TO: Hillary Rodham Clinton
Melanne Verveer
FROM: Jennifer Klein
DATE: 7/12/94
RE: Meeting with Congresswoman Kaptur's Staff

I met today with Congresswoman Kaptur's staff about her proposal for health care reform. She has circulated the plan in hopes of getting support for some pieces of the proposal from other Members and the Leadership. Her staff recognizes, however, that the proposal includes many of the elements of our plan (including universal coverage and an employer mandate) as it has emerged from the Committees. I reiterated our support for her efforts, and they seemed genuinely interested in continuing to work together.

I raised concern about one part of her plan. She proposes that States form "Affinity Health Groups" -- small, community-based groups that perform some of the functions of alliances but also "organize services" (the proposal was developed by her Ohio office, and the staff here does not know what that means). My major concern is that these groups are not large enough to spread risk. Her staff also sees this as a significant problem and asked for help to better understand the structure and functions of alliances. I will continue to work with them.

THE WHITE HOUSE

July 6, 1994

The Honorable Marcy Kaptur
U.S. House of Representatives
Washington, D.C. 20515

Dear Congresswoman Kaptur:

Thank you for writing to share with me the health reform proposal developed by citizens in your Ohio community. The "Kitchen Cabinet" plan and the President's plan for health care reform share many of the same goals -- most importantly an understanding of the need to guarantee to every American private health insurance that can never be taken away.

I know that Jennifer Klein from my office is meeting with your staff on Tuesday, July 12 to discuss this proposal. We look forward to continuing to work with you and your staff in the coming weeks.

Sincerely yours,

Hillary

Hillary Rodham Clinton

You have done a great service developing this plan

General question
. Describe HHGS
. How do they manage the risk?

MARCY KAPTUR
MEMBER
9TH DISTRICT, OHIO

COMMITTEES:
APPROPRIATIONS
SUBCOMMITTEES:
RURAL DEVELOPMENT,
AGRICULTURE, AND RELATED AGENCIES
DISTRICT OF COLUMBIA
VA, HUD, AND INDEPENDENT AGENCIES

WASHINGTON OFFICE
2104 RAYBURN BUILDING
WASHINGTON, DC 20515-3509
(202) 225-4146

DISTRICT OFFICE
FEDERAL BUILDING
234 SUMMIT ST., ROOM 719
TOLEDO, OH 43604
(419) 259-7500

Congress of the United States
House of Representatives
Washington, DC 20515-3509

June 29, 1994

Your consideration will be appreciated!

Mrs. Hillary Rodham Clinton
Chairwoman
Task Force on Health Reform
134 Old Executive Office Building
Washington, D.C. 20500

Dear Mrs. Clinton:

Because you are the leader on health insurance reform, I am writing to share with you a health insurance reform proposal developed by a broad coalition of citizens in my Ohio community.

For many months, our "Kitchen Cabinet" health coalition has been working on a draft against which our community can measure any bills before Congress. Our proposal builds on the employer-based system. After surveying our community, we found most people very satisfied with the quality of care in our area; and a majority satisfied with the type of coverage they have. Our proposal aims to keep satisfied those citizens who are satisfied; and to include those who have been left out or unduly discriminated against in the insurance market.

The major shortcoming people cited to us was the overcomplicated nature of the existing health insurance system. However, only a small percentage of citizens view the single payer system as the solution. We found serious administrative and cost overrun problems exist within both private and public insurance systems due to their very hierarchical structures. We found high levels of satisfaction and sound management within some self-insured, self-administered plans.

Our group concurs with the President that every American must have a "medical insurance home" with coverage that is high quality, affordable, private, covers preexisting conditions, and is portable. We also believe any reform bill must focus on covering people, not medical incidences. Too often the current private and public insurance systems place medical decisions in the hands of billing clerks, resulting in medical care directed by financial intermediaries rather than persons closest to the patient.

Thus, the central focus of our proposal is health insurance coverage for each citizen made available at the local level through participation in any one of a broad range of local Affinity Health Groups (AHG's), either profit or not-for-profit, characterized by a common bond, chartered at the state level, but operating locally

with a governing board. Each AHG's board will include some consumer representatives from that group. The AHG would serve as a "medical insurance home" and primary organizer of services for members including marketing the system to employers, coordinating health care payment methodologies, and providing federal assistance on a sliding fee scale for people needing subsidies. To assure coverage for all, each citizen's enrollment, along with quality assurance information from each AHG, would be reported to a National Health Board through the federal income tax system, with each AHG assigned a tax identification number. Citizens could select annually from among AHG's. States will be directed to community rate AHG's.

Most AHG's will be formed through existing employer based plans. Additional structures serving individuals such as the self-employed, farmers, the unemployed, and members of small business consortia, can be created locally through state law to achieve universal coverage and create real competition for insureds at the local level, even those who are subsidized. Publicly assisted insurance should be provided only as a last resort. But citizens who fall into no other group will be able to obtain health benefits through a Federal Employee Health Benefit structure organized at the local level as an affinity group. In addition, states will be given latitude to create other affinity groups to compete for subsidized clients, including hospital based HMO's. AHG's will be responsible for organizing a full range of provider services for members. Broad physician choice will be negotiated through AHG's.

The "Kitchen Cabinet's" proposal for health insurance reform also incorporates the following features:

(1) Federal incentives will give choice to federally subsidized individuals and allow, but not require, individuals on Medicare, the VA system, CHAMPUS/CHAMPVA, and other government-subsidized plans to form, or join, an AHG if they so choose. Medicaid recipients will be required to join an AHG. The veterans' health system also could function locally as its own Affinity Health Group.

(2) Responsibility for premiums will be shared between employers employees, and each citizen. Our plan builds on the e: employer based system. Every employer will be require minimum of 50% of each full-time employee's (defined a: per year) premium. Premiums which are greater than 80 considered taxable income. There is a 90 day waiting : an employer is fully responsible for the employee's he Generally, businesses with fewer than 25 employees and discrimination test for 401 (k) plan contributions and for a federal small business loan will be eligible for Subchapter S corporations are exempt from subsidy.

] What is this test?

(3) Medicaid as it currently exists will disappear. Health insurance payments to subsidized individuals (up to 250% poverty level) will take the form of Earned Income Health Tax Credits refunded on an annual basis. Able-bodied persons who are not

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with a governing board. Each AHG's board will include some consumer representatives from that group. The AHG would serve as a "medical insurance home" and primary organizer of services for members including marketing the system to employers, coordinating health care payment methodologies, and providing federal assistance on a sliding fee scale for people needing subsidies. To assure coverage for all, each citizen's enrollment, along with quality assurance information from each AHG, would be reported to a National Health Board through the federal income tax system, with each AHG assigned a tax identification number. Citizens could select annually from among AHG's. States will be directed to community rate AHG's.

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standard claim form will be utilized and providers w] How will this work?
to submit claims initially to the affinity groups ra
patient.

(5) Anti-trust, medical malpractice and tort reform implemented, with Alternative Dispute Resolution (ADR) mandatory before a malpractice claim can be tried. A cap on "pain and suffering" of $250,000 is proposed, with punitive damages awarded to state health budgets. Attorneys fees will be capped at 20% of $1 million awards, 10% of $2 million awards, and 5% of awards of $3 million or more.

(6) Quality assurance will be strengthened by requiring consumer information reporting to the State on each affinity group's performance according to a standard "quality" format, including comparisons of benefits and costs for all plans as well as provider performance.

(7) In order to maintain enough committed physicians and other health care professionals, and to build on the number of family practice and primary care physicians, federal policy will be implemented to reduce interest rates on student loans to a lower percentage than the current rates and a percentage of a new physician's patients will be referred through the local affinity groups each year.

The work of our "Kitchen Cabinet" truly represents a broad cross-section of ideas, expertise, opinions and compromise. We offer it as one set of ideas from America's Heartland on the direction of our own health care.

I would very much appreciate your comments and consideration as the health debate ensues.

Sincerely,

Marcy Kaptur

MARCY KAPTUR
Member of Congress

MK:jbl

Enclosure

How will this work?

working but receiving the entirety of their health insurance through government subsidy will be encouraged to pay back a portion of their benefits through voluntary service in a local Community Services Corps.

(4) To streamline the unnecessarily complex insurance market, the federal government is asked to define the Basic Benefit Plan for all insureds in all Affinity Health Groups. The insurance market will be required to standardize optional supplemental insurance plans beyond the Basic Benefit Plan to include no more than nine. One standard claim form will be utilized and providers will be required to submit claims initially to the affinity groups rather than the patient.

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Sincerely,

Marcy Kaptur

MARCY KAPTUR
Member of Congress

MK:jbl

Enclosure

Congresswoman Marcy Kaptur
Ohio - Ninth District
June 1994 Working Draft

1A

AMERICAN HEALTH PLAN

Essential Features: A Medical Insurance Home for All

I. Health Insurance Coverage for each Citizen through Participation in any one of a broad range of Affinity Health Groups (AHG's) characterized by a common bond, chartered at the state level, but operating locally, with a federal tax number

   * Federal definition of a Basic Benefit Plan for All Insureds in all Affinity Groups

   * Shared Responsibility of Employer, Employee along with each citizen

   * Simplification of Paperwork

   * Portability

II. Market Standardization of Private and Public Insurance Marketplaces to include nine supplemental plan options beyond the Basic Plan

III. Quality Assurance

IV. Anti-Trust, Medical Malpractice and Tort Reform

V. Medical Education

AMERICAN HEALTH PLAN

SUMMARY

Assuring Health Coverage For All

I. PURPOSE AND BASIC ADMINISTRATIVE STRUCTURE --A Medical Insurance Home For All

Every American should be covered by affordable, high quality private health insurance. Publicly assisted insurance should be provided only as a last resort. In achieving this goal, reformers must focus on covering people, not medical incidences and building on the employer-based system already developed in our nation. In Ohio's Ninth District, most people are very satisfied with the quality of care received, and a majority are satisfied with the type of coverage they have. The main concerns of persons in our region are: 1) insuring against catastrophic costs of long-term custodial care; 2) covering pre-existing conditions; 3) choosing the doctor a person desires; 4) keeping costs affordable; 5) streamlining the paperwork involved in medical insurance; 6) addressing the costs of long term care; and 7) covering the unemployed, part-time workers, small business employees and the self-employed. By building on the system now in place and remedying the shortcomings, those who are satisfied will remain satisfied and those who are left out will be included.

The economic impact of the lack of insurance for over 37 million Americans at any given point in time, with 8 to 10 million

people chronically uninsured, cannot be ignored. In our area, a few hospitals absorb more than 40% of the care provided as uncompensated. Thus costs are shifted to privately insured individuals, with insurance companies passing those costs onto subscribers. Reform of the system will eliminate hospitals' uneven absorption of uncompensated care and will not allow cost shifting.

Both employers and employees will be expected to make contributions to pay for coverage. The system must be structured in a way that allows individuals to control their plan as part of a group, with employers and employees sharing costs (or the government where subsidy is necessary).

-- Affinity Groups

The formation of carefully administered "affinity groups" of insureds at the local level--as defined by the states--including incentives to allow those on Medicare, Medicaid, and other government subsidized plans to join such groups--will provide a "medical insurance" home for each person. Each person must be enrolled in such a group. These groups will assure careful management and greater accountability of both the insurer and insured, will engender personal and more holistic care for each patient, will curb cost-shifting, and will allow for greater cost-consciousness through careful attention to each individual in every affinity group. There will be no set number of such affinity groups at the local level, but some floor will have to be set by each state on the minimum enrollment level (probably 1000 persons). This

Employers choose to join? Or individuals?

requirement will guard against insolvency of smaller plans. Each citizen's enrollment, along with other minimal quality assurance information from each affinity group, will be reported to a National Health Board through the federal income tax system, with each affinity group being assigned a tax identification number. Through affinity groups, every citizen will be covered and assured continuity of care. Each person will be insured for all medically necessary conditions. Their insurance will be portable, continuous, and will provide coverage throughout the beneficiary's lifetime. Essential to high patient satisfaction is broad physician choice, to be negotiated through each affinity group.

Most affinity groups will be formed through employer health plans, but other alternative structures can be created locally through state law to achieve universal coverage. States and localities will have some discretion in defining the affinity group structure. Those citizens who fall into no other group will be able to obtain health benefits through the Federal Employee Health Benefit structure organized at the local level as an affinity group. Further, states will be given latitude to create other affinity groups to assure coverage of self employed persons, farmers, unemployed persons, veterans' health clinic users, public health or WIC site users, community health clinic users, Chamber of Commerce small business consortia, senior citizens center users, and hospital-based affinity groups serving low and moderate income insureds. Medicaid insureds and persons with no coverage will thus have several choices locally to assure competition between groups.

Medicaid as it currently exists will disappear.

Federal incentives also will allow, but not require, Medicare-eligible people to obtain supplemental insurance from an affinity group including through their former employer. If a Medicare eligible person joins such an affinity group, the National Health Board/HCFA will pay the group 95% of the cost of covering a retiree, while former employers will pay 5% of the normal Medicare cost. Former retirees will then have access to the common bond, benefits and freedom from paperwork which will be handled by the administrative services of that employer's affinity group. Further, the employer will retain insurance responsibility for their retirees. It is anticipated the typical affinity group will be able to deliver the Medicare portion for 90 cents on the Medicare dollar.

Insureds will use their AHG as their entryway into the health care delivery system. Through the locally organized AHG's, people will have a choice of primary care health care providers and physicians, and will be guided through the health care delivery system by that provider. The AHG will monitor each insured's medical history and continuum of care to guarantee a strong link between the individual and the health care delivery system. Careful management of each person in the AHG will ensure consistent, quality care in the most efficient manner. Keeping the AHG's at the local level maintains a sense of community and belonging whi encourage the members of the AHG to continue as health as possible.

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Federal override of state requirements in specified areas,

including licensing for nurses, advanced practice nurses, physicians, and physicians assistants will be allowed.

Existing employer-based plans will be encouraged to emulate "affinity groups," that is, groups of individuals with some common bond, or "medical insurance home," that resemble self-administered, self-insured plans where insureds are all covered, pre-existing conditions accepted, costs monitored, and attention to the insureds' welfare is the hallmark.

-- Controlling Rising Costs and Promoting Responsibility

Through careful administration of the plan by persons hired through the plan and the inclusion of some consumers from each AHG on the governing board, each AHG will promote localized responsibility to strengthen plan management, quality, and cost consciousness. Over a five year period, consumer representation will be graduated to a maximum representation by consumers of up to one-third of the AHG's boards, as provided by state and federal law.

Careful administration by affinity groups is essential to curbing private and public costs. There are several indicators that the current system has flaws that the affinity group structure can address. First, it is assumed in this legislation that it not cost caps but rather careful administration by affinity groups that know their insureds' medical histories, with proper confidentiality maintained, and encourage their proper use of benefits that are the essential elements in curbing costs.

The current system must also be reformed to encourage more

responsible personal behavior that contributes to healthy lifestyles. States will encourage affinity group insurance rates to credit responsible behavior, and discourage unhealthy behavior. Similarly, good usage of the system and attention to one's own health needs and those of the family are not generally rewarded. The current publicly subsidized insurance demonstrates that people left to fend for themselves in accessing the system do not always use it properly. For example, people using Medicaid may not correlate inappropriate usage of emergency rooms with higher costs. Similarly, those who must find their own private health insurance may not be able to obtain the plan best suited to their needs because of the complexity of the existing insurance market. It is not surprising that many individuals carry unnecessary, duplicative private health insurance coverage for services that drive up costs overall. Individuals need help in using this complicated system. States will be directed to community rate AHG's.

Second, affinity groups can help individuals more effectively access and assess the broad range of health care delivery options on a more regular basis. Many current health plans really do not know their individual insureds, that is, there is little or no case management. For example, Medicare and Medicaid provide an accepted insurance payment stream that treats medical incidences. This system, however, does not provide a "medical insurance home" for insureds. These systems do not help individuals negotiate the current system at the local level even in such simple matters as paying premiums and bills, or in coordinating prescription drug

purchases. They do not encourage a patient to use his/her plan wisely or to access preventive measures. They do not encourage "the system" to know the insureds personally. The practice of medicine is sometimes lost in the bureaucracy of reimbursement systems. Too often, the current system places medical decisions in the hands of billing clerks, resulting in medical care being directed by financial intermediaries rather than persons closest to the patient.

-- Ending Job Lock and Uncompensated Care

Finally, able-bodied persons who are not working but receiving the entirety of their health insurance through government subsidy will be encouraged to pay back a portion of their benefits through voluntary service in a local Community Services Corps working in public health, long term care facilities, and community outreach programs such as shelters, school kitchens, and school aftercare or day care centers. This concept also can be more fully developed in the upcoming "Welfare Reform" legislation or the expansion of the National Community Service program.

II. MARKET STANDARDIZATION OF PLANS AND STREAMLINING ADMINISTRATIVE COMPLEXITY

-- Simplify the Market

The federal government will establish standards for a Basic Benefit Plan for all insureds in affinity groups. The federal government, through a National Health Board, will require the public and private insurance market to jointly standardize nine

supplemental plans beyond the basic plan. Through these elective insurance options, for instance including vision, dental, interstate and foreign travel, long term care, and abortion as an exceptional reproductive option in publicly subsidized plans, health services beyond the basic plan will be available to all citizens. This approach also will help streamline current administrative insurance complexity to reduce administrative overhead leading to higher costs. In addition, the basic and supplemental plans will balance services among prevention, acute care, rehabilitation, and chronic disease management. At least two of the health insurance supplemental plans must begin to phase in an insurance system to manage long term care. Although skilled nursing long term care is covered as a basic benefit along Medicare guidelines, insurance to protect against the catastrophic costs of long term custodial care must be developed. Some of the plans will guarantee that the "Family and Medical Leave" health benefits are available as an option, thus replacing the current system wherein coverage is uneven and excludes most families.

The utilization of one standard claim form for all provider admissions which the provider submits to the insurer will be required. Further, all providers will be required to submit claims initially to the affinity group rather than the patient to reduce paperwork error as well as patient anxiety, and then to each patient for verification and final processing for sign-off.

QUALITY ASSURANCE

Quality assurance can be strengthened by requiring consumer information for each affinity group's performance. The federal government through the National Health Board will direct the states to issue this report which will include all providers, physicians, and insurers rated on performance record and rate disclosures, as well as comparisons of benefits and costs for all insurance plans on an annual basis on a standard form.

ANTI-TRUST, MEDICAL MALPRACTICE AND TORT REFORM

Anti-trust, medical malpractice and tort reform provisions will be incorporated in any federal legislation. Alternative Dispute Resolution (ADR) will be mandatory before a malpractice claim can be tried. If the case goes to trial, the results of the ADR must be used as evidence. Compensation will be allowed for actual economic damages, and a cap will be placed on pain and suffering awards. Punitive damages will go into a state health insurance fund to support the state's health insurance subsidy payments. Attorneys who accept frivolous lawsuits will be financially sanctioned, with the money going into this state health insurance fund. Anti-trust regulations will be relaxed to allow a broad range of providers to negotiate with affinity group plans.

MEDICAL EDUCATION

In order to maintain enough committed physicians and other

health care professionals, and to build on the number of family practice and primary care physicians, the medical education system must ease the financial burden on its students. Federal policy will be implemented to reduce interest rates on student loans to a lower percentage than the current rates. A percentage of a new physicians' patients will be referred through the local affinity groups each year, thereby allowing the physician to gradually reduce accumulated debt financed through government assistance.

COMPLETE TEXT

SECTION ONE

ADMINISTRATIVE STRUCTURE

The heart of the system will be "Affinity Health Groups" set up at the local and regional levels, as defined by each state, with some federal guidance in order to maintain uniformity. (Refer below to federal government's role.) In order to capitalize on marketplace innovation, flexibility will be accorded the Affinity Health Groups in terms of how they organize and choose and pay participating providers. Functions of the Affinity Health Groups (AHG) will be as follows:

Marketing: Plans will have distribution systems (direct sales or agents/brokers) to sell products to employers, labor organizations, and other affinity groups.

Risk Assumption: The AHG's will accept full financial risk for the premium payments received. The AHG's, in turn, will share that risk through their relationships with providers. Premiums will be community rated with some effort within each group dedicated to credit healthy lifestyles, in order to ensure an equitable distribution of resources. Contracts will prohibit balanced billing.

Health Care Delivery System: The AHG will be responsible for organizing a full range of provider services for members. An

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or care of any medical conditions. The health care p
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sychologists, and advanced practice nurses.

Why are providers so limited?

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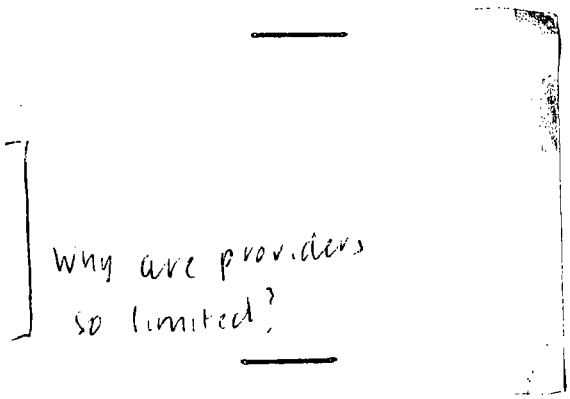
Why are providers
so limited?

individual's primary physician will be responsible for coordinating health services needed by the individual. A primary physician is defined as the first health care provider of choice an insured sees for care of any medical conditions. The health care provider is appropriately licensed and includes internists, general and family practitioners, pediatricians, geriatricians, psychiatrists, clinical psychologists, and advanced practice nurses.

Payment By Plan To Providers: The AHG's will have available the full range of methodologies to pay providers, from full capitation to fee for service, to be determined by the AHG. AHG's would thus compete on the basis of price, service, and provider panels. The competition of the marketplace will contribute toward cost containment.

AHG's may be organized as for profit or not for profit. Employers may form their own AHG's to self-insure, and will retain ERISA preemption for five years, that is, exemption from state regulations. The National Health Board, in conjunction with the States, will have authority to decide whether AHG's will continue to retain ERISA preemption thereafter. Each AHG shall have a governing board to be prescribed by the states. The states will encourage over five years the inclusion of up to one-third of the members of the AHG's governance bodies be elected by its subscribers.

Consumers can select annually from among AHG's. In order to ensure every individual or family is insured through an affinity group, all AHG's will be assigned a number for income tax purposes (like school districts are now). Every individual--regardless of

income--will be required to file an income tax return, and must indicate the AHG in which they are enrolled on the tax form. Individuals and families whose religious or personal views dictate minimal or no health intervention may exempt themselves from the system, but in the event health care bills are incurred, must pay the expense out of pocket or work to reduce the debt through community service.

People who maybe locked into a job because they will otherwise lose their insurance will now be able to seek alternative employment and receive coverage, regardless of pre-existing condition from the first day of employment with the new employer. However, the employer through the AHG and as regulated by the states, may phase in depth of coverage of the Basic Plan and percent of contribution over a period of time. This bill defines 90 days as the target date for full coverage under the Basic Plan of that new employee.

Payment for Insureds Needing Subsidy.

Payment for insureds who require federal assistance will be on a sliding scale fee up to 250% of the poverty level, with the federal government paying the difference. The budgets of current federal health insurance programs, such as Medicaid, would be consolidated and used as the basis for these subsidies. State governments would contribute their current Medicaid match into the federal pool. If inequity exists between states on the current state reimbursement formula, the National Health Board will recommend changes to restore equity to state contributions within five years. If additional funds are needed to subsidize necessary

insureds, each affinity group could be taxed up to a level proposed by the National Health Board, in order to attain necessary subsidy dollars. In addition, employer contributions of greater than 80% will be considered an available source of revenue for subsidy purposes. Those insureds who are able-bodied and subsidized but not working will be required to contribute community service in partial payment for the services rendered. The framework of this community service network will be defined by the state, but could function as an adjunct to the public health system, the National Community Service structure, or be organized in conjunction with welfare reform. Because every insured will be required to file an income tax return, the IRS will verify income for insureds on behalf of the states.

It is the intention of this proposal that health care will be separated from welfare. Health insurance payments to subsidized individuals will take the form of Earned Income Health Tax Credits refunded on an annual basis. The section of the 1986 income tax revisions which removed millions of low income individuals and senior citizens from the federal income tax rolls will be revoked. Thus, every individual/family will be required to complete an income tax statement which lists the AHG to which the individual belongs. A minimum 50% contribution toward health insurance premiums of all full time employees (defined as 1500 hours per year) will be required from all employers, with the federal government subsidizing on a graduated basis those employers with less than 25 employees who both meet the criteria for a federal small business loan and pass

the discrimination test for 401(k) plan contributions. Subchapter S corporations will be exempt from subsidy. Again, employer contributions of greater than 80% will be considered taxable income and the revenues derived from this source will be directed toward paying the insurance costs of low income or other uninsured citizens.

Federal Government's Role:

* create a National Health Board for federal oversight, financial involvement, and reporting purposes
* set a minimum benefit package and require market standardization of supplemental plans
* set a minimum contribution for subscribers and employers
* set the sliding scale fee for subsidized subscribers and fund the subsidies
* require community rating by standard metropolitan statistical areas

State's Role:

* All AHG's will be regulated by the State Department of Insurance regarding financial solvency. All AHG's will be required to report to the State Department of Insurance a federally standardized "report card" showing quality, utilization, outcomes, salaries of office-holders, and profit margins. The State Department of Insurance will ensure that all AHG's follow community rating, guarantee renewals, and cover all pre-existing conditions of each insured.
* The State Health Department will be responsible for oversight of

medical quality assurance, utilization, and outcomes. The federal government will assemble this information from all states under a standard format to be developed by the National Health Board through HCFA.

Underpinning the system of health care is a strengthened role for public health. The primary focus on public health will be through its infrastructure of public health nurses, sanitarians, health educators, and special focus programs as a method of finding people who fall through the cracks and enroll them in affinity groups. AHG's will be authorized to contract with the public health system and other public health providers such as the Visiting Nurse Service to provide these services to its members. The public health system holds enormous unmet potential as a focal point for consumer education to promote prevention and healthy living. The federal government should strengthen the public health system, including some additional resources, to perform these functions.

SECTION TWO

STANDARDIZATION OF PLANS AND STREAMLINING OF ADMINISTRATIVE COMPLEXITY

-- Claim Forms

A standard claim form, based on the White House's Medical Claim Form Prototype, will be developed by the National Health Board in conjunction with HCFA. This form will be used for all medical intervention. With regard to durable medical equipment (DME), a three-part prescription pad will be developed which will allow the physician to use the same form for submission of DME prescriptions to all insurance carriers. One copy of the prescription remains in the patient's chart, and two copies go to the provider of the DME. One copy is subsequently forwarded to the payor.

-- Credentialing

Regional credentialing offices--with federal oversight through the National Health Board/HCFA--will be set up to provide uniformity of the physician credentialing process. All health care entities will pay a fee to the regional credentialing office to obtain all necessary information on a physician. This eliminates the tremendous duplication of effort by hospitals, insurance companies, HMO's, and all other health care facilities which must credential their physicians.

-- Other Federal Health Programs

The VA system, CHAMPUS/CHAMPVA, and Medicare will remain, with individuals utilizing those systems being afforded the opportunity to join affinity groups or organize into affinity groups. Individuals always will retain the option of selecting from a number of affinity groups, but will only be able to be enrolled in one at a time.

-- Basic and Supplemental Plans

The federal government will establish standards for a Basic Benefit Plan for all insureds in affinity groups. The federal government, through a National Health Board, will require the public and private insurance market to jointly standardize nine supplemental plans beyond the Basic Plan.

BASIC BENEFIT PACKAGE

With an annual individual/family deductible of $200/$400 and an annual individual/family maximum out-of-pocket expense of $1000/$2000, the following services will be covered in a Tier 1 Basic Benefit Plan:

BASIC BENEFIT PLAN - Tier I

* prenatal, neonatal, and well baby care covered at 100%
* preventive care, including injections/immunizations, office visits, and annual physicals, covered at 100%
* prescription drugs and biologicals
* outpatient diagnostic, laboratory and x-ray services, with pre-certification for high cost tests
* mental health coverage would not be based on a diagnostic code,

ıt rather 100% coverage to include 45 days inpatient; thirty
essions per year of individual and group therapy will be covered,
ıth a $20.00 copay per session.
long-term case management for severe mental illness
inpatient care including semi-private room & board, ICU & CCU,
readmission testing, physician visits, surgeon and technical
ırgical assistants, anesthesia, nursing, ancillary services, and
ternity
inpatient and outpatient surgical benefits
emergency services defined as life threatening
lemodialysis
:hemotherapy and radiation
:killed nursing and home care based on Medicare guidelines;
urable medical equipment and prosthetics;
ospice coverage following Medicare established guidel

Specified in legislation?

Cost?

<u>ANCED BASIC BENEFIT - Tier 2</u>

The National Health Board will evaluate the feasibi
:ing in the following benefits to the Basic Benefit P
s after the adoption of this legislation. Means tes
ired to ascertain which insureds require government subsidy to
the costs of their insurance premium:
ecialty care (physical/occupational/speech therapy, podiatry,
covered only when services can reasonably be expected to
re significant improvement or prevent significant
ioration;
roductive services covered at 80% (in publicly assisted
its abortion would not be covered in the basic plan but would

Specified in legislation?

Cost?

but rather 100% coverage to include 45 days inpatient; thirty sessions per year of individual and group therapy will be covered, with a $20.00 copay per session.

* long-term case management for severe mental illness

* inpatient care including semi-private room & board, ICU & CCU, preadmission testing, physician visits, surgeon and technical surgical assistants, anesthesia, nursing, ancillary services, and maternity

* inpatient and outpatient surgical benefits

* emergency services defined as life threatening

* Hemodialysis

* chemotherapy and radiation

* skilled nursing and home care based on Medicare guidelines;

* durable medical equipment and prosthetics;

* hospice coverage following Medicare established guidelines;

<u>ENHANCED BASIC BENEFIT - Tier 2</u>

The National Health Board will evaluate the feasibility of phasing in the following benefits to the Basic Benefit Plan within 3 years after the adoption of this legislation. Means testing will be required to ascertain which insureds require government subsidy to meet the costs of their insurance premium:

* specialty care (physical/occupational/speech therapy, podiatry, etc) covered only when services can reasonably be expected to restore significant improvement or prevent significant deterioration;

* reproductive services covered at 80% (in publicly assisted benefits abortion would not be covered in the basic plan but would

be available as an elective option);

* behavioral management techniques;

* two admissions per two years for substance abuse treatment;

* medically necessary plastic and reconstructive surgery.

For both Tier 1 and Tier 2 benefits, except where specified with different payments, coverage will be at 80% up to the maximum out-of-pocket. After the maximum has been met, coverage will be at 100%. Maximum lifetime limits imposed by insurance companies will not be allowed, thus eliminating financial devastation because of a catastrophic illness.

Consumers can purchase supplemental plans which provide coverage in addition to the Basic Plan and the Enhanced Basic Plan. The supplemental plans will be limited to nine, as described below (see attached) with graduated premiums.

STANDARD PLAN OPTIONS

A	B	C	D	E	F	G	H	I	J
BASIC BENEFITS TIER I	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS
BASIC BENEFITS TIER II	DENTAL (ORTHODON-TIA)			DENTAL (ORTHODON-TIA)	DENTAL (ORTHODON-TIA)	DENTAL (ORTHODON-TIA)	DENTAL (ORTHODON-TIA)	DENTAL (ORTHODON-TIA)	DENTAL (ORTHODON-TIA)
		VISION		VISION	VISION	VISION	VISION	VISION	VISION
			ABORTION SERVICES		ABORTION SERVICES	ABORTION SERVICES			ABORTION SERVICES
				HEARING	HEARING	HEARING	HEARING	HEARING	HEARING
						FAMILY & MEDICAL LEAVE	FAMILY & MEDICAL LEAVE	FAMILY & MEDICAL LEAVE	FAMILY & MEDICAL LEAVE
							FOREIGN& INTERSTATE TRAVEL	FOREIGN& INTERSTATE TRAVEL	FOREIGN& INTERSTATE TRAVEL
								CHIRO-PRACTIC	CHIRO-PRACTIC
				LONGTERM CARE				LONGTERM CARE	LONGTERM CARE

SECTION THREE

QUALITY ASSURANCE

The primary objective of quality assurance is to provide consumers with information--in understandable language (use Flesch Test)--in order that they may make quality health care decisions which are cost effective and accountable. This objective will be achieved by requiring the following:

Credentialing:

Develop a provider "report card" which includes:

* outcome-based indicators which include mortality statistics, infection rate, readmission rate, and complications;
* satisfaction indicators which include waiting time standards, length of time for appointments, time spent with patient, communication skills, satisfaction with service and treatment, office location, office policies, and office staff;
* financial indicators which include costs for office visits, treatment, missed appointments, and prescriptions.

Tracking will link medical appropriateness with financial appropriateness. Credentialing criteria will be based on the providers' national and regional recognized standards, delineating differences between populations and urban v. rural areas. Physicians will be measured by following clinical pathways of care, as defined by Milliman and Robertson Health Care Management Guidelines. Medical necessity guidelines will follow those established by the Value Health Sciences Medical Review System. The criteria will be developed into an overall quality index which will

be consistently measured. AHG's will provide all credentialing information to subscribers. Federal and State governments will also assemble this information and make available annually.

Preventive Health Services:

Preventive health services will be developed for all age groups following the recommendations of both the "Guide to Clinical Preventive Services: Report of the U.S. Preventive Services Task Force" and the various medical associations. Both make recommendations on preventive care based on age groups.

Patient Education:

Information on the following will be provided (in language such as the Flesch Test) through each AHG:

* preventive health care;
* specific diseases;
* medications;
* treatment;
* living wills, advanced directives, and Durable Powers of Attorney;
* health risks, patient responsibilities, and non-compliance linkage of financial costs to patients;
* monitoring of patient education and outcomes, following the goals of Healthy People 2000.

SECTION FOUR

TI-TRUST, MEDICAL MALPRACTICE AND TORT REFORM

States will be encouraged to adopt reform of medical lpractice laws and torts by linking federal health subsidies to mpliance. Reform should achieve the following goals:

the formation of Alternative Dispute Resolution councils before ich the parties must appear before taking a case to trial;

the prohibition of collection from more than one entity in a wsuit (e.g. collecting from the hospital, all physicians, all rses, and all staff);

capitation of economic damages will be determined by the state;

a cap on "pain and suffering" of $250,000.00;

any punitive damages awarded will be directed to state health care lgets rather than the plaintiff;

inancial penalty--determined by the state and directed to state lth care budgets--for attorneys who accept frivolous suits;

ees awarded to attorneys will not exceed 20% of $1 million rds, 10% of $2 million awards, and 5% of awards of $3 million or e.

Anti-trust laws will be relaxed to allow physicians iders to consult with one another regarding fees for will allow them to be competitive among AHG's.

What changes?

What changes?

SECTION FOUR

ANTI-TRUST, MEDICAL MALPRACTICE AND TORT REFORM

States will be encouraged to adopt reform of medical malpractice laws and torts by linking federal health subsidies to compliance. Reform should achieve the following goals:

* the formation of Alternative Dispute Resolution councils before which the parties must appear before taking a case to trial;
* the prohibition of collection from more than one entity in a lawsuit (e.g. collecting from the hospital, all physicians, all nurses, and all staff);
* capitation of economic damages will be determined by the state;
* a cap on "pain and suffering" of $250,000.00;
* any punitive damages awarded will be directed to state health care budgets rather than the plaintiff;
* financial penalty--determined by the state and directed to state health care budgets--for attorneys who accept frivolous suits;
* fees awarded to attorneys will not exceed 20% of $1 million awards, 10% of $2 million awards, and 5% of awards of $3 million or more.

Anti-trust laws will be relaxed to allow physicians and other providers to consult with one another regarding fees for services. This will allow them to be competitive among AHG's.

SECTION FIVE

MEDICAL EDUCATION

In order to assist physicians, nurses, and allied health professionals in reducing the debt incurred as a part of their education, and to provide care in necessary and often underserved areas, the
following methods of debt reduction will be allowed:

* referrals to affinity groups to help offset the cost of federally subsidized patients;
* service in public health or community clinics, secondary or post secondary institutions' health clinics, Native American reservations, and migrant centers;
* practice through interdisciplinary health care teams involving a network of professionals;
* lower interest loans, with stronger enforcement for repayment;
* paying back a smaller rate at the beginning of one's practice;
* erasure of 25% of one's debt for those who enter into underfilled medical disciplines.

A lottery selection for specialty training programs will maintain equal opportunity for all applicants. Selection into advanced training will be based only on ability and merit.

All providers will be required to keep current with medical advances by completing Continued Medical Education (CME) credits--the amount of which will be determined by the states' boards--in order to maintain licensure. Although licensure will be maintained at the state level, the federal government would mandate quality of practice, to include a national network for removal of licensure.

The regulatory bodies overseeing licensure will be made up of an interdisciplinary team. Thus, no one health discipline has control.

THE WHITE HOUSE

May 24, 1994

The Honorable Marcy Kaptur
U.S. House of Representatives
Washington, D.C. 20515

Dear Congresswoman Kaptur:

Thank you for your letter. The information and thoughtful comments from you and your constituents reflect a depth of knowledge and experience that are essential to our debate on national health reform. I have enclosed responses to the list of questions. If you would like additional information on any of these questions, please feel free to contact Jennifer Klein on my staff at 456-2599.

I look forward to our continuing dialogue on these and other issues in the coming weeks.

Sincerely yours,

Hillary Rodham Clinton

Enclosures

1. The Clinton plan will make it easier for small groups like the Toledo Firefighters to purchase insurance at competitive rates. Currently, small businesses pay as much as 35 percent more for the same health insurance as large employers. The Clinton plan will improve bargaining power and reduce administrative burdens by allowing small businesses to purchase health insurance in groups.

The President's plan builds on the ideas behind plans like the Toledo Firefighters Health Plan. For example, the Clinton plan, like the Firefighters Plan, gives individuals and families "a personal stake" by giving them a choice of health plans as well as the information they need to choose wisely. Health plans compete for consumers by providing high quality and affordable health care. In addition, both the Clinton proposal and the Firefighters Plan emphasize the importance of prevention and early detection of disease in improving health and saving health care dollars.

2. Generally, under the President's plan, employers are required to contribute 80 percent of the weighted average premium in an area for their employees. If an employee works part-time -- less than 120 hours per month -- the employer will pay a prorated portion of the required contribution. Employers are not required to make contributions for individuals who work less than 40 hours per month or for employees who are covered as a dependent child under a parent's policy. There is no 3.4% tax in the Clinton plan.

In addition, discounts are available to small businesses to limit the employer share of the premium payment to between 3.5 and 7.9 percent of payroll, depending on average wage and size of firm. To accommodate employers that hire large numbers of seasonal or part-time workers, the determination of employer size is based not on the total number of workers, but on the average full-time equivalent employees for a year.

3. There is no requirement in the President's proposal that savings to employers from national health reform be invested within the United States. However, as employers spend less on health care, they will have more to spend on workers' salaries and business development.

4. The President's proposal requires an initial maintenance of effort on state Medicaid payments. State Medicaid funds will continue to be used only for the citizens of that state. States that now have a high effort for AFDC and SSI payments will continue to receive a higher federal match. A commission is established to equalize state Medicaid spending in the future.

5. The President's proposal takes federal action to reduce frivolous lawsuits while protecting patients' rights. The plan establishes an alternative dispute resolution process to resolve malpractice claims in a fair, efficient, timely and affordable way. An individual may bring a case to court only after participating in the process. In addition, before filing a lawsuit, a lawyer must obtain a "certificate of merit" certifying that there is reasonable cause for filing an action.

The Clinton plan also limits attorney contingency fees to one-third of an award and allows states to impose even lower caps. In addition, damage awards must be reduced by the amount of any collateral source of compensation -- such as health or other insurance -- for the same injury, thereby preventing claimants from recovering more than once. The plan also permits damage awards to be paid by a defendant over a period of time.

Finally, the President's plan includes pilot projects. One program releases defendants from malpractice liability if it is demonstrated that they followed appropriate clinical practice guidelines. Another pilot program substitutes liability of the health plan in which a physician practices for the liability of the individual in malpractice cases.

6. Today, insurers tell doctors what services they can provide and how much they will be paid. They second guess medical decisions by using a "black box" of utilization review protocols. These procedures are particularly disturbing given the decreasing choice faced by many individuals today. As employers try to control their health care costs, they increasingly limit their employees choice of plans. Those plans chosen by employers then have tremendous leverage over hospitals and physicians.

Under the President's proposal, consumers -- rather than employers -- choose their health plans. Information will be made available about consumer satisfaction and health outcomes in health plans, enabling consumers to evaluate health plans effectively. This information will include any utilization review protocols used by the health plan. With increased consumer choice, plans will leave to doctors and patients intimate decisions about what is medically necessary or appropriate in a particular situation.

At least one fee-for-service plan must be offered to all Americans. In fee-for-service plans, patients may see any doctor they choose. If an individual joins a health maintenance organization, the plan may require the patient to see a primary care "gatekeeper" before visiting a specialist. However, all health plans must offer a point-of-service option to allow enrollees to see any doctor they choose.

The Clinton plan will not eliminate the need to obtain licensure on a state-by-state basis. It does, however, encourage the appropriate use of professionals, such as advanced practice nurses. The proposed legislation overrides restrictive state practice acts and includes programs to promote the full utilization of the professional education and clinical skills of advanced practice nurses and other health professionals.

7. Medicare will be preserved and enhanced under the President's proposal for health care reform. Today, many seniors are forced to choose between medication and food. The Clinton plan adds a prescription drug benefit to Medicare, and a new long-term care program will expand options for home and community-based care for many elderly Americans. Medicare beneficiaries may continue to purchase supplemental insurance, as they do today.

The President's plan does not cut Medicare. Instead, as it implements cost containment measures in the private sector, it slows Medicare spending from triple the inflation rate to double the inflation rate. In addition, while all of the current health care proposals limit the growth of Medicare, only the President's plan uses the savings to add new benefits for senior citizens.

Under the plan, assignment is mandatory, so that providers must accept Medicare as payment in full. No provider is required to participate in the Medicare program; however, since Medicare patients represent one-third of the health care market, significant incentives remain for providers to participate.

8. See attached description of mental illness and substance abuse benefits.

9. The President's proposal provides coverage for prescription drugs to all Americans at reasonable prices. Today, over 25 percent of all Americans have no coverage for outpatient prescription drugs, including about one-half of the elderly. Over 55 percent of outpatient prescription drug costs are paid out-of-pocket by patients, and over 64 percent are paid out-of pocket by individuals age 65 and older.

In alliance health plans, an overall $1,500 limit applies to all out-of-pocket health costs. Cost sharing for prescription drugs is $5.00 per prescription in lower cost sharing plans and 20 percent coinsurance after a $250 deductible in higher cost sharing plans. Medicare beneficiaries pay 20 percent coinsurance after a $250 deductible, and a $1,000 out-of-pocket limit applies to coverage for prescription drugs.

Manufacturers pay a basic rebate to Medicare for each drug based on the difference between the average manufacturer retail price (AMRP) and the weighted average manufacturer non-retail

price or 17 percent of the AMRP, whichever is greater. For breakthrough drugs without therapeutic alternatives (and therefore no market competition), an Advisory Council on Breakthrough Drugs will advise the Secretary of Health and Human Services if it finds the market price of a drug unreasonable. The findings of the Advisory Council will be available to the public. The Secretary can negotiate rebates for the Medicare program for breakthrough drugs found to be priced unreasonably high. If a Medicare rebate cannot be negotiated, the Secretary may take action ranging from prior approval restrictions for the Medicare program to prohibiting reimbursement for the particular drug.

Businesses like Pharmacy Card Inc. that currently operate in many states will continue as they do today. There is no requirement that they be "approved" by the regional alliance. The Clinton plan has been endorsed by the National Association of Retail Druggists and the National Association of Chain Drug Stores.

10. Taft-Hartley plans that meet broad criteria are not required to join regional alliances under the President's proposal. For example, under the President's plan, any Taft-Hartley plan that is maintained by one or more affiliates of labor organizations covering more than 5,000 employees may form a corporate alliance.

Under the President's proposal, consumers choose among health plans offering lower, higher, or combination cost sharing. In plans offering lower cost sharing, copayments for most services are $10. In plans offering higher cost sharing, coinsurance is generally 20 percent. Combination cost sharing plans offer lower cost sharing within the plan's network of providers and higher cost sharing for services delivered outside of the network. In all plans, there is no cost for preventive services provided according to an established periodicity schedule.

Under the Clinton plan, "benefits of 'better plans' above the national average" would not be taxed, as you suggest in your letter. Other proposals being considered by Congress would subject all employers to a tax on health benefits above the lowest-cost plan in an area. Under the Clinton plan, beginning in 2004, benefits beyond the comprehensive benefit package would be counted as income to employees, but would remain tax deductible to employers.

11. Under the Clinton plan, health plans compete for consumers by providing high quality health care at an affordable price. Managed care plans will have every incentive to utilize advanced practice nurses, as well as other health care

professionals, to provide the full range of services in the comprehensive benefit package.

12. One of the President's primary goals is to simplify the morass of paperwork and procedures described by Helen Gatzke. Too much of our health professionals' time and our health care dollars are spent on administration rather than patient care. By guaranteeing all individuals private health insurance coverage, coordinating care through the health plan selected by the individual, and standardizing billing and other procedures, health care providers will be freed to provide high quality care to all individuals.

MENTAL ILLNESS AND SUBSTANCE ABUSE

Problems in the Current Market

Today's insurance market creates barriers to treatment for mental illness through lifetime day or dollar limits and through preexisting condition exclusions.

- 84% of health plans in the current market report day or dollar limits on psychiatric inpatient care (Hay/Huggins 1993).
- Of those reporting day limits, 61% allow 30 or fewer days (Hay/Huggins 1993).
- 95% of medium and large firms report visit or dollar limits on outpatient treatment for mental illness (Bureau of Labor Statistics (BLS) 1991).
- 48% provided 30 or fewer outpatient visits (BLS 1991).

Current coverage for substance abuse treatment is even more limited.

- Many people have no insurance coverage for substance abuse treatment. 21% of people receiving health insurance through large and medium-sized firms have no insurance coverage for substance abuse inpatient rehabilitation or outpatient care (BLS 1991).
- Those who do have coverage face severe restrictions. 10% of participants in the BLS survey reported lifetime day limits, 14% reported limits on the number of treatments, and 22% reported lifetime dollar limits.

Comprehensive Coverage Through the Health Security Act: The Mental Illness and Substance Abuse Benefit

The Health Security Act covers a broad range of treatment options and eliminates preexisting condition exclusions and lifetime limits that today restrict access of individuals with mental or substance abuse disorders to needed services.

The mental illness and substance abuse benefit in the Health Security Act includes inpatient and residential treatment, intensive nonresidential treatment, and outpatient services, including screening and assessment, diagnosis, medical management, psychotherapy, crisis services, collateral services and case management. Significantly, medical management (even for the severely ill), diagnosis, screening and assessment, and crisis services are not subject to annual day and visit limits.

By January 1, 2001, the Health Security Act replaces current insurance market strategies of annual day limits on inpatient, residential and intensive nonresidential treatment, psychotherapy and substance abuse counseling and relapse prevention with a managed benefit. In addition, higher copayments and coinsurance for psychotherapy, collateral services and some intensive nonresidential treatment days are reduced, and limitations on applying certain expenses to the annual out-of-pocket maximum on cost sharing are eliminated.

Until January 1, 2001, the Act emphasizes a wide range of innovative treatment options, such as case management, partial hospitalization, day treatment programs, and home-based and behavioral aide services -- including services that are important to the treatment of seriously emotionally disturbed children. Providing coverage for this array of treatment options represents a new direction for the delivery of mental illness and substance abuse services and creates incentives for the development of needed capacity.

Health plans are encouraged to utilize the wide array of treatment options to provide individuals with a continuum of care -- that is both appropriate for an individual's needs and cost effective -- through substitution of inpatient and residential days for treatment in other settings. Thirty days of inpatient and residential treatment may be reduced by one day for every two days of intensive nonresidential treatment or by one day for every four outpatient visits for psychotherapy or substance abuse counseling and relapse prevention.

Beyond the services covered through substitution, additional treatments are covered to provide ongoing and appropriate support. A maximum of thirty additional inpatient days are covered for particularly vulnerable individuals. A maximum of 60 additional days of intensive nonresidential treatment are available. Again without substitution, thirty visits of psychotherapy and collateral services are covered for an individual, and 30 visits in group therapy are covered for substance abuse counseling and relapse prevention for individuals who have received other treatment within 12 months.

Through universal coverage, larger numbers of individuals with severe disorders will obtain access to services. While there is promising experience in the private sector with a flexible managed mental health and substance abuse benefit, there is less experience and data on the use of this approach for individuals with severe mental illness or chronic drug and alcohol addiction. Given this uncertainty and consistent with our conservative approach in all of our estimates, we have included protections like a one-day deductible in order to remain conservative in estimating the cost of the benefit. Within this framework, we have developed a benefit structure that encourages flexibility and management so that by January 1, 2001 the benefit no longer needs to rely on specific day and visit limits.

Initiatives for Improving Access to Mental Illness and Substance Abuse Services

In addition to the mental illness and substance abuse benefit, the Health Security Act includes initiatives for improving access to mental illness and substance abuse services.

The Act provides funding for services to remove barriers to treatment for mental illness and substance abuse, including community and patient outreach, transportation and translation services.

The Health Security Act requires states to submit a plan by October 1, 1998 to demonstrate how they will integrate state and local mental illness and substance abuse services with the mental illness and substance abuse services included in the comprehensive benefit package.

The Secretary of Health and Human Services is authorized to make grants for the development of school health service sites. Criteria for grant awards include the provision of health and social services, counseling services, and necessary referrals, including referrals regarding mental illness and substance abuse. Other school-based programs focus on educating school children about substance abuse, including tobacco and alcohol use.