the Executive Director, except for independent functions delegated by statute to FHBEC, SC, and GHPRB. HBA will have budgetary independence (similar to independence in recent legislation for independent SSA)	

B. Federal Health Benefits Equalization Corporation (FHBEC)	Corporate entity established in HBA by not later than June 1, 1993. Board of Directors consists of the HBA board. Sole and exclusive authority over— —assessment and collection from plans (including self-insured employers) of equalization premiums; —distribution of equalization rebates to plans (including self-insured employers) —Has structure and powers similar to those of Pension Benefit Guaranty Corporation (PBGC) under existing law. Most administrative and support personnel and services will be provided by HBA. —Receipts and disbursements will be off-budget (viz., non-budget).	
C. Office of Special Counsel	-Purpose is to receive, process, and (if appropriate) prosecute complaints of violations of Act or plan filed by participants or beneficiaries. [model of Immigration discrimination enforcement] —Appointed by President with Senate confirmation for 6-year term. Removed only for cause. —Recommends Early Resolution Program before proceeding to administrative review in procecutorial fashion before GHPRB or rejecting the case and returning a "right to proceed" letter to the complainant.	
D. Early Resolution Program (ERP) Office	Headed by Director appointed by HBA. Staff will develop program procedures, conduct case intake, maintain roster of "facilitators", coordinate facilitator selection process, provide meeting sites, maintain records, and provide facilitators with legal assistance and administrative support staff.	
E. Group Health Plan Review Board (GHPRB)	9 members appointed by President with Senate confirmation. President designates Chair. 6-year, staggered terms. Removed only for cause. Appoints ALJ's to hear complaints of participants and beneficiaries not resolved through ERP. Governed by APA. (Similar to OSHRC, 29 U.S.C. 661)	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992
Medicare Revisions [title VIII]

Issue/Topic	Policy	Notes
A. REDUCTION IN AGE OF MEDICARE ELIGIBILITY	Reduce, as of January 1, 1995, age of initial eligibility to 60. Provide for a transitional enrollment period, beginning July 1, 1994, during which individuals who will be between 60 and 65 as of January 1, 1995, could enroll. In the future, there would have to be established special enrollment process to take into account the fact that most individuals at age 60 are not receiving Social Security benefits.	

UNIVERSAL MEDICAL CARE (UNIMED) ACT OF 1992
Miscellaneous Provisions [title IX]

Issue/Topic	Policy	Notes
. REPEAL OF COBRA CONTINUATION PROVI-IONS	Effective January 1, 1995, repeal the COBRA continuation requirements contained in ERISA, the IRC, and the PHSA.	
. GRANT PROGRAM FOR EXPANSION OF FED-RALLY QUALIFIED HEALTH CENTERS	Provide an authorization of appropriations of an additional $400, $800, $1200, $1600, and $1,600 millions in fiscal years 1993 through 1997 for expansion of services to medically underserved individuals by Federally qualified health centers.	

Bush v. Clinton Health Plans

Access			
	Bush	**Clinton**	Comment
Goal	Universal access to health insurance	Universal access to health insurance	
Approach	Incentives	Mandates (taxes by another name)	Clinton plan means job loss; slower rate of small business creation.
▸ Methods	– Tax credits and tax deductions – Reforms of the health insurance market to make insurance more affordable.	– Employers must provide health insurance to their employees ("play or play") – Endorses similar market reforms	– Clinton says employers will be eligible for tax subsidies; says nothing about what they would be. – While Clinton offers few details, he endorses proposals similar to the President's; both "take on the insurance companies."
▸ Paying for the plan	– We have identified sufficient savings to meet the $100 billion, five year implementation cost *without raising taxes*.	– Cost controls from "global budgeting" would pay for increased coverage.	– Clinton offers no timetable for implementing access provision nor any details on the size, scale, or composition of his financing package.
Small business – Of 34 million without health insurance; 25 million work for or are family of workers in firms with fewer than 25 employees.	– Guarantee that all small employers can get coverage; rate bands to make sure prices are affordable. – Help for low income workers in small firms through tax credits.	– Mandate that employers provide health care; provide "tax credits to protect businesses."	– Mandates would make it more difficult for small businesses to form; increased labor costs would send more jobs overseas.

Middle class	– Credit and deduction available for all families with incomes up to $80,000. – The deductible amount is $3,750 for families and $1,250 for individuals, minus the value of employer contributions. – 44 million middle-income individuals would receive some help.	– No help for middle-income families with low employer contributions (the 44 million who would be helped under the Bush plan.) – Where employers are hit by the new mandate to buy insurance, employees would be required to pay a share -- all dollars flowing from employees' pockets.	
Insurance security	– Guarantee that workers can move from job to job offering health insurance without losing coverage because of pre-existing conditions (e.g., already pregnant, having cancer.)	– Appears similar; no details provided.	
Choice of benefits	– State laws that mandate benefits would be pre-empted.	– A new "National Health Care Board" will prescribe minimum benefits that all employers must provide.	– Clinton plan could raise costs for employees by requiring them to buy more insurance than they do already. – Clinton plan will create a floor under the cost of plans all employers must provide.
Choice of doctor	– Health insurance credits/deduction available for insurance plans that provide care as consumers want: through private physicians; HMOs, etc.	– Rhetoric of "allow consumers to choose where to receive care."	– Eliminating the "pay" option of "pay or play" in the Clinton plan defuses charge that Clinton approach leads to nationalized plan/loss of consumer choice.

People not working and their families – 10 million of the uninsured do not work.	– Eligible for credit/deduction. – Credit/deduction would be phased in over 5 years. – Those who use credit are guaranteed coverage through at least one plan the state must make available through a private insurer.	– Private coverage for non–workers would be guaranteed private insurance coverage that would be arranged through government run purchasing cooperatives (similar to Bush–proposed "HINs.") – Non–workers will pay a sliding scale premium based on income. – Those now receiving Medicaid would be transferred to this plan. – Savings from cost controls would pay for expansions in coverage; no timetable provided.	– Bush plan is for a five year phase in; Clinton plan may never phase in. – Both plans would leave some uninsured; those uninsured would be those who choose not to buy insurance.

Controlling Costs

	Bush	Clinton	Comment
Goal	Highest quality at the lowest cost	Reduce costs no matter what the quality.	
Approach	Deliver care more efficiently; end causes of waste and abuse	"Global budget;" arbitrary limits on how much can be spent on health care. Annual increase limited to rate of increases in wages.	Clinton plan calls for unprecedented government involvement in health resource allocation decisions.
Role of government	Run government programs more efficiently; address forces that drive costs -- malpractice, market failure, etc. No price regulation.	A National Health Care Board would decide total health spending and set ceilings for each state. States will decide prices for all health services.	"Global budgets" only squeeze the health cost balloon; squeezing through price fixing will lead to shortages (thus rationing) and lower levels of new technology.
Malpractice	▸ Requirement for arbitration before going to court; if you then go to court and don't do better by more than 10 percent, you are liable for the other side's attorney fees. ▸ Tort reform.	▸ Wants to make alternative to courts *available*; no requirement to use alternatives. ▸ No support for tort reform.	

Administrative savings	▸ Use "electronic cards" and automation to reduce the amount of paperwork patients and doctors complete. ▸ Introduce a single, standardized claims form.	▸ Similar.	Clinton borrows from the Bush list.
Prescription drugs	▸ No proposal.	▸ End certain tax preferences for pharmaceutical companies that raise prices faster than the rate of inflation.	
Information for consumers	▸ Require states to make information about the cost of health plans and providers (hospitals, etc.) available for comparison shopping.	▸ No proposal.	

Bush v. Clinton Health Plans

Access

	Bush	Clinton	Comment
	Universal access to health insurance	Universal access to health insurance	
	Incentives	Mandates (taxes by another name)	Clinton plan means job loss; slower rate of small business creation.
▸ Methods	– Tax credits and tax deductions – Reforms of the health insurance market to make insurance more affordable.	– Employers must provide health insurance to their employees ("play or play") – Endorses similar market reforms	– Clinton says employers will be eligible for tax subsidies; says nothing about what they would be. – While Clinton offers few details, he endorses proposals similar to the President's; both "take on the insurance companies."
▸ Paying for the plan	– We have identified sufficient savings to meet the $100 billion, five year implementation cost *without raising taxes*.	– Cost controls from "global budgeting" would pay for increased coverage.	– Clinton offers no timetable for implementing access provision nor any details on the size, scale, or composition of his financing package.
Small business – Of 34 million without health insurance; 25 million work for or are family of workers in firms with fewer than 25 employees.	– Guarantee that all small employers can get coverage; rate bands to make sure prices are affordable. – Help for low income workers in small firms through tax credits.	– Mandate that employers provide health care; provide "tax credits to protect businesses."	– Mandates would make it more difficult for small businesses to form; increased labor costs would send more jobs overseas.

Middle class	– Credit and deduction available for all families with incomes up to $80,000. – The deductible amount is $3,750 for families and $1,250 for individuals, minus the value of employer contributions. – 44 million middle–income individuals would receive some help.	– No help for middle–income families with low employer contributions (the 44 million who would be helped under the Bush plan.) – Where employers are hit by the new mandate to buy insurance, employees would be required to pay a share –– all dollars flowing from employees' pockets.	
Insurance security	– Guarantee that workers can move from job to job offering health insurance without losing coverage because of pre–existing conditions (e.g., already pregnant, having cancer.)	– Appears similar; no details provided.	
Choice of benefits	– State laws that mandate benefits would be pre–empted.	– A new "National Health Care Board" will prescribe minimum benefits that all employers must provide.	– Clinton plan could raise costs for employees by requiring them to buy more insurance than they do already. – Clinton plan will create a floor under the cost of plans all employers must provide.
Choice of doctor	– Health insurance credits/deduction available for insurance plans that provide care as consumers want: through private physicians; HMOs, etc.	– Rhetoric of "allow consumers to choose where to receive care."	– Eliminating the "pay" option of "pay or play" in the Clinton plan defuses charge that Clinton approach leads to nationalized plan/loss of consumer choice.

People not working and their families – 10 million of the uninsured do not work.	– Eligible for credit/deduction. – Credit/deduction would be phased in over 5 years. – Those who use credit are guaranteed coverage through at least one plan the state must make available through a private insurer.	– Private coverage for non–workers would be guaranteed private insurance coverage that would be arranged through government run purchasing cooperatives (similar to Bush–proposed "HINs.") – Non–workers will pay a sliding scale premium based on income. – Those now receiving Medicaid would be transferred to this plan. – Savings from cost controls would pay for expansions in coverage; no timetable provided.	– Bush plan is for a five year phase in; Clinton plan may never phase in. – Both plans would leave some uninsured; those uninsured would be those who choose not to buy insurance.

Controlling Costs

	Bush	Clinton	Comment
Goal	Highest quality at the lowest cost	Reduce costs no matter what the quality.	
Approach	Deliver care more efficiently; end causes of waste and abuse	"Global budget;" arbitrary limits on how much can be spent on health care. Annual increase limited to rate of increases in wages.	Clinton plan calls for unprecedented government involvement in health resource allocation decisions.
Role of government	Run government programs more efficiently; address forces that drive costs -- malpractice, market failure, etc. No price regulation.	A National Health Care Board would decide total health spending and set ceilings for each state. States will decide prices for all health services.	"Global budgets" only squeeze the health cost balloon; squeezing through price fixing will lead to shortages (thus rationing) and lower levels of new technology.
Malpractice	▸ Requirement for arbitration before going to court; if you then go to court and don't do better by more than 10 percent, you are liable for the other side's attorney fees. ▸ Tort reform.	▸ Wants to make alternative to courts *available*; no requirement to use alternatives. ▸ No support for tort reform.	

Administrative savings	► Use "electronic cards" and automation to reduce the amount of paperwork patients and doctors complete. ► Introduce a single, standardized claims form.	► Similar.	Clinton borrows from the Bush list.
Prescription drugs	► No proposal.	► End certain tax preferences for pharmaceutical companies that raise prices faster than the rate of inflation.	
Information for consumers	► Require states to make information about the cost of health plans and providers (hospitals, etc.) available for comparison shopping.	► No proposal.	

H. Kuttner

EXECUTIVE OFFICE OF THE PRESIDENT
COUNCIL OF ECONOMIC ADVISERS
WASHINGTON, D.C. 20500
July 24, 1992

THE CHAIRMAN

MEMORANDUM FOR: SAM SKINNER
NICK BRADY
DICK DARMAN
CLAYTON YEUTTER
ROGER PORTER

FROM: MICHAEL J. BOSKIN

SUBJECT: Deficit Reduction/Tax Increase in the Clinton Plan

How large a tax increase would be needed to reduce the projected 1996 deficit by half while funding all the spending that Clinton proposes in his economic plan?

o The list of spending cuts must be pruned of proposals that simply are not feasible or whose savings are clearly imaginary. These include:

-- unspecified "administrative savings"
-- "reform Defense Department inventory system"
-- "RTC management reform"
-- "streamline USDA field offices"

o Total savings from the Clinton plan (excluding the deleted items) are $31.04 billion in 1996 using his optimistic estimates for the following categories (many of which may also be unfeasible).

	Defense cuts	16.50
	Intelligence cuts	1.50
	100,000 employees	4.50
	Cut White House staff	0.01
	Debt financing reform	2.00
	Cut Congressional staff	0.10
*	Line-item veto	2.00
	Energy conservation	0.85
	Reduce university overhead	0.82
	Special purpose HUD grants	0.13
	Index nuclear waste fees	0.08
	Consolidate foreign broadcasting	0.27
	Freeze consultant spending	0.21
	Consolidate social service	0.27
	Raise Medicare-B costs (technically, a revenue increase)	1.80
		31.04

* We have already given him credit for these claimed budgetary savings. The $2 billion associated with line-item veto means he is either double-counting, or there are $2 billion more in unspecified cuts.

- Total spending increases under Clinton's plan are $134.1 billion in 1996.

  -- The plan involves spending increases of $64.1 billion, not including Clinton's health insurance proposal.

  -- Clinton's health insurance proposal (disguised play or pay) is estimated to cost $70 billion per year by 1996. It is not clear what portion of this cost will be paid with the payroll tax mentioned in the plan.

- Using (heresy) CBO figures, yields a deficit of $222 billion in 1996 (excluding deposit insurance). To cut that in half while enacting his plan, Clinton must generate (222/2 + 134.1 - 31.04) = **$214.06 billion** in revenue.

  -- If that amount is to be raised through increases in the personal income tax, Clinton will need to raise Federal income tax revenues by about **34 percent.**

     - This fraction is based on CBO's projection for income tax revenue of $634 billion in 1996.

     - Actual tax rates would need to be increased by a larger fraction to generate the needed revenue (since taxable income is a decreasing function of the tax rate).

  -- Clinton's plan includes the following tax increases (billions of dollars in 1996, as claimed by Clinton):

     - "increase rates on top 2%, raise AMT, surtax on millionaires:" = **23.0**

     - "prevent tax fraud on unearned income for the wealthy:" = **2.3**

     - "limit corporate deductions at $1 million for CEOs:" = **0.4**

     - "end incentives for opening plants overseas:" = **0.4**

     - "prevent tax avoidance by foreign corporations:" = **13.5**

     - "increased fines and taxes for corporate polluters:" = **2.9**

- "eliminate tax deduction for lobbying expenses:" = **0.1**

- a payroll tax as part of the health care proposal, without any figure given on that tax's revenues

- The total 1996 claimed revenue from the above items (excluding the payroll tax) is **$42.6 billion**

-- Thus, even granting him these overly optimistic revenues, he still is $172 billion short, and would have to raise <u>everyone's</u> federal income taxes by over 25 percent.