3/3 Hearing before the Senate Finance Cmtee on benefits

(A)

I. Judith Feder, Ph.D., Principal Dep. Asst Sec. Office of the Asst. Sec for Planning & Evaluation, Dept of HHS

II. Roger Herdman, M.D. OTA

(B)

I. Susan Eggerson, Exec Dir, Medical & Quality Mgmt BC & BS Assn, Chicago

II. Rhoda Karpatkin, J.D., Pres, Consumers Union of the U.S., Inc., Yonkers, NY

III. Jack McFadden, Ph.D., Mgr., Wash Research Office, Hewitt Associates, LLC

III. Paige Sipes-Metzler, D.P.H, Exec. Dir., Health Services Comm., Oregon Dept. of Human Resources

IV. William Straub, M.D., Sr. Health Policy Analyst, Jackson Hole Group

~~[illegible]~~ Intro

Packwood – supports univ. coverage, but benefits must be limited

Backus – ∅

Moynahan –

Danforth – most important/difficult issue @ health-care reform. Political issue b/c of I groups + b/c the public is concerned + affected so greatly by the decision
But list cannot be complete – must be limited.

Rockefeller – "Clinton package is not a Cadillac plan"
only diff b/w std bc/bs plan + HSA { ① preventive health care
② mental health

(A)

I. D. Ider

Benefits are only a part of the plan, but is addressed in a # of ways

Plan → incentives for efficient / quality care

KEY: Comprehensive Package of Benefits

Why? ① fiscal responsibility ② security

- need to specify package in order to estimate amt of financing necessary + to assure the American people that they can be secure in their Health Care

HSA achieves objectives

- Comprehensive package → comparable to packages out there today. Stated cost-sharing options protect consumers via limits on out of pocket spending, but promotes responsibilities via co-pymts.

= Prevention → not covered by today's plans
↳ Investment!

(A) Good prenatal care
(B) Mental Health / Subst Abuse — NO LIFETIME LIMITS / DISCRIMINATION
(C) Capped fed'l program for Children's h.c.
(D) LTC program

Balance b/w security + affordability

Response to Qs:

Packwood: Benefits package should not be fixed
→ let NHB adjust

Backus: HC Reform : std package v. choice
Where choice → individuals avoid preventive services + end up in emerg room

Is two package system more expensive?
Choice leads to system where providers are controlling care → leads to enormous price differential b/w 2 plans → 2 package approach is too costly

Danforth: Administration is fuzzing up the issue!
NO HINT THAT HARD CHOICES EXIST OR THAT ANYTHING HAS TO BE LEFT OFF
HSA focuses on comprehensive system, + I read it to Amy that everything is on it. He Q-ed Mrs. Clinton @ BABY K - would she be covered + she was politically wise in not answering - Giving America wrong impression b/c everything is not covered.

FEISER: Doesn't answer Q! Issue goes beyond what benefits people get → its how the system runs / what incentives are → to address costs in system

D. What will be off package?

F. -Custodial services, adult dental benefits, hearing aids, phy duty nursing (etc.)

D. What @ Baby K, kidney dialysis, ~~etc~~ neo-natal care?

F. Physicians can best make the decisions in an environment where the incentive system

D We're avoiding the econ / philosophical Qs.

Rockefeller: Any service not medically necess / approp is not included → + is not the decision of Congr. Thank God for him!

Doctors need to make certain decisions

Chafee / Cooper plans don't include any listing of what the benefits are under their plans. You can't estimate the costs w/o it.

D: Need to put price tags on it ~~Rx~~ → otherwise ducking the issue. Need to exclude things other than hearing aids + adult dental care.

R: Drs need to decide what is med necess / approp — to include everything in the plan would be absurd.

Dole: Chaffee bill defines med necess / Clinton doesn't Amer people know its too complicated, don't understand, know its too costly. Will MCs have same hc under plan as every one else?

Elder: YES, extended choice now offered to MCs will be avail to all. (eek!)

Pack: Fed plan ceases to exist. But is a model like that which Amer. will have under the plan. Everyone will be in an alliance.

*** Confusion ① Fed'l plan

Pole: When is Fed plan phased into HSA?

Feder: 1998

Durenburger: we need to put values on med. services to decide what is med necess / approp

Benefits (pkg) has 3 functions

① to make mkts work → comparability to other services

② equity → redistrib of income → affordability

③ Value $s → what are we getting for our $?

*** The key is not the package, but rather the delivery system

NE J of Med, p 607, physician profiling → *medicare pts.

↳ concludes that Oregon is ½ nat'l mean for usage of MRI (etc) + FL is 50% over usage

∴ need a disciplined mkt.

Chafee: Need ~~risk~~ uniform benefit package to prevent risk selection?

F: Yes.

Chafee: Supplemental benefits → offered / tax deductible up to $ in time

↳ not deductible under Chafee plan

How does the Δ in tax structure affect ER/EE?

F: income to employee, taxable fringe benefit

(B)

II Dr. Herdman

Benefit Package → Centerpiece of h.c. Reform

Relationship of package to other parts of plan:

Financing program used as a tool to filter out services → some can be eliminated b/c of underutilization (!)

- Cost-sharing → saves $, diminishes care
- expenditure caps → effectiveness is Q-ed
- utilization control + manged care → require careful structure

Influences on cmtees ē their own agendas
↳ good luck!

- Oregon plan → subjective value based decisions as to what will be included in plan

- HSA → need to do cost analysis on each benefit, particularly the preventive services + mental health

- Slow growth rate of expenditures

Response to Qs:

Packwood

Cost savings → immunizations, pre-natal care

Cost effectiveness → $ amt to save 1 yr of life
↳ look into frequency, necessity → cost in the aggregate

dispensible → ie. Cholesterol tests

"Educated guesses" → new study to look to

Backus

Catastrophic plan → major cost-sharing plan
↳ necessary care is avoided

Chafee: finds merit in this plan whereby benefits package comes b/f Congs for an UP or DOWN vote, can't be a-ed by Congs.

(15)

I. ~~Susan Gleason~~

Dr. Metzler

Follow OR's lead/ experience

Recommend adopting commission structure in developing benefits package
- small # - unique characteristics ← more accessible / neutral / available to listen
- Need to focus on policy recommendations
- Commission → successful structure b/c offers
  Simplicity → no bureaucracy
  - timely in responding to public concerns

Ms. Gleeson (BC/BS)
- welcome hc reform
- FOCUS: INFRASTRUCTURE ADMINISTERING UNIF BENEFITS
↳ Procedures → investigational or non-INV.
  (working c Kaiser / Permanente (?))
  * 19 member panel to decide what is I OR NON-I
  Not an issue which should be determined by
  Competition in the mkt place.

Support coverage for investigational (EXPERIMENTAL) technologies
↳ but most existing legis is too broad → entitlement

Atty. Kargatkin

(1) Consumers want comp hc benefits
90% favor univ access to a compr package.

(2) Consumers need comp hc mkts + priv mkts can't achieve it. Benefits must be comprehensive b/c the private industry doesn't provide hc when you need it most

(3) Cadillac hc coverage is a myth
↳ medically necess care is <u>not</u> cadillac

(4) Cong should not leave design of benefit package to a board/commission

(5) Comp benefits are meaningless if combined c catastrophic insur. Policy → the deductibles will not provide the care needed

(6) Burgeoning supplemental mkt. if comp. benefits are not guaranteed → replacing the current private mkt. → result: multi-tiered system

(7) Consumers need compl. info ⓒ comp h.c.

Dr. Mofadle

* benefit design experts

- The Cos, ERs/EEs decide what should be included
- Plan design is not static, Δs every year
  DATA is the key to benefit design
- Today, plans ∃ diff. levels of sophistication (ie small bus v. ERs)
- Effective plan design relies on related skills of change (?)
- Can now track provider efficiency
- One plan design can't meet all needs
- Variety / Flexibility are key to plan design
  - Must distinguish ↳ can have narrow choice of plan + a wide source of providers.
    ↳ This is what motivates ees to choose

Dr. Straub

Focus: Why need std. benefit plan?
Who should determine " "?

Std benefit plan → fundamental
- (A) facilitates side by side comparison of health plans
- (B) Necessary for competition on a level playing field
- (C) Std cost-sharing / cmmty rating (across all plans)

Can't isolate the benefit plan from the delivery system → look to NEJMed Article again

** Who should develop the plan?
- Scientific documentation of relevancy necessary
  ↳ not yet available
  ∴ Nat'l Health Board should develop

the benefit plan
Opposed to its development at the St or Fed'l level

ID a model or proposed plan that could be modified in the future but that could be approved by Congress b/f its implementation.

Chafee → can't set in concrete what the benefits package is → leave it up to Commission every yr → then give Congr up/down vote → if voted down, go back to commission

Straub → public won't accept vagueness in health care reform, need to give definition to the benefits plan

Chafee → prescription drugs → important part of Chafee bill
↳ Variations in packages = adverse selection

Dr Stelzy → adverse selection is offset in the aggregate → Management is key
Cost shifting can be avoided by managing risk

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION
HEALTH LEGISLATION
WASHINGTON, D.C. 20201

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TOTAL PAGES (INCLUDING COVER): 8

DEPARTMENT OF HEALTH & HUMAN SERVICES

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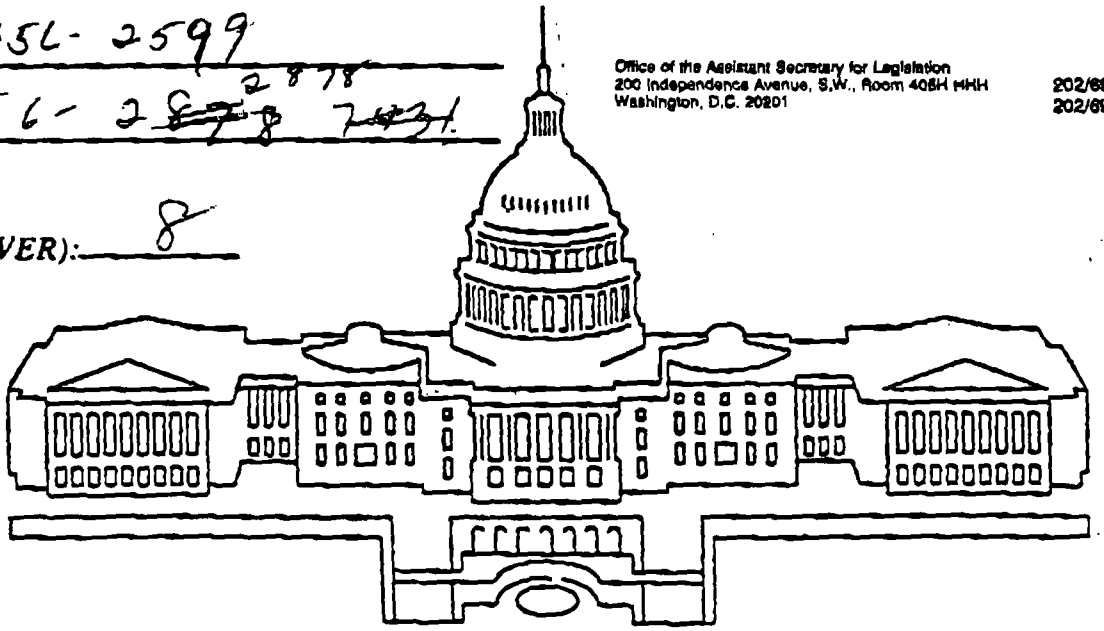

REMARKS:

Karen

copy to
Judy Feder
Jan Klein
Lisa Simpson
Thanks

TESTIMONY OF

WILLIAM H. STRAUB, M.D.

FOR

THE JACKSON HOLE GROUP

BEFORE

THE SENATE COMMITTEE

ON LABOR & HUMAN RESOURCES

Judy is co-panelist at Finance Thursday...

February 4, 1994

Thank you for this opportunity to present the views of the Jackson Hole Group on benefit plans.

As you know, the design of the benefit plan will in large measure determine the cost of a national health program. The benefit plan, in effect, defines the product of one of the largest industries in the country and, consequently, will be the primary determinant of the costs of that industry. While we believe that providing a single uniform effective health benefit plan should be the ultimate goal of a national health plan, we strongly suspect that providing a single comprehensive benefit plan to all Americans at the outset, will be necessarily very costly and potentially delay access to those most in need.

Under an employer or individual mandate the costs of a providing single mandated comprehensive benefit plan could be prohibitive for small employers and individuals alike. There is also the danger of locking-in any single, comprehensive benefit plan, and adding benefits is always easier than taking them away.

What alternatives are there?

- One could begin with a single comprehensive (and costly) plan and gradually phase in access as financing permitted,

or

- **One could begin with a single less costly plan with early access for all and add benefits as financing permitted.**

- **Alternatively, one could initially offer both a less costly or "Basic Plan" with a high cost sharing and a more costly "Standard Plan" with low cost sharing. We suggest that this approach would more closely balance need and affordability while facilitating early universal coverage.**

The principal disadvantage to offering a choice of two benefit plans is that it would temporarily create a two-tier system.

The principal advantage is that it would facilitate early universal coverage for all Americans.

The goal would clearly remain to arrive at a single uniform benefit plan in 5-10 years once more experience is gained with the costs of each plan, and once reform has produced increased efficiency in our delivery system.

Under this approach, we would require all accountable health plans to offer both the Basic and Standard Plans to minimize potential risk selection problems.

A tax cap could be set at the cost of the Standard Plan which would encourage

employers and individuals to buy up to this plan.

Model "Basic" and "Standard" Plans are attached. They differ primarily in the level of cost sharing. It is important to note that both plans are identical in the coverage of preventive services.

The Basic Plan is approximately 25% less costly than the Standard Plan. It is this difference in cost that we feel would facilitate early universal coverage for all Americans.

MODEL BENEFIT PLANS

Cost Sharing Assumptions

	BASIC PLAN	STANDARD PLAN
Deductible:	$1,000	$200
Coinsurance:	70/30	90/10
Out of Pocket Limit:		
Single	$3,000	$1,000
Family	$6,000	$2,000

Note: The above cost-sharing would apply regardless of whether services were delivered through HMO, PPO, or indemnity plans.

MODEL BENEFIT PLAN(s)

SERVICES	BASIC	STANDARD
Acute Care Facility Services:		
Hospital (Acute)	70/30 ($200 Ded/Day)	90/10 ($200 Ded/Stay)
Mental Health / Substance Abuse 30d/10d	70/30	90/10
Emergency Department	70/30	90/10
Surgicenter	70/30	90/10
Diagnostic (Lab/X-Ray)	70/30	90/10
Oncology / Dialysis	70/30	90/10
Professional Services		
Inpatient Visits	70/30	90/10
Office Visits	70/30 $10 Copay	90/10 $10 Copay
Psychotherapy	50/50	50/50
Dental (Age 18 and under)	Prevent & Diagnostic 80/20 $10 Copay	Prevent, Diagnostic, & Fillings 80/20 $10 Copay
Outpatient Prescription Drugs		
Prescription Drugs	70/30 $7.50 Copay /30d	90/10 $5.00 Copay /30d
Extended Care:		
Occupational/Speech Therapy	70/30	90/10
Rehab Services	70/30	90/10
Nursing Home	70/30 (100d)	90/10 (100d)
Hospice Care	70/30	90/10
Home Health Services	70/30	90/10
Durable Medical Equipment	70/30	90/10

Wellness Promotion	Basic	Standard
*Preventative Services:**		
Well Baby Visits	100%	100%
Immunizations	100%	100%
Mammography / PAP / Other Approved Screening Studies	100%	100%
Vision / Hearing Exams	100%	100%
Pre Natal Visits	100%	100%
Physical Exams	100%	100%

**Preventative Services - Deductible does not apply, but well developed schedules for the recommended and approved frequency of preventive and screening services would apply.*

Exclusions from Coverage

- Eyeglasses or hearing aids.
- Preventative and restorative dental services for adults (over 18 years).
- Dental care, except as required secondary to injury.
- Oral Surgery, except for tumor, infection or as required secondary to injury or other medical condition.
- Cosmetic surgery
- Reversal of voluntary sterilization.
- Artificial conception procedures except as approved by plan guidelines (e.g., GIFT or ZIFT for 2 cycles).
- Routine foot care.
- Over the counter drugs.
- Private duty nursing services.
- Custodial care.
- Investigational or experimental therapies procedures, or tests except as approved by the Health Standards Board or AHP.
- Specific conditions or circumstances under which the Health Standards Board or AHP determine that otherwise effective treatments have no net benefit.
- Orthodontia, Endodontia, Periodontia

Model Plan Costs

	BASIC*		STANDARD*	
Plan Type	Single	Family	Single	Family
HMO*	$106	$289	$134	$366
POS*	$120	$327	$151	$414
PPO*	$133	$363	$159	$433

* The cost-sharing for the Basic Plan is the same whether provided by an HMO or PPO, as it is for the Standard Plan.

Model Plan Cost Differences:

- The Basic Plan is 25% less costly than the Standard Plan from an HMO; and 18% less costly from a PPO (for the same product).
- The Basic Plan is 27% less costly if received from an HMO rather than a PPO; and the Standard Plan is 20% less costly if received from an HMO rather than a PPO.

13 pgs

URGENT

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503

February 28, 1994

LEGISLATIVE REFERRAL MEMORANDUM

LRM #I-2132

TO: Legislative Liaison Officer -

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FROM: JANET R. FORSGREN (for) Janet R. Forsgren
Assistant Director for Legislative Reference

OMB CONTACT: Robert PELLICCI (395-4871)
Secretary's line (for simple responses): 395-7362

SUBJECT: HHS Proposed Testimony RE: S 1757, Health Security Act

DEADLINE: 5:00 P.M. March 1, 1994

COMMENTS: Hearing is before the Senate Finance Committee on Thursday, March 3rd. The hearing is on the benefit package contained in the Health Security Act. Judy Feder is the HHS witness.

OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President, in accordance with OMB Circular A-19.

Please advise us if this item will affect direct spending or receipts for purposes of the the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

CC:
Nancy-Ann Min
Gene Sperling (Paul Jamieson)
Ira Magaziner
Bob Boorstin
Jason Solomon
Meegan Prunty
Jennifer Klein
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LRM #I-2132

RESPONSE TO LEGISLATIVE REFERRAL MEMORANDUM

If your response to this request for views is simple (e.g., concur/no comment) we prefer that you respond by faxing us this response sheet. If the response is simple and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a secretary.

You may also respond by (1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); (2) sending us a memo or letter; or (3) if you are an OASIS user in the Executive Office of the President, sending an E-mail message. Please include the LRM number shown above, and the subject shown below.

TO: Robert PELLICCI
Office of Management and Budget
Fax Number: (202) 395-6148
Analyst/Attorney's Direct Number: (202) 395-4871
Branch-Wide Line (to reach secretary): (202) 395-7362

FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

SUBJECT: HHS Proposed Testimony RE: S 1757, Health Security Act

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No objection

_____ No comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of _____ pages, attached to this response sheet

SENT BY:Xerox Telecopier 7021 ; 2-28-94 ; 8:40PM ; → 202 395 6140;# 2

FOR RELEASE UPON DELIVERY

STATEMENT OF

JUDITH FEDER, Ph.D.

PRINCIPAL DEPUTY ASSISTANT SECRETARY

FOR PLANNING AND EVALUATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

SENATE FINANCE COMMITTEE

MARCH 3, 1994

Mr. Chairman and Members of the Committee:

I am pleased to come before you today to talk about the comprehensive benefit package under the Health Security Act. The Act represents the President's commitment to the American people for health security through a guaranteed comprehensive benefit package.

I do not need to remind you that 58 million Americans are unisured for some time each year and that millions more have health insurance that does not meet their needs:

- 81 million Americans with those pre-existing conditions; people who are paying more or can't get insurance at all or they can't even change their jobs because they or someone in their family has one of those pre-existing conditions.

- Sixty nine percent of policies don't cover pre-existing conditions;

- Less than 40% of privately insured individuals have coverage for routine preventive services, and even in HMO's where preventive care is almost universally covered, more than 50% impose cost sharing on these services.

THE HEALTH SECURITY ACT: COMPREHENSIVE BENEFITS DEFINED IN STATUTE

Mr. Chairman, we all agree that the nation must address these inadequacies in our current insurance system. I am pleased to come before you today to talk about how the President's plan provides services and benefits that will enable all Americans to stay healthy, prevent disease, and do this at an affordable cost. The Health Security Act guarantees all Americans will have coverage for a comprehensive set of benefits defined in statute.

We consider it essential to the ultimate success of health care reform to not only define the benefit package in statute, but also to assure that the package is comprehensive.

Defining the benefit package in statute eliminates the confusion that exists today and prevents patients from discovering, just as they need coverage the most, that they have reached their lifetime limit or that a particular illness or condition is not covered. Just as important, it is impossible to estimate the costs of the benefit package to employers, individuals and the government without clearly defined benefits or cost sharing.

In addition to being clearly defined, the benefit package must be comprehensive to avoid the perpetuation of uncompensated care and the cost shifting that exists today. Comprehensive coverage also encourages the use of cost-effective preventive care, instead of the present system, which encourages individuals to wait until their illnesses are severe and costly before seeking treatment.

Second, without a standard comprehensive package, plans may offer benefits designed to attract healthy customers, perpetuating their ability to compete based on adverse selection of "cherry picking", rather than forcing them to compete by providing high quality health care at an affordable price.

Finally, we must ensure access to comprehencive benefits to avoid the creation of a two-tiered system where the wealthy may be able to afford a good benefit package, while the middle class and poor may be forced to purchase only catastrophic coverage with high out-of-pocket expenditures. Certainly those with the means to do so will always be able to purchase "deluxe" coverage - for private hospital rooms, plastic surgery, and other benefits beyond the guaranteed package. Health security, however, requires that everyone has coverage for medically necessary and appropriate care.

RANGE OF BENEFITS

The Health Security Act provides a benefits package which defines a broad range of health services, prohibits plans from excluding anyone due to pre-existing conditions, and has no lifetime limit on the benefits. The Act does not specify classes of providers, rather it provides coverage for a range of services.

Services covered include hospital services and services of health professionals. Health professional services are defined to include those services that are lawfully provided by a physician, or those services which could be performed by a physician and which are provided by another person who is legally authorized to provide those services in the state.

Other services covered include emergency services; clinical preventive services; mental illness and substance abuse services; family planning and pregnancy related services; hospice care; home health care; extended care; outpatient laboratory services; outpatient prescription drugs; outpatient rehabilitation services; durable medical equipment; vision care including routine eye examinations, diagnosis and treatment for defects in vision and eyeglasses and contact lenses for children under age 18; dental care; and health education classes.

This range of benefits is not, however a "cadillac" package. It is comparable to the average coverage enjoyed by individuals with employment based private health insurance. As noted by the Congressional Budget Office, certain benefits are more generous, such as the coverage of clinical preventive services, while others may be less so.

COST SHARING

It is important to note that the comprehensive benefits package provides cost sharing options for consumers which are standardized to ensure simplicity in choosing among health plans. These options serve to protect consumers from the devastating costs of catastrophic illnesses through limits on out-of-pocket expenditures. They also promote personal responsibility and the appropriate use of health services through copayments and co-insurance requirements for all individuals. Low income individuals will be eligible for assistance with these cost sharing requirements, but they are not waived.

CLINICAL PREVENTIVE SERVICES

Prevention is the cornerstone of the Health Security Act. The comprehensive benefits package includes a wide array of preventive services not covered by the majority of today's insurance plans - immunizations, well-child care, mammography, pap smears and other screenings and early detection measures - which will prevent health problems or help resolve them before they become serious illnesses.

- The plan offers periodic clinician visits - for children, adolescents, and adults - which provide occasions for preventive monitoring and counseling appropriate to each person's age, gender and developmental circumstances. These preventive services will be fully covered with no cost sharing.

- Our first investment in healthy children is good prenatal care for mothers. To remove any financial barriers to these critical services, the Health Security Act provides for complete prenatal care with no cost-sharing.

- Children will receive a full range of prevention

services, including immunizations, well-baby checkups with no cost sharing to ensure that all children get off to a healthy start.

- For women, the Act will cover a schedule of preventive screenings, tests and checkups with no cost-sharing. Certain preventive services will be targeted to groups that have a high risk for particular diseases.

- All women receive clinician visits, including clinical breast exams, at regular intervals with no cost-sharing. All women will also receive routine screening mammograms every two years, beginning at age 50, with no cost sharing.

- Additionally, women of any age can receive clinical services, including clinical breast exams, and mammograms at any time when they are medically necessary of appropriate with cost sharing as specified by their plan.

MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES

For the first time, all persons with mental and substance abuse disorders, and their families, will have access to specialized services. The proposal gives health plans the flexibility to provide appropriate types, mix, and level of services for each individual.

The substance abuse and mental illness benefits will provide important services for persons with these disorders. The Health Security Act represents a meaningful improvement over today's typical insurance policy that covers only a narrow range of services, and that encourages expensive inpatient care over more cost-effective alternatives.

The beginning benefit covers services that are important both to reforming the system and to caring for Americans with mental or substance abuse disorders. Distinctly different from typical insurance policies of today, the Act does not limit intensive treatment to inpatient coverage in hospitals but broadens it to residential settings and intensive nonresidential care, such as partial hospitalization and intensive day treatment programs.

Also important in this mix is that the Act includes coverage for diagnosis, medication management, crisis services, and somatic treatment services comparable to that of other health services. Health plans will also have the flexibility to use case management services.

The beginning benefit adopts a flexible benefit design. Under the Act's flexible benefit structure health plans are encouraged to move to a managed benefit. Benefits such as intensive nonresidential services (e.g., partial hospitalization and intensive day programs), outpatient psychotherapy, and substance abuse counseling are available as substitution for the more expensive inpatient and residential settings. This new structuring is consistent with the intent of the Administration's 2001 mental health and substance abuse benefit which will rely on health plan management of the benefit rather than specific limits.

The President is committed to making mental health and substance abuse services an integral part of a national system of health care. The benefit proposed for 2001 is a dramatic step toward eliminating the historic discrimination against mental illness and substance abuse.

PROTECTING LOW-INCOME CHILDREN

Under the Health Security Act, low-income families will be

members of the same health plans with the same health card as other families in their area, and health plans will receive the same premium payment regardless of the income status of the family. Families who today receive health care through Medicaid will join the alliance and receive assistance in paying premiums to ensure that their insurance is affordable. Eligible low-income families will also receive assistance with cost-sharing.

Every American, including those who are so poor that they currently qualify for health coverage under Medicaid, will be able to receive the federally guaranteed benefit package. However, we recognize that some children who are covered under Medicaid currently receive some services that go beyond the new array of benefits. In an effort to ensure that there is no gap in service for low-income children, the plan includes a new, capped, federal program for poor children with special needs.

This "wrap around" program will have federal eligibility criteria, roughly structured on current Medicaid criteria, and it will cover a federally determined set of services for eligible children under age 19. Basically, the services will include Medicaid services that are not included in the comprehensive benefit package, such as hearing aids, transportation, and some therapies.

PROTECTING INDIVIDUALS WITH DISABILITIES

Comprehensive coverage of preventive care and medical treatment goes a long way toward easing the threat of disease that faces all children and families in America. But families who have relatives with chronic health problems or severe disabilities face special challenges.

Outlawing pre-existing condition exclusions and removing lifetime

limits on benefits will help these families enormously. But many of them need more -- they need long-term supports to help them keep their loved-ones at home, in the family, in the community. Families are not looking to be replaced by a service system -- but they need some reinforcement. They need a real choice beyond institutionalizing their relative or bankrupting the whole family to keep their children at home. The plan offers real hope, in the form of a major new expansion in community-based long-term care.

The new long-term care program, which represents a significant increase in spending for community-based long-term care, will provide a range of community supports to people with severe disabilities, regardless of their age or income. This new program will be financed jointly by states and the federal government. However, it will differ from Medicaid in that federal match rates will be higher, federal funding will be capped, people will not have to be poor to qualify, and the program will be highly flexible.

In addition, the Medicaid long-term care program will continue for low income children both institutional services, including ICFs/MR; and community-based services, including personal care, home health, and Medicaid home and community-based waivers.

OTHER INVESTMENTS

The President recognizes that insurance alone can not meet the needs of all Americans. To help improve access to appropriate care and to help prevent disease and promote health, the Health Security Act includes several new investment proposals.

First, the Act includes two new grant programs to support school health education programs and to fund school health services.

Under the Act, $50 million in FY 1995 will be authorized to support the planning and implementation of comprehensive school health education programs for children in kindergarten through grade 12.

In addition, the Act authorizes $100 million in FY 1996 rising to $400 million per year by 1999, to help fund school health services including preventive health services, mental health and social service counseling, substance abuse counseling, care coordination and outreach, management of simple illness and injuries and referral and follow-up for more serious conditions. These funds will be targeted to adolescents and communities most in need of support.

In addition, new funding will be authorized to help support public health initiatives of special importance to the health of children including immunizations, lead poisoning screenings, health education and violence prevention.

Finally, the Health Security Act invests in primary care and enabling services such as transportation and outreach services and in the training of primary care doctors including pediatricians, obstetricians and family physicians to ensure that children and expectant mothers will not lack appropriate medical care.

CONCLUSION

Mr. Chairman, the Health Security Act was designed to guarantee all persons legally residing in the United States access to comprehensive medical care. The President has taken a bold step in spelling out that guarantee by defining a standard package of benefits in legislation. This package is balanced to provide access to the full range of medically necessary or appropriate services while ensuring affordability through the appropriate use

of cost sharing and the emphasis on acute and post acute services. This guaranteed benefit package is essential to the success of health care reform in terms of improved health for all Americans at a cost this Nation can afford.