RURAL/FARM

Smead.

FLEX-I-VISION® HANGING FOLDER

HASTINGS, MN
LOS ANGELES-CHICAGO-LOGAN, OH
McGREGOR, TX-LOCUST GROVE, GA

PHOTOCOPY
PRESERVATION

PHOTOCOPY
PRESERVATION

RURAL / FARM

fill Rend

Congress of the United States
House of Representatives
Washington, DC 20515

October 15, 1993

First Lady Hillary Rodham Clinton
Office of the First Lady
Old Executive Office Building, Room 100
Washington, D.C. 20500

Dear Mrs. Clinton:

We wish to bring to your attention a serious concern that we have with respect to the Administration's current Access Initiative contained in the national health reform plan and its impact on medically underserved populations -- most notably underserved inner-city neighborhoods and rural communities.

As we understand it, the Administration's plan recognizes that medically underserved communities suffer from an acute shortage of accessible health services, especially preventive and primary health care services, and that the people living there will need additional support services beyond those covered in the plan's comprehensive benefit package (such as community outreach, transportation, or translation services), in order to make the provision of covered services effective for them.

We applaud your recognition of these special needs, and the proposed new resources for the National Health Service Corps and school based clinics. We are, however, quite concerned at both the exceedingly limited amount of funding specified in your plan for Community and Migrant Health Centers (C/MHCs) and with the manner in which the plan would distribute funds to community-based primary care providers.

It appears the Administration only plans to make available an additional $100 million annually for C/MHCs in 1996 (current funding level is $644 million). An additional $700 million would be available annually for "flexible capacity and enabling services" in 1996.

We have three concerns. First, the increase for C/MHCs is very small given the need and their proven track record. Today, Community Health Centers provide comprehensive preventive and primary care to more than 7 million medically underserved Americans -- only 15% of the 43 million medically underserved Americans who need access to such care. Despite the poorer overall health of their patients, studies have shown that health centers are tremendously cost-effective, and have dramatically improved the health of their patients and the communities they service.

Second, it appears that the $800 million increase is partially paid for by offsets in other necessary Public Health Service programs that serve these same population groups. Our understanding is that the offsets in 1996 may be as high as $342 million, or 43 percent of the proposed increase.

Third, we understand that most of the funds under the new "flexible capacity and enabling services" category would be administered under a totally new program, which parallels the existing C/MHC program in every respect except the governing board requirements, eligibility for funding, and Federal accountability (reporting/auditing) requirements. The new program would make grants available to a wide variety of organizations, including private health plans, with little or no community involvement. The C/MHC program has, for the past three decades, provided funds to community-owned and community-operated organizations, whose governing boards are required to have at least a majority-consumer membership. This Community Board Requirement has assured grants go to the right place, and that the services of health centers are responsive to community needs.

Health centers were founded with a vision of community and consumer empowerment, and their experience over the past 30 years provides an object lesson on how consumer involvement and community empowerment can succeed where other models have failed. In this sense, health centers may be our best (and perhaps last) hope for communities in shaping their health care system and making it responsive to their needs. This will be particularly important if health reform is to rely on managed care systems and market forces for its success. Managed care entities and HMOs historically have avoided the poor and underserved because of their unique needs and inherently higher costs. The poor and underserved are in the health care predicament they are in because they have been neglected by the current health care market.

We truly believe that any Access Initiative should build on what works. Therefore, we urge you to significantly increase the proposed funding level for health centers in the Administration's plan and maintain the "community involvement requirements" for any flexible capacity and enabling services. Finally, we believe that no offsets should be taken from existing programs. Funds provided to health centers, family planning and other vital programs should be retained and re-invested in these programs to expand their capacity to meet vital needs, which will continue even after health reform is implemented.

We ask your personal attention to the matters raised herein, and we stand ready to discuss these concerns with you in further detail, should you so desire.

Sincerely,

Tom Barrett Nancy Pelosi

Leon C. Woolsey Carrie P. Nat Pete Stark

Mel Reynolds Edward J. Jones John W. Olver

Eva M. Clayton Melvin Watt Jane Evans

Bobby L. Rush Maxine Waters Jim Oberstar

Major R. Owens Ed Towns Nick Rahall

Donald M. Payne Don Edwards Sidney R. Yates

Corrine Brown Alcee L. Hastings Eliot L. Engel

Earl F. Hilliard Thomas Sawyer Rob Portman

Bob Filner Donald M. Payne Lucille Roybal-Allard

Robert A. Underwood Henry A. Waxman Todd C. Peterson

Neil Abercrombie | Henry Bonilla

Eddie Bernice Johnson | Ron Coleman

[illegible] | [illegible] | [illegible]

Glenn Poshard

Members Signed on Community Health Center Letter
To The First Lady

Rep. Conyers
Rep. Reynolds
Rep. Evans
Rep. Olver
Rep. Dellums
Rep. Roybal-Allard
Rep. Torres
Rep. Stark
Rep. Owens
Rep. Clayton
Rep. Towns
Rep. Oberstar
Rep. Hilliard
Rep. Rahall
Rep. Fields
Rep. Watt
Rep. Meek
Rep. Barrett
Rep. Waters
Rep. Woolsey
Rep. Pelosi
Rep. Hinchey
Rep. Payne
Rep. Sanders
Rep. Yates
Rep. Engel
Rep. Hastings
Rep. Corrine Brown
Rep. Don Edwards
Rep. Rush
Rep. Velazquez
Rep. Bonilla
Rep. Underwood
Rep. Fish
Rep. Flake
Rep. Abercrombie
Rep. E.B. Johnson
Rep. Poshard
Rep. Lewis
Rep. Serrano
Rep. Wheat
Rep. Nancy Johnson
Rep. Ron Coleman
Rep. Collin Peterson

The Health Security Plan

RURAL COMMUNITIES

America's rural communities pose special challenges in health care-- both for those who need services and those who provide them. A total of 34 million people--half of them with incomes under 200 percent of poverty--live in rural areas with inadequate health care.

The fragile economies of rural areas often mean that many residents have little or no insurance, making it difficult for rural communities to attract and keep doctors and maintain local hospitals. Twenty-one million rural residents are without access to consistent primary care providers, and the population of younger rural physicians has not expanded to replace those who retire. Rural communities worry that the current shortage of physicians will continue, and limit their access to care even further.

Americans living in rural areas also have a harder time getting to the services they need. More than half of the rural poor do not own a car, and nearly 60 percent of the rural elderly are not licensed to drive.

The Health Security plan will create a system that meets the unique needs of rural communities. The plan will develop strategies for delivering and financing health care in rural areas, making care more easily available, and attracting doctors and nurses to and keeping them in rural areas.

Guarantees Universal Coverage

- The Health Security plan will guarantee comprehensive health benefits for all Americans, no matter who they are or where they live. Since rural areas have a disproporationate number of uninsured, underinsured and Meidicaid recipients, providing universal coverage will help channel significant new resources into rural health care systems.

- The plan will encourage cooperative relationships among rural and urban providers such as developing information sharing capabilities and referral mechanisms to link academic health centers and rural health providers.

- Under the plan, urban health plans may be offered long-term contracts to serve rural areas in their region. They may also be required to serve rural areas as a condition of participation.

Increases Access to Providers

- The Health Security plan will develop an infrastructure and provide support for primary care capacity to help serve rural citizens and providers. An additional 14 million Americans will receive improved health care services as the Health Security plan targets rural areas in which more than half of all residents earn incomes 200 percent or less of the poverty level.

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

- The Health Security plan will expand the National Health Service Corps, placing at least 3,000 primary care practitioners in rural areas by the year 2000.

Encourages Health Networks

- Under the Health Security plan, technical and financial assistance will be provided to develop networks. This will help the rural communities that need outside expertise to establish links with larger referral centers and academic health centers.

- The Health Security plan includes grants to support the development of telecommunications links between underserved providers and other providers, health care centers, and institutions. This will help facilitate "group practices without walls," allowing easier consultation and coordination among rural providers and with urban providers.

- New grants will be provided to academic health centers to help build information and referral infrastructure needed to support rural health networks.

- Investment in currently successful programs, such as community and migrant health centers, will be increased to help them establish and enhance contacts with other providers.

Assures Participation of Essential Community Providers

- For the first five years after implementation, the Health Security plan will designate as "essential providers" qualified practitioners and facilities in underserved areas.

May 11, 1993

To Melanne
Should we respond in writing?
H

The Honorable First Lady
Hillary Rodham Clinton
The White House
Washington, D.C.

Dear Mrs. Clinton:

Due to the exclusion of seasonal farmworkers from health care coverage under the State of Washington's health care reform plan, the undersigned organizations representing the vast majority of those providing services to migrant and seasonal farmworkers throughout the country urge you not to provide any implicit or explicit support for the State of Washington's Health Care Reform Plan. Further, we urge that no federal financial participation be approved for any State-based reform plans that exclude agricultural workers from coverage afforded to others.

We believe that it should be a bottom line that no State-based, or national, health care reform plan that excludes any group of migrant or seasonal agricultural workers from health care coverage is acceptable in the context of this nation's current expectations for health care reform.

Given your commitment to the improvement of our nation's health care system, we know that you are well aware that no group of workers in this country has been more greatly affected by poverty, lack of access to appropriate health care providers, or lack of employer support for health coverage than migrant and seasonal agricultural workers. It is simply unacceptable that any State-based health care reform plan that excludes these workers, or asks them to wait for years for rights being extended to others now, would receive approval for any federal participation. What has occurred with the Washington health care plan serves to underscore our worst fears that state administration of health care reform will be harmful to low income and medically underserved people such as farmworkers.

We ask you to urge Governor Lowry to veto that section of the Washington plan that excludes seasonal farmworkers. If he does not, we ask you not to attend the signing of this piece of legislation. We believe that your presence at the signing, or tacit support for this plan, would send the wrong message at a very critical juncture.

Ideally, mobile workers that move often within a state or among states, should be enrolled into health insurance coverage on a national basis, and afforded services wherever they present. But until such a national reform is put into place, there should be no federal support, or endorsement, for State-based plans which continue current patterns of

discrimination against low-income workers who need the benefits of health care reform the most.

Thank you for your attention to this urgent matter.

Sincerely,

Lyndo Diane Mull, Executive Director
ASSOCIATION OF FARMWORKER OPPORTUNITY PROGRAMS
408 Seventh Street SE
Washington, DC 20003

Moises Loza, Executive Director
HOUSING ASSISTANCE COUNCIL
1025 Vermont Avenue NW
Washington, DC 20005

Ed Zurovveste, M.D., Chair
MIGRANT CLINICIANS NETWORK
1515 South Capital of Texas Highway
Austin, TX 78746

Sister Adela Gross, OSF
MIGRANT MINISTRIES
3211 4th Street NE
Washington, DC 20017

NATIONAL ADVISORY COUNCIL ON MIGRANT HEALTH

Tom Van Coverden
Executive Director
NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS
1330 New Hampshire Avenue NW
Washington, DC 20036

E. Roberta Ryder, Executive Director
NATIONAL MIGRANT RESOURCE PROGRAM
1515 South Capital of Texas Highway
Austin, TX 78746

Génoveva Morales
President
NATIONAL MIGRANT HEAD START DIRECTORS ASSOCIATION
301 N. First St.
Suite #1
Sunnyside, WA

National Advisory Council on Migrant Health
DHHS/Bureau of Health Care Delivery and Assistance/Office of Migrant Health
Room 7A-55 Parklawn Building • 5600 Fishers Lane • Rockville, MD 20857 • (301) 443-1153 voice • (301) 443-4509 fax

MAY 5 1993

The Honorable Mike Lowry
Office of the Governor
Legislative Building
Olympia, Washington 98504-0002

Dear Governor Lowry:

I am the Chair of the National Advisory Council on Migrant Health, a Council selected and appointed by the Secretary of the Department of Health and Human Services. The Council advises the Secretary on efforts to improve health services and conditions for agricultural migratory and seasonal agricultural workers and their families. Our 15 members include migrant farmworker representation, board members from Migrant Health Centers, grower representation and individuals experienced in the medical sciences or administration of health programs.

I have recently learned of Washington's Health Care Reform Legislation which excludes seasonal farmworkers. This discriminatory legislation excludes a largely Hispanic population that make significant contributions to the State's $4 billion agribusiness economy.

We are the only organization that routinely hears directly from migrant farmworkers through a series of public hearings across the country. We hear of their hazardous working conditions, exposure to pesticides, deplorable housing, poor nutrition, lack of access to primary care all of which contribute to their risk. There are three to five million migrant and seasonal farmworkers who are the most vulnerable individuals in the country, yet you turn your back on the workers and their families. How can the State of Washington let an entire industry exclude their workforce?

The Federal Migrant Health Program, enacted in 1962 has attempted to meet the needs of this population through 104 community based organizations and 400 clinic sites across the country and in Puerto Rico. The program, however, serves less than 20% of the population and access to care continues to be a problem.

Health Care Reform at the State and National level cannot forget the farmworkers, who so often have been forgotten in the past, in the areas of basic worker protections and health care benefits.

Page 2 - The Honorable Mike Lowry

I believe that no one will hear the voices of farmworkers and their families unless we speak out now. Coming up with an alternative plan for seasonal farmworkers will lead to a two-tiered system of health care for the residents of the State of Washington.

We look to you for the leadership and the will to include the farmworker in any plan for reform. We urge you to veto the proposed legislation in its current form.

Sincerely yours,

David Duran

David Duran
Chair

cc: Mrs. Hillary Rodham Clinton

Melanne

file

The Health Security Plan

RURAL COMMUNITIES

America's rural communities pose special challenges in health care-- both for those who need services and those who provide them. A total of 34 million people--half of them with incomes under 200 percent of poverty--live in rural areas with inadequate health care.

The fragile economies of rural areas often mean that many residents have little or no insurance, making it difficult for rural communities to attract and keep doctors and maintain local hospitals. Twenty-one million rural residents are without consistent access to primary care providers, and the population of younger rural physicians has not expanded to replace those who retire. Rural communities worry that the current shortage of physicians will continue, and limit their access to care even further.

Americans living in rural areas also have a harder time getting to the services they need. More than half of the rural poor do not own a car, and nearly 60 percent of the rural elderly are not licensed to drive.

The Health Security plan will create a system that meets the unique needs of rural communities. The plan will develop strategies for delivering and financing health care in rural areas, making care more easily available, and attracting doctors and nurses to and keeping them in rural areas.

Guarantees Universal Coverage

- The Health Security plan will guarantee comprehensive health benefits for all Americans, no matter who they are or where they live. Since rural areas have a disproportionate number of uninsured, underinsured and Medicaid recipients, providing universal coverage will help channel significant new resources into rural health care systems.

- The plan will encourage cooperative relationships among rural and urban providers such as developing information sharing capabilities and referral mechanisms to link academic health centers and rural health providers.

- Under the plan, regional alliances may provide incentives to urban health plans to serve rural areas in their region. They may also be required to serve underserved rural areas as a condition of participation.

Increases Access to Providers

- The Health Security plan will develop an infrastructure and provide support for primary care capacity to help serve rural citizens and providers. An additional 14 million Americans will receive improved health care services as the Health Security plan targets rural areas in which more than half of all residents earn incomes 200 percent or less of the poverty level.

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

- The Health Security plan will expand the National Health Service Corps, placing at least 3,000 primary care practitioners in rural areas by the year 2000.

Encourages Health Networks

- Under the Health Security plan, technical and financial assistance will be provided to develop networks. This will help the rural communities that need outside expertise to establish links with larger referral centers and academic health centers.

- The Health Security plan includes grants to support the development of telecommunications links between underserved providers and other providers, health care centers, and institutions. This will help facilitate "group practices without walls," allowing easier consultation and coordination among rural providers and with urban providers.

- New grants will be provided to academic health centers to help build information and referral infrastructure needed to support rural health networks.

- Investment in currently successful programs, such as community and migrant health centers, will be increased to help them establish and enhance contacts with other providers.

Assures Participation of Essential Community Providers

- For the first five years after implementation, the Health Security plan will designate as "essential providers" qualified practitioners and facilities in underserved areas.

- These providers will either be offered contracts with plans, or receive reimbursement on a fee-for-service basis to ensure access to care and continuity of care for rural and other vulnerable populations.

- Federal grants and loans will help essential providers establish links with local practitioners, community hospitals, and academic centers, and form integrated practice networks or community-based plans.

Coordination of Programs

- During the phase-in of health reform, current block grants will continue to pay for clinical services for the uninsured as well as supplemental services for all low-income individuals.

- After universal coverage is achieved, funds which had been used to provide health services to the uninsured will be redirected and combined with new grants to pay for support services to ensure access to care. These services include outreach, follow-up, home visits, transportation, and child care during office visits.

February 17, 1994

Rural and Frontier Areas

Provisions affecting rural and frontier areas are scattered throughout the Act, including the following important areas:

Coverage:

Universal coverage will provide health insurance for uninsured rural people and will improve coverage for those underinsured. This also will eliminate most of the problems of uncompensated care for rural health care providers. (Title I)

Self-employed people will be able to deduct 100 percent of the cost of their health insurance premiums for the comprehensive benefit package purchased through a health alliance, which will help many farm families. (sec. 7203)

The ability of small employers and self-employed people to purchase health insurance through health alliances will help them get more coverage, often for less money. The mandatory use of community ratings will also be a benefit for rural people. (General)

Workforce:

National goals and funding policies will increase supply of primary care physicians. By 1998-1999, the proportion of primary care trainees will increase from about one-third to 55 percent; (sec. 3012)

Funding will be doubled for nurse practitioner, nurse midwifery, and physician assistant training programs; (sec. 3062)

National Health Service Corps (which places about 60 percent of their providers in rural areas) will be expanded from about 1,600 to about 7,700 in 2004. (sec. 3471)

Tax credits are offered for primary care providers serving in underserved areas - up to $1,000 per month is available for primary care physicians and $500 for non-physician providers for up to 5 years of service. The tax credit may be recaptured on a sliding percentage scale for service less than 5 years in a designated area. (sec. 7801)

Allowable depreciation expense for medical equipment is increased by $7,500 for all doctors and by an additional $10,000 for primary care physicians practicing in designated underserved areas. (sec. 7802)

Medicare's 10 percent bonus payment for primary care physicians practicing in underserved areas is increased to 20 percent, while other specialists continue to receive a 10 percent bonus. (sec. 4115)

Essential Community Providers:

Many rural providers will be eligible for transitional protection as essential community providers, including rural health clinics, community and migrant health centers, and hospitals and doctors in underserved areas. This provision will assure that health plans contract with and pay essential providers for the services they provide under the benefit package. (sec. 1431 & 1581)

Capacity Expansion and Enabling Services:

Capacity Expansion programs in rural and urban areas will provide:

- grants for communities to form "community health plans and networks", enhancing their ability to compete in the new system and to maximize their control of their own destiny; (sec. 3421)

- loans and loans guarantees to help capitalize programs serving low-income patients and underserved areas, including construction, renovation, and conversion of facilities to more appropriate uses; (sec. 3441) and

- grants to public and non-profit entities to provide services that overcome non-financial barriers to care, such as transportation, outreach, and translation/interpretation services. (sec. 3461)

Technology:

Information and communications technologies will be supported through PHS Capacity Expansion programs, as well as through grants to Academic Health Centers that will enable them to reach out into rural areas with technology and information and referral systems. (sec. 3421, 3441 & 3132(AHC))

Special provisions:

Alliances are permitted to offer incentives to health plans to encourage them to provide coverage in rural areas. (sec. 1329)

Guidelines for risk adjusting premiums will have a factor for geographic isolation. (sec. 1541)

States may opt for a single payer system for their state or for a full alliance area. (sec. 1221)

Medicare drug and long term care benefits will benefit rural areas, which usually have higher proportions of seniors. (Title II)

Rural Electric Cooperatives and Rural Telephone Cooperatives may function as corporate alliances for their members. (sec. 1311)

HEALTH SECURITY ACT OF 1993:

BENEFITS TO RURAL AND FRONTIER AREAS

RURAL AND FRONTIER AREA BENEFITS

The Health Security Act will greatly benefit rural and frontier areas. Provisions affecting rural and frontier areas are scattered throughout the Act. Together they provide a comprehensive array of improvements.

- Universal coverage will provide comprehensive and continuous benefits to millions of uninsured and underinsured rural residents and assures reimbursement for providers who care for them
- Financing provisions are tailored to assist self-employed residents and small businesses pay for coverage.
- Special programs assure that health care providers will be available to care for rural areas.
- Flexible alternatives are offered for creating rural systems of care.

UNIVERSAL COVERAGE

The Health Security Act:

- Provides health insurance for the estimated 8 million uninsured rural Americans.
- Improves the benefits available to many million more underinsured rural residents.
- Relieves rural providers' uncompensated care burden which amounts to billions of dollars, over $1.5 billion for rural hospitals, alone.

FINANCE AND INSURANCE REFORM

- Self-employed people will be able to deduct 100 percent of the cost of their health insurance premiums for the comprehensive benefit package purchased through a health alliance, which will help many farm families.
- Alliances will provide increased purchasing power for individuals, small businesses and self-employed people, often at less costly rates.
- Alliances will make health insurance purchasing decisions easier and more rational for individuals and small businesses.

- Cost sharing, even under fee-for-service plans, will be less than many rural residents currently pay with their commercial insurance.

- Insurance industry reforms will prohibit current practices of redlining, previous condition exclusions, etc. which affect individual insurance rural purchasers.

INCREASING THE AVAILABILITY OF PROVIDERS THROUGH EDUCATION

- National effort will increase primary care physician trainees to 55 percent.

- New funding for training primary care physicians and underrepresented minorities.

- New funding for training of non-physician providers:

  -- Graduate nurse education programs receive $200 million per year
  -- Additional funding for training physician assistants, advanced practice nurses, and administrators

ASSURING THE AVAILABILITY OF PROVIDERS THROUGH PLACEMENT AND RETENTION

- Universal coverage will eliminate uncompensated care and pay providers for what they do.

- National Health Service Corps (which places about 60 % of their providers in rural areas) will expand nearly five-fold.

- Tax credits are offered for primary care providers serving in underserved areas - up to $1,000 per month is available for primary care physicians and $500 for non-physician providers for up to 5 years of service.

- Allowable depreciation expense for medical equipment is increased an additional $10,000 for primary care physicians practicing in designated underserved areas.

- Medicare's 10 percent bonus payment for primary care physicians practicing in underserved areas is increased to 20 percent, while other specialists continue to receive a 10 percent bonus.

DEVELOPING SYSTEMS OF CARE

- States may require health plans to cover all or specific parts of a regional alliance area as a condition of contracting with an alliance.
- Alliances are permitted to offer incentives to health plans to encourage them to provide coverage in rural areas.
- Many rural providers will be eligible for transitional protection as essential community providers.
- Guidelines for risk adjusting premiums may have geographic factor.
- States or alliances may opt for single payer systems.
- Academic health centers may apply for grants to develop service relationships with rural and inner-city areas, including information and referral networks and telecommunications.
- PHS Capacity Expansion programs will provide:
  - grants for communities to form "community health plans and networks", enhancing their ability to compete in the new system and to maximize their control of their own destiny.
  - loans and loans guarantees to help capitalize programs serving low-income patients and underserved areas, including construction.

IMPACT ON RURAL HOSPITALS

- Universal coverage will relieve the burden of over $1.5 billion in uncompensated care.
- Linkages with other providers will increase as health plans seek to assure benefit package coverage.
- Access to larger, more appropriate workforce pool for recruiting.
- May apply for Essential Community Provider designation.
- May apply for PHS capacity expansion grants and loans.
- Largest Medicare cuts are in programs that have smaller impact on rural hospital reimbursement rates (disproportionate share and graduate medical education).

IMPACT ON RURAL DOCTORS

- Universal coverage will provide new source of revenue.
- Paperwork burden on doctors' offices should be lightened.
- Primary care doctors will be in great demand and in a good bargining position with health plans.
- Medicare bonus payments for primary care doctors in underserved areas will rise from 10 percent to 20 percent.
- Tax credits and accelerated equipment depreciation will be available to doctors in underserved areas.
- May apply for Essential Community Provider designation.

IMPACT ON SMALL EMPLOYERS

- Discounts for low-wage small business will be provided.
- Small employers with low-wage employees will be able to obtain coverage for as little as $1.00 to $2.00 per day per employee.
- Most employers now providing insurance probably will see their costs go down.
- Insurance industry practices of red-lining, price baiting, gouging and dropping coverage when employees or their families get sick will be eliminated.
- Cost increases in health insurance premiums will be controlled.
- Alliances will increase small business purchasing power and dramatically reduce administrative costs of obtaining coverage.

ESSENTIAL COMMUNITY PROVIDERS

The Essential Community Provider program provides transitional protection to federally-funded and others delivering care in difficult-to-service areas. The program will assure that providers caring for vulnerable populations are included in health plan development.

- Health plans must contract with all ECPs in service area.

- ECPs must be paid at a negotiated, contracted rate or, at the election of the ECP, at an appropriate Medicare rate (e.g., FQHC, RHC, or Medicare capitation rate) or on the alliance fee schedule.

- Some providers are automatically certified, including:

  - Community and Migrant Health Centers
  - Rural Health Clinics
  - Federally-Qualified Health Centers
  - Indian Health programs (including tribal units and 638 contractors)
  - other federally-funded providers

- Other providers may apply for certification, including
  - rural hospitals
  - physicians
  - health departments

IMPROVING ACCESS IN UNDERSERVED AREAS

QUESTION:

What does the plan do to improve access in underserved areas?

ANSWER:

First and foremost, under the Health Security Act, all Americans and legal residents will have insurance coverage. Their insurance will provide for a package of basic benefits that can never be taken away. However, insurance alone will not assure access to care. Thus, the President's proposal will expand the system's capacity and increase the number of primary care providers, especially in underserved rural and inner city areas so that people living there have an adequate choice of providers and plans.

In addition, the President's plan enhances services to underserved populations in the following ways:

- The Act builds on the strengths of successful programs, such as Community and Migrant Health Centers, which receive increased funding to expand the number of people they serve.

- Through the new capacity expansion program, funds are authorized for integrating into the reformed system of care providers who now care for the low-income people and helping them work together and negotiate effectively with plans. Loans and loan guarantees are also available to help establish new practice sites and renovate existing sites.

- The essential provider provisions help assure the viability of health care providers who have been successfully serving vulnerable populations by requiring that health plans contract with all certified essential providers in their area.

- Some services are not included in the comprehensive benefit package that are important in meeting the needs of low-income, hard-to-reach populations. These "enabling services," including outreach, transportation, translation, and non-medical case management, will help assure that underserved populations will be able to overcome non-financial barriers to care. The Act includes an authorization for a new flexible enabling service program, and additional services from existing PHS programs will be available to meet these needs.

- A five-fold expansion of the National Health Service Corps field strength and tax incentives for non-NHSC primary care providers will help assure that there are more people

providing care in underserved areas.

CHOICE OF PLANS IN RURAL AREAS

QUESTION:

What does the President's plan do to ensure that people in rural areas will have a choice of health plans?

ANSWER:

The Health Security Act will greatly benefit rural and frontier areas. Provisions affecting rural and frontier areas are scattered throughout the Act. Together they provide a comprehensive array of improvement that will offer rural residents more choices.

- Universal coverage will insure millions of uninsured and underinsured rural residents and assure reimbursement for providers who care for them.

- The Act will provide funding for increasing the supply of primary health care providers and payment and tax incentives to retain them in rural practice.

- Rural providers may form health plans with the support of grants and loan guarantees from the Public Health Service.

- Rural providers will be able to offer residents more choices of plans because they will be able to join multiple health plans offered in their alliance areas. Alliances are permitted to offer incentives to health plans to encourage them to provide coverage in rural areas or to help establish new plans.

- States are tasked with maximizing the choices of alliance health plans offered to its residents. States are also responsible for certifying all health plans operating in the state, and they may require health plans to cover an entire alliance area or selected parts of an alliance area.

- States may also opt for a single payer system within their whole state or in an alliance area. This option, combined with provisions to increase the supply of primary care providers, could offer rural residents an increased choice of providers.

- Despite these efforts, some more remote rural or frontier areas may have the limited choice of only a fee-for-service plan, but these areas should be able to increase choice by increasing the number of providers available to them.

MEDICARE CUTS AND RURAL HOSPITALS

QUESTION:

Since rural hospitals tend to take care of higher proportions of the elderly, won't the Medicare cuts in the plan hurt them more?

ANSWER:

The Health Security Act will have many benefits for rural hospitals, including:

- Universal coverage will eliminate their uncompensated care;
- Workforce initiatives will provide valuable new resources for training health providers that are in great demand in many parts of rural America;
- Tax incentives and increased bonus payments to help retain the doctors currently providing services in rural hospitals;
- Funding in the new PHS access initiatives that will help rural hospitals and other providers in underserved communities develop community-based health plans; and
- Essential community provider certification which may be available to some rural hospitals will assure that they will be integrated into health plans.

Despite these benefits, rural hospitals are going to share in the responsibility for reductions in the Medicare program. The burden of these cuts is somewhat eased by the following:

- In spite of rural hospitals' disproportionately elderly case load, the proposed Medicare savings do not fall disproportionately on rural hospitals. This is because many of the savings are targeted at special payment rules that tend not to affect rural hospitals.

The Health Security Act

OLDER AMERICANS

Despite federal efforts to meet the health care needs of older Americans at an affordable cost, rising health care fees and changing demographics, have strained our ability to pay. Many older Americans face a choice between medication and food. Long-term care services are largely unavailable unless people virtually impoverish themselves. All too often, early retirees lose their health insurance when employers, faced with overwhelming health care costs, are forced to scale back or drop coverage.

At the same time, the success of Medicare has made Americans over age 65 the only age group that has any degree of health care security today. The Health Security plan preserves this by continuing and improving the Medicare program.

Older Americans will see little change in the new system. They will continue to receive Medicare benefits and see the same doctor or doctors if they choose. But they will also be given new help in paying for prescription drugs and long-term care and opportunities to choose among a broader set of plans.

Prescription Drug Benefit

- Current Medicare benefits will be enhanced to include prescription drug coverage filling a major gap in the health security of older Americans.

- After meeting an annual deductible of $250, the elderly will no longer have to pay the full costs of prescription drugs out-of-pocket.

- Beneficiaries will pay 20 percent of the cost of each prescription up to a $1,000 out-of-pocket annual limit. Prescription costs in excess of $1,000 will be fully covered by the new benefit.

- Education efforts on proper administration of medications will enhance the quality of care for older Americans.

Long-Term Care Options

- The Health Security plan will establish a new home and community-based care program. This could enable up to 2.2 million older Americans to at home in community based settings, while receiving the long-term supports they need.

- The Health Security plan will improve the quality of life for Medicaid recipients in nursing homes residents by allowing them to keep $50 per month for living expenses. States may also allow single nursing home residents to keep $12,000 in assets instead of today's $2,000, yet still be eligible for Medicaid. An estimated 1.2 million nursing home residents will benefit from this change.

- Under the Health Security plan, all Americans will be better able to protect themselves against the high cost of long-term care. Private long-term care insurance will be improved through the adoption of new federal standards and better consumer education. Qualified policies will receive the same tax preference as health insurance, making them more affordable as well.

Protection for Older Americans

- Under the Health Security plan, doctors and other providers will no longer be allowed to bill Medicare recipients for more than the approved Medicare amount, a practice that exists today as 'balanced billing'.

- Older Americans who purchase Medigap policies to supplement their Medicare benefits will no longer face discrimination based on pre-existing conditions. The Medigap plans must accept all applicants regardless of their age or health status and guaruntees annual open enrollment.

Giving Older Americans New Options

- Medicare will continue primarily as a fee-for-service health program but will offer beneficiaries a wider range of health plans, including the option to enroll in a preferred provider networks, or a health maintenance organizations.

- After a state joins the new system, newly eligible Medicare beneficiaries will be able to choose to join Medicare or remain in their alliance-certified health plan.

- States will eventually have the option of integrating all their citizens, including Medicare beneficiaries , into alliances or a single payer system. But they will be required to submit a plan to the Secretary of Health and Human Services for approval. They must guarantee that all Medicare beneficiaries have equal or better coverage in the new system than under Medicare, at no additional cost to the Medicare program.

Early Retiree Protection

- People who retire early will no longer have to live in fear of losing their health benefits. Retirees, like working Americans, will be responsible for no more than 20% of the average cost of health premiums.

- Retired people between the ages of 55 and 65 who have worked for at least 10 years but are not yet eligible for Medicare will receive financial assistance from the federal government to cover the employer's share of their premium.

- Early retirees also may get assistance for their share of the premium, if their former employers have contractual obligations or chose to pay for retiree health benefits. Retirees with incomes near the poverty level will receive assistance from the federal government to assist with these costs.

February 17, 1994

The Health Security Act

SMALL BUSINESS

Small business is the nation's engine of economic growth. Yet this growth is threatened by a health care system that is stacked against small business. Their health care coverage costs more and offers less. Insurers often attract small businesses by offering low premiums, but then raise them dramatically -- as much as 50% in a single year. As a result, small businesses can face premiums that vary in price by as much as 350% for similar benefits. Administrative costs eat up more than 40 cents of every dollar small businesses spend on health insurance premiums, eight times as much as large companies.

Despite these problems, most small businesses want to provide health care coverage to their employees -- and most do. Today 62% of American businesses with less than 100 employees provide insurance. But these businesses that provide insurance are paying for the ones that don't. On any Main Street, the health care bills for the dry cleaner who insures their employees keep going up because the owner of the car wash down the street does not cover their employees and they end up in the emergency room when they are injured or fall ill.

The Health Security Act will end this unfair "cost-shifting," lowering costs for most small businesses but ensuring that no one gets a free ride. The Act will give small businesses a better deal by eliminating hassles and paperwork, giving low wage employers substantial discounts, and reforming today's complex and inefficient workers compensation system. Small businesses will be able to get the security of rock solid coverage for their employees and their families, and the vast majority will see lowered costs.

Controls Costs

- The Health Security Act will put small businesses and consumers in the driver's seat -- creating large purchasing pools that enable small businesses to get the same deal from the insurance companies that large companies get today. Health plans will be forced to compete for business, bringing down prices and improving the quality of care.

- Administrative costs will be drastically reduced because the regional health alliance will assume the administrative burden for the small business -- administering benefits, enrolling employees, negotiating and renewing coverage, and bargaining for reasonable coverage.

Helps Small Businesses Grow

- The Health Security Act will help those firms that are creating the most jobs and growing the fastest. The 62% of small businesses that provide insurance today are the fastest growing small businesses in America. New, more affordable coverage will help them expand even more, leading to more jobs and higher wages. **The Wall Street Journal wrote: "For many small businesses, saddled with escalating health care costs, President Clinton's health care package comes as an unexpected windfall."**

- Experience shows that the Health Security Act will create a better climate for small businesses to grow and prosper. 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), and small business creation rates have remained high (the number of employers grew almost 200% from 1970 to 1991).

- When all small business employees are guaranteed a comprehensive package of health benefits, employers will be able to retain a stable, high-quality workforce.

Provides Discounted Coverage for Low-Wage Small Businesses

- Small businesses of less than 75 employees with an average wage of less than $24,000 will receive **discounts of 10% to 56%**, depending on their average size and wage. These premiums **replace** what businesses pay today.

- Contributions for health coverage will amount to only about 15 cents an hour for the small employer whose average worker makes minimum wage. Added to the minimum wage, that is still below the minimum wage during most of the 1980s, when adjusted for inflation. And that buys a comprehensive package of benefits.

- Small businesses that currently provide health benefits will likely pay substantially less under reform, due to falling administrative costs and lower premium rates.

- Small businesses who today are only able to provide bare bones insurance will be able to provide a comprehensive package of benefits to their employees and their own families at a reasonable price.

Gives 100 Percent Tax Deduction to the Self-Employed

- The self-employed and independent contractors will be able to deduct 100% of the cost of the comprehensive benefits package from their taxes, just as all other businesses do today. The self-employed are currently allowed to deduct 25% of health care costs.

Reforms Workers Compensation

- Under the plan, injured workers will obtain treatment through their health plans, just as they would for other injuries or illnesses. This will stop duplication, help workers get back to work quickly, and reduce costs for small businesses.

- Workers' compensation insurers will continue to provide coverage and reimburse the worker's health plan according to a fee schedule.

- A Presidential Commission will be established to study the issues involved in full financial integration and make detailed recommendations, advisable to the President by July 1, 1995.

Ends Insurance Industry Abuses of Small Businesses

- The Health Security Act makes it illegal for health plans to raise premiums if an employee gets sick. In today's system, small businesses often see their premiums skyrocket when just one of their employees or someone in their family gets sick.

- Under the Health Security Act, health plans will charge small businesses the same premium as big businesses in the same region (based on family composition) for the uniform, comprehensive package of benefits. Low-wage small businesses will receive a discount.

- Insurance companies will have to accept all who apply for coverage. This will end "occupational redlining," the practice where insurers refuse to cover certain industries, such as hospitals, grocery stores, and barber shops.

February 17, 1994