DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

PHONE: (202) 690-6870 FAX: (202) 401-7321

Date:

From: Sharman Stephens To: Jennifer Klein

Phone: (202) 690- _____ Phone: _____
(202) 690-6870
FAX: (202) 401-7321 Fax: _____

Number of Pages (Including Cover): 3

Comments: This guy called on Friday & I referred him to you, but he called back because he could not reach you. I had him send in his request which I left for Ken.

OFFICE OF CONGRESSMAN GEORGE MILLER

April 15, 1994

4:25 pm
2nd
Transmission

FAX TRANSMISSION

FR: Daniel Weiss
Administrative Assistant
Office of Congressman George Miller
202/225-2095

TO: Ken Thorpe, HHS

RE: Cost-Estimate on Mental Health Benefit amendment to HR 3600

TOTAL PAGES INCLUDING THIS PAGE IS 2

NOTE: Phyliss Borzi asked me to run this amendment by you to see if you could eye-ball it and determine whether it will increase the cost of the President's plan, and if so by how much. Even if you only have a general idea, your thoughts would be greatly appreciated, such "increase it slightly, not at all, a lot."

As you can imagine, time is of the essence. We have been asked for an answer today. Anything you can do to help us would be greatly appreciated.

Thank you.

HR3600 Amendment by Mr. Miller, Ed + Labor

Add new section:

ORGANIZED SYSTEMS OF CARE FOR CHILDREN

(1) DEFINITION. For purposes of this subtitle, the term "organized system of care" means a deliberately organized, community-based service delivery network for children under age 22 with serious or complex mental or substance abuse disorders. Such systems of care have the capacity to:

(A) Involve and coordinate multiple child-serving agencies and providers (including child welfare, education, juvenile justice, health, mental health, and substance abuse).

(B) Involve families of children with mental and substance abuse disorders in treatment planning and service delivery.

(C) Develop individualized treatment plans, through multidisciplinary or multiagency teams, that are recognized and honored across multiple child-serving agencies and providers.

(D) Ensure the delivery and coordination of the array of services needed by children with serious or complex mental or substance abuse disorders.

(E) Manage the individualized treatment plans and respond flexibly to treatment needs as they change over time.

(2) PROVISION OF SYSTEMS OF CARE. Health plans shall ensure that mental health and substance abuse services for children under age 22 who have serious or complex disorders are provided through an organized system of care. Health plans will be deemed to have met this requirement if one of the following conditions is met: The plan has established a system of care for children enrolled; the plan has established linkages with an existing public sector system, or systems, of care in the area, or the health plan is participating in the development or operation of a joint public-private system of care set up with appropriate public agencies in the health plan area.

Federal Medicaid Impacts of Health Care Reform **REVISED**

Using FY95 President's Budget Baseline and Assumptions as of 1/11/94

(billions of dollars)

FISCAL YEAR BASIS	FY1996	FY1997	FY1998	FY1999	FY2000	FY96-2000
Offset for Medicaid-only eligibles in alliances	-1.4	-5.4	-15.6	-23.4	-27.5	-73.3
alliance-covered services	-0.1	-0.4	-1.2	-1.8	-2.2	-5.7
wraparound (adults only)						
Cost of providing emergency services undocumented individuals	0.1	0.2	0.4	0.5	0.6	1.8
DSH Savings	-1.0	-3.7	-10.4	-15.2	-17.4	-47.6
Offset for "reserve"	0.1	0.3	0.7	0.8	0.8	2.6
Savings from Capitation of Cash eligibles	-0.3	-1.2	-3.7	-6.6	-9.7	-21.4
Pa Lag Liability for Cash eligibles	0.6	1.8	4.7	1.4	0.0	8.7
State Maintenance of effort MCD-only - non-DSH						
alliance-covered services	-1.5	-4.8	-13.5	-16.6	-17.3	-53.7
offset for undocumented individuals	0.1	0.2	0.5	0.5	0.5	1.7
State Maintenance of effort - DSH 1/	-0.5	-1.6	-4.5	-5.5	-5.7	-17.8
Medicare Drug Benefit Offset	-0.5	-0.9	-1.1	-1.2	-1.4	-5.1
Long-term Care liberalizations	0.4	0.5	0.5	0.5	0.5	2.4
Impact of Wraparound Program for Children						
Curr Baseline Fed Spending Offset						
CASH	-0.1	-0.3	-0.9	-1.3	-1.5	-4.0
MCD-Only	0.0	-0.1	-0.4	-0.6	-0.7	-1.8
New Program Fed Spending 2/						
CASH	0.1	0.5	1.4	2.0	2.1	6.1
MCD-Only	0.1	0.2	0.6	0.9	1.0	2.8
State MOE 3/ CASH	-0.1	-0.2	-0.6	-0.8	-0.9	-2.6
Total	-3.9	-14.9	-43.0	-66.4	-78.9	-207.1

Non cash adult wrap

1/ DSH MOE based on inpatient general and mental hospital services

2/ Fed+State Shares grown at budget rates

3/ State Share of Cash grown at budget rates

112/modhcr7b

16:50
01/11/94

Cost of Alternative Kid Wrap Programs
3-30-94

$ billions

	FY96	FY97	FY98	FY99	FY00	96-00
Curr Fed Baseline (w/ phase-in)	0.1	0.4	1.2	1.9	2.2	5.9
New Program Fed Spending (100% match)						
Curr HSA pricing (no elig changes)	0.2	0.7	2.0	2.9	3.1	8.9
Curr Law Max Participation	0.3	0.9	2.7	3.8	4.1	11.8
150% PL Max Par	0.3	1.3	3.6	5.1	5.5	15.7
200% PL Max Par	0.4	1.6	4.5	6.3	6.8	19.5
State MOE (cash)	0.1	0.2	0.6	0.8	0.9	2.6
Net Fed Cost						
Curr HSA pricing (no elig changes)	0.0	0.1	0.2	0.1	0.0	0.4
Curr Law Max Participation	0.1	0.3	0.9	1.1	1.0	3.3
150% PL Max Par	0.2	0.6	1.8	2.3	2.3	7.2
200% PL Max Par	0.3	0.9	2.6	3.6	3.7	11.0

19.5

Δ over current law

Kids 18 =

extend

03/30/94 09:16

114/mag 160b

FAX TRANSMITTAL

To: Ken Thorpe — From: John Klemm

Dept./Agency — Phone #: 456-7914

Fax #: — Fax #:

# of pages ▶ 2

NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

COMMITTEE ON EDUCATION AND LABOR

Subcommittee on Labor-Management Relations

U.S. House of Representatives

320 Cannon House Office Building

Washington, DC 20515

phone: (202) 225-5768
fax: (202) 225-3614

FACSIMILE TRANSMISSION SHEET

DATE: _____

TO: Jennifer Klein

FROM: **Jon Weintraub**__ **Fred Feinstein**__ **Phyllis Borzi**__ **Rick Jerue**__

Gail Brown__ **Susie Ringel**__ **Allison Hogue**__ **Tony Guiles**__

NUMBER OF PAGES TO FOLLOW: _____

MESSAGE: PIs use the Chan's mark description to highlight what needs costing out in Women's + mental health pkg

H.R. 3600

Chairman's Mark

HEALTH CARE REFORM

PAT WILLIAMS, Chairman

Subcommittee on Labor-Management Relations

Committee on Education and Labor

APRIL 18, 1994

The Chairman's Mark consists of a substitute for H.R. 3600 (Health Security Act), comprised of the following:

(1) Title I [*Substitute for entire title, attached*]

(2) Title II [As contained in H.R. 3600]

(3) Title III [As contained in H.R. 3600 *with the addition of a part 3 to subtitle F and a subtitle J, attached*]

(4) Title IV [As contained in H.R. 3600]

(5) Title V [As contained in H.R. 3600, *with a substitute for part 1 of subtitle C, attached*]

(6) Title VI [*Substitute for entire title, attached*]

(7) Title VII [As contained in H.R. 3600]

(8) Title VIII [As contained in H.R. 3600, *with a substitute for subtitles E and F, attached*]

(9) Title IX [As contained in H.R. 3600]

(10) Title X [As contained in H.R. 3600]

(11) Title XI [As contained in H.R. 3600]

Description of Chairman's mark

The base document will be H.R. 3600. Except as noted below, the Chairman's mark will reflect the introduced bill.

Changes include:

-- **structure:**

* replace mandatory alliances with new structure requiring states to perform functions previously handled by alliances. States could fulfill these requirements by establishing a single mandatory consumer purchasing cooperative per community-rated area, a single voluntary consumer purchasing cooperative per community-rated area or no cooperative at all. The state could also establish one or more private sector clearinghouses to perform certain functions (e.g., enrollment or premium collection).

* provide more generous subsidies for all small businesses: target majority of new assistance to businesses with fewer than 25 employees; provide additional subsidy to employers with 25-75 workers

* increase premium subsidies for workers in low income households by increasing the subsidy to those at 200% of poverty instead of 150% and increasing the income disregard from $1000 to $2000

* require the membership of the National Board to reflect the diversity of the population served

* preclude states from certifying health plans designed to serve boarder areas from discriminating against out-of-state providers

* expand the duties of the consumer ombudsman; assure that consumers have adequate information and assistance in making choices of plans, getting information from plans; assure that adequate procedures and remedies exist to enforce consumer rights to items, services, and treatment for benefits.

* ensure that boards of consumer purchasing cooperatives are directly accountable to the people they represent by establishing strong fiduciary obligations for members of the boards

* establish transition rules for states that have already enacted significant health care reform

* clarify that health plans may be sponsored by groups of providers organizing themselves into integrated health networks

-- **benefits:**

* provide grants for states to create organized systems of care for mental health and substance abuse services for children under the age of 22

* create comprehensive managed mental health programs by giving flexibility to the States to develop integrated delivery systems

* increase mammogram screening without copayments: every two years for women age 40-49, and every year for women age 50 and above

* provide pap smears and pelvic examinations without copayments for women who have reached childbearing age

* provide clinical breast exams without copayments

* clarify that necessary dental care as part of treatment for adults with seizure disorders is covered immediately

* explicitly cover "outpatient vision-related rehabilitation services for the purpose of restoring or preventing deterioration in independent functioning" (pending receipt of cost estimate showing little additional cost)

* include a hearing aid benefit for children under 18 (pending receipt of cost estimate showing little additional cost)

* broaden the definition of durable medical equipment to include items such as bath tub lifts, grab bars and mobility canes

* clarify that coverage for accessories and supplies used with durable medical equipment includes all things that directly relate to the equipment (e.g., drip bottles), replacement of worn out or damaged equipment, and equipment repair

* expand coverage to include devices or equipment which "minimize" or "stabilize" deterioration, rather than just those which "prevent" further deterioration in function

* broaden the "illness or injury" criteria for outpatient rehabilitation eligibility to include "disorder, or other health condition" to assure coverage for chronic or congenital conditions

* broaden definition of enabling services to include transportation for person accompanying a patient who would otherwise be unable to travel along (e.g., child or incapacitated adult)

-- **providers:**

* designate OB/GYNs as primary care providers
* lengthen the sunset provision for essential community providers from 5 years to 7 years
* add medical assistance facilities, Native Hawaiian Health Centers, and others to the list of providers designated as essential community providers
* require the National Board in developing the rules for risk adjustment to develop a payment system to assure that increased payments for serving high-risk patients and persons with disabilities are passed along to the provider, rather than kept by the plan
* require that plans using gatekeepers designate one or more specialists to serve as gatekeepers for persons with disabilities
* include a non-discrimination rule prohibiting plans from refusing to include an entire class or type of provider (e.g., chiropractors)

-- **underserved and special populations:**

* provide the same Medicaid wrap around coverage for children under the age of 22 who are in families with incomes below 200% of poverty as was provided under the President's bill for a smaller group of children
* establish a fee for service plan for migrants and seasonal farm workers administered by DOL and HHS and using Medicare payment rates
* require all consumer purchasing cooperatives and health plans to have outreach programs for underserved populations
* assure uninterrupted coverage for victims of domestic violence
* provide for special rules to assure uninterrupted coverage for runaway and homeless youth

-- **rural initiative:**

* increase number of primary care physicians and services
* help hospitals that are dependent on Medicare populations
* expand and improve emergency medical systems

DESCRIPTION OF VOLUNTARY ALLIANCES IN CHAIRMAN'S MARK

General principles:

1. Each state would be required to divide the state into one or more community-rated areas (CRA). Every part of the state must be in one and only one CRA, but no CRA could be smaller than a metropolitan statistical area (MSA).

2. Residents of the state who are self-employed, non-workers, part-time workers, or full-time workers of employers with 5,000 or fewer employees would be covered under community-rated health plans. Individuals and their families, not employers, would choose which health plan to join. Community-rated health plans could not be self-funded.

3. Residents of the state who work for "large group sponsors" would be covered under experience-rated health plans. Large group sponsors would be: employers with more than 5,000 employees nationwide, employers who contribute to Taft-Hartley plans covering more than 5,000 employees nationwide, and employers who contribute to rural electric or rural telephone cooperative plans covering more than 5,000 employees nationwide.

4. Large group sponsors could either self-fund their plans or insure the benefits, but they must offer three different plans, at least one of which is a fee-for-service plan.

Alternative structure for regional alliances:

In addition to the duties assigned to states under H.R. 3600, states would also be required to perform or delegate certain functions that were previously assigned to the regional alliances under H.R. 3600. These functions include:

* **enrollment** - establish an open season and provide for one or more public points of enrollment for all individuals and families eligible to enroll in community-rated plans.

* **premium collection** - collect employer and family premiums and pay all community-rated plans (like the President's plan, this assures that small employers can write one check, rather than having to pay each plan chosen by one or more of its employees separately).

* **distribution of consumer information and oversight of marketing practices** - prepare and distribute booklet describing all community-rated plans, their prices, provider networks and delivery sites, and consumer quality information; responsible for enforcing the marketing restrictions on community-rated plans (similar to the fair marketing rules which have been developed by the National Association of Insurance Commissioners (NAIC)).

* **enforce quality standards and data collection** - assure that carriers and plans meet quality standards, data collection and privacy of medical information requirements.

* **determination eligibility for and payment of subsidies** - determine eligibility, notify families and employers, conduct end-of-year reconciliation to assure that correct subsidy was received.

* **enforcement of insurance reforms** - assure that all community-rated plans observe the insurance reforms (e.g., guaranteed issue, guaranteed renewability, no preexisting conditions, community rating, portability and continuation of coverage). As under the President's plan, the Department of Labor would enforce the insurance reforms with respect to large group sponsors.

States could perform these functions in one of three ways:

1. A state could set up a single mandatory consumer purchasing cooperative per community-rated area.

2. A state could establish a single voluntary consumer purchasing cooperative per community-rated area so that individuals and families could choose either to purchase through the cooperative or in the marketplace. Sign-ups could be handled directly or through agents, but if an agent was used, the consumer would have to pay the agent directly; no agent compensation through the plan selected would be permitted. Additional rules governing market conduct to prevent risk selection would be necessary.

3. A state could delegate one or more of the functions to private-sector clearinghouses, overseen by the state.

This structure would achieve the same goals as the President's proposal but without requiring mandatory alliances.

WOMEN'S HEALTH AMENDMENTS TO H.R. 3600

WOMEN'S HEALTH IN BASIC BENEFIT PACKAGE

Page 42, strike lines 3 through 15 and insert in lieu thereof:

(A) Annual Papanicolaou smears and pelvic exams for females who have reached childbearing age, but more often if prescribed by physician due to abnormal smear or abnormal indications found in pelvic exam.

(B) Annual screening for sexually transmitted diseases for sexually active individuals who are at risk of infection.

Page 43, strike lines 1 through 11 and insert in lieu thereof:

(A) Annual Papanicolaou smears and pelvic exams for females, but more often if prescribed by physician due to abnormal smear or abnormal indications found in pelvic exam.

(B) Annual clinical breast exam for females.

(C) Annual screening for sexually transmitted diseases for individuals who are at risk of infection.

(D) Cholesterol every 5 years.

Page 43, strike lines 17 through line 9 on page 44 and insert in lieu thereof:

(A) Annual Papanicolaou smears and pelvic exams for females, but more often if prescribed by physician due to abnormal smear or abnormal indications found in pelvic exam.

(B) Annual clinical breast exam for females.

(C) Annual Mammograms for females, but more often if prescribed by physician due to high risk of breast cancer.

(D) Annual Osteoporosis screening for females.

(E) Annual screening for sexually transmitted diseases for individuals who are at risk of infection.

(F) Cholesterol every 5 years.

Page 44 strike lines 20 through 24 and insert in lieu thereof;

(A) Annual Papanicolaou smears and pelvic exams for females, but more often if prescribed by physician due to abnormal smear or abnormal indications found in pelvic exam.

(B) Annual clinical breast exam for females.

(C) Annual Mammograms for females but more often if prescribed by physician due to high risk of breast cancer.

(D) Annual Osteoporosis screening for females.

(E) Cholesterol every 5 years.

FAMILY PLANNING SERVICES AND SERVICES FOR PREGNANT WOMEN

Page 63, strike lines 8 through 13 and insert in lieu thereof:

(2) Contraceptive drugs and devices that are subject to approval by the Secretary of Health and Human Services under the Federal Food, Drug, and Cosmetic Act.

COST-SHARING

Page 83, strike lines 16 through 18 and insert in lieu thereof:

(7) may not require any deductible for family planning services, contraceptive drugs and devices, and clinician visits and associated services related to prenatal care or 1 post-partum visit under section 1116.

Page 88, amend the "copayment and coinsurance chart" as follows:

Benefit	Section	Lower Cost-sharing	Higher Cost-sharing
Family planning services, contraceptive drugs and devices, and clinician visits and associated services related to prenatal care and 1 post-partum visit.....	1116	No copayment	No coinsurance

ANTIDISCRIMINATION LANGUAGE

Page 99, Line 11: after "race" insert "sex,"

Page 226, Line 22: after "health care," insert "race, sex, language, religion, national origin, disability, socioeconomic status"

Page 228, Line 13: after "based on" insert "race, national origin, sex, language, age,"

Page 1352, Line 23: after "based on" insert "race, national origin, sex, language, age, religion, disability, socioeconomic status,"

HEALTH EDUCATION

Page 567, line 12

(4) Public information and education programs to reduce risks to health such as use of tobacco, alcohol and other drugs, sexual activities that increase the risk of HIV transmission and sexually transmitted diseases, poor diet, physical inactivity, and low childhood immunization levels. Such programs shall include information on the health risks prevalent in certain segments of the population, including women, ethnic and racial groups.

GEORGE MILLER
7TH DISTRICT, CALIFORNIA

2205 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-0507
(202) 225-2095

DANIEL WEISS
ADMINISTRATIVE ASSISTANT

CHAIRMAN
COMMITTEE ON NATURAL RESOURCES

COMMITTEE ON EDUCATION AND LABOR

Congress of the United States
House of Representatives
Washington, DC 20515-0507

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VALLEJO, CA 94590
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TTY (202) 225-1904

April 15, 1994

TO: CHAIRMAN WILLIAMS

FROM: GEORGE MILLER

RE: COST ESTIMATES FOR MENTAL HEALTH AND SUBSTANCE ABUSE AMENDMENTS

The premium cost of my mental health and substance abuse amendments #s 1 and 2 cumulatively are estimated to be between $150 and $200 per person per year, according to the CBO's report to Chairman Stark. According to the same CBO report to Chairman Stark, the premium cost of the mental health and substance abuse benefit as currently written in HR 3600 is $241 per person per year.

A cost-estimate for my mental health and substance abuse amendment #3 has been solicited but not yet returned. I do not expect this amendment to add any significant cost to the premium or to the cost of the bill.

Thank you for your support of my efforts in this area.

Dan Weiss 225-2095

PRINTED ON RECYCLED PAPER

STATEMENT OF CHAIRMAN PAT WILLIAMS (D-MT) REGARDING THE SUBCOMMITTEE CONSIDERATION OF HR 3600, THE HEALTH SECURITY ACT APRIL 18, 1994

On Thursday, April 21st, at 10:15 a.m., the Subcommittee on Labor Management Relations will begin its consideration of The Health Security Act. As Chairman, I will be introducing my own substitute modeled along the lines of the President's proposal. We will also be considering a single payer bill.

My substitute, which will be the text before the subcommittee this Thursday, has been developed as a result of many bipartisan health care hearings that this subcommittee conducted across the country and in Washington. It also includes a number of ideas put forth by Democratic members of the Education and Labor Committee in the caucuses we have held during the last two months.

The major changes from the Health Security Act in my substitute include:

1) replacing mandatory alliances with a new structure requiring states to perform functions previously handled by alliances. States could fulfill these requirements by establishing a single mandatory consumer purchasing cooperative per community-rated area, a single voluntary consumer purchasing cooperative per community-rated area, or no cooperative at all.

2) providing more generous subsidies for all small businesses by targeting the majority of the new support to businesses with fewer than 25 employees and by providing an additional subsidy to employers with 25-75 workers. Under my plan, businesses with fewer than 25 employees, about 4.2 million small businesses, would pay only 8.5 cents/hour for health benefits for a minimum wage worker making $4.25/hour compared to 15 cents/hour

under the President's plan. This is a 43% savings for America's smallest businesses.

3) <u>increasing premium subsidies for workers in low income households</u> by phasing-out the 20% share subsidy at 200% of poverty instead of 150% and increasing the income disregard from $1000 to $2000. By raising the percentage of poverty eligible for the premium subsidy from 150% to 200%,

this plan will assist 19 million more people and 9 million more families. Overall, my plan will help a total of 66.8 million people and 38.4 million families because of the increase in the earned income disregard and the percentage of poverty.

4) providing the same Medicaid wrap around coverage for children under the age of 22 who are in families with incomes below 200% of poverty as was

provided in the President's bill for a smaller group of children

5) providing grants for states to create organized systems of care for mental health and substance abuse services for children under the age of 22

6) increasing mammogram screening without copayments: every two years for women age 40-49, and every year for women age 50 and above

7) providing pap smears and pelvic examinations without copayments for women who have reached childbearing age

8) providing clinical breast exams without copayments

9) adding a rural initiative designed:

[A] to increase number of primary care physicians and services; [B] to help hospitals that are dependent on Medicare

populations; and, [C] to expand and improve emergency medical systems

We intend to begin our markup this Thursday and continue on Tuesday and Wednesday, April 26th and 27th.

The Chairman's Mark consists of a substitute for H.R. 3600 (Health Security Act), comprised of the following:

(1) Title I [*Substitute for entire title, attached*]

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(3) Title III [As contained in H.R. 3600 *with the addition of a part 3 to subtitle F and a subtitle J, attached*]

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* provide more generous subsidies for all small businesses: target majority of new assistance to businesses with fewer than 25 employees; provide additional subsidy to employers with 25-75 workers

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* require the membership of the National Board to reflect the diversity of the population served

* preclude states from certifying health plans designed to serve boarder areas from discriminating against out-of-state providers

* expand the duties of the consumer ombudsman; assure that consumers have adequate information and assistance in making choices of plans, getting information from plans; assure that adequate procedures and remedies exist to enforce consumer rights to items, services, and treatment for benefits.

* ensure that boards of consumer purchasing cooperatives are directly accountable to the people they represent by establishing strong fiduciary obligations for members of the boards

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* explicitly cover "outpatient vision-related rehabilitation services for the purpose of restoring or preventing deterioration in independent functioning" (pending receipt of cost estimate showing little additional cost)
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-- **providers:**

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-- **underserved and special populations:**

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* establish a fee for service plan for migrants and seasonal farm workers administered by DOL and HHS and using Medicare payment rates
* require all consumer purchasing cooperatives and health plans to have outreach programs for underserved populations
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* provide for special rules to assure uninterrupted coverage for runaway and homeless youth

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* help hospitals that are dependent on Medicare populations
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2. Residents of the state who are self-employed, non-workers, part-time workers, or full-time workers of employers with 5,000 or fewer employees would be covered under community-rated health plans. Individuals and their families, not employers, would choose which health plan to join. Community-rated health plans could not be self-funded.

3. Residents of the state who work for "large group sponsors" would be covered under experience-rated health plans. Large group sponsors would be: employers with more than 5,000 employees nationwide, employers who contribute to Taft-Hartley plans covering more than 5,000 employees nationwide, and employers who contribute to rural electric or rural telephone cooperative plans covering more than 5,000 employees nationwide.

4. Large group sponsors could either self-fund their plans or insure the benefits, but they must offer three different plans, at least one of which is a fee-for-service plan.

Alternative structure for regional alliances:

In addition to the duties assigned to states under H.R. 3600, states would also be required to perform or delegate certain functions that were previously assigned to the regional alliances under H.R. 3600. These functions include:

* **enrollment** - establish an open season and provide for one or more public points of enrollment for all individuals and families eligible to enroll in community-rated plans.

* **premium collection** - collect employer and family premiums and pay all community-rated plans (like the President's plan, this assures that small employers can write one check, rather than having to pay each plan chosen by one or more of its employees separately).

* **distribution of consumer information and oversight of marketing practices** - prepare and distribute booklet describing all community-rated plans, their prices, provider networks and delivery sites, and consumer quality information; responsible for enforcing the marketing restrictions on community-rated plans (similar to the fair marketing rules which have been developed by the National Association of Insurance Commissioners (NAIC)).

* **enforce quality standards and data collection - assure** that carriers and plans meet quality standards, data collection and privacy of medical information requirements.

* **determination eligibility for and payment of subsidies** - determine eligibility, notify families and employers, conduct end-of-year reconciliation to assure that correct subsidy was received.

* **enforcement of insurance reforms** - assure that all community-rated plans observe the insurance reforms (e.g., guaranteed issue, guaranteed renewability, no preexisting conditions, community rating, portability and continuation of coverage). As under the President's plan, the Department of Labor would enforce the insurance reforms with respect to large group sponsors.

States could perform these functions in one of three ways:

1. A state could set up a single mandatory consumer purchasing cooperative per community-rated area.

2. A state could establish a single voluntary consumer purchasing cooperative per community-rated area so that individuals and families could choose either to purchase through the cooperative or in the marketplace. Sign-ups could be handled directly or through agents, but if an agent was used, the consumer would have to pay the agent directly; no agent compensation through the plan selected would be permitted. Additional rules governing market conduct to prevent risk selection would be necessary.

3. A state could delegate one or more of the functions to private-sector clearinghouses, overseen by the state.

This structure would achieve the same goals as the President's proposal but without requiring mandatory alliances.

COMMITTEE ON EDUCATION AND LABOR

Subcommittee on Labor-Management Relations

U.S. House of Representatives

320 Cannon House Office Building

Washington, DC 20515

phone: (202) 225-5768
fax: (202) 225-3614

FACSIMILE TRANSMISSION SHEET

DATE: 4/14/94

TO: Jennifer Kline

FROM: Jon Weintraub___ Fred Feinstein___ Phyllis Borzi___ Rick Jerue___
Gail Brown___ Susie Ringel K Allison Hogue___ Tony Guiles___

NUMBER OF PAGES TO FOLLOW: 10

MESSAGE: Any chance you or someone else could give us an idea on possible costs for amendments 3, 4, 6 - 10 on the attached? (specs follow)

Susie

LEGAL ACTION CENTER

236 Mass. Ave. NE, Suite 510 • Washington, DC 20002 • (202) 544-5478 • FAX: 544-5712

TO: Health Care Staff

FR: Ellen Weber and Susan Galbraith, Legal Action Center

RE: Proposed Amendments to the Substance Abuse Benefit in H.R. 3600/S.1757

DATE: February 24, 1994

The organizations identified below request that you consider the following ten amendments to the substance abuse provisions of the Health Security Act as you mark-up H.R.3600 and S.1757.

The amendments address the following topics:

Amendment 1:	Comprehensive substance abuse benefit
Amendment 2:	Modified substance abuse benefit within the H.R.3600/S.1757 benefit structure
Amendment 3:	Amendment to the case management provision - add in para
Amendment 4:	Amendment to the collateral (family) treatment provision
Amendment 5:	Amendment to the health education provision
Amendment 6:	Utilization review amendment
Amendment 7:	Cost sharing amendment: out-of-pocket expenses
Amendment 8:	Cost sharing amendment: amount of cost sharing
Amendment 9:	Essential community provider amendment
Amendment 10:	State funding for substance abuse treatment maint. of effort

By way of explanation, we have developed two different amendments on the overall benefit structure. Amendment 1 is a substitute for the proposed benefit in the Health Security Act and Amendment 2 amends the Act's proposed benefit.

Amendments 3 and 4 have been incorporated in Amendment 2, but are presented separately so that they can be dropped in easily.

Amendment 6 presents two different options for revising the utilization review provision of the current benefit. To the extent Amendment 2 is adopted, one of these options would have to be incorporated also.

153 Waverly Place • New York, NY 10014 • (212) 243-1313 • FAX: (212) 675-0286

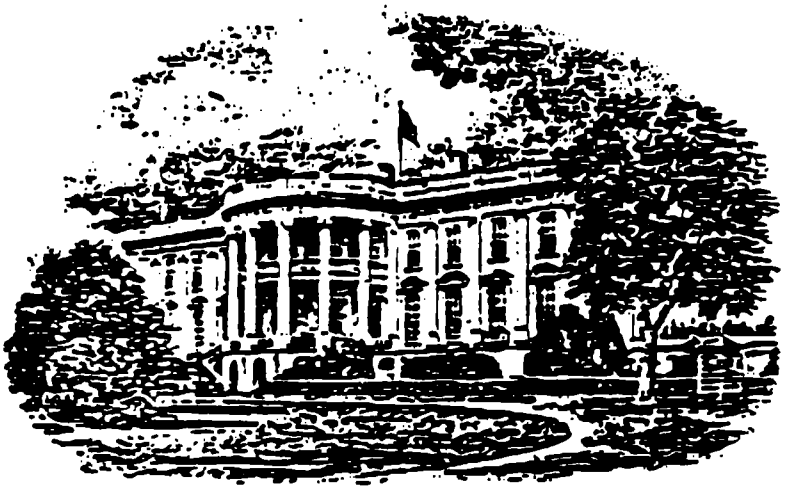
These proposed amendments are endorsed by ten national organizations that work on drug and alcohol issues. The full set is endorsed by the American Society of Addiction Medicine, the Employee Assistance Professionals Association, Inc., the Legal Action Center, the National Association of Alcoholism and Drug Abuse Counselors, the National Coalition of State Alcohol and Drug Treatment and Prevention Associations, the National Council on Alcoholism and Drug Dependence, Phoenix House, and Therapeutic Communities of America, Inc. The Hazelden Foundation supports Amendments 1 and 3-10, and Narconon International supports Amendments 2-9. Other national drug and alcohol organizations are still reviewing the proposals.

Thank you for considering these proposed amendments. We will contact you in several days to discuss them. If you have questions in the meantime, please contact Ellen Weber or Susan Galbraith at (202)544-5478.

DATE: _____
TIME: _____

THE WHITE HOUSE

WASHINGTON



FAX COVER SHEET

TO: Ken Thorpe

_____

PHONE: (___) _____

FAX: (___) 401-7321

Ken -
More from Ed & Labor to add to the list.
Thanks!
Jen

FROM: Jennifer Klein

PHONE: (202) 456- 2599

PAGES FOLLOWING COVER SHEET: _____

Amendment 3

Benefit Package Amendment: Provide Case Management
To Individuals in Residential and Intensive Nonresidential Care

Objective: The Act would only provide case management for individuals who are in outpatient substance abuse care. The amendment would provide such services to all individuals who are receiving substance abuse treatment regardless of the setting or type of care.

Rationale: Case management is defined under the Act as "services that assist individuals in gaining access to needed medical, social, educational, and other services." These services are an essential component of every substance abuse treatment program, because individuals with drug and alcohol problems often have lost their support systems and jobs, have not addressed multiple health problems and need assistance in many areas of life. Substance abuse treatment programs must link their clients with such services to enable them to recover and prevent relapse.

It is unclear why the Act would limit access to these essential case management services to only those in outpatient care. Indeed, individuals who need residential or intensive nonresidential care often need case management services even more because they generally have more serious conditions and are less functional.

Failing to cover this component of care in all treatment settings would certainly constitute a step backward in substance abuse treatment.

Amendment:

P. 48. Section 1115(b)(2)(B) insert in line 23 the following underlined language:

> the individual is eligible to receive coverage for, and is receiving, inpatient and residential substance abuse treatment, intensive nonresidential substance abuse treatment or outpatient mental illness and substance abuse treatment with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder.

Note: this provides different services in the mental illness area.

Amendment 4

Benefit Package Amendment: Provide Family (Collateral) Services to Individuals Regardless of the Treatment Status of the Individual with the Alcohol or Drug Problem.

Objective: The Health Security Act would limit access to family (collateral) services to those individuals whose family member is receiving drug or alcohol treatment. The proposed amendment would enable an individual to get family services regardless of the treatment status of the individual with the substance abuse problem as long as that individual would be eligible to receive treatment.

Rationale: Several studies have documented that individuals who have a family member with a drug or alcohol problem have higher health care costs than individuals who do not have a family member with such a problem. Studies have also demonstrated that the health costs of family members decrease if they receive care.

For example, the McDonnell Douglas Company found that providing collateral services to family members (dependents) of those with substance abuse and psychiatric problems, saved the company even more on dependent medical claims -- $3 million over 4 years -- than its savings in employee claims -- $2.1 million over 4 years.

Because substance abuse takes a huge toll on the entire family, it is shortsighted to provide services to only those individuals whose family member is participating in substance abuse treatment. Individuals with substance abuse problems often refuse to go to care because they are in "denial" (failing to even recognize they have a drug or alcohol problem) and/or they fear the adverse impact the disclosure of a problem may have on their employment. Others drop out of treatment.

Nevertheless, family members still suffer the consequences of the problem and should receive services. Indeed, providing care to the family members may be the best way to help the family intervene and force the individual with the problem to go to treatment, and, thus, reduce general health care costs associated with substance abuse problems.

Amendment:

Page 49. Section 1115(b)(4), lines 14 through 18, revise as follows:

an individual who is receiving inpatient and residential mental illness treatment, intensive nonresidential mental illness treatment or outpatient mental illness treatment or an individual who is eligible to receive inpatient and residential substance abuse treatment, intensive nonresidential substance abuse treatment or outpatient substance abuse treatment.

Amendment 6

Utilization Review Amendment: Eliminate Separate Utilization Review Requirements for Substance Abuse Treatment or Specify Standards

Objective: Unlike the utilization review procedures for all other health care, the Act would place all substance abuse and mental health care decisions in the hands of a "health professional designated by the plan" and would permit each plan to develop its own utilization review (U.R.) standards and procedures. The Act would not set any standards for client placement or require the "health professional" to have any expertise in substance abuse treatment.

The following two amendments would address this issue. The first would eliminate this provision and have the U.R. standards and practices that apply to all other health services apply to substance abuse treatment. The second, fall-back position would impose standards on the "health professional" and the placement criteria used by the plans.

Rationale: While utilization review must be a part of health care reform, the separate and distinct utilization review/gatekeeping requirements for substance abuse treatment will give health plans total discretion to deny effective care and base decisions solely on the bottom line cost. For years, individuals who would fit the Act's definition of "health professionals" have been denying necessary care and appropriate placement in the private sector in order to save money. As a result, many sick individuals ultimately end up in the public treatment system, often requiring longer, more extensive care than would have been necessary initially.

One need only examine the genesis of this utilization review provision to know that the insurance industry intends to continue these practices. According to the Administration, this provision was included at the request of the insurance industry because it feared that, with the lifting of life-time caps on substance abuse and mental health care, individuals would seek care in the private system rather than the public system.

Client "dumping" has burdened the publicly funded treatment system for years. It is estimated that in 1993, 20% of patients in publicly funded treatment had private health insurance that was not paying for covered substance abuse services. This means that the public system subsidized private insurance by at least $866 million in 1993. (Lewin-VHI at 16).[1] A substantial part of this "dumping" is the direct result of U.R. practices that deny necessary care to

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[1] Lewin-VHI, Inc. **Healthcare Reform and Substance Abuse Treatment: The Cost of Financing Under Alternative Approaches.** (February 2, 1994).

individuals.

It is unconscionable that every American will be forced to pay for this additional layer of administrative review as well as the health care costs that will result from untreated substance abuse. Instead, these dollars should be put directly into substance abuse treatment.

The Act also takes a giant step backwards in terms of developing uniform patient placement criteria by allowing each plan to develop its own standards. Uniform placement criteria exist and should not be cast aside. Criteria known as the Cleveland Criteria have existed since the 1987. In addition, over the past five years, the substance abuse treatment field in conjunction with benefits managers and insurance industry representatives have developed, tested and refined uniform placement criteria, known as the ASAM (American Society of Addiction Medicine) Patient Placement Criteria.

The Act must require plans to follow some uniform placement criteria. Otherwise, permitting each plan to develop its own criteria will undermine the use of uniform care standards, which should be the goal in all health areas. In addition, it will be impossible to develop outcome data to guide future coverage decisions because there will be no uniform standards by which to evaluate treatment effectiveness. The provision is setting up the substance abuse treatment system to fail.

Amendment: Option 1:

Delete all references to "a health professional designated by the plan in which the individual is enrolled determines that the individual should receive such services."

Section 1115(b)(2) Case Management. Page 48, delete lines 18 through 21. Renumber subsection (B) as (A). (for the case management, we have drafted another amendment that would expand case management services to individuals in residential and intensive nonresidential care also. So that language would also modify subsection (B).)

Section 1115(c)(2)(B) Residential Substance Abuse Treatment. Page 51, end subsection with the word "hospital" on line 9, and delete everything following the word "hospital" through line 14.

Section 1115(c)(2)(D) Annual Limit on Inpatient/Residential Treatment. Page 52, end line 3 with the word "if" and delete the remainder of line 3 through line 5.

Section 1115(d)(2)(A) Intensive Nonresidential Limitation: Page 54, delete subsection (A) Discretion of Plan, lines 1 through 7 and renumber the remaining subsections accordingly.

Section 1115(d)(2)(C)(ii) Annual Limit for Intensive Nonresidential. Page 55 (additional days), line 19 delete after the word "if" "a health professional designated by the health plan in which the individual is enrolled" and insert the following:

the person primarily responsible for providing intensive nonresidential substance abuse treatment

(Note that this is the same standard that is applied in the Act to determine whether home health care (section 1118) and outpatient rehabilitation services (section 1123) should continue beyond an initial 60-day period of care for each.)

Section 1115(e)(2)(B) Outpatient Substance Abuse Counseling. Page 57 Delete subsection (B) Discretion of Plan, lines 17 through 25 and lines 1-2 on page 58. Renumber subsections accordingly.

Option 2.

Establish standards for the "health professional designated by the plan" and the placement criteria used.

A. To address the standards for "health professional designated by the plan," amend the following:

Section 1115(f), add a new definition (4):

(4) Health Professional Designated by the Plan.-- the term "health professional designated by the plan" means an individual trained and certified or licensed in the area of alcohol and drug abuse and dependence, including certified employee assistance professionals. The term does not include any individual who receives direct compensation or any specific part of compensation based on his or her determination of type or course of treatment, length of stay or level of care for an individual patient or group of patients.

B. To address the placement criteria, amend the following:
Section 1115(c)(2)(B), page 51, lines 12-13;

Section 1115(d)(2)(A) page 54, lines 5-6; and

Section 1115(e)(2)(B), page 57, lines 23-24;

In each subsection delete the phrase "(based on criteria that the plan may choose to employ)" and insert

(based on uniform patient placement criteria).

Section 1115(f), add a new definition (5):

(5) Uniform Patient Placement Criteria. -- The term "uniform

patient placement criteria" means criteria established by the American Society of Addiction Medicine (ASAM) or other alcohol and drug diagnostic criteria developed or approved by the National Health Board in conjunction with and authorized for use in a State by the single state authority on drugs and alcohol.

maint. of effort

Amendment 10

State Funding For Substance Abuse Services: Require States to Maintain ~~Their~~ Level of Funding for Substance Abuse Treatment Until A Comprehensive, Unlimited Benefit is Provided.

Objective: The Health Security Act would not require States to maintain their level of funding for substance abuse treatment even though a comprehensive benefit is not provided. This amendment would require States to maintain their funding level for these services until a comprehensive, unlimited benefit is in place.

Rationale: The substance abuse benefit in the Health Security Act with its strict day limits and merger with mental illness care will not provide coverage for many who now receive care in the publicly funded system. The Administration has recognized that the publicly funded system must remain in place until a comprehensive benefit is provided in order to serve those who cannot access services under the proposed benefit, those who exhaust their benefit or are denied services and those not covered under reform. (Although the level of funding and possible offsets in the federal system have not been defined.)

State and local funds currently account for at least half of the treatment dollars in each state. In 1993, public funds accounted for $4.33 billion of the $6.7 billion our nation spent on substance abuse treatment. (Lewin-VHI at 6 and 13).[1] Yet the Health Security Act does not require States to maintain their funding for such services during the transition to a comprehensive benefit.

Reliance on the publicly funded system will remain great under the Administration's plan for several reasons. First the substance abuse benefit is an acute care benefit that will not cover the longer term care needs that many individuals need. Second, utilization review will limit access to the private system and continue client "dumping" into the public system. It is estimated that under the Health Security Act, $3.69 billion in public funds will be needed to just maintain the level of care now obtained. (Lewin-VHI at 19).

Clearly, state and local funds will be needed to maintain current treatment services and expand services to those who do not now get care in the publicly funded system.

Amendment:

Add Subpart C -- State Funding of Substance Abuse Services to Title

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[1] Lewin-VHI, Inc. **Healthcare Reform and Substance Abuse Treatment: The Cost of Financing Under Alternative Approaches.** (February 2, 1994).

III, Subtitle F, Part 2.

Subpart C -- State Funding of Substance Abuse Services

Section 3531 State Funding of Substance Abuse Services

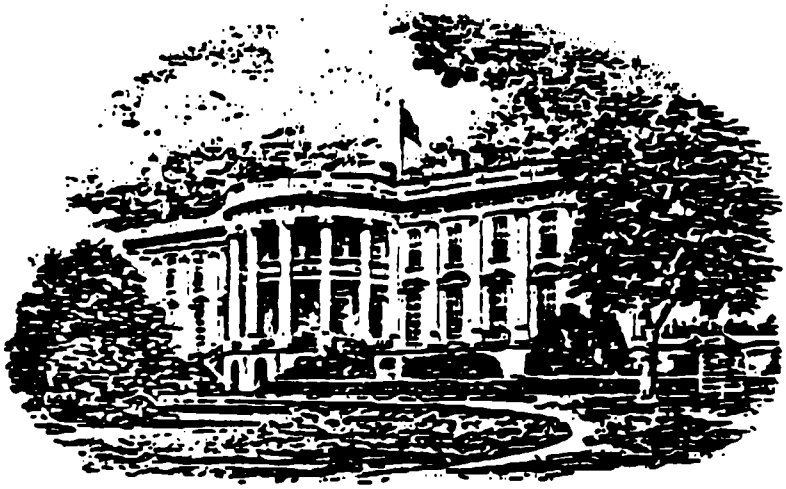
(a) In General -- As a condition of being a participating State under title I, each State shall agree to maintain expenditures of non-Federal amounts for substance abuse treatment at a level that is not less than the average level of such expenditures maintained by the State for the two fiscal years preceeding the first fiscal year in which the State could have become a participating state.

(b) Waiver -- The Secretary shall determine based on the report submitted pursuant to Section 3511 and other information requested by the Secretary whether to waive all or part of the requirement under paragraph (a). Under no circumstances, will a State be permitted to reduce its expenditures before an unlimited substance abuse benefit is included as part of the comprehensive benefit package in title I.

DATE: _____
TIME: _____

THE WHITE HOUSE

WASHINGTON



FAX COVER SHEET

TO: Ken Thorpe

PHONE: ( )

FAX: ( ) 401-7321

FROM: Jennifer Klein

PHONE: (202) 456- 2599

Ken - Here is EDL's revised list. See what you can do. Some of this is really silly. Thanks!
Jen

PAGES FOLLOWING COVER SHEET: _____

COMMITTEE ON EDUCATION AND LABOR

Subcommittee on Labor-Management Relations

U.S. House of Representatives

320 Cannon House Office Building

Washington, DC 20515

phone: (202) 225-5768
fax: (202) 225-3614

FACSIMILE TRANSMISSION SHEET

DATE: 4/11/94

TO: JENNIFER KLINE

FROM: **Jon Weintraub**___ **Fred Feinstein**___ **Phyllis Borzi**___ **Rick Jerue**___
Gail Brown___ **Susie Ringel** X **Allison Hogue**___ **Tony Guiles**___

NUMBER OF PAGES TO FOLLOW: 5

MESSAGE: We need ~~Please~~ whatever you can cost of these ASAP - I know some are clearly ridiculous - start w/ whatever is easiest, I guess.

Thanks [illegible] we couldn't

BENEFITS

Mental Health

1. Full parity for coverage of mental health care.

2. Parity for mental health coverage for children under 22 years old.

3. Change the co-pay for outpatient psychotherapy and substance abuse treatment from 50% to 20% for kids.

4. Bring mental health/substance abuse coverage to levels currently offered to low-income population under Medicaid.

5. Substitute substance abuse and mental health benefits in HR 1200 for those in HR 3600.

6. Include neuropsychology and psychology in the definition of screening and assessment services.

7. Include provisions for psychological and neuropsychological services in the definition of outpatient rehabilitation services.

Women's Issues

1. Designate OB/GYNs primary care providers.

2. Cover all women, regardless of age, with an annual clinical breast exam as part of a regular physical examination.

3. Mammograms: for women 40-49, every two years; for women over 50 years, every year.

4. Link to the American Cancer Society periodicity schedule.

5. Include pap smears without co-pays in all plans as part of regular physical examination for all women, at least annually, and more often on advice of physician, due to abnormal indications found in the pelvic examination or from a previous pap smear.

7. Cover screening for osteoporosis as part of annual examination.

8. Cover contraceptive drugs and family planning services

with no co-payment.

9. Cover pregnancy and post-partum services with no co-payment.

Dental Care

1. Cover dental care for high-risk populations with documented special oral health needs as of effective date of Act.

2. Cover dental care for adults with seizure disorders, upon enactment.

3. Expand dental coverage per attached (Miller) amendment.

Vision/Hearing

1. Broaden coverage to include "outpatient vision-related rehabilitation services for the purpose of restoring, or preventing deterioration in independent functioning" under a new section 1123(a)(4).

2. Include a hearing aid benefit.

Durable Medical Equipment

1. Broaden the H.S.A./Medicare definition of Durable Medical Equipment (to include, i.e., bath tub lifts, grab bars, and mobility canes).

2. Include coverage for accessories and supplies used directly with this equipment, replacement of worn out or damaged equipment, and equipment repair.

3. Expand coverage to include devices or equipment which "minimize" rather than wholly "prevent" further deterioration in function.

Outpatient Rehab.

1. Broaden the "illness or injury" criteria for outpatient rehabilitation eligibility to include "illness, injury, disorder, or other health condition"

2. add outpatient services: speech-language pathology and audiology services, and respiratory therapy

Misc.

1. Add to Section 5003(b) "methods for assuring that all consumers who do not speak English as a first language will have access to culturally & linguistically appropriate services.

2. Cover physical therapy.

3. Broaden definition of enabling services to include transportation & translation.

6. Cover testing for all sexually transmitted diseases.

4. Add HIV testing for those 13 and over to the preventive services covered with no cost-sharing.

5. Provide coverage and access for all pharmaceuticals, as prescribed by physicians, with the same deductible and co-payment requirements (if any) as other medical treatments. This should apply at least to low-income people (i.e. up to 200% or 150% of poverty).

STRUCTURE

1. Concern about use of I.D. card to track undocumenteds.

2. Diversity requirement for members of the National Health Board.

3. Modify provision regarding discontinuation of disproportionate share hospital (DSH) payments by gradually phasing them out over 4 years and at the same time to increase and phase-in the proposed allocation of vulnerable population adjustment (VPA) funding amount. Narrow definition of disproportionate share hospitals.

4. Allow state & local government corporate alliances and exempt them from the 1% assessment. Question of accelleration of timing for the cap?

5. Allow federal government workers to be considered a corporate alliance.

6. Insure access to capital for set-up and expansion of minority health facilities.

7. Strengthen federal authority to ensure that states administer the system to promote uniform and quality health services, regardless of geographic location.

8. Require regional alliances to contract with any health plan certified by any state in the U.S. and its territories.

9. Outline the duties of the alliance ombudsman and provide for adequate consumer assistance.

10. Eliminate cost-sharing for families below 200% of poverty.

11. Eliminate cost-sharing for children (under 18) below 200% of poverty.

13. Ensure that the Board of Directors which governs the regional alliances are directly accountable to the individuals whom they represent.

14. Ensure that Puerto Rico is subject to federal taxes on tobacco products and in return have P.R. receive full and equal benefits for its residents.

15. Provide a premium discount to businesses offering a qualified worksite program (standards and discounts to be determined by HHS).

16. Create a national database network.

17. Develop a system to meet rural health needs, including: funding to help develop community health plans, creation of a reinsurance fund for rural community health plans, creation of a new rural hospital-based Community Health Center program, link-up between academic health centers and other programs, provision for comprehensive coverage for Emergency Medical Services (i.e., transportation), and allowances for some consumers in a corporate alliance to opt into a regional alliance to be able to receive local care, rural population representation on the National Health Board, National Quality Management program to focus on appropriate geographical standards, rather than uniform standards, and appropriate reimbursement levels.

18. Provide for national solvency standards.

19. Require large employers who do business in the territories to enroll all employees who work in the regional alliance plan for that territory.

20. Offering medicare or medicare-like plan as an option for the population at large.

Mink - Group 1

Womens Issues in Health Care Reform

I. Preventive Screening: Breast Cancer

A. The plan should cover all women, regardless of age, with an annual clinical breast exam as part of a regular physical examination.

B. For women age 40 to 49, the plan should cover cost of mammograms every two years.

C. For women over 50 years old, the plan should cover cost of mammograms every year.

D. For women at risk of cancer, mammograms should be provided as part of routine checkups as required by the physician.

II. Preventive Screening: Pelvic Exams

Pap smears should be included in all plans as part of the regular physical examination for all women, at least annually, and more often if require by a physician, due to abnormal indications found in the pelvic examination or from a previous pap smear.

III. Screening for Sexually Transmitted Diseases

The plan should cover testing for all sexually transmitted diseases.

IV. Osteoporosis Screening

Screening for osteoporosis should be covered in the plan as part of the annual examinations.

V. Planning for Families

Full reproductive health care services should be included in the plan.

Contraceptive drugs and family planning services as well as pre-natal and post-partum care should be included without co-payment.

VI. OB-GYN physicians must be considered as primary-care providers.

VII. The plan must be written so as to assure non-discriminatioin against women and women in different cultural settings.

MEMO

TO: Interested Ed and Labor Committee Staff
FR: Susan Zettler
DT: 3/23/94
RE: Congressman Strickland's Health Care Reform Concerns

As per my conversation with David Micheals, the following are some of things we would like to see in the final form of the Health Security Act.

Mental Health

Ted wants to ensure that any benefit package that contains mental health benefits offers a full range of services and these services are provided by mental health professionals non-discriminately. He feels it is of the utmost importance that an individual and their mental health care provider are able to choose the services that are most appropriate for their condition.

He would also like to chart a course for the mental health benefit as close as possible to what is evolving in the Ways and Means Committee and the Energy and Commerce Committee. Ted feels that with this consensus the mental health benefit will ultimately be defended by a louder chorus of supporters.

Representative Stark's Plan

Ted does think Rep. Stark's plan is a step in the right direction, but he is anxious to receive the CBO analysis. If Rep. Stark's plan is adopted there are some considerations we would like to see made. Currently in the Health Security Act (HSA) screening and diagnostic services are included in the high/low cost definition, so that the initial contact with a mental health provider is reimbursed at the 80/20 rate. This would ensure for the individual that there was no great monetary barrier for the initial contact with a mental health professional. Mr. Stark's bill makes no allowances for this provision, therefore, we encourage the use of the HSA language in Section 1115(e).

He also have questions relating to the enhanced benefits regarding the distinction between the intensive residential services and intensive community services. After reading the amendment we are under the assumption that the intensive residential services would be utilized in acute cases and the community services would be used on a long-term basis. He would like more clarification on this provision and the vision for the type of services that would be obtained through these programs.

Ted is very supportive of the amendment for the establishment of a state managed mental health care system for the severely mentally ill. We may hear some concerns from the mental health community that we are creating a two tier delivery system, but we do feel that this may deliver the services more appropriately to the severely mentally ill population.

The Stark benefit covering outpatient mental health and substance abuse services for children with a 20 percent co-pay is one provision that Ted was very pleased with. We have already contacted the American Academy of Actuaries concerning this provision and they confirmed that this benefit does not increase the cost of the mental health benefit noticeably.

Health Security Act

Ted is a co-sponsor of the Health Security Act. He was a member of the task group which designed the mental health benefit and additionally has had personal input with Ira Magaziner, Judy Feder, Guy King (lead HCFA actuary), and others who shaped this benefit. He understand the intricacies and the interests involved in formation of this benefit and what he is now asking for are

changes clarifying this mental health benefit. The changes he envisions fall into two categories: (1) changes involving the benefit itself and (2) changes surrounding the training of mental health care providers to ensure the successful delivery of the mental health care benefit.

Mental Health Benefit

Technical changes:

- ▸ •The definition for initial point of entry should be amended so that mental health providers could be the initial point of entry for those with mental illnesses. Currently, individuals with mental health problems would have to access the system through a primary care provider.
- •The definition of hospital should be amended so that psychologists are able to care for their patients independently.
- ▸ •The definition of health provider should be amended to permit psychologists and other non-physician providers, as long as they are licensed, to offer their full scope of practice services without discrimination against a class by state, health plan, or other entity. I think most of you have heard Ted speak on this issue. He wants to ensure that health plans are unable to discriminate on the basis of the class of provider.
- •The definition of screening and assessment services should include neuropsychology and psychology. These services are widely used in the health care setting now in cases of spinal and brain injury and in trauma cases.
- •Along with this, the definition of outpatient rehabilitation services should include provisions for psychological and neuropsychological services.
- •We are very supportive of the substitution model, and we do want to ensure in the legislation that every plan must offer the substitution model. (Aside, the substitution model is what the market is currently doing today.)

Clarifying changes:

- •Ted has some concern about the use of the terms medically necessary and least restrictive setting in the legislation as it relates to mental health. He wonders if there is no report language or other mechanisms that these definitions could be defined independently by individual health care plans and providers.

Additional changes:

- •The National Health Board should establish managed care and utilization review standards to which health care plans and providers must adhere. Because of the problems associated with managed care and managed mental health care in particular, we believe this provision would ensure that individuals do receive the benefits to which they are entitled.

Mental Health Training

To become a licensed psychologist it takes between six to eight years of post graduate work. During this period individuals are usually unable to pay for their living expenses and their school expenses. Consequently, many take out loans to pay for their schooling during this period. At the time of graduation it is not uncommon to have student loans in excess of $50,000 dollars. Potential students are often discouraged by this debt load and by the lack of financial support available to help them achieve their goal. Often the students who are most discouraged are those from disadvantaged backgrounds; given the proper education and training these individuals are more likely to choose to return to their place of origin to serve. Therefore, because of the current financing of psychological training we may be discouraging those most apt to understand and help individuals identify their behaviors that lead to the most troubling situations currently facing in our nation, such as criminal behaviors.

Technical changes:

- For purposes of Title III, the definition of health professional to explicitly include psychology.
- In the listing of professions for training of minorities and disadvantaged groups, include psychology to the list.
- In the provisions for professionals needed within the health care system, include psychologist and set aside specific funds for this training.
- In the development of the health care workforce include representatives from psychological schools on the advisory board.
- We would like to see pilot programs in Title III relating to mental health and substance abuse treatment to have the option of increasing training for providers to determine if the increased training has an effect on treatment outcomes.

Rural Health

Ted represents rural Southern Ohio which boarders both West Virginia and Kentucky. Nine of the fourteen counties he represents have populations and/or areas that are classified as health professional shortage areas. Needless to say we know there are a lot of problems, but we don't know exactly how to solve all of them. Some of our ideas include:

- ▸ Including the individual providers in the initial definition of essential community providers if they meet all of requirements. Currently, in the HSA individual providers must go through the state to be granted this designation. The federal regulators granting essential community provider status will be more familiar with the requirements entailed and will be better able to advise providers of measures they must be put in place to receive this designation.
- Also in designating an essential community provider, local input should be gauged to see if that provider is or will be appropriate to carry out all the services they are charged with under this definition.
- Reimbursing primary care providers at a nominally higher rate in health professional shortage areas.
- ▸ Because of the large discrepancy in pay between primary care providers and specialists, we would like the National Health Care Board to commission a study to determine ways that reimbursements could reach a more equitable level.
- ▸ Showing some consideration for individuals that originate from rural and other underserved medical areas when determining who will receive a medical school slot.
- Linking up school based health clinics and health education curriculum with the most appropriate academic health center. This provision would accomplish three objectives: (1) the schools will have less of a financial investment with a resident or appropriate level medical student; (2) the science/health classes would benefit from the expertise of someone learning the most up to date medical knowledge; (3) it may encourage more children to enter a health related field and it may encourage the medical provider to serve a population of this nature.

Ted is also interested in encouraging the development of telemedicine technology and the expansion of emergency services in rural areas.

▸ **Signifies Priority**

COMMITTEE ON EDUCATION AND LABOR

U.S. HOUSE OF REPRESENTATIVES
518 HOUSE ANNEX I
WASHINGTON, DC 20515-6107

SUBCOMMITTEE ON SELECT EDUCATION AND CIVIL RIGHTS

TO: Committee on Education and Labor
FROM: Gary Karnedy
RE: Disability Health Care Reform Issues
DATE: March 24, 1994

A. OUTPATIENT REHABILITATION Section 1123

Rehabilitation is an essential component of health treatment for persons with disabilities. Rehabilitation prevents disabilities, minimizes the health deterioration of individuals with disabilities, and minimizes the development of complications and secondary disabilities.

Section 1123 of the Health Security Act coverage for outpatient rehabilitation services does not adequately provide for individuals with disabilities. We propose three revisions which will afford individuals with disabilities with the rehabilitative care that they need, and drive down the long term costs of health care for all Americans.

AMENDMENTS

1. Broaden coverage to include "outpatient vision-related rehabilitation services for the purpose of restoring, or preventing deterioration in independent functioning" under a new Section 1123(a)(4).

CURRENT LANGUAGE: Section 1123(a) does not explicitly provide for vision-related rehabilitation services.

RATIONALE FOR AMENDMENT: Failure to provide the blind with the sort of outpatient rehabilitation they require is discriminatory. This rehabilitation provides the blind with an opportunity to function independently and contribute to society.

2. Broaden the "illness or injury" criteria for outpatient rehabilitation eligibility to include "illness, injury, disorder, congenital, degenerative, or other health condition."

CURRENT LANGUAGE: Section 1123(b)(1) limits outpatient rehabilitation to conditions resulting from an illness or injury, excluding congenital, developmental, and other conditions from receiving services.

RATIONALE FOR AMENDMENT: Current language amounts to a pre-existing condition exclusion. Many private insurance policies currently provide this broader coverage, and this language is also consistent with quality practice guidelines elsewhere in the Health Security Act.

3. Broaden coverage to include maintenance of functioning and prevention of deterioration.

CURRENT LANGUAGE: Section 1123(b)(2) limits coverage to restoration of capacity or minimization of limitations.

RATIONALE FOR AMENDMENT: Failure to maintain function and prevent deterioration may result in big ticket secondary disabilities and institutionalization.

B. SPECIALIST AS GATEKEEPER Section 1402

AMENDMENT

Requirements relating to enrollment and coverage.

Propose additional section (h) providing that managed care health plan using primary care physician "gatekeepers", that an individual with a disability be able to choose from a list of gatekeeper physicians which include specialists in the medical management of their condition. The National Health Board would be directed to develop and publish a list of chronic conditions and disabilities that are likely to require specialized health care services over a prolonged period of time.

CURRENT LANGUAGE: No provisions for specialists as gatekeepers, however an individual with a disability may choose a specialist provider outside the managed care network, at a significantly higher cost.

RATIONALE FOR AMENDMENT: Specialists are often the primary care provider for individuals with disabilities, and would generally be the best informed to manage the resources and services needed by individuals with disabilities. Managed care systems often prohibit the use of specialists in such roles.

C. DURABLE MEDICAL EQUIPMENT Section 1124

AMENDMENTS

1. Addition of a number of relatively inexpensive items under the definition of durable medical equipment which may save substantial expenditures in the future on costly corrective therapy and items. (e.g. bath tub lifts, grab bars, and mobility canes).

RATIONALE FOR AMENDMENT: Definition of DME in Health Security Act

refers to restrictive, acute-care definition currently used in Medicare.

2. Clarify that accessories and supplies used directly with this equipment, replacement of worn out or damaged equipment, and equipment repair are covered.

RATIONALE FOR AMENDMENT: Clarifications merely codify current Medicare policy and the policy of most private insurers.

3. Expand coverage to include devices or equipment which "minimize" rather than wholly "prevent" further deterioration in function.

RATIONALE FOR AMENDMENT: Cost-effective limiting secondary disabilities and costly institutionalization.

D. MENTAL HEALTH Section 1115

AMENDMENT

Provide the mental health benefit under the Health Security Act to be effective upon enactment.

CURRENT LANGUAGE: "Prior to January 1, 2001" limitation for mental health services.

RATIONALE FOR AMENDMENT: The National Institute of Mental Health estimates that providing a comprehensive mental health services for the severely mentally ill will result in $2.2 billion in annual savings in criminal justice, welfare, and health care costs. This savings would finance the added cost of extending immediate coverage to all Americans upon enactment. (See attached report)

E. EPSDT

AMENDMENT

Section 4221 should be revised to eliminate the creation of a two-tiered system for children under Medicaid.

RATIONALE FOR AMENDMENT

Although the language is unclear, it appears that children will be eligible for different service packages, depending on how they became eligible for Medicaid. Children who live in low-income households will be eligible for a more comprehensive set of services than children who live in non-low-income households. In the latter situation, families could only obtain such services by paying the full cost.

AMENDMENT

Add more explicit language under Section 4222 ensuring that the

services under the EPSDT mandate continue to be provided to eligible low-income children.

RATIONALE FOR AMENDMENT: Section 4222 provides a new supplemental services modeled upon the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate under Medicaid. The details of this program are left to the Secretary of HHS, who is directed to issue regulations on how the program is to be administered no later than July 1, 1995.

AMENDMENT

Adjust the new program's spending levels to account for low enrollment in FY 1993.

RATIONALE FOR AMENDMENT: The Health Care Financing Administration reports that in FY 1993, the year for which the Health Security Act caps the federal contribution, only 41 percent of all children eligible for EPSDT had been enrolled by the states.

F. HEARING AID BENEFIT

AMENDMENT

(a) Coverage The hearing care described in this section includes treatment for deficits in hearing including hearing aids. Hearing aids are covered when recommended by an audiologist or physician.

(b) Limitations

(1) Hearing Aids are covered for individuals less than 18 years of age.

(2) Individuals over 18 years of age are eligible for this benefit if they are:

(a) AFDC recipients (as defined in section 1902(3) of the Health Security Act);

(b) SSI recipients (as defined in section 1902(33) of the Health Security Act)

(3) Individuals over 18 years of age are limited to one hearing aid every 5 years, two hearing aids if a binaural fitting is required.

CURRENT LANGUAGE: Section 1141(b)(3) of the Health Security Act excludes hearing aid and related services coverage.

RATIONALE FOR AMENDMENT: Early identification of hearing loss, particularly in children, will result in early intervention and habilitation to ensure that the individuals academic, employment, and social skills will be maximized. Individuals with hearing are explicitly excluded while Section 1125 covers vision care, including eyeglasses and contact lenses for children.

G. LONG TERM CARE

1. Eligibility

AMENDMENT

Rather than granting the Secretary of Health and Human Services unrestricted authority to promulgate detailed assessment protocols and eligibility criteria, language should specify the procedures the Secretary must follow in formulating policy.

RATIONALE FOR AMENDMENT: The Health Security Act provides a new home and community based federal state grant program which must be implemented through equitable assessment methods and criteria to ensure that those with the most severe functional limitations are provided for.

AMENDMENT

Require the Secretary to establish comparable eligibility criteria applicable to individuals with a combination of disabling conditions or a chronic physical, mental, cognitive or sensory impairment in combination with severe, chronic medical condition.

RATIONALE FOR AMENDMENT: Many individuals may not qualify for benefits but nonetheless may have a severe disability when all health related factors are taken into account.

2. Covered Services

AMENDMENT

Revise Section 2104(g)(1) of the bill by adding after the words "daily living" and before the comma the following phrase: "and for people with primarily mental, cognitive or sensory impairments such instrumental activities of daily living as deemed necessary and appropriate,"

RATIONALE FOR AMENDMENT: This change would not entail additional federal or state outlays, since annual caps on federal participation is established under Section 2109. Since States are not permitted to limit eligibility for services, a State may attempt to restrict the types of services it elects to purchase through the grant program. Individuals requiring assistance with instrumental activities of daily living (e.g. money management, supportive housing arrangements) would be denied access to the types of services and supports they need to succeed in the community.

3. Cost Sharing

AMENDMENT

Section 2105(b) of the bill should be amended to add a stop/loss feature that limits the amount of out-of-pocket costs a recipient of services is required to pay per annum. This out-of-pocket cap should be coordinated with the annual individual/family limits on deductibles and co-insurance payments provided in the basic health

benefit package.

RATIONALE FOR AMENDMENT: The absence of this feature would make home and community-based services a financially non-viable option for participants with a combination of relatively low income and high cost services. In addition the lack of stop-loss feature, may make institutional services more financially attractive, undermining one of the key policy goals of the new program.

H. DENTAL CARE

AMENDMENT

Expand coverage under Section 1126 to include adults with disabilities, particularly those with seizure disorders, upon enactment rather than 2001.

RATIONALE FOR AMENDMENT: Individuals with disabilities are more in need of preventive dental care than the rest of the population, due to medical and genetic conditions, and poor oral hygiene.

I. PAYMENT BASED ON TIME AND EFFORT

AMENDMENT

A special characteristics rate modifier must be available to every practitioner through the accountable health plans, which takes into account the time and effort necessary to serve persons with cognitive and developmental disabilities.

RATIONALE FOR AMENDMENT: Persons with disabilities, particularly, those with cognitive disabilities, often take two or three times as long to treat per office visit. Reimbursement formulas must include adjustments for time-intensive services required for some persons with disabilities.

J. INPATIENT REHABILITATION

AMENDMENT

Coverage of inpatient rehabilitation services should be clarified to include the services of rehabilitation units in general hospitals as defined in Section 1861(e).

March 24, 1994

TO: **ALAN LOPATIN**, EDUCATION AND LABOR COMMITTEE
PHYLISS BORZI, SUBCOMMITTEE ON LABOR MANAGEMENT RELATIONS

FR: DANIEL WEISS AND CHARLOTTE FRAAS
OFFICE OF CONGRESSMAN GEORGE MILLER
x5-2095

RE: AMENDMENT BY REP. MILLER TO HR 3600 CONCERNING MENTAL HEALTH BENEFITS

Attached is Congressman Miller's amendment to the mental health benefits section of HR 3600, as discussed in our group meetings on health care reform. Congressman Miller would prefer to extend full benefits with no limits to adults and children. Because of cost considerations, however, he would like to do the following:

1) Request from the CBO and the White House their estimates of the cost of eliminating the limits on benefits in the bill for adults and children as well as just for children.

2) Prepare the amendment as written in the attached document for the children's option, option number 2, in the several instances where it applies.

In addition, Mr. Miller would like to ensure that the school-based clinics are linked legislatively with the mental health benefits section. We need more time to develop this proposal and will seek to do so today. Mr. Miller and Ms. Woolsey both support the notion of a "trained" or "qualified" person to be in attendance at the school clinic who can identify children with mental illness or in need of counseling for mental illness or substance abuse.

Thank you very much.

George 5-2095
Miller's
Amendments

HK 3600

(j) CLINICIAN VISIT.—For purposes of this section, the term "clinician visit" includes the following health professional services (as defined in section 1112(c)):

(1) A complete medical history.

(2) An appropriate physical examination.

(3) Risk assessment.

(4) Targeted health advice and counseling, including nutrition counseling.

(5) The administration of age-appropriate immunizations and tests specified in subsections (b) through (h).

(k) IMMUNIZATIONS AND TESTS NOT ADMINISTERED DURING CLINICIAN VISIT.—Notwithstanding subsection (i)(5), the clinical preventive services described in this section include an immunization or test described in this section that is administered to an individual consistent with any periodicity schedule for the immunization or test during the age range specified for the immunization or test, and any administration fee for such immunization or test, even if the immunization or test is not administered during a clinician visit.

SEC. 1115. MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES.

(a) COVERAGE.—The mental illness and substance abuse services that are described in this section are the

following items and services for eligible individuals, as defined in section 1001(c), who satisfy the eligibility requirements in subsection (b):

(1) Inpatient and residential mental illness and substance abuse treatment (described in subsection (c)).

(2) Intensive nonresidential mental illness and substance abuse treatment (described in subsection (d)).

(3) Outpatient mental illness and substance abuse treatment (described in subsection (e)), including case management, screening and assessment, crisis services, and collateral services.

(b) ELIGIBILITY.—The eligibility requirements referred to in subsection (a) are as follows:

(1) INPATIENT, RESIDENTIAL, NONRESIDENTIAL, AND OUTPATIENT TREATMENT.—An eligible individual is eligible to receive coverage for inpatient and residential mental illness and substance abuse treatment, intensive nonresidential mental illness and substance abuse treatment, or outpatient mental illness and substance abuse treatment ~~(except case management and collateral services)~~ except screening & assessment, crisis services, & collateral services) if the individual—

(A) has, or has had during the 1-year period preceding the date of such treatment, a diagnosable mental disorder or a diagnosable substance abuse disorder; and

(B) is experiencing, or is at significant risk of experiencing, functional impairment in family, work, school, or community activities.

For purposes of this paragraph, an individual who has a diagnosable mental disorder or a diagnosable substance abuse disorder, is receiving treatment for such disorder, but does not satisfy the functional impairment criterion in subparagraph (B) shall be treated as satisfying such criterion if the individual would satisfy such criterion without such treatment.

(2) CASE MANAGEMENT.—An eligible individual is eligible to receive coverage for case management if—

(A) a health professional designated by the health plan in which the individual is enrolled determines that the individual should receive such services; and

(B) the individual is eligible to receive coverage for, and is receiving, outpatient mental illness and substance abuse treatment with re-

spect to a diagnosable mental disorder or a diagnosable substance abuse disorder.

(2) SCREENING AND ASSESSMENT AND CRISIS SERVICES.—All eligible individuals enrolled under a health plan are eligible to receive coverage for outpatient mental illness and substance abuse treatment consisting of screening and assessment and crisis services, without regard to the eligibility criteria described in (B).

(3) COLLATERAL SERVICES.—An eligible individual is eligible to receive coverage for outpatient mental illness and substance abuse treatment consisting of collateral services if the individual is a family member (described in section 1011(b)) of an individual who is receiving inpatient and residential mental illness and substance abuse treatment, intensive nonresidential mental illness and substance abuse treatment, or outpatient mental illness and substance abuse treatment.

This needs clarification -DW

(c) INPATIENT AND RESIDENTIAL TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term "inpatient and residential mental illness and substance abuse treatment" means the items and services described in paragraphs (1) through (3) of section 1861(b) of the Social Security Act when

provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder to—

(A) an inpatient of a hospital, psychiatric hospital, residential treatment center, residential detoxification center, crisis residential program, or mental illness residential treatment program; or

(B) a resident of a therapeutic family ~~or~~ home, group treatment home ~~or~~ community residential treatment program, or ~~and~~ recovery center for substance abuse.

The National Health Board shall specify those health professional services described in section 1112 that shall be treated as inpatient and residential mental illness and substance abuse treatment when provided to such an inpatient or resident.

(2) LIMITATIONS.—Coverage for inpatient and residential mental illness and substance abuse treatment is subject to the following limitations:

(A) RESIDENTIAL MENTAL ILLNESS TREATMENT.—Such treatment, when provided with respect to a diagnosable mental disorder in a setting that is not a hospital or a psychiatric hospital, is covered only to avert the need for, or as an alternative to, treatment in a hospital

or a psychiatric hospital, as determined by a health professional designated by the health plan in which the individual receiving such treatment is enrolled.

(B) RESIDENTIAL SUBSTANCE ABUSE TREATMENT.—Such treatment, when provided with respect to a diagnosable substance abuse disorder in a setting that is not a hospital or a psychiatric hospital, is covered only if a health professional designated by the health plan in which the individual receiving such treatment is enrolled determines (based on criteria that the plan may choose to employ) that the individual should receive such treatment.

(C) LEAST RESTRICTIVE SETTING.—Such treatment is covered only when—

(i) provided to an individual in the least restrictive inpatient or residential setting that is effective and appropriate for the individual; and

(ii) less restrictive intensive nonresidential or outpatient treatment would be ineffective or inappropriate.

(D) ANNUAL LIMIT.—Prior to January 1, 2001, such treatment is subject to an aggregate

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(D) Annual Limit

Option 1: Delete section (removing limits for adults and children)

Option 2: Add the following at asterisk on page 52:

These limits do not apply to children under age 22. Inpatient and residential services shall be provided to children under age 22 based upon medical or psychological necessity as determined by ~~the health plan.~~ a health professional designated by the health plan in which the individual is enrolled.

annual limit of 30 days. A maximum of 30 additional days of such treatment shall be covered for an individual if a health professional designated by the health plan in which the individual is enrolled determines in advance that—

(i) the individual poses a threat to his or her own life or the life of another individual; or

(ii) the medical condition of the individual requires inpatient treatment in a hospital or a psychiatric hospital in order to initiate, change, or adjust pharmacological or somatic therapy.

(E) INPATIENT HOSPITAL TREATMENT FOR SUBSTANCE ABUSE.—Such treatment, when provided in a hospital or a psychiatric hospital with respect to a diagnosable substance abuse disorder, is covered under this section only for detoxification requiring the management of psychiatric conditions associated with withdrawal from alcohol or drugs. The items and services described in this section do not include medical detoxification as required for the management of medical conditions associated

with withdrawal from alcohol or drugs (which is covered under section 1111).

(d) INTENSIVE NONRESIDENTIAL TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term "intensive nonresidential mental illness and substance abuse treatment" means diagnostic or therapeutic items or services provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder to an individual—

(A) participating in a partial hospitalization program, a day treatment program, a psychiatric rehabilitation program, or an ambulatory detoxification program; or

(B) receiving home-based mental illness services or behavioral aide mental illness services.

The National Health Board shall specify those health professional services described in section 1112 that shall be treated as intensive nonresidential mental illness and substance abuse treatment when provided to such an individual.

(2) LIMITATIONS.—Coverage for intensive nonresidential mental illness and substance abuse treatment is subject to the following limitations:

(A) DISCRETION OF PLAN.—An individual shall receive coverage for such treatment if a health professional designated by the health plan in which the individual is enrolled determines (based on criteria that the plan may choose to employ) that the individual should receive such treatment.

(B) TREATMENT PURPOSES.—Such treatment is covered only when provided—

(i) to avert the need for, or as an alternative to, treatment in residential or inpatient settings;

(ii) to facilitate the earlier discharge of an individual receiving inpatient or residential care;

(iii) to restore the functioning of an individual with a diagnosable mental disorder or a diagnosable substance abuse disorder; or

(iv) to assist such an individual to develop the skills and gain access to the support services the individual needs to achieve the maximum level of functioning of the individual within the community.

(C) ANNUAL LIMIT.—

(i) IN GENERAL.—Prior to January 1, 2001, the number of covered days of inpatient and residential mental illness and substance abuse treatment that are available to an individual under the 30-day limit described in the first sentence of subsection (c)(2)(D) shall be reduced by 1 day for each 2 covered days of intensive nonresidential mental illness and substance abuse treatment that are provided to the individual, until such number is reduced to zero.

(ii) ADDITIONAL DAYS.—After the number of covered days referred to in clause (i) has been reduced to zero with respect to an individual, the individual shall receive coverage for a maximum of 60 days of intensive nonresidential mental illness and substance abuse treatment if a health professional designated by the health plan in which the individual is enrolled determines that the individual should receive such treatment.

(D) DETOXIFICATION.—Intensive nonresidential mental illness and substance

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(C) Annual Limit

Option 1: Delete section (removing limits for adults and children)

Option 2: Add the following at asterisk:

The limits specified in (C) (i) and (ii) do not apply to children under age 22. Intensive nonresidential services shall be provided to children under age 22 based upon medical or psychological necessity as determined by ~~the health plan.~~ a health professional designated by the health plan in which the individual is enrolled.

abuse treatment consisting of detoxification is covered only if it is provided in the context of a treatment program.

(E) OUT-OF-POCKET MAXIMUM.—Prior to January 1, 2001, expenses for intensive nonresidential mental illness and substance abuse treatment that an individual incurs prior to satisfying a deductible applicable to such treatment, and copayments and coinsurance paid by or on behalf of the individual for such treatment, may not be applied toward any annual out-of-pocket limit on cost sharing under any cost sharing schedule described in part 3 of this subtitle if such treatment is provided—

(i) with respect to a diagnosable substance abuse disorder; or

(ii) pursuant to subparagraph (C)(ii).

(e) OUTPATIENT TREATMENT.—

(1) DEFINITION.—For purposes of this subtitle, the term "outpatient mental illness and substance abuse treatment" means the following services provided with respect to a diagnosable mental disorder or a diagnosable substance abuse disorder in an outpatient setting:

(A) Screening and assessment.

(B) Diagnosis.

(C) Medical management.

(D) Substance abuse counseling and relapse prevention.

(E) Crisis services.

(F) Somatic treatment services.

(G) Psychotherapy.

(H) Case management.

(I) Collateral services.

(2) LIMITATIONS.—Coverage for outpatient mental illness and substance abuse treatment is subject to the following limitations:

(A) HEALTH PROFESSIONAL SERVICES.—Such treatment is covered only when it constitutes health professional services (as defined in section 1112(c)(2)).

(B) DISCRETION OF PLAN.—An individual shall receive coverage for outpatient mental illness and substance abuse treatment consisting of substance abuse counseling and relapse prevention if a health professional designated by the health plan in which the individual is enrolled determines (based on criteria that the plan may choose to employ) that the individual should receive such treatment. This subpara-

(C) Annual Limits

(i) PSYCHOTHERAPY AND COLLATERAL SERVICES.

Option 1: Delete section (removing limits for adults and children)

Option 2: Add the following at the asterisk on page 58:

These limits do not apply to children under age 22. Psychotherapy and collateral services shall be provided to children under age 22 based upon medical or psychological necessity as determined by ~~the health plan.~~* by a health professional designated by the health plan in which the individual is enrolled.

Was determined by a health professional in a health plan?

graph does not apply to group therapy covered pursuant to subparagraph (C)(ii)(II).

(C) ANNUAL LIMITS.—

(i) PSYCHOTHERAPY AND COLLATERAL SERVICES.—Prior to January 1, 2001, psychotherapy and collateral services are subject to an aggregate annual limit of 30 visits per individual. Additional visits may be covered, at the discretion of the health plan in which the individual receiving treatment is enrolled, to prevent hospitalization or to facilitate earlier hospital release, for which the number of covered days of inpatient and residential mental illness and substance abuse treatment that are available to an individual under the 30-day limit described in the first sentence of subsection (c)(2)(D) shall be reduced by 1 day for each 4 visits. After such number has been reduced to zero, no additional visits under the preceding sentence may be covered.

(ii) SUBSTANCE ABUSE COUNSELING AND RELAPSE PREVENTION.—

(C) Annual Limits

(ii) SUBSTANCE ABUSE COUNSELING AND RELAPSE PREVENTION

Option 1: Delete section (removing limits for adults and children)

Option 2: Add the following at the asterisk on page 60:

(III) Children. -- The limits specified in (C) (i) and (ii) (I) and (II) do not apply to children under age 22. Substance abuse counseling and relapse prevention services shall be provided to children under age 22 based upon medical or psychological necessity as determined by ~~the health plan.~~ a health professional designated by the health plan in which the individual is enrolled.

(I) IN GENERAL.—Except as provided in subclause (II), the number of covered days of inpatient and residential mental illness and substance abuse treatment that are available to an individual under the 30-day limit described in the first sentence of subsection (c)(2)(D) shall be reduced by 1 day for each 4 visits for substance abuse counseling and relapse prevention that are covered for the individual under subparagraph (B). After such number has been reduced to zero, no visits for substance abuse counseling and relapse prevention may be covered, except as provided in subclause (II).

(II) GROUP THERAPY.—Prior to January 1, 2001, substance abuse counseling and relapse prevention consisting of group therapy is subject to a separate aggregate annual limit of 30 visits, if such therapy occurs within 12 months after the individual has received, with respect to a diagnosable

substance abuse disorder, inpatient and residential mental illness and substance abuse treatment or intensive nonresidential mental illness and substance abuse treatment. The provisions of clause (i) and subclause (I) do not apply to therapy that is described in the preceding sentence.

(D) DETOXIFICATION.—Outpatient mental illness and substance abuse treatment consisting of detoxification is covered only if it is provided in the context of a treatment program.

(E) OUT-OF-POCKET MAXIMUM.—Prior to January 1, 2001, expenses for outpatient mental illness and substance abuse treatment that an individual incurs prior to satisfying a deductible applicable to such treatment, and copayments and coinsurance paid by or on behalf of the individual for such treatment, may not be applied toward any annual out-of-pocket limit on cost sharing under any cost sharing schedule described in part 3 of this subtitle.

(f) OTHER DEFINITIONS.—For purposes of this subtitle:

Note: Pls. check correct placement of this amendment.

Page 60

Add new section (f); change Other Definitions to (g)

(f) ORGANIZED SYSTEMS OF CARE FOR CHILDREN

(1) DEFINITION. For purposes of this subtitle, the term "organized system of care" means a deliberately organized, community-based service delivery network for children under age 22 with serious or complex mental or substance abuse disorders. Such systems of care have the capacity to:

(A) Involve and coordinate multiple child-serving agencies and providers (including child welfare, education, juvenile justice, health, mental health, and substance abuse).

(B) Involve families of children with mental and substance abuse disorders in treatment planning and service delivery.

(C) Develop individualized treatment plans, through multidisciplinary or multiagency teams, that are recognized and honored across multiple child-serving agencies and providers.

(D) Ensure the delivery and coordination of the array of services needed by children with serious or complex mental or substance abuse disorders.

(E) Manage the individualized treatment plans and respond flexibly to treatment needs as they change over time.

(2) PROVISION OF SYSTEMS OF CARE. Health plans shall ensure that mental health and substance abuse services for children under age 22 who have serious or complex disorders are provided through an organized system of care. Health plans will be deemed to have met this requirement if one of the following conditions is met: The plan has established a system of care for children enrolled; the plan has established linkages with an existing public sector system, or systems, of care in the area, or the health plan is participating in the development or operation of a joint public-private system of care set up with appropriate public agencies in the health plan area.

(1) CASE MANAGEMENT.—The term "case management" means services that assist individuals in gaining access to needed medical, social, educational, and other services.

(2) DIAGNOSABLE MENTAL DISORDER AND DIAGNOSABLE SUBSTANCE ABUSE DISORDER.—The terms "diagnosable mental disorder" and "diagnosable substance abuse disorder" mean a disorder that—

(A) is listed in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised or a revised version of such manual (except V Codes for Conditions Not Attributable to a Mental Disorder That Are a Focus of Attention or Treatment);

(B) is the equivalent of a disorder described in subparagraph (A), but is listed in the International Classification of Diseases, 9th Revision, Clinical Modification, Third Edition or a revised version of such text; or

(C) is listed in any authoritative text specifying diagnostic criteria for mental disorders or substance abuse disorders that is identified by the National Health Board.

(3) PSYCHIATRIC HOSPITAL.—The term "psychiatric hospital" has the meaning given such term in section 1861(f) of the Social Security Act, except that such term shall include—

(A) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(1), a facility of the uniformed services under title 10, United States Code, that is engaged in providing services to inpatients that are equivalent to the services provided by a psychiatric hospital;

(B) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(2), a facility operated by the Department of Veterans Affairs that is engaged in providing services to inpatients that are equivalent to the services provided by a psychiatric hospital; and

(C) in the case of an item or service provided to an individual whose applicable health plan is specified pursuant to section 1004(b)(3), a facility operated by the Indian Health Service that is engaged in providing services to inpa-

tients that are equivalent to the services provided by a psychiatric hospital.

SEC. 1116. FAMILY PLANNING SERVICES AND SERVICES FOR PREGNANT WOMEN.

The services described in this section are the following items and services:

(1) Voluntary family planning services.

(2) Contraceptive devices that—

(A) may only be dispensed upon prescription; and

(B) are subject to approval by the Secretary of Health and Human Services under the Federal Food, Drug, and Cosmetic Act.

(3) Services for pregnant women.

SEC. 1117. HOSPICE CARE.

The hospice care described in this section is the items and services described in paragraph (1) of section 1861(dd) of the Social Security Act, as defined in paragraphs (2), (3), and (4)(A) of such section (with the exception of paragraph (2)(A)(iii)), except that all references to the Secretary of Health and Human Services in such paragraphs shall be treated as references to the National Health Board.

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Amendment to Sec. 1114 (insert on pg. 39, after line 21)

(b) PROVISION.---Individuals shall be not be prohibited from obtaining the clinical preventive services from the physician of their choice who practices in one of the primary health care specialties, as defined under Title 3, Subtitle A, section 3012(e)(3).

[following subparagraphs would need to be relettered; eg, current subparagraph (b), entitled "Individuals under 3" would become subparagraph (c)]

(From Jeny)