## B. COMPREHENSIVE BENEFITS

POLICY BRIEFS:

COMPREHENSIVE BENEFITS
MENTAL HEALTH AND SUBSTANCE ABUSE
WOMEN'S HEALTH
PRESCRIPTION DRUGS → see Older Americans Section for complete info & answer

Q & A
- what you will pay
- Benefits package
- ABORTION
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# POLICY BRIEF

# COMPREHENSIVE BENEFITS

*Today's insurance market offers a multitude of policies, each of which spells out benefits, co-insurance schemes, and detailed exceptions and policy riders. The vast majority of policies place severe limits on certain conditions and have lifetime limits. They pay doctors and hospitals only when people get sick, rather than reimbursing providers to keep people healthy. Consumers must also cope with policies that are incomprehensible and are often denied benefits after discovering exclusions hidden in the fine print.*

*Guaranteeing every American a comprehensive package of benefits that can never be taken away will do much to eliminate these problems.*

## Guaranteed Comprehensive Benefits

- Every American will receive a Health Security Card that will guarantee a comprehensive package of benefits as generous as those offered by most Fortune 500 companies - - including hospital and professional services, hospice and home care, durable medical equipment, mental health, and other services.

## No Lifetime Limits

- Unlike many current insurance plans, the plan places no lifetime limits on medical coverage and guarantees a full range of medically necessary or appropriate services.

## Uniform Benefits Help Consumers Choose

- A single set of benefits and standard cost-sharing arrangements will replace the hundreds of different benefits packages in today's market. Consumers, not insurers, will be in the driver's seat, choosing among plans on the basis of price and quality. There will be no hidden loopholes - - and regardless of age, income, or health status, the same set of rules apply to everyone.

**Preventive Services**

- This benefits package will include a full range of services that detect and prevent illness -- going beyond virtually all current insurance plans. Preventive services -- including annual physicals, well-baby care, immunizations, pre-natal care, cholesterol screenings, mammograms, and Pap smears -- are provided at no charge, no matter how a person gets care.

**Mental Health Services**

- For the first time, mental health and substance abuse services will be an integral component of the national system of health care. This historic change in the treatment of mental illness and substance abuse will require a phase-in period to allow time to develop the service system capacity to deliver and manage this more comprehensive benefit.

- The year 1996 will mark the first time every American will have some mental health and substance abuse coverage.

- Expanded mental health and substance abuse benefits will be offered no later than the year 2001, once the service and management capacity is in place.

**Prescription Drugs Coverage**

- Medicare recipients will receive all the benefits that they do today. In addition, the Health Security plan will expand Medicare coverage to include outpatient prescription drugs.

**New Home and Community-Based Long-Term Care Benefits**

- Seniors and Americans with disabilities will be able to stay at home or in the community and still receive the care they need through a new long-term care benefit.

- Medicaid nursing home coverage will be improved so that individuals can keep more of their resources.

CHART 11

# BENEFITS UNDER THE HEALTH SECURITY PLAN

## COVERED:

- Hospital Services
- Emergency Services
- Services of Physicians and other Health Professionals
- Clinical Preventive Services
- Mental Health and Substance Abuse Services
- Family Planning Services
- Pregnancy-related Services
- Hospice
- Home Health Care
- Extended-care Services
- Ambulance Services
- Outpatient Laboratory and Diagnostic Services
- Outpatient Prescription Drugs and Biologicals
- Outpatient Rehabilitation Services
- Durable Medical Equipment, Prosthetic and Orthotic Devices
- Vision and Hearing Care
- Preventive Dental Services for Children
- Health Education Classes

## NOT COVERED:

- Services that are not Medically Necessary or Appropriate
- Private Duty Nursing
- Cosmetic Orthodontia and other Cosmetic Surgery
- Hearing Aids
- Adult Eyeglasses and Contact Lenses
- In Vitro Fertilization Services
- Private Room Accommodations
- Custodial Care
- Personal Comfort Services and Supplies
- Investigational Treatments, (except for Medically Necessary or Appropriate Care provided as part of an Approved Research Trial)

CHART 13

# BENEFITS: THE HEALTH SECURITY PLAN COMPARED WITH CURRENTLY OFFERED PLANS

| BENEFITS | HEALTH SECURITY PLAN | | BLUE CROSS STANDARD, FEHBP | FORTUNE 500 COMPANY |
|---|---|---|---|---|
| | LOW COST SHARING (HMO) | HIGH COST SHARING (FFS)[1] | | |
| Medical Plan Maximum | No lifetime dollar maximum limit | No lifetime dollar maximum limit | Lifetime maximum for organ/ tissue transplants, mental health and substance abuse | Lifetime maximum for inpatient substance abuse |
| Out-of-Pocket[2] | $1500 / individual<br>$3000 / family maximum | $1500 / individual<br>$3000 / family maximum | $3000 / individual<br>$3000 / family | $1,000 per covered individuals - does not include deductibles |
| Deductibles | None | $200 / individual<br>$400 / family | $200 / individual<br>$400 / family | $200/individual<br>$400/family |
| Inpatient Hospital[3] | Full coverage, no coinsurance<br>no dollar or day maximum | 20% coinsurance<br>no dollar or day maximum | $250 per admission deductible<br>No dollar or day maximum | Full coverage in-network; 20% coinsurance out-of-network |
| Doctors Office Visits, Hospital Outpatient | $10 copay per visit<br>no dollar or visit maximum | 20% coinsurance<br>no dollar or visit maximum | 25% coinsurance | 20% coinsurance |
| Outpatient Lab | Full coverage | 20% coinsurance | 25% coinsurance | Full coverage in-network<br>20% coinsurance out-of-network |
| Emergency | $25 copay per visit, waived in emergency | 20% coinsurance | Full coverage within 72 hrs. of accident | Full coverage - required plan notification within 48 hours |
| Preventive Services[4] | Full coverage, based on periodicity schedule | Full coverage, based on periodicity schedule | 25% coinsurance<br>100% well childcare | not specified |
| Prescription Drugs | $5 per prescription | $250/year deductible<br>20% coinsurance | $50 deductible<br>40% coinsurance | 20% coinsurance<br>50% coinsurance for drugs for treatment of mental or nervous conditions |

1. FFS - fee for service
2. Deductibles counted toward out-of-pocket limits.
3. Mental health and substance abuse have separate provisions, see below.
4. Including well-child and prenatal care, periodic health exams, targeted tests and vaccines.

| BENEFITS | LOW COST SHARING (HMO) | HIGH COST SHARING (FFS) | BLUE CROSS STANDARD, FEHBP | FORTUNE 500 |
|---|---|---|---|---|
| Inpatient Mental Health (MH) and Substance Abuse (SA)[5] | Full coverage<br><br>30 day limit / episode<br>60 day annual limit | [redacted]<br>20% coinsurance<br><br>30 day limit / episode<br>60 day annual limit | $250 per admission deductible; 40% coinsurance<br><br>Unlimited days<br><br>$3,000 maximum for substance abuse treatment program - 28 day max.<br><br>$50,000 lifetime maximum | 20% coinsurance pre-certification required<br><br>Substance abuse: Full coverage in-network<br><br>20% coinsurance out-of-network; 30 days per stay; 2 stays maximum |
| Outpatient Mental Health and Substance Abuse | All outpatient except psychotherapy - $10 / visit<br><br>Psychotherapy - $25 / visit; 30 visits annual maximum<br><br>Hospital alternatives - full coverage; 120 day annual maximum | All outpatient except psychotherapy - 20% coinsurance<br><br>Psychotherapy - 50% coinsurance; 30 visits annual maximum<br><br>Hospital alternatives - 1 day deductible, 20% coinsurance; 120 day annual maximum | 40% coinsurance; 25 visits annual maximum - includes partial hospitalization<br><br>$50,000 lifetime maximum | 20% coinsurance for employee<br><br>50% coinsurance for dependent<br><br>Substance Abuse: 20% coinsurance, 30 visit maximum |
| Hospice | Full coverage | 20% coinsurance | 100% coverage for home hospice; $250 per admission for inpatient hospice with 5 consecutive day limit | Not specified |
| Home Health (HH)/ Extended Care (ECF - SNF and Rehab Hospitals) | Full coverage as inpatient alternative<br><br>100 day annual limit extended care facilities | 20% coinsurance as inpatient alternative<br><br>100 day annual limit extended care facilities | 25% coinsurance<br><br>25 visit limit for home nursing care | 20% coinsurance |
| Routine Eye Exams, Eyeglasses | $10 per exam, or 1 set of glasses.<br><br>Glasses limited to children only | 20% coinsurance<br><br>Glasses limited to children only | Not covered | Not specified |
| Preventive and Emergency Dental[6] | $10 / visit<br><br>Preventive services limited to children <18 | 20% coinsurance<br><br>Preventive services limited to children <18 | Covered at fee schedule | Not specified |
| Prenatal Care | Full Coverage | Full Coverage | 25% coinsurance | 20% coinsurance |
| Outpatient Rehabilitation | $10 copay per visit; reassessed at 60 days for continuing improvement | 20% coinsurance; reassessed at 60 days for continuing improvement | 25% coinsurance<br><br>25 visit limit | Not specified |
| Durable Medical Equipment | Full coverage | 20% coinsurance | 25% coinsurance | Not specified |

5. In 2001, inpatient and outpatient MH/SA limitations and higher cost sharing are phased out.

6. In the year 2000, adult prevention / restoration, orthodontia.

# MENTAL HEALTH AND SUBSTANCE ABUSE BENEFIT SUMMARY

*When untreated, mental disorders and substance abuse generate high social and economic costs. Treatment yields important benefits to both the individual and society, such as improvement in overall health, increased productivity, and reduced costs for health services, social welfare, and other public services.*

*Traditional mental health and substance abuse coverage, however, has been an impediment to realizing these aims. Currently, most private insurance plans cover only a very narrow band of mental health services and limit inpatient hospital care and outpatient visits to mental health professionals. Annual limits, lifetime caps, and copayments higher than for other illnesses further restrict access to mental health care.*

*Recent experience shows the promise of a different approach. Under this model, a health plan covers a comprehensive array of services and has the flexibility to manage the services according to medical and psychological necessity. This approach underlies the mental health coverage in the Health Security Act.*

[Note: Work is still underway on this particular aspect of the health care reform plan so there may be changes in this coverage prior to the time the proposed legislation is submitted to Congress.]

## Mental Health and Substance Abuse included in Comprehensive Benefit Package

- For the first time, mental health and substance abuse services will be an integral component of the national system of health care. This historic change in the treatment of mental illness and substance abuse will require a phase-in period to allow time to develop the service system capacity to deliver and manage this more comprehensive benefit.

- The year 1996 will mark the first time every American will have <u>some</u> mental health and substance abuse coverage.

## Annual and Lifetime Limits and Preexisting Condition Exclusions will be Eliminated

- Lifetime and annual mental health and substance abuse coverage limits will be eliminated.

- Individuals with a wide range of mental and substance abuse disorders are covered and exclusion from coverage based on pre-existing conditions will be eliminated.

**Encourages use of Innovative Alternatives to Inpatient Treatment**

- The new benefit is designed to encourage use of proven, cost-effective, innovative alternatives to inpatient treatment by including non-residential options such as partial hospitalization, day treatment, psychiatric rehabilitation, ambulatory detoxification, home-based services, behavioral aide services.

- In addition, outpatient services including diagnosis, brief office visits for medical management, substance abuse counseling and relapse prevention are covered to encourage early intervention and less restrictive treatment options.

**Support Provided for Family Members of Patients**

- Family members of an individual receiving mental or substance abuse services may receive medically necessary or appropriately related services in conjunction with the patient (so-called collateral treatment).

**Expansion of Benefits in 2001**

- Efficient management of benefits will determine the utilization of these services by the year 2001, prior to then utilization limits will exist.

- At this time, beginning in 1996, inpatient treatment is covered a maximum of 30 days per episode with a 60 day annual limit. As the treatment system adapts to the anticipated changes, the annual limit increases to 90 days in 1998 and is replaced by benefit management by 2001.

**Maintenance of Current Public Programs During Phase-in**

- The phase-in period requires continuation of the existing public system of mental and substance abuse treatment services. However, states are encouraged to integrate all aspects of treatment by combining their expenditure for public mental health and substance abuse programs with the funds available to health alliances .

## Health Research Initiatives

- Under health research initiatives, research in the area of mental disorders in children and adolescents, child abuse and neglect, women's mental health, mental disorders in the elderly and their caregivers, severe mental disorders and violence.

Sept. 93

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## WOMEN'S HEALTH

*Women are more likely to need health care than men, and yet are less likely to have insurance. Women are most likely to provide health care -- both professionally and informally-- yet are least likely to receive needed care themselves. They are increasingly the victims of life-threatening illness, yet still are at the bottom of our medical research agenda.*

- *Women make up a larger portion of the population holding part-time jobs and clerical or sales jobs--jobs which usually don't offer health insurance to employees.*

- *Women tend to live longer and thus require more long-term and home health services, services that are often unavailable and underfinanced.*

- *Many women must rely on their spouses for health insurance, and risk being dropped if they divorce or if they are widowed.*

### A Comprehensive Benefits Package

- Women will be guaranteed a comprehensive package of benefits that will include unprecedented coverage of preventive care, such as mammograms, diagnostic services, and prenatal care.

- All women will be guaranteed universal coverage regardless of marital status, employment status, or their ability to pay.

- It also provides coverage for diagnostic for women experiencing menopause including diagnostic visits and estrogen replacement therapy when medically advised.

### New Emphasis on Women's Health Research

- New research initiatives will concentrate on child health (including birth defects, prenatal care, and adolescent health), and on chronic and recurrent illnesses that primarily strike women -- including breast cancer, ovarian cancer, and osteoporosis.

- Medical research initiatives will be expanded to include efforts to isolate and cure diseases such as breast cancer and cervical cancer.

## Expansion of Home and Community-Based Long-Term Care Services

- Long term care services will be expanded to include new coverage for home and community care and strengthened coverage for nursing home care. This will alleviate the undue burden born by women, our nation's primary care givers for both children and elderly relatives.

Sept. 93

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## PRESCRIPTION DRUGS

*Prescriptions drugs are frequently the most cost effective intervention to treat medical conditions. However, these potentially life-saving products are often inaccessible because there is inadequate insurance coverage for Americans and because the cost of pharmaceuticals have far outpaced the general inflation rate. Until very recently, prescription drug price increases dwarfed percentage increases in the rest of the economy. Between 1980 and 1992, while the general inflation rate increased by 22 percent, drug prices increased 128 percent. New medications, especially biotechnology drugs -- although full of potential to advance medical treatment advance potential, are extremely expensive.*

*Almost 25 percent of Americans under age 65 do not have any type of public or private prescription drug insurance coverage. As a result, expensive, frequently taken medications (like antibiotics for children) become such a financial burden that many vulnerable populations go without.*

*The high cost of prescription drugs and their heavy reliance on medications, cause a significant financial burden for Older Americans. Since Medicare does not cover outpatient prescription drugs, only 46 percent of all drug costs for seniors are paid for by public or private insurance plans. As a result, prescription drug costs are the highest out-of-pocket medical costs for 3 out of 4 older Americans. A recent AARP study found that nearly 8 million Americans over the age of 55 report that they must choose between buying food and paying for prescription drugs.*

### Coverage for Prescription Drugs Included within the Comprehensive Benefit Package:

- All health plans for the under 65 population will be required to cover outpatient prescription drugs. Under the low-cost sharing option plan, the beneficiary will pay $5 per prescription. Under the high-cost sharing option plan, the beneficiary will be covered for 80 percent of his/her prescriptions after a $250 deductible is met. The insured person's copayments will count towards the overall out-of-pocket $3,000 cap.

### Provides a New Medicare Outpatient Prescription Drug Benefit:

- Like the nationally guaranteed package, Medicare beneficiaries will have 80 percent coverage for their medications after a $250 deductible is reached. In addition, a $1,000 annual cap is placed on out-of-pocket prescription drug costs. Costs above this amount will be fully covered.

**Drug Costs for the Under 65 Population will be Controlled:**

- The national guaranteed benefit, offered by private sector plans, will use managed care purchasing mechanisms to hold down the rate of growth of current drug prices. For new drugs, private purchasers will have the benefit of information provided by the National Health Board about the appropriateness of prices. The Board cannot regulate prices.

**Provides for Cost Containment of Medicare Prescription Drug Benefit:**

- The Medicare program, which will become the world's largest purchaser of medications, will receive a discount for prescription drugs currently on the market. Without the authority to use parallel private sector purchasing tools, the Secretary of Health and Human Services will be given authority to negotiate the price of new drugs for the Medicare program.

**Patient Counseling by Pharmacists:**

- To help avoid unnecessary, inappropriate and expensive hospitalizations, pharmacists will be required to provide patient counseling.

Sept. 93

# QUESTIONS AND ANSWERS

## WHAT YOU WILL PAY

Q: How much will I have to pay for the new benefits package?

A: Nobody can tell you exactly how much you'll pay for health care when the reform takes affect in your state. It will vary, of course, depending on where you live and which plan you choose. Everyone -- employers and individuals -- will be asked to take responsibility for contributing something, even if its only a small amount, to the cost of their health care. Premiums for working Americans will be shared by employers who pay 80% of the average cost premium and employees who pay the remaining 20%. If you choose a lower cost plan, you'll pay a little less and, like today, if you choose a higher cost plan, you'll pay a little more.

## BENEFITS - - SPECIALIZED SERVICES

**Q: If I develop cancer will I still be able to go to the Mayo Clinic?**

**A:** Academic health centers like the Mayo Clinic are the flagships of our health care system. Their research has fueled advances in medical care that have spread throughout the world. We also know that for some medical conditions, especially where treatment is very complex or the technology is changing rapidly, care is best provided in an academic center.

Under our proposal, all health plans must contract with one or more academic health centers for certain, specialized procedures and diseases. Health plans will be monitored to ensure that patients are offered appropriate referral to those centers.

Of course, not every health plan in the country will contract with the Mayo Clinic. If you live far away from Minnesota, you may have to join the fee-for-service option in the alliance which will cover the Mayo Clinic and any other hospital. If, on the other hand, you are interested in assuring that you can be cared for in a local academic center, plans will publish a listing of their contractual relations. And you can choose a plan which contracts with that center.

## ABORTION

**Q: Does the plan cover abortion?**

A: The comprehensive insurance package covers pregnancy-related services. Though abortion, like other types of surgery, is not specifically mentioned, most plans will cover it -- as they do now. Plans will cover abortions, as all procedures, when a doctor believes it is appropriate or necessary. Abortion coverage is not mandated, and a conscience clause allows doctors and health institutions, like a Catholic hospital, to exclude abortion coverage for moral or religious reasons.

What is new in this health plan is coverage for preventive care, including family planning, which should reduce the number of abortions which is our common goal.

The President has ~~I've~~ worked to create a health plan that covers abortion where necessary, but ~~I have~~ he has also worked to make sure that people have a choice and that abortion is as rare as possible.

## Mammography

Q: I am a women who is 42 years old and am concerned about the issues surrounding mammography screening. Under the Health Security Act will it be difficult to get this screening and will I have to pay a lot of money for this service?

A: The Health Security Act is deeply committed to womens' health issues. The plan is designed to work toward ensuring appropriate mammography screening in order to reduce the tragedy of breast cancer. Mammography screening is included for women over the age of 50, at no cost every two years. This recommendation was based on the best scientific literature available today, including the National Cancer Institute. For all other women mammography screening will be covered when it is medically necessary or appropriate. This decision will be made between a women and her physician. For these women, mammography will be covered with the same co-payments, just as any other medical procedure.

# MENTAL HEALTH BENEFITS Q & A

1. **Aren't mental illnesses and substance use disorders very different than other conditions? If these aren't real medical problems, we shouldn't cover them in health care reform.**

1A. No, MH/SA disorders are <u>not</u> different than other conditions. MH/SA disorders cause distress, and disability. They can produce significant dysfunction. Medical treatments are available that reduce distress and dysfunction, and prevent disability. Left untreated, MH/SA disorders lead to direct costs (including other health care problems) and indirect costs (e.g., lost productivity).

The majority of private insurance plans now cover MH/SA treatment, as well as Medicaid, Medicare, and CHAMPUS. Insurance companies have recognized the legitimacy of the suffering and disability these disorders cause.

2. **Won't everyone want to see a therapist if insurance will pay for it?**

2A. No, everyone will not want to see a therapist under health care reform. In a given year, only 10–11% seek care for a MH/SA problem. Only 6% of the population currently seek specialty MH/SA services. Of those who use ambulatory services, 50% only go once or twice. There is a great deal of misunderstanding of MH/SA conditions, as well as resistance to treatment, and stigma about seeking treatment. Many people are reluctant to admit they have MH/SA problems and seek help for them.

Furthermore, not everyone seeks care because not everyone has a mental disorder. Even those people with symptoms do not always experience distress or functional impairment sufficient to seek help.

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Furthermore, not everyone seeks care because not everyone has a mental disorder. Even those people with symptoms do not always experience distress or functional impairment sufficient to seek help.

**If there aren't any benefit limits, won't people be entitled to receive everything they want? How will decisions be made about who receives services?**

3A. People will receive services based upon what they need. Like all of health care services under health care reform, providers will be operating within a budget and will have to manage care. Their incentive will be to provide only care that is medically appropriate. Providers will make decisions about the scope, volume, and duration of services that are necessary and appropriate. A wide range of services will be available for those who need them.

4. **Won't we be paying for coverage of the worried well? I don't want to pay for someone to talk to my neighbor about their problems of living.**

4A. Enrollees will not receive care unless they have a diagnosable MH/SA disorder. Not everyone meets the criteria for such illnesses. Even when they meet the criteria, not everyone would meet the criteria of significant risk for functional impairments at work, home, school, or community. Any enrollee will be evaluated if they perceive a need for MH/SA treatment, but no one will get care unless it is medically necessary and appropriate. Persons with SA problems or serious psychological symptoms will be eligible for these services. Enrollees will still be free to pay out-of-pocket for services they may desire outside the health plan.

5. **Given the dissatisfaction among providers with managed care, why is this being proposed?**

5A. People have complained about restricted access, micro-management, intrusion on professionals' decisions about care. Utilization management strategies will now be used for all of health care -- mental health providers are not being singled out for special attention. Health care reform offers the opportunity and challenge to providers to organize and manage care, to assure efficient and appropriate utilization of health care resources.

**Does the health reform proposal include treatment on demand for drug abuse?**

6A. The plan includes treatment for substance abuse. Experience tells us that this benefit will increase access and number of users of the benefit, likely by 30–40%. However, careful management of the benefit will decrease the volume of services per user. This is not a costly treatment, compared to the costs that result from lack of treatment. Substance abuse is estimated to encompass only approximately 1.5% of total health care costs, and 15% of MH/SA care costs.

7. **Why should we cover substance abuse in this plan?**

7A. Right now, we are spending much more in this country to deal with the effects of substance abuse than we are on treating the problem itself. Increased crime, criminal justice costs including incarceration, lost productivity, premature mortality, child abuse, fetal alcohol syndrome, crack babies, spread of the AIDs epidemic, a resurgence of TB -- all of these costs are a direct or indirect result of the monumental drug abuse problem in this country.

If we redirect adequate dollars to prevention and early intervention, we can improve the quality of life for many Americans, and save many billions of dollars at the same time.

8. **How will we know that plans don't ignore the needs of the severely ill and undertreat those with mental illness or substance abuse? How will we know if plans are doing what they are paid to do?**

8A. The system includes stringent accountability standards for AHPs. A "report card" will be completed on each plan every year. Plans will be monitored for their treatment of the severely ill, and those suspected of undertreatment will be investigated. HAs may reprimand, reeducate, or decertify substandard AHPs. Consumer surveys will be another important measure of AHP performance.

**Aren't we taking a major risk if health care reform leads to an elimination of the public sector MH/SA system and "safety net"?**

9A. The Plan provides for an array of services that cover all of the functions once performed by the public system, except forensic services. One goal of health care reform is to create a unitary system of care. The current system is fragmented, duplicative, unfair, confusing, inequitable, and discriminatory. Health care reform allows the elimination of this two-class, two-tiered system. The states will have a major role in system oversight and monitoring.

Resources from the public sector are brought in to be part of the reformed system. States can bring in public sector providers and programs as preferred providers during a transition period; the transition period is intended to ensure that states can develop necessary capacity.

10. **How will health care reform help the homeless person on the street who has a mental illness? Won't the elimination of the public sector safety net result in more homeless persons with mental illness?**

10A. The Plan includes a strong outreach effort. A special funding stream has been proposed which will provide outreach to the homeless mentally ill and other historically underserved populations. We will also increase access through educational programs for all Americans about what health care reform means for them.

Currently, no one is accountable to provide services to the homeless. This plan provides guaranteed coverage, outreach, and flexibility to provide mobile services and a range of services that are more likely to respond of homeless persons with mental illness. We do not believe this plan will create more homeless mentally ill, and monitoring activities will watch this issue closely.

**Aren't mental health and substance abuse treatments open-ended, without clear cut goals or endpoints?**

11A. This is a myth. The fact is that when people feel better and their symptoms resolve, they stop treatment. Most people only go for 1 or 2 sessions of therapy. Mental health and substance abuse experts have developed innovative treatments, which are able to help people with these problems in shorter time than ever. Traditional, longer therapies are still available for those with more complex problems. In addition, medications now offer symptom control for many persons who previously required indefinite hospitalization because of mental illness. Scientific advances promise to improve treatments even more in the future.

**12. Does the plan stipulate who can provide mental health and substance abuse treatment?**

12A. The President's plan leaves decisions about providers and settings to the states, which will be responsible for licensing and certification. These decisions will not be made more explicit at the federal level. If a given professional group provides cost-effective services, it would be to the state's advantage to include them as providers.

**13. What will happen to solo practitioners?**

13A. Solo practitioners will be able to enroll as providers in AHPs, to qualify for reimbursement for the care of plan enrollees. They may remain independent, and receive reimbursement as out-of-plan providers. Individuals will be permitted to pay out-of-pocket for any service they desire which the AHP does not provide to them.

**Does this plan cover psychotherapy?**

14A. The Plan covers medically necessary individual, group, and family therapies of all types. Most people will have brief episodes of treatment. Persons with more severe and complex disorders (who are very symptomatic and functionally impaired) will be provided extended psychotherapy. Like all MH/SA treatment, this will be part of a managed system of care.

15. **Is the fact that MH/SA is being included going to increase premiums?**

15A. It is likely that most people will see an increase in their premiums. In return, enrollees receive full MH/SA benefits, including catastrophic coverage in the private sector (which now results in transfer to the public system of care).

6. **Are there gatekeepers? Is there a procedure for grievance? Denial of services?**

16A. Under the plan, each enrollee will be entitled to screening and assessment of MH/SA complaints, with referral for medically appropriate services. For enrollees unhappy about treatment or denial of services, a grievance procedure will be available.

17. **What happens if an enrolllee doesn't get along with the assigned therapist?**

17A. Each AHP will have a selection of therapists. If the enrollee does not get along with one therapist, others will be available.

18. **Won't AHPs want to avoid enrolling people with mental illness and substance abuse?**

18A. The Plan will include a system of risk adjustment. AHPs will be paid a combination of pre-payment and reimbursement based on services provided. Adjustments will be made for high-cost cases, to minimize the incentives to undertreat. In addition, because AHPs have responsibility for the care of their enrollees, and have no public system in which to dump patients, it will make financial sense for them to treat those with MH/SA disorders rather than waiting until symptoms become so severe that more expensive treatment is required.

Clinical Laboratory Improvement Act (CLIA)

Ease reglatory burden on laboratories performing simple and moderately complex tests. Revise personnel standards for rural and urban underserved ares.

Rural Cooperatives

# Clinton Presidential Records
# Digital Records Marker

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This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

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## C. STATES UNDER REFORM

POLICY BRIEFS:

TRANSITION TO NEW SYSTEM
STATES: THEIR ROLE IN REFORM

Q & A

- Single Payer

# POLICY BRIEF

DRAFT

## TRANSITION

*States may enter the new system as early as January 1, 1995 and all states must enter the new system by January 1, 1997. States are given start-up funds and technical assistance in developing state plans and legislation. States entering the new system on a fast track have some additional flexibility in complying with federal regulations, all of which may not have been completed at the time of a state's entry into the new system. To assure a rapid transition, the National Health Board, the Department of Labor and the Department of Health and Human Services are authorized to issue any regulations on an interim and final basis.*

### Incentives for States to Enter the New System Quickly:

- Federal discounts for low-wage small businesses and individuals;
- Access to additional start-up funds;
- Reduced Medicaid costs;
- Faster achievement of guaranteed, comprehensive benefits for the state's residents.

### Immediate Insurance Reform Measures:

To reduce the potential for disruption in the health care system during the transition, certain insurance reform measures will be enacted, and will take effect immediately upon passage of the legislation. These include:

- Prohibiting insurers from dropping people or failing to renew their coverage, with strictly defined exceptions.
- Limiting premium increases. Premium increases that exceed a prescribed percentage will be subject to prior approval by state insurance commissioners.
- Limiting the application of exclusions for pre-existing medical conditions to new employees and their dependents.
- Prohibiting self-funded health plans and employers with insured health plans from imposing waiting periods for coverage on any employee otherwise eligible under terms of the plan.

- Prohibiting employers and insurers from reducing existing coverage for any medical condition or course of treatment if the anticipated cost is likely to exceed $5,000 a year.

- Authorizing the Secretary of HHS to establish a national high-risk pool. It will provide insurance coverage to individuals who get dropped by their health plans or who otherwise could not get coverage during the transition. The pool will be funded through premiums charged to enrollees and assessments against health insureers included self-funded plans.

**Limiting Price and Expenditure:**

While there is no imposition of short-term cost controls, the President will urge all health care sectors to limit price and expenditure increases to a specified amount.

- The Secretary of HHS will monitor prices and expenditures and periodically report on conformity with the President's request.

- The Secretary is given increased statutory authority to obtain information on prices and expenditures to assist in monitoring compliance.

- Confidentiality of data is assured.

Sept. 93

DRAFT

## STATES-- A NEW ROLE UNDER HEALTH REFORM

*Right now, federal and state governments lack sufficient authority to control costs. Many states, facing rising Medicaid budgets and diminishing private insurance coverage, have tried to contain costs and expand access, only to run into road blocks in federal law, such as ERISA, Medicaid, and Medicare. Although the states regulate private insurers, the haven of self-insurance created by ERISA has greatly limited the states' ability to control health costs.*

*On the other hand, while the federal government determines policy for Medicare, it shares authority with the states over Medicaid, and it has no responsibility for regulating private health insurance. Federal cost containment measures focus on public programs and often have the effect of shifting costs to private payers. Limiting expenditures only for federal programs has resulted in increased cost-shifting from Medicaid and Medicare to private insurers and the states.*

*The health reform proposal follows a comprehensive approach to controlling the growth of costs in both the public and private sectors, and establishes a new partnership between the states and federal government, with joint responsibility for assuring high quality health care, universal coverage, and enforceable cost control.*

*The program will not try to run health care from Washington-- it will allow states, alliances, and health plans competing for consumers to work out solutions at the local level.*

### The Federal Framework

The federal framework sets a uniform standard for financing, benefits, and quality assurance. Under the new system, employers and individuals have the same obligations nationwide. A state cannot deny coverage to any person guaranteed health benefits under federal law, nor can a state reduce benefits beneath the federally guaranteed level. Similarly, states must adhere to the financing system established for the guaranteed benefit package.

### The State Role

Within the national framework, the program allows for wide variations in state policy on the organization and delivery of health services. Under the Health Security program, direct control of the regional health alliances, the certification of health plans, and the licensing of providers will rest with the states.

- Under the new system, the states remain responsible for regulating health plans and health care providers. The states also immediately become responsible for establishing the new regional health alliances. Thus, the states have the capacity to adapt the national framework to suit their own conditions.

- The phasing in of the new program will proceed state by state. Within the years 1995 to 1997, states will determine how quickly the alliances are established and coverage is extended to all. State-by-state phase in and a central role for the states in running the new system will allow for adjustments in the national framework to fit local conditions.

- Federal support will make it possible to extend coverage to all without overburdening employers and employees in low-wage areas. Without this financial assistance, states with low per capita income and large numbers of part-time and unemployed workers would be hard-pressed to achieve universal coverage.

- A reserve fund established under the program will help states cope with regional recessions.

- States will continue to administer the Medicaid program for long-term care, and to oversee or conduct enrollment for cash assistance recipients who get their plan paid for through Medicaid.

## HEALTH CARE REFORM - BENEFITS TO THE STATES

*Governors and state legislators find themselves in the position of writing smaller and smaller checks for schools and roads and libraries and bigger and bigger checks for Medicaid and state employee health benefits.*

*In an effort to lighten the load of exploding Medicaid costs, state capitals and Washington have engaged in a game of fiscal hot potato -- shifting costs of the program back and forth to one another, while costs keep rising. The health security plan will help to end the gaming and build a new and constructive partnership between states and the federal government. A partnership based on seamless coverage, enforceable cost control, and Medicaid savings will benefit everyone -- especially the states.*

### DISCOUNTS

- The Federal government will provide the funds for employer and consumer discounts for low-wage firms and low-income families.

- The Federal government, not state employee health programs, will help pay for the health benefits of early retirees.

### CAPS

- The Federal government will take responsibility for enforcing caps on premium increases.

- State Medicaid spending for the guaranteed benefits will be capped at the budgeted rate of growth, resulting in substantial savings from projected spending.

### REDUCED SPENDING

- States and localities will be able to reduce direct spending on the thousands of residents on General Assistance/General Relief medical assistance when those individuals will be guaranteed the comprehensive benefits package.

- States and localities will be able to reduce direct support to hospitals and clinics that now care for the uninsured.

- Spending on Medicaid long-term care services will be transferred to the new long term care program and capped at the budgeted rate of growth. In aggregate, state spending for the new long term care program will be the same as baseline spending for long term care services under Medicaid.

# QUESTIONS AND ANSWERS

## SINGLE PAYER

**How would the single payer system work?**

A state that wants to use a single payer system would describe in a plan how its single payer system will work, just as it would describe how a regional alliance system would work. It would submit the plan to the National Board.

The plan would have to demonstrate how the state will accomplish the requirements under the new system -- the comprehensive benefit package, universal coverage, quality, information, and compliance with budget requirements. A state has the authority to include everyone in the single payer system, including those who would otherwise be covered by corporate alliances.

If a state wants to include the Medicare population, it would have to receive a waiver from HHS. The waiver would be granted only if the state could demonstrate that Medicare recipients and the Medicare trust fund would be no worse off.

The National Board will approve the plan if the state plan demonstrates how it will meet the requirements, such as universal coverage and the benefit package.

A state must finance a single payer system either with the financing under this plan or with a payroll tax that produces the same amount of revenue. Additional costs, such as for reduced premium payments by individuals, or for additional benefits, could be financed in any way the state chooses.

A single payer system is one in which the state or a designated agency makes payments directly to health care providers with no intermediaries, health plans, or other entities assuming financial risk. Providers, such as HMO's, networks of doctors, and hospitals, may continue to assume risk by accepting captitated payments to cover individuals.

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## D. HEALTH ALLIANCES

POLICY BRIEF:

HEALTH ALLIANCE BOARD

Q & A

- Alliances

# POLICY BRIEF

## HEALTH ALLIANCE BOARDS

*Health alliances will represent the interests of local consumers and employers, bargaining on their behalf and ensuring that health plans meet quality and information standards. The alliance boards will negotiate and contract with health plans. Although states will appoint board members of regional alliances, the Health Security plan will specify general criteria to ensure that alliances represent the business and families paying for health care in that area.*

### Status of Alliance Boards

- Alliances may be established as nonprofit corporations, their boards will include an even number of employer and consumer representatives, plus one member to serve as chair.

- States may also establish alliances as public agencies or independent public corporations, but they must include advisory boards representing both consumers and providers.

### Board Representation

- Boards must include representatives of at least four groups that purchase coverage through the alliance: employers, employees, self-employed individuals, and consumers.

- Health care providers, owners of health plans, individuals who derive substantial income from health plans or providers, or owners, employees, board members, and others who derive substantial income from pharmaceutical companies or suppliers of medical equipment, devices, and services will be prohibited from serving on alliance boards.

## Provider Advisory Boards

- Each alliance will establish a Provider Advisory Board, with representation of doctors, nurses, and other health care professionals who practice in the plans offered in that area.

## Nominating Councils

- States may establish statewide councils composed of representatives of employer and consumer organizations to prepare lists of nominees for alliance boards.

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# QUESTIONS AND ANSWERS

# ALLIANCES

Q: ~~Two issues are of particular concern to Republicans on the Committee, and it might make sense for Mrs. Clinton to address them in her opening statement. Senator Kassebaum is very concerned that the~~ alliances ~~will~~ Won't be too big, regulatory, and bureaucratic--more like government agencies than purchasing cooperatives?

A: --The alliances will represent the purchasers of health care in an area; **it is the purchasers who will control the alliance, not the Federal government.**

**--The alliances resemble the benefits departments of large corporations much more than they do governmental entities.** Their job is to negotiate the best deal possible with health plans on behalf of the members of the alliance, to provide information to consumers, to handle enrollment, and to adjudicate complaints.

**--Alliances do not regulate health plans.** That responsibility is left to state governments, where it is today.

--In fact, alliances are **required** to offer any health plan that is certified by the State government, is willing to fulfill the same contractual obligations as any other insurer offered by the alliance, and will offer a premium consistent with the budget.

--The whole point of the managed competition system is to **put the individual consumer in the driver's seat, not the government and not the health plans.**

## HEALTH ALLIANCES

**Q: Don't the boards of the health alliances offer plenty of opportunities for political corruption?**

A: No. First of all, the plan has very strict rules preventing anyone associated with the health care industry from serving on the board of an alliance. Only representatives of the employers and consumers who receive coverage through the alliance can serve on the board. The board and the alliance will be held accountable, with all its workings in full, public view. If any problems were to develop, there would be a powerful constituency -- everyone who gets health care in that region -- with an interest in solving the problem immediately.

The alliance's responsibilties are limited. It acts as a purchasing agent -- and makes sure health plans meet certain standards. It cannot reject any health plan which meets the standards specified in the law; it must accept all qualified plans.

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## E. HEALTH PLANS/INSURANCE REFORMS

POLICY BRIEFS:

INSURANCE REFORMS
RISK ADJUSTMENT AND REINSURANCE

Q & A

- Risk Adjustment & Reinsurance

# POLICY BRIEF

DRAFT

## INSURANCE REFORM

*Currently, health insurers use a variety of stratagies to discourage or prevent less healthy people from getting insurance. For example, insurers commonly (1) refuse coverage to people who cannot meet "medical underwriting" criteria; (2) limit benefits to people with preexisting health conditions; (3) charge higher premiums for less healthy people; and (4) refuse to insure people in certain industries or occupations. As a result, many people who need health insurance cannot get it.*

The Health Security plan will change the insurance market by doing the following:

- **Requiring all health plans to accept all applicants**, regardless of health status
- **Prohibiting all pre-existing condition exclusions** and guaranteeing that coverage cannot be dropped for any reason
- **Spreading risk broadly** through the use of community rating
- **Enhancing financial protection** of enrollees and providers in the case of financial failure of health plans.

### Guarantees Choice of Health Plans:

- The Health Security plan will require all health plans to accept any person who applies for coverage, regardless of the applicant's health status, job or claims history.

### Provides Security:

- The Health Security Act will provide security to all Americans by assuring that their coverage will not be limited or dropped for any reason. People who switch jobs or move to a new place will have no gaps in their coverage.

**Community Rating:**

- The Health Security plan will rely on community rating -- charging healthy people the same as sick people -- to spread health costs over a large population. Premiums for the comprehensive benefit package will be adjusted only for geographic location and family status.

- Rate increases will not be targeted to sick people or groups. No one will pay more for health insurance because of a pre-existing condition, current illness or any other individual characteristic.

**Enhanced Financial Protection:**

- If a health plan does have financial problems, people will be protected through immediate enrollment in new health plans. Physicians and hospitals will be not be permitted to bill individuals for the unpaid claims of a financially troubled health plan.

- Health plans will be required to meet federal minimum standards for solvency.

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# ADDRESSING BIASED SELECTION THROUGH REINSURANCE AND RISK-ADJUSTMENT

## BACKGROUND

Competitive insurance markets must address the problem of "biased selection." Biased selection occurs when a health plan enrolls a population with a better or worse than average health status.

The problems of biased selection can result from the actions of individual consumers or health plans.

Individual consumers can contribute to biased selection through their decisions about when to purchase insurance and the level of coverage to purchase. Consumers who know they are in poor health or at higher risk for needing health care services are more likely to choose to insure and to choose more extensive benefits when they do insure. This tendency is often referred to as "adverse selection." In a reformed market, adverse selection may occur if higher-risk people systematically select certain types of health plans (e.g., plans that offer greater choice of health care providers).

Health plans can contribute to biased selection through the use of various techniques which discourage enrollment by higher-risk people and attract healthier enrollees. In the current marketplace, insurers use medical underwriting, preexisting condition exclusions, minimum group participation requirements, and industry exclusions to prevent enrollment by poorer risks. Even in a reformed market, health plans may attempt to influence the composition of their enrollment. Decisions relating to which providers to contract with, where to locate service areas and facilities, and the amount of service and support to provide higher-cost patients all can affect the mix of enrollees attracted to a health plan.

Biased selection affects the premiums charged by health plans and therefore how the competitive market operates. If biased selection occurs, health plans with relatively sicker or higher-risk enrolled populations generally will have higher claims expenses than plans with average enrollment mixes, and will be forced to charge higher premiums to cover their higher costs. On the other hand, health plans with relatively healthier enrolled populations will have relatively lower claims expenses and can charge lower premiums.

To the extent that health plan premiums reflect biased selection rather than the efficiency and quality of the competing plans, the benefits of competition are diminished. To achieve all of the benefits of competition among health plans, strategies to address the problem of biased selection must be pursued.

**ADDRESSING BIASED SELECTION**

The health reform plan addresses biased selection in several ways:

- Universal coverage and insurance reform address the problem of health plans cherry-picking only healthy risks.

- In the short-run, limited premium adjustments and mandatory reinsurance is used to protect health plans from adverse selection.

- Within a couple years after reform, a prospective risk-adjustment system will be developed. Premiums paid to health plans will be adjusted to reflect the health status of the plan's enrollees.

Universal Coverage and Insurance Reform

Many of the risk selection problems that exist in the current system are addressed through assuring universal coverage to comprehensive benefits and through insurance reforms.

- Universal coverage. In the current system, insurers worry that people with or at high-risk for health problems are more likely to seek coverage. In the reformed system, everyone will have health insurance coverage. People will be unable to wait until they have health problems to choose coverage, so this component of the adverse selection problem will disappear.

- Uniform comprehensive benefit package. In the current system, insurers worry that less healthy people tend to choose richer benefits. In the reformed system, everyone will have the same comprehensive benefits package. There will be less reason for high-risk or low-risk people to systematically choose a particular health plan because of the level of benefits offered.

- Guaranteed issue and renewability of coverage. Insurers use medical underwriting and a host of other strategies to discourage enrollment by higher-risk people. Under a reformed system, all health plans will be required to accept any enrollee who applies for coverage. Plans will not be able to discourage enrollment based on health status.

- Enrollment through alliances. Under the current system, health plans can influence the composition of their enrollment through their marketing activities. Under a reformed system, enrollment will occur through alliances. Regulations can be used to assure that marketing is not directed only toward more desirable areas. Standard service areas for integrated health plans could be used

to limit the ability of health plans to avoid higher-cost areas.

- Satisfaction and disenrollment surveys. Health plans can discourage higher-risk enrollees by giving them poor service or failing to contract with providers that can address special needs. Under a reformed system, enrollees can be periodically surveyed to detect problems with health plan service. People who switch plans can be surveyed to determine if they left their former plan because of poor service or inadequate access to specialists. Problems uncovered can be addressed through alliance contract negotiations or state certification.

Mandatory Reinsurance

Mandatory reinsurance will be used to protect health plans that attract a disproportionate share of enrollees with high-cost or chronic illnesses.

Under a reinsurance approach, health plans share the costs of treating higher-cost or chronically ill enrollees. If a health plan has a high-cost claim or enrollee, the reinsurance system reimburses a portion of a health plan's payments for these cases. Health plans are required to pay premium to the reinsurance fund for this protection.

Reinsurance systems are being used today in a number of states as part of their insurance reform efforts. For example, as part of its community-rating law, the State of New York created a reinsurance pool for high-cost cases. Insurers are required to pay a premium to the reinsurance pool; in exchange they receive lump-sum or periodic payments from the pool when they have a claim for one of the conditions covered by reinsurance.

Risk Adjustment to Health Plan Premiums

**Short Term Strategy**

A short-term strategy to address biased selection will be pursued that contains both prospective and retrospective components. This approach was recommended by a panel of experts on risk adjustment

In the short-term, the following measures will be relied upon:

- Demographic adjustments to premiums. Cost weights for demographic cells (age, sex, etc.) will be developed from National Medical Expenditure Survey (NMES) and private insurance data sources.

- Limited health status adjustments. Adjustments may be made for perceived health status or the presence of

chronic conditions, based on data collected through the use of health status surveys. NMES and private insurance data will be used to develop cost weights in the short term.

- Retrospective adjustments for high cost cases. Reinsurance will be used to reimburse health plans for some of the costs associated with high-cost cases or diagnoses. Reinsurance may reimburse a percent of costs above a reinsurance threshold or may provide specific payments for identified high cost conditions, like AIDS or organ transplantation. Cost weights will be developed from a private insurance data base (New York State uses weights developed from Kaiser data).

- Geographic adjustment. Adjusters will be developed to adjust for price (and perhaps utilization) variations within health alliance areas. Such adjustors already exist to some extent for Medicare. Cost weights will be developed from private insurance and Medicare data.

**Medium Term Strategy**

Within a few (3-5 years) years, health status risk adjustors will be developed which rely on diagnosis-based measures. The risk adjustment system will rely on diagnosis and treatment information collected through the data and quality information system implemented as part of health care reform. Reinsurance may continue to be used for particularly high-cost cases.

**Mental Illness**

Given the present state of knowledge, mental illness will need to be treated differently than other conditions in a risk adjuster system. There is more disagreement about an appropriate patient classification system than with physical illness, and the severity and resource demands of patients within a diagnostic category probably vary more than with physical illnesses. In addition, underservice is a problem for the severely mentally ill, and a purely prospective payment could exacerbate the problem. A heavy reliance on reinsurance will be necessary in the short and medium terms.

**Research and Model Systems**

Federal research efforts will be necessary to support the development of model risk adjustment and reinsurance systems that can be used by states and alliances. The federal government will increase its support for new research related to the development and testing of risk adjustment systems for the short and medium terms. An on-going program aimed at improving existing risk adjustment measures and developing new approaches will be maintained at the federal level.

# QUESTIONS AND ANSWERS

## Risk-Adjustment Questions and Answers

**Q: Researchers and others have been trying to develop a risk-adjustment system for Medicare for ten years and have not succeeded. How are you going to develop a system in two years?**

Our plan deals with the risk-adjustment problem in two stages. During the first couple years after reform, we rely on a combination of demographic premium adjustments and mandatory reinsurance to address biased selection. Demographic adjusters for age, gender and area are possible with current technology. Reinsurance is currently being used in a number of states as part of small group reform. We also will develop limited health status adjusters, based in survey information collected from health plan enrollees.

Beginning several years into reform, risk-adjusters will be developed which rely on diagnosis-based measures. Health plans will be paid based on the relative health status of the population they enroll.

The new quality management system is key to our ability to develop a sophisticated risk-adjustment system. Current efforts to implement good risk-adjusters have been frustrated by the lack of information about the relative health status of enrollees of health plans, especially HMOs. Our quality management system captures diagnosis and treatment information about each patient encounter, which will for the first time give us the ability to evaluate the relative health status of the enrollees of each health plan.

**Q: How did you arrive at this strategy?**

During the task force process, we met with the leading experts in risk-adjustment field. We also met with health plans that are currently experimenting with or actually using risk-adjustment, for example to adjust payments to group practices. There was broad agreement that our approach was appropriate.

**Q: Current risk-adjusters explain only a small amount of the variation of costs for any specific enrollee. Critics question whether this is enough to protect health plans?**

No adjustment system can explain all expected cost variation at the individual level-- much of the variation in costs is random. The goal is to develop adjusters that predict enough variation in health care costs so that health plans can compete successfully on the basis of efficiency.

The issue of how much variation in costs can be "explained" by risk adjusters is very complicated. For example, critics claim that current adjusters based on demographic factors, such as age and gender, explain only about one percent of variation in expected costs for an individual. This is true. However, these factors explain quite a bit of the variation in expected costs across

groups, such as the groups of enrollees in two health plans. Thus, adjustments for age and gender are very important to assure proper payment to health plans that get a disproportionate share of older people or woman of child-bearing age.

Several promising risk-adjustment approaches are currently being developed and implemented. They use prior health care use by individuals to predict their future costs and have the potential to explain a meaningful percent of the cost variation that can be explained. The federal government will be conducting and sponsoring research efforts and demonstrations to develop and improve these adjusters over the next couple of years.

**Q: Until risk adjusters are perfected, won't health plans have incentives to avoid higher risk enrollees? How will these people be protected?**

While the incentive may still be there, the insurance reforms under the proposal -- such as community rating, enrollment through alliances, guaranteed renewability -- effectively eliminate the tools health plans use to cherry-pick.

**Q: Critics are concerned that fee-for-service plans suffer from adverse selection if the risk-adjusters are not good enough. For example, the fee-for-service plan in the Minnesota public employees program became financially inviable when managed competition was put in place there. How will these plans be protected?**

We recognize the need to protect fee-for-service plans from adverse selection. That is why we mandate reinsurance for high-cost cases. Reinsurance will be required until better risk-adjusters are developed.

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## F. QUALITY AND RESEARCH

POLICY BRIEFS:

QUALITY
RESEARCH
PROTECTING AGAINST FRAUD AND ABUSE

Q & A

- Rationing
- ~~Research~~ & New Technology

# POLICY BRIEF

DRAFT

## QUALITY MANAGEMENT AND IMPROVEMENT

*Quality assurance programs in the current system rely on external checks, forms and process manuals. Insurance carriers, peer review organizations, and state and federal inspection agencies audit the work being done in hospitals, doctors' offices and laboratories, and penalize providers if they fail to follow rules, and to fill out forms properly. Patients play a minor role, lacking reliable information to compare the quality of health plans, doctors or treatments.*

*Health reform will transform the current paper-driven process into patient-driven quality system focused on performance measures and continuous improvement.*

### Standardized Reporting of Information on Quality:

- Easy-to-understand, comparative information on quality of care helps doctors and consumers pick health plans, doctors, hospitals and courses of treatment best for them.

- It also enables health plans and providers to evaluate and improve the quality of their care and enables assessment of the level of quality in the system as a whole.

### Quality Protections for Health Plans:

- Health plans must meet nationally determined conditions of participation to participate in the health alliances. These standards will cover:

  -- fiscal soundness;
  -- truth in marketing;
  -- credentialing of providers;
  -- enrollee rights and responsibilities;
  -- confidentiality;
  -- complaints;
  -- disenrollment for cause;
  -- disclosure of utilization controls;
  -- internal quality management;
  -- data management and reporting; and
  -- confidentiality.

**Quality Improvement by Clinicians and Institutions:**

- Quality improvement will be accomplished most successfully by providing quality improvement tools, not new rules. Better information about the effectiveness of treatments, increased development and dissemination of practice guidelines, and data to examine variation in practice patterns give health plans and providers the management tools they need to drive quality improvement in their own organizations.

**Strengthened, Streamlined Quality Oversight:**

- The Health Security Act will strengthen and significantly streamline ~~the~~ three quality assurance programs--the Medicare PRO program, the Clinical Laboratories Improvement Act (CLIA), and licensure and certification standards for institutional providers-- that provide basic consumer protection.

- It will alleviate the undo burden on providers these three separate programs place on providers..

**Quality Improvement through Research, Technology and Guidelines:**

- The Federal Government will support the development and dissemination of clinical practice guidelines.

- It will also support research on topics central to quality management, including dissemination methods, quality measurement, and design of information systems.

- In addition, the Federal Government will set priorities for evaluation research (e.g. effectiveness, cost effectiveness, and outcomes research).

- The assessment of costs and effectiveness of new procedures and technologies will be increased through expanded funding and refocusing of clinical trials on more common conditions, high-cost procedures, and highly variable treatment patterns.

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## RESEARCH

*Medical research is an important strategy for containing and reducing health care costs, while improving quality of care. The advancement of research and technology increases the potential for more effective, cheaper treatments increases.*

*Historically, small investments in research have paid billion dollar dividends in terms of decreased costs and restoration of productivity. A recent NIH report estimated that approximately $800 million invested in clinical and applied research had the potential to realize a one-year savings of between $5.2 billion and $6.7 billion based on 1989 prices.*

*Advances in medical science, development of new medications and technology, as well as innovations in the organization and delivery of personal and public health services hold the promise of increased efficiency in the health care system, longevity and improved quality of life.*

### Expands Prevention Research

- The National Institutes of Health will expand prevention research in priority areas including:
    - Child health
    - Alzheimers
    - Cancer
    - Heart disease
    - Bone and joint disease.
    - Reproductive health
    - Mental health
    - Substance abuse
    - Vaccine development for AIDS, Tuberculosis, and other infectious diseases
- Health and wellness promotion include research into the effects of nutrition, including examining dietary links to disease, physical activity, and environmental health hazards on better health.
- Workplace injury and illness prevention research and demonstration programs.

**Quality and Outcomes Research:**

- The Health Security plan will also expand research into improving the effectiveness and appropriateness of clinical practice such as quality and outcomes research. The development and dissemination of clinical practice guidelines will provide the knowledge to increase the cost-effectiveness of care in a reformed health care system.

**Consumer Choice and Quality Information:**

- The Health Security Act relies on consumers making cost and quality conscious decisions regarding their choice of provider and health care plan. Accordingly the plan provides for research into improving information resources that enable consumers to make these choices.

- Prospective research includes consumer awareness of benefit plans, supplemental coverage, cost sharing and utilization; effect of consumer knowledge on selection of plans; forms of information and media most effective in assisting consumers; and customer satisfaction.

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## PROTECTING AGAINST FRAUD AND ABUSE

*Health care fraud and abuse rob American taxpayers of as much as $80 billion each year[1]. Common examples include overcharging for services, charging for medical care that was never delivered, delivering unnecessary services and providing financial incentives to doctors to refer patients to certain facilities.*

*Simplifying the health insurance system will eliminate opportunities for fraud based on exploiting today's complex system, both public and private. Reforms such as the adoption of standard forms throughout the industry and a uniform coding system will not only reduce administrative costs but also reduce opportunities for fraudulent billing.*

### Criminalization of Health Care Fraud

- For the first time, health care fraud will be designated as a crime, and violators will face stiff penalties.
- A new health care fraud statute, modeled after existing mail and bank fraud laws, will establish penalties for schemes that defraud health plans.
- A new federal criminal statute will prohibit making false statements deliberately to health plans, health alliances or state agencies.
- A new criminal statute will ban the payment of bribes, gratuities or other inducements to employees of health plans, health alliances or state government agencies.

### Federal Anti-Fraud Efforts

- The scope of federal anti-fraud efforts will extend beyond government programs to include fraud in the private sector.
- The Departments of Justice and Health and Human Services will organize an All-Payer Health Care Fraud and Abuse Enforcement Program to coordinate federal, state and local law-enforcement activities.
- Federal authority to seize assets from fraudulent providers and to levy criminal penalties for health care fraud expand to include filing false claims against health plans and other fraudulent activity. Assets seized will be used to help support anti-fraud efforts.

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[1] General Accounting Office

## Enforcement of Anti-Kickback Laws will be Enforced

- The existing anti-kickback law will protect all health plans, prohibiting the payment or receipt of any item of value as an inducement to refer patients for any type of health care service.

- With specific exceptions to ensure adequate services, physicians and other health professionals will be prohibited from referring patients to laboratories or treatment centers in which the health professionals have a financial interest.

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# QUESTIONS AND ANSWERS

## RATIONING

Q: **Won't these tight cost controls lead to health care rationing?**

A: **"Rationing" is the scare tactic used every time by those who don't want reform.** Let me emphasize that one of the principles of this proposal is to improve the quality of what is already the finest medical care in the world. **We're going to guarantee everyone comprehensive benefits, including preventive care**, so that we keep people healthy instead of waiting until they get sick. And decisions about your treatment will continue to be decided by you and your doctor. When opponents of the plan talk about "rationing," they're just trying to scare the American people.

Now, there will be limits on how much insurance premiums can go up. For that, I make no apologies. Our international competitors – – Germany, Japan, Denmark, Sweden and Canada – – have kept their costs well below ours'. Germany was at levels comparable to ours in the 1970's. Since the 1980's, they've kept their health care costs in line with GDP and have maintained their high levels of quality.

There's no reason why we can't stop the insurance companies from raising your premiums every year at two or three times the rate of inflation and still get the highest-quality care in the world.

## RESEARCH AND NEW TECHNOLOGY

Q: **Won't the Clinton plan impair the development of new lifesaving drugs and medical technologies?**

A: No, the plan will encourage more of the research and innovation that has made American medical care the best in the world. We're investing more in biomedical and prevention research and in research on outcomes and effectiveness.

Just as they do today, the pharmaceutical industry will continue to develop new lifesaving drugs. Although we are asking the drug companies to hold their prices down, they will have plenty of new customers because prescription drug coverage is included in the comprehensive benefits package and in the Medicare program. **And the proposal is designed to encourage the development of new medical technologies -- because it rewards high-quality care that keeps patients healthy.**

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## G. SMALL AND BIG BUSINESS

POLICY BRIEFS:

JOBS AND HEALTH REFORM
SMALL BUSINESS
BIG BUSINESS
WORKERS' COMPENSATION
UNIONS AND HEALTH REFORM

Q & A

- Small Business
- Unions & Health Care

# POLICY BRIEF

## JOBS AND HEALTH CARE

*Comprehensive health care reform is a necessary element in a compehensive economic growth strategy to bring down long-term economic growth, reduce the deficit, and create jobs. Today, the rising cost of health care is a hidden tax on employers -- hurting businesses, depressing wages, limiting job creation and threatening our competitiveness. The bottom line is this: most businesses provide health care to their workers, and health care reform will lower their health care costs -- allowing them to create jobs and increase wages.*

While no one may be able to give you a precise estimate of the overall job impact, there is no question that for small businesses to manufacturers like Chrysler and US Steel, costs will be controlled and money will be freed up for job creation. The Wall Street Journal said that "for many small businesses, saddled with escalating health care costs, President Clinton's health care package comes as an unexpected windfall." Studies show that the fastest growing small businesses are the ones that provide health insurance. In addition, there will be jobs created in the health care industry, particularly for nurses and home health workers who will be providing more care.

### Health Care is One Element in a Comprehensive Economic Growth and Jobs Plan:

- Health care reform is one element in a comprehensive economic growth plan to lower the deficit, lower interest rates, and create jobs.
- The current system is hurting job creation, because rising health care costs have served as a hidden tax on employers leading to less job creation and less wage increases. *Does anyone dispute that we would have better job growth in our country if we kept costs at the level that our competitors do?*

### Negative Job Studies Have Failed to Analyse the Subsidies and other Details of the Health Security Act:

- The current studies put out by the NFIB are bogus and do not consider the discounts provided to low-wage small businesses nor the positive effects that lowering health care costs will have on businesses that currently provide insurance.

**Lower Costs for Many Businesses, Lead To Higher Wages and More New Hires:**

- Most businesses provide health care.
- The Health Security Act will lower their costs, which will make it easier for them to hire future workers and give wage increases to their existing workers.

**Small Businesses Who Provide Coverage Will Have Lower Costs:**

- Most small businesses provide health care to their workers -- paying high administrative costs and bear tremendous risk if even a single worker in their business gets sick.
- Small businesses pay as much as 35% more than big businesses.
- The Health Security Act will lower health care costs for these small businesses, giving these firms more money to hire more workers and pay their existing workers higher wages. This act will be a job creator for small businesses that do provide health insurance.

Listen to the lead of the Wall Street Journal on Monday. "For many small businesses, saddled with escalating health care costs, President Clinton's health care package comes as an unexpected windfall." ["*Small Business See Burden Getting Lighter*," Wall Street Journal, 9/13/93]

**Will Help the Fastest Growing Small Business:**

- Studies show that the fastest growing small businesses are the ones that offer health care insurance to their workers. These firms will see their costs go down under the Health Security Act.
- Health reform will help those firms that are creating the most jobs and growing the fastest.

**Manufacturing Jobs Will Benefit:**

- Manufacturers -- the employers that pays the highest wages to average people -- have been forced to lay off workers.
- The Health Security Act will have a dramatic effect on lowering the costs of manufacturers and making it easier for them to compete and create new jobs.
- Currently, American automakers pay $1100 more per car than their competitors in Japan.
- Making this part of our economy stronger is especially important because it creates more exports, which is key to greater job creation.

**Increased Health Care Jobs:**

There will be job creation in for health care workers that serve people -- instead of pushing paper.

- Joshua Weiner, a health economist at the Brookings Institution, predicts that the Health Security Act will create 750,000 home health care jobs, and that overall the plan will be a job creator. (Reuters, "Health Care Reform Impact on Jobs," 9/16/93)

**Hawaii – Look at the Evidence:**

- Since Hawaii asked all employers to provide insurance for their employees in 1974, the unemployment rate has dropped to one of the lowest in the nation (2.8% in 1991).
- Meanwhile, small business creation rates have remained high (the number of employers grew almost 200% from 1970 to 1991).
- In addition, only 2% of Hawaii's "rainy day" fund -- set up to assist the smallest businesses -- has been used. [The Hawaii Department of Health, June 8, 1993]

**No More Job Lock or Medicaid Lock:**

- People who are in jobs they want to leave but can't for fear of losing their benefits will be freed to switch jobs or start a small business, meaning more jobs and greater productivity.

- Tens of thousands of people on welfare will no longer have the disincentive of Medicaid benefits without the guarantee of future benefits to keep them from taking a job.

**Minimum Wage – Look at the Evidence:**

- Because we limit the amount that any small business employer would have to pay, health care reform is the equivalent to a modest increase in the minimum wage for those firms that currently do not provide health insurance.

- Studies by economists at Harvard and Princeton show that increases in the minimum wage do not hurt job growth, and that in fact, it can make it easier to hire people. *These were not abstract studies: these were real world studies of real small businesses and restaurants in Pennsylvania, Texas and New Jersey.*

- Real studies that would again support that health care will certainly not cost jobs, and will create many new jobs in manufacturing and growing small businesses.

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## SMALL BUSINESS

*Today, small business is still one the largest growing sectors in the economy. Small business owners are doing all that they can on their own to control costs by changing their insurance carrier, self-insuring, cost sharing, and reducing benefits. Yet, after all of these efforts, health care costs have hindered small businesses from expanding to their full capacity. Our system, rooted in the private sector, will be maintained under the Health Security Act. The Health Security Act will offer many benefits to the small business community.*

### REDUCTION IN INSURANCE COSTS

- Small businesses which currently cover their employees, will most likely see premium and health insurance cost decrease.

- Small businesses will be given purchasing power due to their participation in the health alliances. By pooling their resources into large purchasing groups, small businesses will obtain the purchasing power enjoyed today by many large corporations.

- Discounts will be offered (30% to 80%) to low-wage businesses and to low wage workers.

- The self-employed will be able to deduct 100% of the cost of their health insurance premium, instead of the 25% they can now deduct.

- Premiums for workers' compensation will be reduced.

### REDUCTION IN ADMINISTRATIVE BURDEN AND ABUSE

- Small businesses now pay 40% in administrative costs versus 5% for large companies.

- Establishes a single, comprehensive benefits package eliminating the need for time-consuming annual reviews of benefits packages.

- Consolidates reimbursement and claims submissions into a one style form.

- Abuses in the current health insurance marketplace will be removed. Businesses will no longer see astronomical rate increases or loss of their coverage because of a sick employee or their dependent.

**RETAINS A QUALITY WORKFORCE**

- Job productivity will be improved by giving workers' health, security, and mobility
- Provides an economic foundation for small business to prosper in the future

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## BIG BUSINESS

*The majority of American corporations consider health coverage a benefit of employment, and have continued to provide coverage for their workers and families, despite ever rising costs. But in a system where some companies provide coverage and some don't, where many remain uninsured and government programs often underpay, the employers that do provide coverage wind up paying more than they should. They not only pay to cover their own employees, they also pay to cover their employees' spouses who work for companies that don't provide coverage, as well as for the uninsured, who show up in emergency rooms but can't pay the bill. These shifts cost up to* ***$25 billion dollars.***

*Some companies have had success paying their workers' health care costs directly -- in effect becoming their own insurance agencies. But others, particularly those with older workers or many retirees, find health care costs eat up as much as one fifth of their payroll, eroding competitiveness in the global marketplace, and siphoning dollars away from new capital investments.*

**Employer Responsibility:**

- Under the Health Security Act, all employers will be required to contribute to their workers' coverage. Employers will pay for 80% of an averaged price for insuring working families. But in exchange, health reform will include a number of advantages and protections aimed at American businesses.

**An Active Role in the Local Health Care System:**

- Every business will have a say in the health care system set up to serve their workers. Companies, Taft-Hartley plans , and Rural Cooperatives with over 5,000 employees will be able to operate their own alliance if they wish allowing them to build on the many cost control innovations in operation in self insured plans today.

- Businesses which wish to form their own corporate alliance will have to meet federal standards for regional alliances including the same comprehensive benefits package and offering their employees a choice of plans.

- All regional alliances will have employers represented on their boards.

**Real and Enforceable Cost Control:**

- **Market Forces**-- The Health Security Act will aggressively control costs by bringing market forces to bear in the health care system. Corporate alliances will continue using the innovative cost control strategies they've found successful-- and regional alliances will build on those same strategies of pooling purchasing power and bargaining for better rates.

- **Administrative Savings**-- The Health Security Act will streamline the burdensome and costly regulation that eats up more than 25 cents of every health care dollar. And by replacing the 1500 different insurance packages with a standard benefits package and a single claim form, more money will go to benefits and less to underwriters and marketers.

- **The Security of a Budget**-- The Health Security Act takes no chances in assuring that health care spending is slowed. It includes as a backstop an enforceable budget, insuring that health care cost will be brought in line with spending in the rest of the economy by the end of the decade.

**Fair and Equitable Financing:**

- **Capped at a Percent of Payroll**-- Many employers today spend more than 10 percent of their payroll for health insurance. Under reform, all employers in a regional health alliance will pay no more than 7.9 percent of their payroll for health care.

- **Shared Responsibility for Family Coverage**-- All employers are responsible for their own workers and share responsibility for family health coverage since many families have 2 workers.

- **An End to the Cost-Shift**-- By covering the 37 million Americans who today have no insurance, and by requiring all employers to contribute to coverage, the burden of "cost shifting" is lifted from the businesses who today overpay.

- **Preserves the Tax Deductibility of Health Insurance**-- Under reform, premium payments will continue to be fully tax deductible for employers and will not be included in employee's taxable income. Employers are free to continue for ten years to offer whatever benefits

they are offering today and to deduct these payments from their taxes. In ten years, when the benefits package is fully phased in, it will offer as much as the best plans today.

**Relief for the Costs of Retiree Health Care:**

- Today many businesses, including the country's largest manufacturing companies, are at a real disadvantage in global markets because of the high cost of health care for their retired workers. Under reform, the employer share of early retiree premiums will be subsidized. This will relieve many of our nation's largest employers of a significant financial burden and allow them to be more competitive.

**Workers Compensation Reform:**

- Under the Health Security Act, injured workers will obtain treatment through their health plan just as they would for other injuries or illnesses. Workers compensation insurers will reimburse health plans according to a fee schedule. Health plans will be required to demonstrate their ability to provide care for work-related injuries and appoint a case manger to assure that work-related injuries are properly treated.

- The Health Security Act calls for appointing a Presidential Commission to study the issues involved in full integration of the workers' compensation and auto insurance systems.

**Background facts:**

- In 1992, American businesses paid almost $4,000 per employee for health care, double what they paid just 8 years before.[1]

- If health care costs had grown at the same rate as the overall economy during the 1980s, employers would have saved more than $1,000 for every worker they insure in 1992..

- Last year, General Motors spent more on health benefits than it did on steel.[2]

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[1]Christian Science Monitor, 11/21/91
[2]TIME, 11/25/92

- Companies that provide insurance for their workers paid $11.5 billion in 1991 to cover spouses and other dependents who worked for companies that did not provide insurance.[3]

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[3]National Association of Manufacturers, in *Washington Post* 5/13/93

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# WORKERS' COMPENSATION INTEGRATION

*The Health Security Act integrates workers' compensation medical benefits into the new health care system in two steps.*

*The first step integrates the delivery systems. Injured workers will receive services through their health plans, which must demonstrate their capacity to treat work-related injuries and meet new standards for quality and efficiency. Current workers' compensation carriers will retain financial responsibility and reimburse health plans for the services they provide to injured workers.*

## Advantages for Workers

- Workers will be able to go to the same health plans for all of their medical care.

## Controls Workers' Compensation Costs in the Short-Run

- Workers' compensation costs will be reduced in the short run:

  -- The growth in fees for medical services will be constrained with the health care budget.

  -- Fraud and excessive doctor and hospital visits will be reduced because services will be provided through certified health plans.

  -- Experiments with capitation for workers' compensation medical costs will reduce current costs and pave the way for full capitation of health plans for work-related medical costs.

## Applies the Same Quality Standards as for Regular Health Plan Services

- Medical services provided to injured workers will be subject to the same standards and oversight for quality of care as other medical services delivered by health plans.

*The second step develops a detailed strategy for full integration of the financing of workers' compensation benefits into the health care system.*

## Full Financial Integration

- A Commission on Health Benefit and Integration will be established to examine and make recommendations on the following issues crucial to accomplishing full financial integration:

  -- Whether premiums for workers' compensation medical benefits should continue to be experience rated

  -- Development of uniform benefit and eligibility standards for workers' compensation medical benefits.

  -- Development of a system paying health plans on a captitated basis to treat work-related injuries and illnesses.

  -- Development of a method to move from the paying upfront for all expected future health costs common to liability coverage to paying for costs annually like regular health insurance.

The Commission will report to the President by July 1, 1995 on the best method to accomplish financial integration--so that businesses only have to pay once for their workers' health care.

## Potential for Greater Cost Reduction with Full Integration

- Costs of workers' compensation may be further reduced in the long-run, if the financing of the two systems can be integrated making health plans fully at-responsible for providing medical benefits to injured workers. This will bring work-related injuries and illnesses under the cost containment incentives provided in the new system.

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## UNION PLANS AND HEALTH REFORM

*Millions of Americans have worked hard to get the solid health benefits that they enjoy today - - trading increases in wages in order to maintain the same health benefits. In some cases, they have been willing to accept reduced benefits in order to ensure that they still have some coverage. But even those with excellent health benefits live in constant fear of losing that protection. Insurance can disappear overnight as people move, change jobs, lose their job, or become ill.*

**Preserving Benefits:**

- The Health Security Act will provide the comprehensive benefits all Americans deserve. For those with coverage beyond the federally guaranteed package, the tax preference for those benefits will be preserved for ten years. Employers who currently pay 100% of the premium, or contribute to the coinsurance and deductibles or pay for benefits over and above the comprehensive benefits package can continue to do so.

**Guarantees Security:**

- Americans will always have coverage even if they change jobs, lose their job, move, become ill, or have a preexisting condition.

**Helps Restore Lost Wage Increases:**

- Millions of American workers will have their first real chance for wage increases in years. For two decades, rising health care costs have robbed American workers of wage increases they need and deserve. With guaranteed, comprehensive benefits, unions will no longer ahve to negotite away wage increases in order to preserve benefits.

**Increases Your Choices**

- Today, only one of every three companies that employ fewer than 500 people offers employees a choice of health plan. The Health Security plan will allow every individual the choice of at least three plans in every area: a traditional fee-for-service plan like many people have today, a network of doctors and hospitals, and an HMO-type plan. Individuals - - not their employers or benefits managers - - will choose their health plans and doctors.

**Preserves Taft-Hartley Trusts:**

- Taft-Hartley trusts may continue to operate their own health plans or subcontract with health plans as they do today or they will have the option of joining the regional health alliances.

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# QUESTIONS AND ANSWERS

## SMALL BUSINESS IMPACT

Q: **Won't small businesses be driven under by the employer mandate?**

A: Two-thirds of small businesses currently cover their employees. For these businesses, health care reform will mean a chance to expand and create new jobs. **The Wall Street Journal calls the plan "an unexpected windfall" for small businesses.**

Some people say that this proposal is going to hurt small businesses. And it's important to keep in mind that my critics are right on one important point: asking all employers -- including low-wage small businesses -- to provide comprehensive coverage for their employees without discounts would be unreasonable. But that's not what my plan is -- my plan provides **discounts of between 30 and 80%** for small businesses, depending on the average wage of their workers.

Most small businesses will receive a windfall because they will be getting substantial discounts compared to what they pay now. Studies show that **the fastest growing small businesses are the ones that provide health insurance.** So they will be able to create new jobs and expand their businesses.

You see, the whole problem with the way people get insurance today is that **the insurance companies have all the power, and small businesses and consumers get the short end of the stick.** My plan changes the market to give small businesses and consumers more bargaining power and really put them in the driver's seat.

**A lot of small businesses that don't provide insurance want to -- they just can't afford it.** Listen to Diane Welch of San Jose, California -- she owns an Italian restaurant there with 40 employees. She says -- this was in the newspaper a few days ago -- that she is looking forward to my proposal because it has bothered her that she and her husband couldn't afford to provide coverage for their employees. With the discounts, health care would finally be reasonable, she said. And she said of the price: "It's something we could definitely handle."

Let's look at what a low-wage small business might pay. For a small business whose employees make an average of $12,000 a year, they would only have to pay $420 a year per employee to get their employees comprehensive health benefits. In today's market, they might have to pay as much as $4000 per year per employee, but after reform, it's affordable because of the discounts which we are proposing for small businesses, Now compare that to the average big business, paying $2200 a year for each employee. We're talking about a discount of 80% for the small business.

When we look at what effect this will have on small businesses, one interesting example is Hawaii. Hawaii passed a plan in 1974, the Prepaid Healthcare Act, that requires all businesses to contribute to the cost of their employees' health insurance. But small businesses have continued to thrive. In 1991, Hawaii was the nation's third fastest-growing state for small businesses, and Hawaii's unemployment rates are consistently among the lowest in the country.

## UNIONS AND HEALTH CARE

**Q: I've got a good union plan. What's going to happen to me?**

A: Millions of Americans have worked hard to get the solid health benefits that they enjoy today – – trading increases in wages in order to maintain the same (or reduced) health benefits. And millions are locked into their jobs; wanting to find better jobs but can't leave because they fear losing health insurance and not being able to get a new policy.

But even if you have an excellent health insurance package, you are not guaranteed coverage. Insurance companies hold all the cards: they can drop someone for almost any reason.

My plan does the following things for you:

**Guarantees security**. You will always have coverage even if you change jobs, lose your job, move, become ill, or have a preexisting condition.

**Preserves benefits.** The Health Security plan brings all Americans up to the comprehensive benefits package. For those with benefits more comprehensive than the federally guaranteed package, tax preference is preserved for ten years. Employers who do so today may continue to pay 100% of the premium, contribute to the coinsurance and deductibles and pay for benefits over and above the comprehensive benefits package.

**Increases your choices**. Today, fewer than one of two employees has any choice of plan. Under reform, individuals have a choice of health plans in every area: a traditional fee–for–service like many people have today, a network of doctors and hospitals, and an HMO–type plan. Individuals – – not their employers or benefits managers – – choose among health plans and providers.

**Help restore lost wage increases**. Millions of American workers will have their first real chance for wage increases in years., For two decades, rising health care costs have robbed American workers of wage increases they need and deserve. No longer will you have to negotiate away wage increases just to keep your benefits. Your benefits will be comprehensive and guaranteed.

**Preserves Taft–Hartley trusts.** Taft–Hartley trusts may continue to operate their own health plans or subcontract with health plans as they do today or they have the option of joining the regional health alliances.

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## H. PROVIDERS

POLICY BRIEFS:

HOSPITALS
DOCTORS
NURSES
MALPRACTICE REFORM
ADMINISTRATIVE SIMPLIFICATION
CREATING A NEW HEALTH WORKFORCE
ACADEMIC HEALTH CENTERS

Q & A

- DOCTOR-Patient Relationship
- Malpractice

# POLICY BRIEF

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## HOSPITALS AND HEALTH CARE REFORM

*In many ways, hospitals are where everything right about American health care comes together: where well-trained health care providers cooperate to provide high quality care to patients from every walk of life. Unfortunately, hospitals are also where everything wrong with our health care system comes together, making it more and more difficult for hospitals to fulfill their mission.*

- *Care provided to millions of uninsured Americans who have no insurance but seek treatment in their emergency room. Their unpaid bills end up as uncompensated care that drains billions of dollars from American hospitals each year.*

- *The crush of paperwork by the more than 1500 private insurance companies and government health programs hits hospitals particularly hard. Faced with requirements from peer review organizations, government inspectors, industry regulators, billers, coders and fiscal middlemen, hospitals treat more pieces of paper than they do patients; they hire four new administrators for every new doctor.*

- *The tensions caused by "defensive medicine" play out in hospitals where countless tests and procedures are performed not out of medical necessity but out of fear of malpractice lawsuits.*

*Health reform ends the vicious cycle of mounting paperwork, declining service and cost-shifting in today's system and reinforces efforts by hospitals to provide high-quality patient care.*

### Universal Coverage Ends Uncompensated Care

- Universal coverage will guarantee hospitals that when they treat patients they will get paid for their services.

### Flexibility in Contract Arrangements

- Hospitals may contract with as many health plans as they choose working out their own arrangements with competing health plans or organizing plans themselves.

**Administrative Simplification**

- Streamlined paperwork requirements and regulations will reduce the costs of hospital administration considerably.

- Single claims forms and electronic data systems will save hospitals time and money.

**Antitrust Reform**

- The Health Care Security Act will relax barriers to collaboration in purchasing equipment and other investments. It will encourage providers to share technology, helping slow the growth in health care spending and allow them to join together to form competitive networks.

**Malpractice Reform**

- Medical malpractice reform will give hospitals increased protection against frivolous lawsuits, and reduce defensive medicine.

**Protections for Specialty Hospitals and Academic Health Centers**

- The Health Security Act will also recognize that not all hospitals are alike. Some hospitals perform the most specialized care, or conduct research and training. Others care for very poor patients in rural communities and cities. The Act will provide continuing support for each of these unique roles.

- The Health Security Act will recognize and reinforce the unique role that teaching hospitals play in advancing clinical research and treating complex illnesses by dedicating special funding to support these institutions.

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## DOCTORS

*The personal relationship between a doctor and a patient is the cornerstone of patient care. Yet under the present system, that relationship is undermined by paperwork requirements that bury doctors and take time away from their patients. It is undermined by all the insurance company oversight -- the billers and authorizers who look over the doctors' shoulders and decide who is sick enough to receive what type of care. And it is undermined by the way the legal system has crept into the medical offices -- the potential for lawsuits have bred distrust and fear in both doctors and patients.*

### Preserves Doctors Choice

- The Health Security Act will preserve the ability of American consumers to choose their doctors.

### Preserves Physician Independence:

- By guaranteeing a fee-for-service network in every alliance, doctors who want to keep their private practices in an individual office will be able to do so and still participate in the new system.

- Physicians will be able to join more than one plan -- thus ensuring that they can see the patients they see today.

### Simplifies Administration and Reduces Paperwork

- The plan will reduce paperwork by creating a single claim form that all doctors and hospitals will use, replacing today's hundreds of claims forms. Electronic exchange of insurance and patient information will further reduce costs and frustration for doctors.

- With the introduction of a standard, comprehensive benefit package, doctors will no longer have to ferret out information on whether certain services are covered. Under the plan, covered services are comprehensive and standard cost-sharing rules will simplify accounting for providers.

**Reforms Malpractice**

- **see brochure!!!!!!!**

- The Health Security plan will increase training opportunities for medical graduates entering primary care.

**Ensures Quality**

- A national quality program stressing results over process will remove insurance companies, utilization review firms and the government from the back offices of physicians and hospitals.

- Practice guidelines and information on the treatment outcomes will give doctors the tools they need to improve their quality of care.

**Reforms Antitrust Regulations**

- The Health Security plan will reform antitrust regulations and level the playing field. Doctors will be able to join together to form their own networks and negotiate collectively with health plans, so long as they represent less than 20 percent of the physicians in an area and share in the financial risk.

**Incentives to Increase the Number of Primary Care Physicians**

- The Health Security plan will increase training opportunities for medical graduates entering primary care.

- Federal support will be provided to train doctors in a variety of settings where primary care is provided.

- As an incentive to doctors to provide primary care, the Health Security plan will increase Medicare payments for such care.

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## NURSES AND OTHER HEALTH CARE PROFESSIONALS

*Health care reform will increase the role of nurses, nurse midwives, and other health care professionals in primary and preventative care. It will reduce professional barriers for these health care providers and cut the paperwork that forces them to spend as much time at a desk as at a bedside.*

### Nurses Role in Providing Care will be Expanded:

- Health care reform will reinforce the role of nurses as health care providers for primary, preventive, mental health, and long term care services. Advanced practice nurses -- registered nurses who have met advanced educational and clinical practice requirements -- will play a crucial role in guaranteeing that every American receives high-quality care.

### Inappropriate Barriers to Practice will be Removed:

- To remove inappropriate barriers to practice, model professional practices statutes for advanced practice nurses and physician assistants will be developed.

- Nurses will be able to contribute on the basis of their skills and work to the full scope of their training. They will work in partnership with physicians and other health providers to ensure high-quality care.

### Increased Funding for Training:

- Funding for training of nurse practitioners and other health care providers will be increased to double the number of graduates annually and to expand existing programs.

### More Time on Care: Less Time on Paperwork:

- Use of a single claims form and electronic billing will reduce paperwork so that nurses can concentrate on providing care to patients -- not filling out forms.

**Incentives to Practice in Underserved Areas:**

- Incentives will be provided for nurses and other health care providers to work in undeserved rural and urban areas.

**New Opportunities Providing Details of Home and Community-Based Long-Term Care:**

- The new home-based and community-based long-term care program for older Americans, persons with disabilities, the chronically ill, and other vulnerable populations such as the mentally ill and children with special needs, will expand professional opportunities for nurses.

**Attention to Racial and Ethnic Diversity:**

- Racial and ethnic diversity among nurses will be increased so that patients will be served by nurses and health care providers with community roots.

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# MALPRACTICE REFORM

*Malpractice and the fear of it has been one of the more divisive issues in our health care system - - and neither patients nor doctors believe today's system works. The doctor-patient relationship has been undermined by the way the legal system has crept into the doctor's office - - the threat of lawsuits, has instilled distrust and fear in doctors and other providers.*

*Premiums for malpractice coverage for physicians and hospitals comprise about one percent of overall health spending. The amount spent on so-called "defensive medicine" is in dispute. But nearly everyone agrees that action is needed; the Health Security plan will reduce frivolous lawsuits and protect patients' rights.*

## Establishes Alternative Dispute Resolution Programs

- Each health plan will certify an Alternative Dispute Resolution (ADR) process using one or more models developed by the National Health Board. If this process does not satisfactorily resolve the conflict, a patient still retains the right to go to court.

## Requires Certificate of Merit

- Before filing a lawsuit, a lawyer will be required to obtain a certificate of merit from a medical specialist stating that the specialist believes the physician did not meet the proper standard of care.

## Limits Attorneys' Fees and Prevents Double Recoveries

- So that awards reach the injured parties, the Health Security plan will limit attorney fees.

- The Health Security plan will prevent double recoveries by barring those who are injured from recovering more than once for their injuries. If health insurance covers medical costs, they will not recover again form collateral sources for those costs in court.

## Public Access to Professional Records

- To protect patients from seeking care from risky providers, the public will have access to data about doctor practices and previous history of malpractice.

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## ADMINISTRATIVE SIMPLIFICATION

*Paperwork clogs today's health care system. Insurance overhead eats up a significant chunk of each health care dollar, paying for administration, underwriting and marketing by more than 1500 private insurance companies. Doctors and hospitals spend more and more of their resources keeping up with the paperwork, codes, inspections and regulatory procedures imposed on them by insurers and government programs.*

### Simpler for Consumers

- Every American gets a health security card and every American gets coverage.

- Guaranteed comprehensive benefits virtually eliminates the hassle of determining and tracking coverage; consumers will no longer have to wade through fine print and spend long hours negotiating reimbursement.

### Simpler for Providers

- The introduction of a standard, comprehensive benefit package will free providers from negotiating with health plans to determine the level of services covered. Comprehensive services will not vary from plan to plan; standard cost-sharing rules will simplify accounting for providers.

- A single standard reimbursement form and uniform reporting requirements will replace the hundreds of existing claims forms. Electronic exchange of information will further reduce provider costs and frustration.

### Patients Over Paperwork

- A national quality program will stress results over process and remove insurance companies, utilization review firms and the government from the physicians' offices and hospitals. Regulation of clinical laboratory testing will emphasize quality protection while reducing administrative burden.

- Coordinated inspections will replace the multiple inspections that hospitals and doctor's offices undergo today.

**Improvements in Medicare**

- Medicare will simplify and streamline its reimbursement and claims system. Specific reforms will be aimed to rebuild trust between hospitals, doctors, patients and Washington.

Oct-93

# MEDICARE STREAMLINING
# IMPACTS ON A HOSPITAL

The following analysis demonstrates the impact several suggestions to streamline Medicare would have on a well-run, highly-automated hospital in Florida, the Lakeland Regional Medical Center. It does not take into account any of the longer-term initiatives to institute a single claims form or standardized rules.

Lakeland, an acute-care hospital licensed for 897 beds, has been cited as a leader in Total Quality Management and a pioneer in Patient Focused Care and has been showcased in Modern Healthcare, by the Health care Forum, and by Tom Peters in his "In Search for Excellence" program. Lakeland processes 98% of its Medicare claims electronically. Lakeland processes roughly $300 million in charges annually, $150 million of which are Medicare.

| | | FTE Savings | Cash Flow Savings | Operational Savings |
|---|---|---|---|---|
| 1) | **PRO Denial of Payments**<br><br>**The PRO retroactively reviews medical records to determine whether delivered care was necessary. The PRO denies payment for those services it determines are unnecessary. The hospital may contest the denial to the PRO. If the PRO upholds the denial, the hospital has to appeal to an Administrative Law Judge. LRMC contracts with Medical Review Consultants, a firm in Kansas to handle its appeals. It spends over $250,000 just for appeals. 95% of all appealed denials for this hospital were reversed.**<br><br>**According to Medical Review Consultants, which represents 1100 hospitals nationwide, their average reversal rate is approximately 80%. In Florida, the rate is 95% for the 96 hospitals they represent.**<br><br>**RECOMMENDATION: ELIMINATE CHART-BASED REVIEW** | **1.0** | **-** | **$250,000** |
| 2) | **HCFA holds claims for 14 days for claims transmitted electronically**<br><br>98% of Lakeland's Medicare claims are transmitted electronically.<br><br>Reducing the accounts receivable by 5 days would result in an increase in cash flow of $2.5 million, generating additional investment income of $125,000.<br><br>**RECOMMENDATION: REDUCE THE 14-DAY HCFA HOLD PERIOD TO 9 DAYS** | **-** | **$2,500,000** | **$125,000** |

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| 3) | **Prebilling physician attestation**<br><br>For the period ending 5/22/93, LRMC had $7.3 million tied up in the billing department, primarily because they were awaiting for physician signatures on bills. LRMC estimates that Medicare claims are held up an average of ten days in the billing department awaiting attestation. Medicare bills made up 92% of the aged bills. (See attachment #1)<br><br>LRMC utilizes two FTEs who maintain an automated system of tracking incomplete attestations and seeing that they are signed and dated. The paper chase costs the hospital approximately $100,000 annually in Personnel and Supply expense.<br><br>**RECOMMENDATION: ELIMINATE PREBILLING PHYSICIAN ATTESTATION; ELIMINATE ANNUAL PHYSICIAN ACKNOWLEDGEMENT - REQUIRE SINGLE ATTESTATION AT TIME OF ADMITTING PRIVILEGES** | **2.0** | **$2,500,000** | **$225,000** |
| 4) | **Patient forms - "An Important Message from Medicare" - complex**<br><br>Many elderly patients do not understand the purpose or the content of the form. Further, when patients bypass the Admitting Office because they are too ill, they must be traced down and have the form explained to them. The forms are expensive and should be made more concise and easier to understand. (See attachment #3)<br><br>**RECOMMENDATION: SIMPLIFY FORMS** | **0.6** | **-** | **$10,000** |

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| 5) | **Retroactive system changes cost money**<br><br>LRMC uses 2 FTEs to resolve rejected claims due to retroactive system changes. There are over 5,000 rejection cosdes published by the intermediary. An additional expenditure of $40,000 a year is incurred for a billing program designed to edit claims for code rejections prior to electronic billing. (See attachment #4)<br><br>**RECOMMENDATION: LIMIT CHANGES TO ONCE EVERY SIX MONTHS; GIVE PROVIDERS A MINIMUM NOTIFICATION WINDOW (E.G. 120 DAYS)** | **2.0** | **-** | **$80,000** |
| 6) | **Photocopying of medical records for the PRO**<br><br>In the past three years, LRMC has photocopied over 9,000 medical records and shipped them to the PRO offices. These amounted to 684,000 sheets of paper at an estimated cost of $240,000. Initially, the PRO did not pay for these copies, then faced with a lawsuit, agreed to pay $0.0298 per page. Later, after intense negotiations with the Florida Hospital Association, the PRO increased the payment to $0.0498 per page. Recently, the PRO increased the payment to $0.07; however, even this does not cover the expenses of staff time, equipment rental, supplies and postage. We calculate the true cost to be $0.35 per page. Since the inception of PRO, they have received $22,431, leaving a loss of roughly $217,000.<br><br>95% of LRMC's denied payments were successfully appealed.<br><br>**RECOMMENDATION: ELIMINATE CHART-BASED REVIEW** | **1.0** | **-** | **$72,000** |

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| 7) | **Multiple provider inspections**<br><br>During the past 18 months, LRMC has had 24 federal, state and other review agencies surveys and audits. Each of these inspections was different enough to cause considerable confusion, duplication of effort and frustration in trying to interpret individual agency standards.<br><br>**RECOMMENDATION: THE NATIONAL BOARD SHOULD DEVELOP A SINGLE SET OF STANDARDS FOR INSPECTIONS; INSPECTIONS SHOULD BE COORDINATED AT THE STATE LEVEL.** | **2.0** | – | **$80,000** |
| 8) | **The cost report process is complex and time consuming**<br><br>Hospitals conduct quarterly time studies of individual departments, which require detailed logs, followed by a settlement and an appeals process. They compute cost of inputs for both their inpatient and outpatient services, even though the inpatient services are reimbursed on a prospective basis.<br><br>If outpatient services were paid on a prospective basis, LRMC suggests that the need for detailed cost reports would be eliminated. Annual savings in Personnel, Consulting and Computer time is estimated to be $100,000. This does not take into consideration the cost HCFA would save by reducing the need for intermediary audits.<br><br>**RECOMMENDATION: REVIEW AND SIMPLIFY THE COST REPORTING PROCESS** | **1.0** | – | **$100,000** |
| **TOTAL** | | **9.6** | **$5,000,000** | **$942,000** |

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# CREATING A NEW HEALTH WORKFORCE

*While American medical schools train the finest physicians in the world, improving the quality of health care for the future and to provide access for all Americans will require changes in the education and training of health professionals.*

## Training More Pimary Care

- The Health Security plan will specify that, after a five-year phase-in period, at least 50 percent of new physicians will be trained in primary care -- family medicine, general internal medicine and general pediatrics -- rather than in specific specialty fields. The total number of first-year residency positions available will continue to exceed the number of graduates of U.S. medical schools.

- The plan will support "loan forgiveness" programs for medical students who are trained in primary care and re-training programs for mid-career specialists who wish to serve as primary care physicians.

## Increases Medicare Payment Rates for Primary Care

- In addition to refocusing federal support for physician education on primary care, the Health Security plan will increase Medicare payment rates and the expenditure target rate of growth for primary care services.

## Increases Funds to Train Nurse Practitioners and Physician Assistants

- Nurse practitioners and physician assistants will play an important in providing high-quality care to Americans. The Health Security plan increases funding for the training of nurse practitioners and physician assistants to double the number of graduates produced annually.

## Removes Inappropriate Barriers

- To remove inappropriate barriers to practice, the Department of Health and Human Services will develop and encourage the adoption of model professional practice statutes for advance practice nurses and physician assistants.

**Increases the Diversity of the Health Care Workforce**

- The plan will provide support to programs that increase the number of health professionals among racial minority groups and disadvantaged persons.

- The goal is to double the level of under-represented minorities by the year 2000 with financial assistance and an increased effort to recruit under-represented minorities to enter the health professions.

- The National Service Program will reach out to high-risk and disadvantaged youth, as well as to students who are considering or have entered health professions, and will offer them vocational training, service stipends and college tuition credit to work in health care.

**Supports State and Regional Workforce Planning and Development**

- A rural health provider grant program will support new training programs for rural practitioners, the development of rural health education curricula and the improvement of medical communications technology.

- A health professions special projects and training authority will be established to support the transition to the new health system. It will provide support for training in mental health, substance abuse treatment and geriatrics; training of school-based health providers in issues such as immunization, efforts to reduce substance abuse and violence; and training medical providers in cost-effective medicine, and continuous quality improvement techniques.

**Encourages Providers to Practice in Underserved Rural and Urban Areas**

- New work force initiatives, including tax incentives, increased reimbursement, retraining, scholarships and loan forgiveness programs, will encourage health care providers to practice in underserved rural and urban areas.

- The National Health Services Corps will be expanded to reduce the shortage of primary care practitioners in medically underserved areas.



## ACADEMIC HEALTH CENTERS

*America's 132 Academic Health Centers form a unique national resource, driving advances in medical sciences and biotechnology. They secure America's position as the world leader in medical training and specialized care.*

*These centers are major employers encompassing a network of university hospitals, county hospitals, Veterans Administration hospitals, affiliated community hospitals, and area health education centers. The Health Security plan will preserve and strengthen the role of Academic Health Centers which provide front-line health care for residents of rural states and inner-city communities.*

### Strengthens Academic Centers

- The Health Security plan will include a "set-aside" from all health plan premiums to create a separate pool of funds channeled to academic health centers. Funds will be distributed through a formula that recognizes each center's contributions to education, research and patient care.

### Maintains Specialty Services

- While most people will not obtain routine health care at an academic health center, the plan will ensure that every American has access to the specialized care offered at an academic health center if conditions warrant such treatment.

### Supports Cutting-Edge Care and Research

- Health plans will cover the costs of routine patient care associated with research conducted in academic health centers. This will enable academic health centers to continue to develop the advanced and highly specialized care they provide today, from heart-lung transplants to laser surgery for brain aneurysms.

# QUESTIONS AND ANSWERS

## DOCTOR–PATIENT RELATIONSHIP

Q: Will my doctor and I be free to decide how to treat my illness?

A: Yes. Under the current system, doctors have too many people looking over their shoulder, second–guessing their professional judgment. Reform will get insurance companies and the federal government out of doctor's offices and leave your medical decisions to you and your doctor – – where they belong. Consumers will have more information about the benefits and risks of treatments and will be more involved in making decisions about their own health care.

## MALPRACTICE

Q: **Will the plan have serious malpractice reform?**

A: Yes, the plan has serious malpractice reform to reduce lawsuits and let doctors practice medicine.

Everyone knows that the current system of malpractice needs to be changed. **In the current system, doctors are forced to spend too much time practicing what's called "defensive medicine"** -- performing extra tests because they're looking over their shoulders for lawyers. It's not helping to improve care or protect patients -- but it is helping to drive doctors out of the profession and pushing up costs.

**My proposal will limit lawyers' fees in order to discourage frivolous lawsuits.** If there's a legitimate concern about the care you get, then that's one thing. But what we've got today is too many lawsuits that just aren't legitimate.

Besides limiting lawyers' fees, the plan will also require patients and doctors to use alternative forms of dispute resolution before they end up in court. There will be out-of-court panels to hear disputes in order to reduce the number of lawsuits.

This is all a part of everyone taking more responsibility in our health care system. We say to lawyers: we respect your role as protector of the patient when he or she is treated badly, but you must be responsible and not file frivolous lawsuits. To make sure that doesn't happen, we're going to require that you try settling this out of court, and if you do go to court, we're going to limit your fees. We say to doctors: we're going to stop the lawyers and insurance companies from looking over your shoulder, but we're going to hold you accountable for delivering high-quality care. And we say to patients: even if you don't get the proper care, the answer is not always to go out and sue the first person you see. It's all about taking responsibility.

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## I. CONSUMER PROTECTION

POLICY BRIEFS:

CONSUMER CHOICE
PRIVACY

Q & A

- Doctor Choice
- Forcing People into Managed Care

# POLICY BRIEF

# CONSUMER CHOICE

*One of the fundamental principles of the Health Security Act is consumer choice: choice of doctors and health plans.*

*Increasingly, employees and individuals do not have the option of choosing their doctor or plan: Employers choose for them. Only half of those who receive health coverage through their employers are able to choose their own health plan. In turn, too many families find themselves where the doctors they want are not available to them, locked into plans and too many doctors find themselves locked out.*

## Increased Choices for Individuals

- Individuals, not employers, will choose among health plans.
- Health alliances will be required to offer a minimum of three plans including a traditional fee-for-service plan that provides individuals the option of seeing any doctor in their area, and a health maintenance organization (HMO), a network of doctors and hospitals (preferred provider organization, PPO).

## Information to Aid Consumer Choices

- Simple, easy-to-understand and up-to-date information about high plan quality and providers' prices will help individuals choose among plans.
- The comprehensive benefits package will reduce confusion and fear that a surprise exclusion will place families at financial risk.

Oct-93

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# PRIVACY AND SECURITY OF HEALTH CARE INFORMATION

*Accurate and timely information is critical to all aspects of health care delivery and administration. At the same time, health care information is perhaps the most intimate, personal and sensitive of any information maintained about an individual. In a 1991 Harris poll on consumer privacy, 79% of those surveyed were concerned about threats to privacy and 71% believed that consumers have lost control over the ways that personal information about them is used. In today's system, only the thinnest legal protection guards personal medical information from disclosure or inappropriate use. No uniform, comprehensive privacy standards for health care information exist.*

*Accountability in the new health care system depends on information, including the establishment of unique identification numbers, making iron-clad privacy protection a critical element of the plan.*

## Establishes National Safeguards to Protect Privacy:

- The Health Security Act will construct solid protection and legal barriers to guard individual medical information, creating a new level of privacy protection for all Americans. National safeguards will shield all individual health records, on paper, in computers or in any other form.

- The Health Security Act also establishes effective mechanisms for enforcement of the new privacy and confidentiality standards, including setting significant penalties for breach of that trust.

## Health Data and Health Identification Numbers Protected from Other Uses:

- Data collected as part of the operation of the new health care system will be used only for that purpose and not shared with any other entity.

- Both regional and corporate alliances will not be allowed to use health care information as a basis for employment decisions.

- The national privacy policy explicitly forbids linking of health care and other information through health identification numbers.

# QUESTIONS AND ANSWERS

## DOCTOR CHOICE

Q: **Will I still be able to see my own doctor? Will I have to pay extra?**

A: **You will always be able to choose your doctor.** Everyone will have a choice of health plans. You'll be able to follow your doctors and nurses into a traditional fee-for-service plan, join a network of doctors and hospitals, or join an HMO.

What you pay will depend on which plans your doctor joins. There will be a range of plans available at a range of prices and your doctor will be free to join a number of plans - - so the choice will always be yours.

The opponents of reform are using scare tactics -- telling you that the Clinton plan will separate you from your doctor -- in order to preserve the status quo. But make no mistake about it -- you will be able to see your doctor, and nothing any special interest says will change that.

## FORCING PEOPLE INTO MANAGED CARE

**Q: Won't the Clinton plan force all people into managed care?**

A: No. In fact, Americans will have increased choice under the health security plan. Everyone will be able to choose their doctor. And no one will be forced into anything. In fact, people will have increased choices of health plans. Today, fewer than one out of two working people have any choice of health plans. And in an effort to cut costs, many employers have ben forced to move their employees into managed care plans. That will be impossible after reform.

Under reform, all Americans will be able to choose from among a traditional fee-for-service plan, a network of doctors and hospitals, or an HMO. Your boss or insurance company won't choose where or from whom you get your care -- you will.

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