CIVIL RIGHTS

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LEADERSHIP CONFERENCE PROPOSED ANTI-DISCRIMINATION AMENDMENTS TO THE HEALTH SECURITY ACT OF 1993

I. CIVIL RIGHTS PROTECTIONS

A. General Civil Rights Provision

The Bill should be amended to include a general civil rights provision as set out in Attachment A.

The Health Security Act (HSA) includes several important civil rights protections, but these are fragmented and inconsistent. The general anti-discrimination amendment, including the private right of action and remedies, is designed to prohibit and make actionable discrimination by any actor in the healthcare system that receives federal financial assistance, including the National Health Board, States, Regional Alliances, and Health Plans. Language prohibiting actions that have the "effect" of discrimination must be explicitly included, because in interpreting Title VI the Supreme Court in Guardians Ass'n v. Civil Service Comm'n, 463 U.S. 582, 598, 602 (1983), ruled that retrospective relief for unintentional violations should be withheld unless Congress explicitly indicates otherwise.[1] Legislative history should indicate that this explicit language is used to ensure a remedy and should not be interpreted to suggest that Congress believes that less explicit language in other statutes is insufficient to include the effects standard.

Under the Administration's Bill, anti-discrimination provisions, causes of action and remedies are contained in separate provisions addressing the States, the Regional Alliances and Health Plans. These provisions are inconsistent in the types of discrimination covered and the bases on which discrimination is prohibited. The single provision proposed would streamline the anti-discrimination provisions and would apply the same rules and remedies to all persons and entities receiving federal financial assistance.

B. Other Technical Civil Rights Amendments

The Bill also should be amended to include the technical, more detailed provisions set out in Attachment B. Appendix B also sets out the reasons supporting these amendments.

C. Individuals Eligible For Coverage

Undocumented immigrants should be eligible for benefits. Section 1001(c) of the Bill should be amended to provide: "An eligible individual is any person who resides in

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[1]Although this was a plurality opinion by Justice White, it represents the holding of the Court because Justice White was the 5th vote in a very splintered decision.

the United States, Puerto Rico and the territories." It should also be amended to rename §1005 "Treatment of Nonimmigrants" and delete §1005(a), which states that "undocumented aliens" are ineligible for benefits.

II. ENDING FINANCIAL BARRIERS TO NECESSARY HEALTH CARE SERVICES

A. Co-payments

Individuals and families with incomes under 100% of the federal poverty level should not be required to make any copayments. Medicaid eligibles should not be required to make co-payments higher than those currently allowed under the Medicaid program and persons with incomes between 100% and 200% of the federal poverty level should receive a 60% discount on required copayments. The same discounts that apply for copayments should apply for out-of-pocket costs. The same copayment discounts should be made available to eligible individuals forced to seek health services out-of-network. Out-of-pocket costs incurred for mental health services should be applicable for calculation of the stop-loss amount. Low-income persons in need of long term care must be provided the same stop loss protection that exists for acute care services.

Under the HSA, all individuals and families, regardless of how little they earn, would have to pay fees for covered health services (except for health screenings, immunizations, prenatal care and one post-partum visit). The lowest cost plan created by the Act would require that enrollees pay $10 for each physician visit, $5 for each prescription and $25 for each outpatient psychotherapy visit. (Higher cost plans would also be created by the Act, but are too expensive for most low-income people).

Individuals and families eligible for Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) benefits would be entitled to a reduction of 80% of co-payments (except for non-emergency use of emergency rooms) (§1371).

Co-payments for AFDC and SSI beneficiaries will be: $2 per doctor visit, $1 for each prescription and $5 for outpatient psychotherapy. Although this level of cost-sharing is consistent with limits currently required under the Medicaid program in states that have cost-sharing, most states do not require copayments at all. Thirty-one states and the District of Columbia require no copayments for physician visits and 9 states only require a $.50 copayment for physician visits. Twenty-four states and the District of Columbia require no copayments for prescriptions. Low-income people who are not AFDC or SSI beneficiaries, about 40% of the Medicaid eligible population, and other low-income people ineligible for Medicaid will not be able to afford health services if they are required to make copayments.

The HSA requires all health plans to cap out-of-pocket cost sharing to $1,500 for individuals and $3,000 for families. (§1332(a)(2)). However, these limits are not sufficient

to ensure that low-income people will be able to afford necessary health care services.

The copayment discount only applies to services received from the health plan with which the eligible individual is enrolled. However, people with disabilities or illness requiring specialty care may not be able to get necessary care from participating health plan providers. Furthermore, these "stop-loss provisions" do not apply to long-term care services.

B. HEALTH INSURANCE PREMIUMS

The Bill should fully subsidize premiums for low-income people earning below 200% of the federal poverty level.

Generally, families would be required to pay 20% of the premium amount. Employers would have to pay the other 80%. Families not covered through employment would make premium payments directly to the regional alliance.

Some individuals and families would be eligible for a premium discount. The federal government would pay a premium subsidy (§9102(b)) for those eligible (§6104((a)(1)). AFDC and SSI beneficiaries would pay no premiums (§6104(c)(1)(A)). Families who are not AFDC or SSI beneficiaries but are below 150% of the federal poverty level would receive the premium discount. The subsidy to fund the discount would be the amount necessary to help the family pay a premium that is equal to the weighted average of premiums for the family's class of enrollment (§6104(b)). Families who are not AFDC or SSI beneficiaries, but have incomes under 150% of the federal poverty level would pay on a sliding scale up to 3.9% of their incomes toward the premium amount. Families with incomes between 150% and $40,000 would pay 3.9% of their incomes toward the premium amount (§6104(c)(2) and (3)).

Many low-income consumers are employed but do not earn enough money to pay health insurance premiums required by their employer based health plans, even with the premium subsidy. Moreover, the premium subsidies only help people purchase health coverage up to the average priced plan, relegating low-income people to cheaper plans. Furthermore, low-income people will not get premium subsidies for out-of-network services, such as a second opinion.

III. HEALTH INFRASTRUCTURE:

A. Essential Community Providers

Doctors in private practice serving underserved populations should be included as essential community providers and affirmative obligations must exist to include them in health plans. The protections of essential community providers should not be subject to

a fixed deadline. Instead, such protections should exist until such time as Congress enacts legislation to terminate them. The Secretary of HHS should be instructed to conduct studies by 2001 and at appropriate intervals thereafter that assess the treatment of essential community providers and the impact of health care reform on them and to submit its recommendations to Congress. In addition, tax deductions should be provided for practitioners currently serving underserved communities.

The Bill provides some protections for health care providers currently serving traditionally underserved populations. Such "essential community providers" would include migrant health centers, community health centers, homeless program providers, family planning clinics, Indian Health programs, AIDS providers under the Ryan White Act, Maternal and Child Health providers, rural health clinics, and community practice networks (as defined in the Public Health Access Initiatives) under the Act (§1582). The Secretary of HHS would be authorized to certify other providers as essential community providers, which provide services in health manpower shortage areas or to medically underserved populations (§§1581, 1583). Doctors in private practice are not clearly included as "essential community providers" even though they provide essential services to low-income populations.

The Bill's substantive protections[2] for essential community providers are good, but the 5-year expiration period (§ 1432) on these protections is too short.

The cost of serving low-income underserved communities is higher than serving wealthier communities with better health infrastructure. Low-income people tend to be sicker and need more services than wealthier people. Moreover, they need support services to access health care services, such as transportation and translation services.

Providers serving low-income and underserved communities need grants and loans for capitol improvements, such as renovation, expansion and equipment. Additionally, public and private providers in low-income communities lack the financial resources to convert their practices to accommodate a health delivery system based primarily on managed care. Existing providers will need financial support to set up their own networks, but incentives for practitioners to locate in underserved areas are necessary. Incentives should include grants for equipment and capitol available to both new and existing providers.

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[2]Health Plans are required either to enter into a written provider participation agreement with essential community providers or enter into a written agreement to make payments to essential community providers (§1431). Health Plans also are required to treat the provider at least as favorably as other providers with respect to the scope of services, payment rates, availability of financial incentives, risk limitations, and assignment of enrollees.

B. Subsidies for Charity Hospitals

The cap on subsidies to hospitals serving vulnerable populations should be eliminated, sufficient funding for such providers guaranteed and the five-year expiration date on these subsidies deleted.

The Act would eliminate payments to a state for hospitals serving disproportionately high numbers of charity and Medicaid patients. As part of the Public Health Access Initiatives, the Act would provide for payments to hospitals serving vulnerable populations, which is capped at $800,000,000 per year (§3481). Payments would only be made under this section for a period of 5 years. This may not be enough money for municipal, not-for-profit, voluntary and traditionally minority hospitals.

IV. CONSUMER PROTECTIONS

The Bill should be amended to provide stronger consumer protections, including enforcement mechanisms and performance standards, as set out in Attachment C.

In addition, the Bill should be amended to eliminate the national health card. Furthermore, the Bill does not provide sufficient privacy protection with regard to medical information and should be amended to include express protections. Such protections should include that personal information may only be disclosed with the consent of the individual, that health record information systems must be required to have security measures built in to protect personal information from unauthorized access and disclosure, that employers be denied access to personally identifiable health records and contain a private right of action for an violation of these requirements. There should also be an appropriate punishment for unauthorized disclosure of protected information.

Consumers' rights to privacy must be protected. The bill would require that a national health card be issued for enrolled individuals. Such a national identification card would likely become a de facto national identification card required to prove lawful status in the United States and would yield discrimination against persons who appear to be foreign. Furthermore, the bill does not prohibit the use of social security numbers as the identification care number, which could be used to gain access to a vast amount of personal medical information.

V. DEFINITION OF FAMILY

This Bill should be amended as set out in Attachment D to make clear that various forms of non-traditional families meet the definition.

VI. COMPREHENSIVE BENEFITS PACKAGE

The Bill should be amended to ensure that health services currently available under the Medicaid program will continue to be available to all Medicaid eligibles as part of the comprehensive benefits package, that all mandated services be provided on the effective date of the Act and that the preventive services meet the health needs of low income women.

The HSA creates a mandatory set of health care services, known as the comprehensive benefits package, that must be covered by participating health plans. Although its aim is to create a comprehensive set of basic health services for all eligible individuals, the HSA fails in at least two fundamental ways to ensure that certain health services will be available under Medicaid.

First, under the HSA, many low income eligible individuals will not have access to health services currently available under Medicaid and some important services will not be provided upon the effective date of the Act. By failing to include or by excluding certain health services from the bill's comprehensive benefits package, many low income individuals will not be able to afford health services that they currently receive under the Medicaid program. For example, the proposed comprehensive benefits package would not cover some vision and dental care services for adults, rehabilitation services for congenital illnesses or to prevent deterioration, medically necessary mental health services beyond short-term care, and enabling and supportive services such as transportation costs. Many of these health services are vital and without them low income individuals will go without health care services that might minimize the potential for more serious and costly health care problems.

The HSA also limits the availability of important health services to low income individuals by permitting some services to be phased-in as late as the year 2001 and by excluding from coverage important health services that are now available to individuals currently eligible for Medicaid. Denying some low income individuals access to critical health services for a phase-in period effectively undermines the bill's stated purpose of providing universal coverage to all eligible individuals.

Second, many low income people will not get the preventive services they need. For example, women will be unable to obtain certain cancer screening tests with sufficient frequency to improve the chances for early detection. The HSA covers clinical breast exams, Pap smears and mammograms every two or three years depending on the age of the woman. To improve the chances of early detection, the frequency limits currently stated in the HSA should be replaced with the periodicity schedule recommended by the American Cancer Society.

ATTACHMENT A TO LEADERSHIP CONFERENCE MEMORANDUM

ANTI-DISCRIMINATION

(1) IN GENERAL -- (a) No person or entity in the United States, its territories or Puerto Rico may engage (either directly or through contractual arrangements) in any activity **under any health program or activity receiving Federal financial assistance**, that has the effect of discriminating against any individual on the basis of race, national origin, gender, **citizenship status, age, religion, language, disability, sexual orientation**, income, health status or anticipated need for health services.[1]

(b) All federal payments to any health program or activity shall be treated as Federal financial assistance for the purposes of this Section.

(2) CIVIL ACTION BY AGGRIEVED PERSONS-- Any person who is aggrieved by the failure of **a person or entity** to comply with **paragraph (1)** may commence a civil action against the person or entity in an appropriate State or district court of the United States.[2]

(3) STANDARDS. -- [Narrowly tailored compelling business necessity defense and provision re statute of limitations to be inserted.]

(4) RELIEF. -- In an action under paragraph 2, if the court finds that the **person or entity** has failed to comply with **paragraph 1**, the aggrieved person may recover compensatory and punitive damages and the court may order any other appropriate relief.[3]

(5) ATTORNEY'S FEES. -- In any action under paragraph 2, the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee (including expert fees **and other out-of-pocket expenses**) as part of the costs, and the United States shall be liable for costs the same as a private person.[4]

(6) ACTION BY SECRETARY. -- Federal administrative

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[1]This provision is modelled after § 1402(c)(1) of the Administration's Bill. Differences from the Administration's language are in **bold type.**

[2]This provision is modelled after § 5238(a)(1) of the Administration's Bill.

[3]Modelled on Administration Bill § 5238(a)(3).

[4]Modelled on Administration Bill § 5238(a)(4).

enforcement shall be available to each federal department or agency which is empowered to extend Federal financial assistance to any health program or activity to effectuate the provisions of this Section with respect to such program or activity by issuing rules, regulations or orders of general applicability. [Further specificity on enforcement mechanisms to be provided.]

ATTACHMENT B

WORKING DRAFT: February 23, 1994

LEADERSHIP CONFERENCE PROPOSED AMENDMENTS

The bill would require amendments in addition to a general anti-discrimination provision to ensure that protected groups receive health care services.

A. THE NATIONAL HEALTH BOARD:

The Act would create a National Health Board that would have seven members appointed by the President with the consent of the Senate. The Board would have regulatory authority over many aspects of the new health care delivery system created by the Act, including defining services covered in the comprehensive benefits package and quality of health services. It would also approve state plans to implement new health care delivery systems created by the Act. Because the U.S. Department of Health & Human Services (HHS) already administers state plan approval under the Medicaid Act and has an existing civil rights compliance and enforcement structure through the Office for Civil Rights, plan approval authority should be place with HHS. Title I, Subtitle C, § 1200(b)(1) should be amended to provide:

> (1) IN GENERAL - In order to be approved as a participating State under section 1511, a State shall submit to the [**strike, "National Health Board" and insert, Secretary of the U.S. Department of Health & Human Services"**] a document (in a form and manner specified by the [**strike "Board" and insert "Secretary"**]) that describes the State health care system that the State is establishing (or has established).

Title I, Subtitle F, Part I, Subpart B, § 1511 [provision on NHB responsibility regarding approval of state plans] should be stricken. Title I, Subtitle F, Part 2, Subpart A, § 1571 should be amended to include a new subsection (b) to include the provisions of § 1511 and all references tot he National Health Board changed tot he Secretary of the Department of Health & Human Services. Title I, Subtitle F, Part 2, Subpart C, § 1522(a) should be stricken, subsection (b) should be amended by striking "(b) and inserting "(a)", the phrase "Upon receiving notice under subsection (a)" and inserting, "When the Secretary of Health and Human Services determines that this subpart shall apply to a State for a calendar year"

B. STATES:

To reduce the occurrence of discrimination, States should be required to develop health care delivery system plans that will yield access to quality services for all its residents. In seeking approval for their plans, States should be required to submit "civil rights compliance plans" that must be approved before a State receives federal funds under the Act and is permitted to implement its plan. To ensure that such requirements are not simply a paper promise, the Leadership Conference should seek a commitment from the administration that it will adopt implementing regulations. The following includes language that may be adopted as amendments, much of which could be proposed regulations. In addition, a new provision should be included as subsection § 1511(a)(1)(3) which provides:

CIVIL RIGHTS COMPLIANCE AND ENFORCEMENT REVIEW - No State shall be approved as a participating State, unless it has provided documentation required under subsection (a)(1)(3)(A) and (B) and approved by the Secretary.

> **(A) Each State shall submit to the Secretary of the U.S. Department of Health and Human Services, in a form to be determined by the Secretary, a plan (civil rights compliance plan) to ensure compliance with the anti-discrimination provisions of this Act and any applicable civil rights laws. The civil rights compliance plan shall include:**
>
> > **i. the number of regional alliances to be created by the State,**
> >
> > **ii. the geographic region represented by each alliance area and designated by census tracts,**
> >
> > **iii. the demographic makeup of each alliance area, including the number of residents by race, national origin, sex, disability, health status, limited English proficiency, including the languages they speak, and the number of residents between 250% and 150% of the federal poverty level, between 150% and**

100% of the federal poverty level and below 100% of the federal poverty level,

iv. a statement detailing how the proposed alliance areas will provide access to health services for underserved communities and populations, including minority communities, low-income communities, high risk populations, rural areas and persons with disabilities,

v. a description of the number of existing health infra-structures in each proposed alliance area, including but not limited to hospitals, clinics and physicians, their patient capacity and services provided, and their physical accessibility,

vi. a description of all standards to be used in health plan certification, including federal requirements for health plan certification in Section 1203(a)(2)(C), and standards to ensure that health plans seeking certification will not be discriminated against in the application or approval process based on the characteristics of the health plan owners, operators, physicians or enrollees,

vii. a statement of initiatives to ensure that a sufficient number of health plans bargain with each regional alliance to ensure that traditionally underserved communities, including, but not limited to, minority communities, low-income communities and rural areas, receive quality health care services,

viii. a description of a State civil rights review plan to ensure that regional alliances and health plans are in compliance with the applicable anti-discrimination provisions and civil rights laws. The review plan must include:

> **a. a description of methods to be adopted to increase timely access to covered services for individuals protected by the anti-discrimination provisions of this Act and applicable civil rights laws,**

b. a description of methods to ensure that health plans contract with minority health professionals,

c. a requirement that regional alliances and health plans make data available to the State sufficient to determine compliance with the anti-discrimination provisions of this Act and all other applicable civil rights law. Such data shall include the number of health plans that applied for certification, the number of health plans that were certified and the number of health plans that were denied certification including the number of physicians with which the plan has contracts by race, national origin, sex and other characteristics relevant to the enforcement of this provision,

d. a requirement that regional alliances and health plans regulated by the State make data available to the State for the purpose of determining utilization patterns by race, national origin, sex, language, age, income, disability and changes in general health status of enrollees,

e. enforcement mechanisms to redress violations of relevant civil rights laws by regional health purchasing alliances and health plans, including the agency responsible for enforcement, except that no such enforcement mechanism may require exhaustion of administrative remedies by an aggrieved party.

(B) Each State that has received a waiver of Medicaid Act requirements from the Secretary under § 1115 of the Social Security Act, is subject to the requirements of this provision and shall file a civil rights compliance plan within 120 days of the effective date of this Act.

(C) The Secretary shall conduct annual reviews of each participating State to determine whether the State is complying with the anti-discrimination provisions of this Act and of applicable civil rights statutes.

(i) In the event that the Secretary determines that a State is in violation of any such provision or law, the Secretary shall inform the State of the violation and provide the State 120 days to devise and submit a plan to correct the violation. The Secretary shall provide technical assistance to the State. If Secretary approves the plan, the Secretary shall monitor implementation of the plan and assess within a reasonable time, whether the violation has been corrected.

(ii) In the event that the violation continues or that the Secretary disapproves the plan, the Secretary may, in her discretion, assume operation of the State health system as a whole or the regional alliance or health plan(s) in violation of the relevant provisions or law, may withhold federal financial assistance provided under the Act [, or may refer the matter to the U.S. Attorney General for further action.]

(iii) Nothing in this section shall be interpreted as affecting an aggrieved person's or entity's right to bring a court action under any provision of this Act.

Currently, insurance companies engage in various forms of redlining of "undesirable" communities in the areas of mortgage and automobile insurance. Redlining is likely to occur in any insurance based health care delivery system, such as that created by the Administration's bill. Redlining is prohibited under the general discrimination amendment, but additional protections are necessary. States would be required to create regional alliances to bargain with health plans to serve residents of the areas designated to be served by the regional alliances. Health plans will not be required to bargain with any particular regional alliance and will be allowed to choose with alliances areas they wish to serve. In order to reduce insurance redlining, States must have an affirmative obligation to create regional alliances areas that are not socio-economically identifiable, racially identifiable, or identifiable in any other way that may reduce the likelihood that health plans will seek to

serve them. Title I, Subtitle C, Part I, Section 1202(b)(2)(A) should be amended to provide:

> (2) POPULATION REQUIRED. -
>
> > (A) IN GENERAL. - Each alliance area shall encompass a population large enough to ensure that the alliance [**insert, "will comply with the anti-discrimination provisions of this Act and applicable civil rights laws"**] and has adequate market share to negotiate effectively with health plans providing the comprehensive benefit package to eligible individuals who reside in the area.

Because States would be required by this amendment to take race, sex, age, language and other characteristics into account in establishing alliance areas, the following amendment would be necessary. Title I, Subtitle C, Part I, Section 1202(b)(4) should be amended to provide:

> (4) BOUNDARIES. - In establishing boundaries for alliance areas, the State may not discriminate on the basis of [**strike, "or otherwise take into account**] race, [**insert, "sex,"**] age, citizenship status, language, religion, national origin, socio-economic status, disability, health status or sexual orientation.

The Act would not allow a State to divide a metropolitan statistical area in creating alliance boundaries. Metropolitan statistical areas are defined by the Office of Management & Budget (OMB) and are geographic areas that have a large population nucleus and adjacent communities that are economically and socially integrated with that nucleus. In other words, a subdivision of a County with cities and towns may be designated a metropolitan statistical area. However, OMB also creates primary metropolitan statistical areas, which are usually cities and their suburbs. No State should be permitted to divide a primary metropolitan statistical area, because redlining could occur if wealthier suburbs

are not included in the same alliance area as the city they surround. Title I, Subtitle C, Part I, Section 1202(b)(5) should be amended to provide:

> (5) TREATMENT OF METROPOLITAN AREAS [**Insert, "AND PRIMARY METROPOLITAN STATISTICAL AREAS"**]. - The entire portion of a metropolitan statistical area [**insert, "and primary metropolitan statistical areas"**] located in a State shall be included in the same alliance area.

Only State certified health plans will be permitted to bargain with the regional alliance created by the State. The bill should provide affirmative obligations on States to ensure that they do not certify health plans that may redline. Title I, Subtitle C, Part 1, § 1203(a)(2)(C) should be amended to provide:

> (C) the plan's capacity to [**insert, provide access to health care services covered in the comprehensive benefit package"**] in the designated service area [**strike "," and insert, "and shall include -**
>
> > **(i) the plan's compliance with or ability to comply with the anti-discrimination provisions of this Act and all applicable civil rights laws,**
> >
> > **(ii) the plan's capacity to provide covered health care services to undeserved areas, including manpower shortage areas, minority communities, low-income communities and rural communities,**
> >
> > **(iii) the plan's capacity to provide covered health care services in a timely manner, including the provision of appointments and referral services within a reasonable time,**
> >
> > **(iv) whether the plan has health care service providers accessible to all eligible individuals in the designated service area, and**
> >
> > **(v) whether the plan has contracts with minority physicians, rehabilitation providers, durable medical equipment providers,**

community and migrant health centers and other essential community providers as defined in section 1582 of this Act.

C. REGIONAL ALLIANCES:

Regional alliances would contract with State certified health plans under the bill. They should have affirmative obligations to reduce the occurrence of redlining. Title I, Subtitle D, Part 2, Section 1321(a)(1) should be amended to include a subsection (A) that provides:

(A) Each regional alliance shall require that a health plan with which it bargains State how it will comply with the anti-discrimination and anti-redlining provisions of the Act and applicable civil rights laws and may not enter into a contract with any health plan that is not in compliance with such provisions and laws.

A regional alliance should be required to deny contracts with health plans that do not comply with the anti-discrimination provisions of the Act or any other applicable civil rights laws. Title I, Subtitle D, Part 2, Section 1321(b) [listing circumstances under which a regional alliance can refuse to contract with a health plan] should be amended to include a subsection (3) that provides:

(3) the plan failed to comply with, or has not demonstrated the capacity to comply with the anti-discrimination provisions of this Act or applicable civil rights laws.

D. HEALTH PLANS:

Under the bill health plans would be provided a defense against a claim of discrimination that is so broad, it would be very difficult for a plaintiff challenging conduct that has the "effect" of discrimination to prevail. it would allow health plans to simply state

that the challenged conduct is engaged in for a "business necessity." This language is so ambiguous that almost any conduct could be found to relate to a business necessity.

Title I, Subtitle E, Part 1, Section 1402(c)(3) [business necessity defense for health plans] should be stricken. Alternatively, the provision should be amended to provide:

> (3) BUSINESS NECESSITY. - **[strike, "Except in the case of intentional discrimination it" and insert, "A health plan"]** shall not be **[delete "a", and insert "in"]** violation of this subsection, or of any regulation issued under this subsection, **[insert, "if it proves that the act sued upon is necessary to meet a compelling business interest, is narrowly tailored to meet that compelling business interest and is the least discriminatory alternative available." and strike "for any person to take any action otherwise prohibited under this subsection, if the action is required by business necessity."]**

Even with the above amendments, health plans would still be permitted to redline portions of a regional alliance area by filling to capacity with "desirable" enrollees and denying enrollment to "undesirable" enrollees on the ground that they are at or over capacity. Therefore, Title I, Subtitle D, Part 2, Section 1323(f) should be amended to provide:

> (f) OVERSUBSCRIPTION OF PLANS. -
>
> > (1) IN GENERAL - Each regional alliance shall establish a method for establishing enrollment priorities in the case of a health plan that does not have sufficient capacity to enroll all eligible individuals seeking enrollment **[insert, "in a manner that will ensure [compliance with the anti-discrimination provisions of this Act and applicable civil rights laws"]**.
> >
> > (2) PREFERENCE FOR CURRENT MEMBERS. - Such method shall provide that in the case of such an oversubscribed plan -
> >
> > > (A) individuals already enrolled in the plan are given priority in continuing enrollment in the plan, **[insert, "unless such preference would**

> **violate the anti-discrimination provision of this Act or applicable civil rights laws"]** and
>
> (B) other individuals who seek enrollment during an applicable enrollment period are permitted to enroll in accordance with a random selection method, up to the enrollment capacity of the plan **[insert, "unless such random selection results in the violation of the anti-discrimination provisions of this Act or applicable civil rights laws"]**.

Moreover, health plans should have affirmative obligations not to discriminate, including discrimination in marketing and advertising, to reduce the possibility that they will target "desirable" patients for enrollment. Title I, Subtitle E, Part I, § 1402(a)(1) should be amended to provide:

(a) NO UNDERWRITING.-

> (1) IN GENERAL. - Subject to paragraph (2), each health plan offered by a regional alliance or a corporate alliance must accept for enrollment every alliance eligible individual who seeks such enrollment. No plan may engage in any practice that has the effect of attracting or limiting enrollees on the basis of personal characteristics, such as **[delete, "health status, anticipated need for health care, age, occupation, or affiliation with any person or entity"] [insert, "those defined in the anti-discrimination provisions of this Act"]**.

Title I, Subtitle D, Part 2, Section 1325(b) should be amended to include the following subsection:

> (b) MARKETING. - Each regional alliance shall, consistent with section 1404, review and approve or disapprove the distribution of any materials used to market health plans offered through the alliance.
>
> **(1) A regional alliance shall not approve a health plan's marketing materials that do not affirmatively describe and**

> **promote the availability of the health plan on an equal opportunity basis, consistent with the anti-discrimination provisions of this Act, or that use human models that are not fully representative of the population in the area served by the health plans.**

Section 1325 should also be amended to include the following subsection:

> **(c) Any marketing or other information and materials made available to consumers must also be made available to limited English proficient consumers in their respective languages if they belong to a single language minority where:**
>
> > **(1) more than 5% of consumers in the alliance are members of that single language minority and are limited English proficient; or**
> >
> > **(2) more than 10,000 of the consumers in the alliance are members of that single language minority and are limited English proficient.**

Title I, Subtitle E, Part 1, § 1404(a)(1) should be amended to provide:

> IN GENERAL. - The contract entered into between a regional alliance and a regional alliance health plan shall prohibit the distribution by the health plan of marketing materials within the regional alliance that contain false or materially misleading information **[insert, "or that contains any message or suggestion of discrimination or preference in violation of the anti-discrimination provisions of this Act"]** and shall provide for prior approval by the regional alliance of any marketing materials to be distributed by the plan. **[insert, "The contract shall further provide that all marketing materials distributed by the health plan within the alliance area shall affirmatively describe and promote the availability of the health plan on an equal opportunity basis and in a manner consistent with the anti-discrimination provisions of this Act."]**

The bill currently requires regional alliances to provide health plans with which they seek to bargain information on the demographic characteristics of the regional alliance areas. This information could only be used to determine whether to redline the alliance

area or where to redline within the alliance area. Therefore, these provisions should be stricken.

Title I, Subtitle D, Part 3, Subpart A, Section 1341(a) should be amended as follows: strike subsection (2)(A) and (F) [requiring regional alliances to supply health plans with information on the demographic characteristics of the regional alliance eligible individuals [(A)], and the AFDC and SSI bid portions and per capita premium amounts [(F)]).

E. CORPORATE ALLIANCE:

The bill would require corporations with more than 5,000 employees that do not choose to participate in regional alliances to create corporate alliances. The bill does not contain sufficient anti-discrimination protections with regard to these alliances. The general anti-discrimination amendment would be applicable to corporate alliances as entities regulated under the Act. They would be regulated by the U.S. Department of Labor. Corporations creating such alliances should have affirmative obligations to reduce discrimination. Therefore, the Secretary of Labor should be expressly required to seek "civil rights compliance plans" from corporate alliances and to conduct annual "civil rights compliance reviews" as would be required for regional alliances. As with the draft civil rights compliance language for regional alliances, much of the language could be adopted as regulations. Title I, Subtitle D, Part 4, Section 1387(a) should be amended to include subsection (a)(1) and (2):

> (a) IN GENERAL. - A corporate alliance shall provide a written submission to the Secretary of Labor each year (in such form as the Secretary may require) detailing how the corporate alliance will carry out its activities under this part.
>
> **(1) Such submission shall include a plan (civil rights compliance plan) to ensure compliance with the anti-**

discrimination provisions of this Act and [other applicable civil rights laws (notwithstanding § 501(b) of the ADA?)] and any other relevant civil rights laws the Secretary determines are applicable. The civil rights compliance plan shall include:

(A) a statement assessing the diversity of the proposed premium areas by race, national origin, sex, language, age, health status, disability and income,

(B) a statement assessing how the proposed premium areas will impact access to health services for employees who are members of underserved communities and populations, including minority communities, low-income communities, high risk populations and rural communities,

(C) a statement of initiatives to ensure that health plans with which the corporate alliance contracts or that it creates will provide accessible services to traditionally underserved employees, including minority communities, low-income communities and rural areas,

(D) a description of a civil rights review plan to ensure that health plans are in compliance with the anti-discrimination provisions of this Act and civil rights laws. The review plan must include:

(1) a description of methods to be adopted to provide timely access to covered services for racial minorities, low-income persons, women, the aged and persons with disabilities,

(2) a description of methods to ensure that health plans seek to contract with minority physicians,

including those already practicing in underserved communities,

(E) a requirement that corporate alliances collect and make available data to the Secretary for the purpose of determining compliance with the anti-discrimination provisions of this Act and applicable civil rights laws,

(F) a requirement that the corporate alliance plans make data available to the Secretary for the purpose of determining utilization patterns by race, national origin, sex, age income, language and disability and changes in general health status of enrollees,

(G) enforcement mechanisms to redress violations of the anti-discrimination provisions of this Act and applicable civil rights laws by health plans [except that no such enforcement mechanism may require exhaustion of administrative remedies by an aggrieved party].

(2) The Secretary shall conduct an annual review of each corporate alliance to determine whether it is complying with anti-discrimination provisions of this Act and of applicable civil rights statutes.

(A) In the event that the Secretary determines that a corporate alliance is in violation of any such provision or law, the Secretary shall inform the corporate alliance of the violation and provide it 120 days to devise and submit a plan to correct the violation. The Secretary shall provide technical assistance to the corporate alliance. If the Secretary approves the plan, the Secretary shall monitor implementation of the plan and assess within a reasonable time, whether the violation has been corrected.

(B) In the event that the violation continues or the Secretary disapproves the plan, the Secretary

may, in her discretion, assume operation of the corporate alliance as a whole or of the health plan(s) in violation.

(C) Nothing in this section shall be interpreted as affecting an aggrieved person's or entity's right to bring a court action under any provision of this Act.

Title I, Subtitle D, Part 4, Section 1387(c)(1) should be amended to include:

(1) CORPORATE ALLIANCE. - Each corporate alliance shall submit to the Secretary of Labor, by not later than March 1 of each year, information on the number of full-time employees or participants obtaining coverage through the alliance [**insert, "by race, national origin, sex, the number of employees over the age of 55, the number of employees who are limited English proficient and the number of employees who are persons who are disabled"**] as of January 1 of that year.

II. DATA COLLECTION:

In order to ensure that every segment of the health care delivery system is functioning as it should for protected and traditionally underserved groups data must be collected to show if protected groups are receiving covered services. If they are receiving covered services, it is necessary to have data that shows where, when and how they are receiving services. The bill should be amended to include the following provision:

(a) The Secretary shall promulgate regulations and the necessary forms that provide for the routine collection and reporting by health care providers of the following information by race, national origin, sex, language, income, age, religion, language, sexual orientation, income and residence by census track:

1) data on enrollment and disenrollment,

2) data on clinical encounters, and other items and services provided by health care providers,

3) data on health outcomes,

4) grievances

(b) Such data shall collected, analyzed and maintained in a computerized system, shall be publicly available and shall be subject to the privacy provisions applicable to medical information in this Act.

III. RESEARCH OBLIGATIONS:

The bill would create research obligations without any concomitant requirement that such research be conducted in a nondiscriminatory manner. Because medical research under the present system frequently pays little attention to the diseases that impact upon people of color and women and excludes them as subjects of study, the bill should include provisions to ensure that this oversight is not perpetuated in the reformed health care system.

Title III, Subsection C, §3201(2)(A) should be amended as follows:

(A) The Director of NIH, in collaboration with the Associate Director for Prevention and with the heads of the agencies of the National Institutes of Health, shall ensure that such Institutes conduct and support biomedical and behavioral research promoting health and preventing diseases, disorders, another health conditions (including Alzheimers disease, breast cancer, heart disease, and stroke).

(B) In carrying out subparagraph (A), the Director of NIH shall give priority to [**insert, "ensuring that the objects of study include members of traditionally underserved populations (including but not limited to low income persons, women, African Americans and Latinos)"**], conducting and supporting research on child and adolescent health (including birth defects), chronic and recurrent health conditions, [**insert, "particularly those affecting underserved populations,"**], reproductive health, mental health, elderly health, substance abuse, infectious diseases, health and wellness promotion, and environmental health, and to resource development related to such research.

IV. PUBLIC ACCOUNTABILITY:

The bill would establish new boards and entities using broad criteria for membership. However, there would be no requirement that persons representing underserved populations be appointed to serve on boards or have decision making positions. Many persons have the necessary expertise and experience to provide guidance in administering the reformed health system. Accordingly, there should be a provision that diversity based on race, national origin, gender and other categories be included among the criteria used in selecting Board members, in addition to a demonstrated ability to provide health services to underserved populations.

Title I, Subtitle F, §1502 should be amended as follows:

> (b) BASIS OF SELECTION.- Board members will be selected on the basis of their experience and expertise in relevant subjects, including the practice of medicine, nursing, or other clinical practices, health care financing and delivery, state health systems, consumer protection, business, law, and delivery of care to vulnerable populations. **[insert, "In addition, members shall be fairly balance in terms of points of view represented and shall consist of a cross-section of the population."]**

ATTACHMENT C

PROPOSED LEADERSHIP CONFERENCE CONSUMER PROTECTION AMENDMENTS

The bill contains important consumer protection enforcement provisions that would help ensure that enrollees get the services mandated by the bill. However, some technical amendments are necessary to make sure that the enforcement process is meaningful. The following amendments would improve the enforcement process for those enrolled in managed care plans and ensure that low income people will receive necessary services or treatment in a timely fashion.

1) The bill provides an administrative appeal procedure for enrollees in the event that a health plan denies a claim for services. The same procedure should apply even when a health plan denies services more informally. In managed care plans claims for reimbursement or authorization for payment of services are not submitted as in fee-for-service plans. Therefore, a managed care plan, under the current language, could refuse to provide an enrollee with a covered service or treatment and the enrollee would have no recourse. The definition of a "claim" must explicitly include informal requests for a service or treatment, including requests by a doctor on behalf of the enrollee.

Title V, Subtitle C, Part 1, Subpart A §1501(a)(1) should be amended as follows:

> (1) CLAIM.- The term "claim" means a claim for payment or provision of benefits under a health plan or a request for preauthorization of items or services which is submitted to a health plan prior to receipt of the items or services. **In the case of a managed care health plan, a request for services or treatment by an enrollee of a health plan, or a request by a physician for approval to provide a service or treatment to an enrollee, shall be deemed a "claim" for purposes of this Part.**

2) In managed care plans enrollees must see doctors who have contracts with the plan. The plan would not be required to pay for second opinions given by doctors who do not have contracts with the health plan. Low income people will not be able to pay for second opinions. In some instances a health plan will refuse to provide a service or treatment because it does not deem it "medically necessary." A health plan may also refuse to provide the treatment or service that the enrollee chooses, and provide a less expensive treatment or service. Unless an enrollee can afford to pay for a second opinion from a doctor that does not work for the health plan, the enrollee will not have evidence to demonstrate the need for the service or treatment at issue. Therefore, the bill should be amended to require the health plan to pay for second opinions.

ATTACHMENT C

Title V, Subtitle C, Part 1, Subpart A, Section 5201(b)(4)(C) [requiring *de novo* reviews of a health plans denial of a claim] should be amended to provide:

> (C) shall include review by a qualified physician if the resolution of any issues involved requires medical expertise. **In the event that medical expertise is required for an enrollee who qualifies for a reduction in copayments under §1371 or a premium subsidy under §6104 the health plan shall pay for an out-of-network second opinion.**

3) The bill must also protect the rights of complainants by requiring that coverage continues during the appeal. A provision should be included that provides:

> **(a) No health plan shall terminate or in any way deny an enrollee benefits of the health plan in retaliation against the enrollee for pursuing any right or remedy under this Subtitle.**

4) A hearing officer in the administrative review process would have to provide a hearing within 24 hours of receiving a complaint for denial of a request for preauthorization of urgent treatment without which the enrollee might suffer serious injury of severe impairment. §5204(c)(4). In some instances an enroll may need such services or treatment but have not requested preauthorization. An enrollee would need the same protections available if he or she sought preauthorization.

Title V, Subtitle C, Part 1, Subpart A, §5204(c) should be amended as follows.

> (c) TREATMENT OF URGENT REQUESTS TO PLANS **[strike, "FOR PREAUTHORIZATION"]**.-
>
> > (1) IN GENERAL.- This subsection applies in the case of any claim submitted by an individual claimant or a provider claimant consisting of a request **[strike, "preauthorization of" and insert, "for"]** items or services (other than emergency services which under section 1406(b) may not be subject to preauthorization) which is accompanied by an attestation that --

Because of the serious nature of the services or treatment involved, the enrollee should be able to seek an injunction from the hearing officer for immediate provision of the treatment at

issue. By the time the enrollee has filed the complaint, he or she would have waited at least 24 hours for the preauthorization denied by the health plan.

The bill should also provide that the health plan pay for an out-of-network second opinion, if one had not already been obtained, for low income people. Any determination that treatment should be provided prior to determination of the health plan's liability would be based solely on the opinion of the health plan's own physician without the provision of an out-of-network second opinion.

Title V, Subtitle C, Part 1, Subpart A, §5204(c)(4) should be amended as follows:

> (4) EXPEDITED HEARINGS.- Notwithstanding section 5203 and the preceding provisions of this section, upon receipt of a complaint containing a claim described in section 5201(c)(1), the complaint review office shall promptly provide the complainant with the opportunity to make an election under section 5203(a)(3) and assignment to a hearing on the complaint before a hearing officer. The complaint review office shall ensure that such a hearing commences not later than 24 hours after receipt of the complaint by the complaint hearing office.
>
> **(1) The hearing officer may, upon complainant's request, require the health plan to pay for the treatment or service at issue if the complainant qualifies for a reduction in copayments under §1371 or a premium subsidy under §6104.**
>
> **(2) the hearing officer shall direct the health plan to pay for an "out-of-network" second opinion, if one was not already provided under §5204(C)(4).**

5) The State complaint review board would decide cases on a "preponderance" standard (§5204(d)). However, the bill does not state which party has the burden of persuasion. The bill should be amended to provide that health plans have the burden of persuasion.

Title V, Subtitle C, Part 1, Subpart A, §5304(d)(1) should be amended as follows:

> (1) IN GENERAL.- The hearing officer shall decide upon the preponderance of the evidence whether to decide in favor of the complainant with respect to each alleged act or practice. **The respondent shall have the burden of**

demonstrating that it is not required to provide for the treatment or service.

6) Low income people will not be able to afford interpreters. In order that the process be accessible and fair, interpreters should be provided by the administrative agency in the event a complainant is limited English proficient or deaf.

Title V, Subtitle C, Part 1, Subpart A, §5204 should be amended to include a new subsection (d) that provides:

(d) the State shall provide at all hearings interpreters for limited English proficient and hearing impaired complainants.

7) The decision of the hearing officer is a final one (§5204(e)(1)), except for expedited decisions on preauthorization requests for services an enrollee needs who is at risk of serious jeopardy, such as impairment of bodily functions under §5201(c)(10). §5204(e)(2). **The bill should be amended by striking §5204(e)(2).**

8) Federal courts would only have jurisdiction over appeals of the Review Board if the amount in controversy exceeds $10,000 (§5205(e)). **The $10,000 amount in controversy should be reduced to $1,000.**

9) The bill does not provide any appellate review of acts of corporate alliances. §5202(d). Corporate alliances should be subject to the same appellate review provisions as regional alliances.

Title V, Subtitle C, Part 1, Subpart A, §5202(d) should be amended to provide:

(d) **[strike,** "EXCLUSIVE MEANS OF"] REVIEW FOR PLANS MAINTAINED BY CORPORATE ALLIANCES. - **[stike,** "Notwithstanding part 2"] proceedings under sections 5203 **[strike,** "and"] , 5204 **[strike,** "pursuant to complaints filed under subsection (b), and review under section"] **and** 5205 **[strike,** "of determinations made under section 5204, shall be the exclusive means of review of acts or practices described in subsection (b) which are engaged in by"] **shall be available to enrollees in** a corporate alliance health plan or **[strike,** "by"] any plan maintained by a corporate alliance **[strike,** "with respect to benefits under"] providing a supplemental benefit policy described in section 1421(b)(1) or a cost sharing policy described in section 1421(b)(2) **for acts or practices described in subsection 5203(b).**

ATTACHMENT C

10) The bill should be amended to provide private rights of action against federal officials for failure to promulgate timely regulations under the Act and for failure to enforce the Act or regulations promulgated under the Act.

> **(a) IN GENERAL.- The failure of any federal agency or entity to promulgate regulations under any provision of this Act in a timely fashion confers an enforceable right of action on any person who is aggrieved by such failure. Such a person may commence a civil action against the federal agency or entity in an appropriate district court of the United States.**

[Note: This provision is modeled after §5237 of the bill, which would confer a private right of action against a regional or corporate alliance for failure to carry out any of its responsibilities.]

Leadership Conference Proposed Amendments on Performance Standards and Data Collection - ATTACHMENT C

1. Performance Standards

In order to ensure that states are involved with making certain that health plans comply with the Act's quality performance standards, section 5013 should be modified as follows (new language is underlined):

Each health plan shall --

(1) measure and disclose performance on quality measures used by --
  (A) participating States in which the plan does business;
  (B) regional alliances and corporate alliances that offer the plan; and
  (C) the National Quality Management Council;
(2) furnish information required under subtitle B of this title and provide such other reports and information on the quality of care delivered by health care providers who are members of a provider network of the plan (as defined in section 1402(f)) as may be required under this Act;
(3) <u>provide information and reports on the quality of care delivered by the health plan to the State in which the plan does business; and</u>
(4) maintain quality management systems that --
  (A) use the national measures of quality performance developed by the National Quality Management Council under section 5003; and
  (B) measure the quality of health care furnished to enrollees under the plan by all health care providers who are members of a provider network of the plan.

2. Data Collection

Data should be collected in a format that permits monitoring of the various actors in the plan. Accordingly, Title V, Subtitle B should be modified as follows:

Section 5003(b) Subject of Measures. -- National measures of quality performance shall be selected in a manner that provides information on the following subjects. . .

(7) Compliance with the anti-discrimination provisions of this Act.

Section 5101(d) Uses of Information. -- The health care information described in subsection (e) shall be collected and reported in a manner that facilitates its use for the following purposes . . .

(9) Establishing and monitoring compliance with the anti-discrimination provisions of this Act.

Section 5101(e) Health Care Information. -- The health care information referred to in subsection

(a) shall include data on -- . . .

(12) any fact that may be necessary to determine whether an entity is in compliance with anti-discrimination provisions of this Act, including data regarding the race, sex, national origin, citizenship status, language, socio-economic status, disability, sexual orientation, and locality of eligible individuals by census tract.

(f) Public Information. -- (a) The following information shall be available to the public --

(1) information concerning providers, such as costs, identity, location, qualifications, and availability;

(2) procedures used to control utilization and to assure and improve quality of care;

(3) data regarding the race, sex, national origin, citizenship status, language, socio-economic status, disability, sexual orientation, and locality of eligible individuals; and,

(4) all such information shall be available to eligible individuals in foreign languages and other alternative formats.

(b) Public information gathered under this section shall be collected and maintained in a manner that is consistent the privacy and security standards established under Section 5120.

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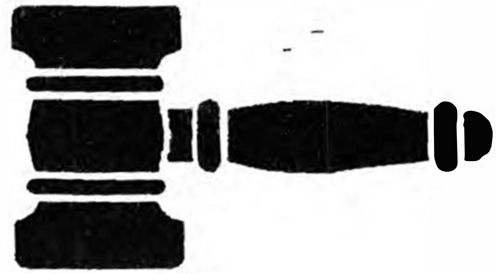

DATE: 5/10/94

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No. of Pages (including cover) 5

DISCRIMINATION ISSUES IN HEALTH CARE REFORM

I. Redlining issues - i.e., manipulation of geographic boundaries

A. Setting Alliance boundaries -

HSA prohibits discrimination by states in setting boundaries for alliances. (§1202(b)(4)). Also, a Metropolitan Statistical Area cannot be subdivided (except to the extent that it crosses state lines). (§1202(b)(5)). This prohibition on breaking up a MSA also applies to corporate alliances in setting premium areas. (§1384). Under Chairman's mark, voluntary purchasing coops would be established by states. If latter are smaller than state-wide, same issues would apply of potential use of boundaries to shape alliances/coop areas that in effect separate low-income or other less desirable enrollees from others. Community rate is based on population of the alliance.

B. Selection of service areas by health plans

HSA prohibits discrimination in any action, including selection of service areas. (§1402(c)) State has discretion to require health plan to serve certain areas as a condition of the certification or bid. (§1203(e)(1)(B)).

II. Basic inclusion in system

A. Enrollment - refusals to enroll

HSA prohibits underwriting and requires health plans to enroll all eligble individuals, with no discrimination based on a number of factors, referencing personal characteristics. (§1402(a)(1)). Health plan can cut off enrollment when capacity is reached, but cannot use capacity as a proxy for discrimination. (§1402(a)(2)). This is the point where there is the strongest basis for using concept of no denial for any reason unrelated to eligibility to participate. Other bills have similar provisions: S. 1170, §1111; S. 1579, § 1204.

B. Enrollment - indirect manipulation of enrollment

There is much concern about how plans will market themselves so as to more or less blatantly discourage enrollment by less desirable groups. HSA forbids plans from any practice "that has the effect of attracting or limiting enrollees on the basis of personal characteristics such as" several protected categories. (§1402(a)(1). HSA also prohibits marketing materials that are false or misleading, or that are distributed to less than the full service area of a plan. (§1404(a)).

C. Coverage limits

1. Again, HSA and other bills prohibit directly any differentiation in benefits offered by a plan and any or most (depending on bill) pre-existing conditions provisions. HSA §1402(b); S. 1770 §1112; S. 1579, § 1204.

III. Direct discrimination in services

Refusals to provide services on the same terms and conditions to one group as that offered to other groups -

Once a health plan has enrolled an individual, it has the duty to provide services on the same terms and conditions for all enrollees. Putting aside the effects test question, this would cover official policies that distinguish among enrollees on the basis of certain characteristics. Here, a definitive list of protected characteristics probably would be needed.

Arguably, the sections cited above from S. 1770 and S. 1579 could cover instances of direct/intentional discrimination, prohibiting, for example, limits on coverage based on, inter alia, "any characteristic of the individual that may relate to the need for health care services." S. 1579, §1204(a).

IV. Indirect exclusions

This is the most difficult area, and one where civil rights groups expect many of the worst problems to arise. The problem here is that plans may include low-income enrollees or other "undesirables," but then structure their operations such that services of lesser value or quality are available to identifiable populations. Because low-income persons will not be able to afford the point-of-service option in most instances, there is a potential for serious problems of underservice.

The three types of activity most expected by civil rights groups are the following:

* Policies on selection of providers - There are a number of possible examples. Some plans use facially neutral criteria such as a requirement of board certification that would tend to screen out minority providers (very similar to Griggs). Some plans will screen based on who a doctor's patients are, rather than any characteristic of physician him/herself. Some will tend to limit the number of doctors who are expert in certain fields of medicine (AIDS care, e.g.) as a way to keep out certain patients. The HSA contains anti-discrimination provisions that cover these situations. (§1402(c)(2)).

This is the area most closely analogous to employment. Typically, health plans contract with physicians rather than hire them, so doctors are often unprotected by existing employment discrimination laws. Often these contracts provide for de-selection with notice only, no cause. On the one hand, this is an area where the HSA presumes plans will have latitude to recruit and hire physicians based on a wide range of criteria. It is also an area where there is no entitlement to be selected, in contrast to the entitlement to enroll. On the other hand, it is probably the most potent method for a plan to use to indirectly curtail enrollment by certain groups.

Another path to tackling this problem, also included in HSA, is the essential community provider section. (§1431). This requires health plans to contract with designated essential community providers for at least five years, after which the ECP provision sunsets.

* Sites and hours for service - Siting of facilities has led to several claims of discrimination by health care facilities under existing law (such as the suit against Columbia-

Presbyterian by NAACP LDF, after the hospital relocated one of its satellite facilities out of a low-income neighborhood in New York City). Limiting sites and/or hours in certain neighborhoods is widely anticipated as a method of discouraging certain enrollees at the outset and/or indirectly suppressing service use. In addition to its general anti-discrimination requirement, the HSA specifically prohibits using this method to discourage use of services by recipients of public aid. (§4043(d)(8)).

* Sham services, generally - There is fear that plans will locate in underserved areas but offer services of lesser quality or practical availability than services offered in other neighborhoods. In such instances, the effort is not to exclude enrollees but to minimize enrollee utilization of services.

V. Business necessity defense

The approach of the HSA was to include effects test coverage, but to give the defendant health plans the safety valve of a business necessity defense. If a health plan can show that a practice is necessary to achieve a legitimate business purpose which cannot be substantially accomplished through less discriminatory means, then practices that indirectly exclude certain groups will not be invalidated.

VI. Remedies

As with all of this memo, the following list of options is offered as technical assistance or consultation, not as recommendations.

An effects test already exists in the law with regard to some aspect of discrimination based on race, sex, religion (Title VII has an effects test that presumably applies to all covered categories, even though there is little case law on religion), and national origin; disability, and age. Existing anti-discrimination law tends to apply either to employment or housing situations, or tracks the flow of federal dollars. In health care, there is an additional approach under the Hill-Burton statute. The Hill-Burton regs require that any institution built with Hill-Burton funds (which includes most hospitals) make services available to persons in the service area "without discrimination on the ground of race, color, national origin, creed, or any other ground unrelated to an individual's need for the service or the availability of the needed service in the facility." 42 CFR §124.603(a). The Hill-Burton precedent does not employ an effects test per se, but it does bar discrimination on a broad array of factors, not all of which are specifically enumerated. It is the precedent for the similar language in the HSA and in some of the other bills.

* One option would be to distinguish types of situations, along the lines of the way this memo is organized. Barring any differentiation unrelated to eligibility to participate might fit best with regard to enrollment, least well with regard to employment. The most difficult question remains the indirect exclusions category.

* One option would be to apply an effects only to those protected categories which already have such a standard established in anti-discrimination law. Other categories could

be protected from intentional or direct discrimination only.

* One option for alleviating the concern about the effects test in the basic prohibition section would be to adjust the remedies available in litigation. Proof of an effects test violation could lead to only make-whole remedies. In the health care setting, restitution-based remedies may include some forms of compensatory damages -- including lost wages, for example, but excluding non-pecuniary damages such as pain and suffering or emotional distress.

* For the provisions applying an anti-discrimination rule to states and alliances, one might consider limiting remedies to those currently available against such entities under Title VI.

4/22/94

I. ANTI-DISCRIMINATION PROTECTION FOR CONSUMERS

A. Against redlining in drawing alliance boundaries

SEC. 1202 (b)

(2)(B) TREATMENT OF CONSOLIDATED METROPOLITAN STATISTICAL AREAS. An alliance area that includes a Consolidated Metropolitan Statistical Area (as defined by the Office of Management and Budget) within a State is presumed to meet the requirement of subparagraph (A).

(3) SINGLE ALLIANCE IN EACH AREA.--No geographic area may be assigned to more than one regional alliance.

(4) BOUNDARIES.--In establishing boundaries for alliance areas, the State may not discriminate or engage in any activity that has the effect of discriminating on the basis of~~, or otherwise take into account~~ personal characteristics that are unrelated to an individual's eligibility to participate in a plan, such as race, age, sex, English language fluency, religion, national origin, income, ~~socio-economic status,~~ disability, ~~or~~ perceived health status, or anticipated need for health services.

(5) TREATMENT OF METROPOLITAN AREAS.--The entire portion of a ~~m~~Metropolitan ~~s~~Statistical ~~a~~Area (as defined by the Office of Management and Budget) located in a State shall be included in the same alliance area.

B. Against covert underwriting

SEC. 1402. REQUIREMENTS RELATING TO ENROLLMENT AND COVERAGE.

(a) NO UNDERWRITING.--

(1) IN GENERAL.--Subject to paragraph (2), each health plan offered by a regional alliance or a corporate alliance must accept for enrollment every alliance eligible individual who seeks such enrollment. No plan may engage in any practice that has the effect of attracting or limiting enrollees on the basis of ~~personal characteristics, such as health status, anticipated need for health care, age,~~ occupation, affiliation with any person or entity, anticipated need for health services, or personal characteristics that are unrelated to an individual's eligibility to participate in a plan such as race, age, sex, English language fluency, religion, national origin, income, disability, or perceived health status.~~occupation or affiliation with any person or entity.~~

C. Against discriminatory acts by states, alliances or health plans

Sec. ~~1402 (c)~~ [move to Title V] ANTIDISCRIMINATION.--

(1) IN GENERAL.--(a) No state, alliance, or health plan may discriminate, or engage (directly or through contractual arrangements) in any activity, including the selection of a service area, that has the effect of discriminating against an individual on the basis of ~~race, national origin, sex, language,~~

~~socio-economic status, age, disability, health status, or~~ anticipated need for health services or on the basis of personal characteristics unrelated to the individual's eligibility to participate in a plan such as race, age, sex, English language fluency, religion, national origin, income, disability, or perceived health status.

(b) The prohibition is subparagraph (a) does not create a cause of action for individuals denied employment, nor does it create a cause of action with regard to non-health care-related activities on the part of a state or alliance.

D. Against exclusion by alliances of certain plans

SEC. 1328. ADDITIONAL DUTIES.

(a) ANTI-DISCRIMINATION.--In carrying out its activities under this part, a regional alliance may not discriminate against health plans on the basis of ~~race, sex, national origin, religion,~~ the anticipated need for health services to be provided by a plan, mix of health professionals, location of the plan's headquarters, ~~or~~ organizational arrangement (except as specifically provided in this part) ~~organizational arrangement~~, or on the basis of personal characteristics of a plan's enrollees, prospective enrollees or providers of health services that are unrelated to the individual's eligibility to participate in a plan, such as race, age, sex, English language fluency, religion, national origin, income, disability, or perceived health status.

II. ANTI-DISCRIMINATION PROTECTION FOR PROVIDERS

SEC. ~~1402(c)(2)~~ [move to Title V] SELECTION OF PROVIDERS FOR PLAN NETWORK.

In selecting among providers of health services for membership in a provider network, or in establishing the terms and conditions of such membership, a health plan may not engage in any practice that has the effect of discriminating against a provider--

(A) based on ~~the race, national origin, sex, language, age, or disability of the provider~~ personal characteristics of the provider unrelated to the provider's licensure or professional competence, such as race, age, sex, English language fluency, religion, national origin, income, disability or perceived health status; or

(B) based on the ~~socio-economic status, disability, health status, or~~ anticipated need for health services of patients of the provider or the personal characteristics of patients of the provider that are unrelated to a patient's eligibility to participate in a health plan, such as race, age, sex, English language fluency, religion, national origin, income, disability or perceived health status.

III. BUSINESS NECESSITY DEFENSE

Sec. ~~1402(e)(3)~~ [move to Title V] BUSINESS NECESSITY.--Except in the case of intentional discrimination, it shall not be a violation of this subsection, or of any regulation issued under this subsection, for any person to take any action otherwise prohibited under this subsection, if the action is ~~required by business necessity~~ necessary to achieve a legitimate business purpose which cannot be substantially accomplished through less discriminatory means. In establishing business necessity, the burden of proof shall be on the defendant.

IV. REMEDIES

Sec. 5238 (a) CIVIL ACTION BY AGGRIEVED PERSON.--

(1) IN GENERAL.--Any person who is aggrieved by the failure of a state, alliance or health plan to comply with section 1202(b)(4), 1328, [new sections] 1402(a) or section 1402(c) may commence a civil action ~~against the plan~~ in an appropriate State court or district court of the United States.

(2) STANDARDS.--The standards used to determine whether a violation has occurred in a complaint alleging discrimination on the basis of age or disability under section 1202(b)(4), 1328, [new sections] 1402(a) or 1402(c)

shall be the standards applied under the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.) and the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.).

(3) RELIEF.

(A) Actions against health plans. --

In an action under paragraph (1), if the court finds that ~~the~~ a health plan has intentionally failed to comply with section 1202(b)(4), 1328, [new sections] 1402(a) or section 1402(c), the aggrieved person may recover compensatory and punitive damages and the court may order any other appropriate relief. If there is no finding of intentional failure, the aggrieved person may recover declaratory and injunctive relief, attorneys fees as set forth in paragraph (4), and compensatory damages, excluding non-pecuniary damages such as pain and suffering, emotional distress and loss of consortium.

(B) Actions against states and alliances -- In an action under paragraph (1), if the court finds that a state or alliance failed to comply with section 1202(b)(4), section 1328, or [new sections - 1402]. the court may order such relief as is provided under 42 U.S.C. §2000d.

(C) State immunity. -- A state shall not be immune under the eleventh amendment to the Constitution of the United States from an action in federal or state court

of competent jurisdiction for a violation of this Act. In any action against a state for a violation of the requirements of this Act, remedies (including both at law and in equity) are available for such a violation, as provided in this Act.

(4) ATTORNEY'S FEES.--In any action under paragraph (1), the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee (including expert fees) as part of the costs, and the United States shall be liable for costs the same as a private person.

(b) ACTION BY SECRETARY.--Whenever the Secretary of Health and Human Services finds that a health plan has failed to comply with section 1202(b)(4), 1328, [new sections] 1402(a) or section 1402(c), or with an applicable regulation issued under such sections, the Secretary shall notify the plan. If within a reasonable period of time the health plan fails or refuses to comply, the Secretary may--

(1) refer the matter to the Attorney General with a recommendation that an appropriate civil action be instituted;

(2) terminate the participation of the health plan in an alliance; or

(3) take such other action as may be provided by law.

V. MISCELLANEOUS

A. Insulating composition of supplemental plans

SEC. 1422. STANDARDS FOR SUPPLEMENTAL HEALTH BENEFIT POLICIES.

(d) EFFECT OF COMPLIANCE WITH SECTION.-- The selection of services and items to be offered in a supplemental health benefit policy that complies with the requirements of this section and with any standards or regulations issued under this section shall not be deemed a violation of any anti-discrimination provision of federal law. Nothing in this section shall be construed to permit other practices, such as marketing or enrollment, that are in violation of the anti-discrimination provisions of this Act.

b. Preserving more protective state anti-discrimination laws

SEC. 5243. ~~GENERAL NONPREEMPTION OF~~ EXISTING RIGHTS AND REMEDIES

(a) GENERAL NONPREEMPTION.--Nothing in this title shall be construed to deny, impair, or otherwise adversely affect a right or remedy available under law to any person on the date of the enactment of this Act or thereafter, except to the extent the right or remedy is inconsistent with this title.

(b) LAWS PROVIDING GREATER OR EQUAL PROTECTION FOR THE RIGHTS OF INDIVIDUALS NOT INCONSISTENT WITH THIS TITLE.--Nothing in this Act shall be construed to invalidate or limit the remedies, rights, and procedures of any federal law or law of any state or political subdivision of any state or jurisdiction that provides greater or equal protection for the rights of

individuals on the basis of race, national origin, sex, religion, English language fluency, income, age, disability or any other basis provided for in such laws.

#34

Mr Lewis

AM

Title X

Page 131 of the Chairman's mark
Amend Title X, section VIII, (A) to read

"Any health plan, any health alliance, any state, or any health program or activity receiving federal financial assistance, that engages in activity, either directly or through contractual arrangements, that has the effect of discriminating against any individual on the basis of race, national origin, gender, age, religion, language, disability, sexual orientation, income, health status or anticipated need for health services would be liable to that individual or entity"

(underlined language would be added)

4/22/94

What we were asked for

* New language modeled on Lewis amendment in Ways and Means
* Reconsideration of remedies for discrimination based on effects, rather than intent
* Insulation for supplemental policies

Reasons

* Inconsistencies in list of protected classes in HSA provisions
* Desire to include sexual orientation (as in Lewis amendment)
* Lack of protection against sex discrimination and discrimination based on religion in by actions of states and alliances; inconsistencies between who is protected from discrimination by health plans or from discrimination by states and alliances
* Negative reaction to business necessity defense
* Remedies for effects violations of Title VII are limited to injunctive relief, back pay, front pay (?), attorneys fees

New Draft

* New statement of protected classes to be used consistently
* Concept of protection for characteristics unrelated to eligibility to participate in plan; concept based on consumer picking plan, different than that for employment discrimination, where employer picks you
* Merger of anti-discrimination provisions into one section with distinctions for:
  1/ remedies against states and alliances
  2/ remedies for intentional versus effects test violations
* Clarification of business necessity defense
* Specific preservation of stronger state laws (including those prohibiting discrimination based on sexual orientation)

c rights

NATIONAL WOMEN'S LAW CENTER

Women Need Comprehensive Civil Rights Protections to Ensure Full Access to Health Care

Civil rights protections are key to ensuring that women, who are among those historically underserved by the health care system, have meaningful access to health care. Under the existing health care system, discrimination is pervasive: hospitals have turned away expectant mothers because they have had little prenatal care; insurance companies have redlined minority and low-income communities; health care facilities have refused to treat persons with limited English proficiency.

Therefore, civil rights provisions are necessary to ensure that universal coverage is a reality for all eligible persons. Otherwise, without strong proscriptions against discrimination, providers and other actors in the reformed health care system will be permitted to continue practices that result in health care for only the most "desirable" persons -- generally, those with the resources to pay. Comprehensive civil rights protections that apply to all actors in the new system, as well as health programs or activities that receive federal funding are critical to any health care reform package to ensure that the goal of health care reform is realized: expanded access to health care for all eligible persons.

- Widespread discrimination in the existing health care system means that for many, access to necessary health care is a function of one's sex, race, or national origin, for example, an untenable result. The reformed system must prohibit all entities from denying eligible persons health care on the basis of such personal characteristics. Full protections of this nature are found in the House Committee on Education and Labor's Mark.

- In addition, in the context of health care, discrimination also appears in other diverse forms, such as refusing to treat persons with illnesses deemed too costly or who lack the means to pay for their care. For example, a New York hospital has segregated maternity patients, and, as a consequence limited the type of care available to them, based on whether they had private insurance or Medicaid. Consequently, any health care reform legislation must also provide civil rights protections for persons that have historically been excluded from access to health care, such as health status, and socio-economic status. The Senate's Labor and Human Resources Mark, among others, contain protection that address these types of discrimination.

- Existing federal civil rights laws contain significant gaps. For example, prohibitions against discrimination in federally-funded programs do not apply across the board to women. Title VI, Section 504, and the Age Discrimination Act provide protection in federally-funded programs on the basis of race, national origin, disability, and age, but not gender. Consequently, legislation implementing health care reform must contain a prohibition against discrimination in federally funded health programs or activities. The House Committee on Ways and Means Mark provides this protection.

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- If the gaps in existing laws are not filled, entities in the new health care system will be permitted to continue discriminatory practices. For example, a federally funded health program could use sex discrimination as a defense for otherwise impermissible discrimination: e.g., a provider could justify a decision not to treat an African American woman by stating it did so, not because of her race, but because of her sex.

- In addition to prohibiting discrimination, any health care legislation must contain appropriate remedies for injured parties. Consequently, a reform package must contain an appropriate enforcement mechanism that allows victims to recover monetary damages, including punitive damages, injunctive relief, and reasonable costs, including attorney's fees and expert witness fees, all of which are available under other types of federal civil rights laws. There should also be a provision to permit federal agencies to withhold funds from recipients who have discriminated. This powerful remedy, available under Title VI, Section 504, and the Age Discrimination Act, provides actors with the incentive to comply with anti-discrimination laws. The House Ways and Means Committee Mark provides for this type of enforcement mechanism.

NATIONAL WOMEN'S LAW CENTER

Women Lack Key Civil Rights Protection Essential to Ensuring Full Access to Health Care

Civil rights protections are key to ensuring that women, who are among those historically underserved by the health care system, have meaningful access to health care. The Ways and Means Committee Mark provides a useful model for comprehensive anti-discrimination safeguards. It prohibits discrimination by all actors in the reformed health care system, as well as in federally-funded health programs or activities and provides an effective enforcement mechanism. This coverage of federally-funded programs is necessary to ensure that women are afforded the full array of civil rights protections available for other protected classes.

- Existing prohibitions against discrimination in federally-funded programs do not apply across the board to women. Title VI, Section 504, and the Age Discrimination Act provide protection in federally-funded programs on the basis of race, national origin, disability, and age, but not gender.

- Even with a comprehensive anti-discrimination provision that covers all actors in the reformed health care system, certain entities may choose to provide health care under the traditional fee-for-service model and not affiliate themselves with health plans or other entities in the new system. As a consequence, a civil rights provision that applies to actors subject to the legislation would have no effect on these independent entities.

- Without the prohibition against sex discrimination in federally-funded programs, actors unaffiliated with a health plan, such as providers and hospitals, both of which receive federal funding, will be able to discriminate against women.

- Moreover, sex discrimination will become a defense for otherwise impermissible discrimination: e.g., a provider could justify a decision not to treat an African American woman by stating it did so, not because of her race, but because of her sex.

- As a practical matter, this gap in the law means the discriminatory practices that the legislation seeks to eradicate will persist, such as hospitals' closing of obstetrical care units in order to keep from having to treat poor women, or the blatant refusal to treat low-income expectant mothers.

- In addition to prohibiting sex discrimination in federally-funded health programs or activities, the health care legislation must contain an appropriate enforcement mechanism that allows federal agencies to withhold funds from recipients who have discriminated. This powerful remedy, available under Title VI, Section 504, and the Age Discrimination Act, provides actors with the incentive to comply with anti-discrimination laws.

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NYT 7/18/94 Pg. A12

THE STATES

A Promise on Coverage; a Hint on Abortion

By ROBERT PEAR
Special to The New York Times

BOSTON, July 17 — The Senate majority leader, George J. Mitchell, told the nation's governors today that he would not compromise on the goal of providing health insurance for all Americans, but a Clinton Administration official hinted at an accommodation on the question of insurance coverage for abortion services.

Senator Mitchell, a Maine Democrat, said he was having great difficulty blending health care bills into a form that would guarantee health insurance for all, restrain costs and command the support of a majority in the Senate.

"It's going to be exceedingly difficult" to devise a coherent, sensible health plan that attracts enough support to pass the Senate, he said.

The Senator, speaking at the annual meeting of the National Governors' Association here, said that "unless we enact meaningful reform, states will spend more and more of their budgets on health care, and so will business."

Compromise Is Hinted

Under President Clinton's proposal and under the bills approved by four Congressional committees, the Federal Government would define a standard package of health benefits that must be provided by all insurance plans, and abortion services are among these benefits.

But when asked today to list the essential elements of health care legislation, Leon E. Panetta, the newly appointed White House chief of staff, did not mention coverage for abortions. He hinted that the Administration was open to a compromise under which coverage of abortion might be omitted from some insurance plans.

On the NBC News television program "Meet the Press," Mr. Panetta said the Government should not "necessarily impose one approach or the other."

"When a person buys health insurance now, if they make a decision that they want coverage for that kind of situation, they can do that," Mr. Panetta said. "That's their choice. Frankly, if we provide any kind of major health care reform in this country, people ought to continue to have that choice."

Gov. Robert P. Casey of Pennsylvania, a Democrat who opposes abortion, contended that the major Democratic proposals in Congress included "an affirmative Federal mandate to provide access to abortion." He said that such bills, if passed, would lead to "a vast proliferation of abortion clinics in places where they are not located today."

Gov. Christine Todd Whitman of New Jersey, a Republican, said she did not want to see the Federal Government specify abortion coverage as a requirement for private health plans. But she said states should be free to cover abortion under their Medicaid programs, as New Jersey now does.

The magnitude of the political problems facing Mr. Mitchell and the Clinton Administration was illustrated in comments to the governors by Senator Don Nickles of Oklahoma, the chairman of the Senate Republican Policy Committee. He said most Republican senators oppose not only requirements for employers to buy health insurance for their workers, but also the definition of a standard package of health benefits by the Federal Government.

In February, the National Governors' Association adopted a policy saying there ought to be a standard package of benefits "comparable to those that are now provided by the most efficient and cost-effective health maintenance organizations."

Senator Mitchell said the governors were right to criticize a Senate Republican proposal that would set strict limits on Federal spending for Medicaid. The proposal would shift costs to the states and "it will devastate your states' budgets," he said.

At the same time, Mr. Mitchell said, "If health care reform is not enacted this year, it is as close to a certainty as there can be in the legislative process that there will be a cap on Medicaid and Medicare next year."

Such a cap would limit the growth of Federal payments for the care of the elderly and the poor, but would not stop doctors and hospitals from raising their charges to private health plans to offset the loss of Federal money.

The governors object to features of Democratic proposals as well as Republican plans. Several governors expressed concern about a proposal by the House Ways and Means Committee that would create a new part of Medicare to provide health insurance to poor people and those who have no other source of coverage. Medicare already covers 32 million elderly people and 4 million who have disabilities, and some experts estimate that 90 million additional people would ultimately be eligible for the new Federal Medicare program.

Gov. Howard Dean of Vermont, a Democrat who is vice chairman of the National Governors' Association, said today, "I have very grave concerns about a system that would put 40 percent of the total health budget under control of the Federal Government, as in the House Ways and Means bill." This proposal, he said, "cuts states out of the process of managing the health care system."

DIARY

Health Care Developments

OVER THE WEEKEND

In a letter to Senator Bob Dole, governors from both parties said on Saturday that they opposed an element of the plan offered by Senate Republicans that sets strict limits on Federal spending on Medicaid. Senator George J. Mitchell, the majority leader, told the governors at their conference yesterday that he would not compromise on providing health coverage for all Americans.

CONGRESS

Senate and House — Congress resumes work today with just four weeks until its scheduled summer recess. Leaders again take up the task of trying to find a consensus.

WHITE HOUSE

Leon E. Panetta, the new White House chief of staff, hinted on the NBC News program "Meet the Press" yesterday that the Administration was open to a compromise under which coverage of abortion might be omitted from some insurance plans.

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