CHILDREN AND HEALTH CARE:
The Problem Today

MILLIONS OF CHILDREN HAVE NO INSURANCE; MILLIONS MORE INSECURE:

- 9 million children and half a million pregnant women have no health insurance. [Census Bureau, CPS, 3/93]
- One out of every ten children under age six are uninsured, perhaps the most critical years of a child's development. [Census Bureau, CPS, 3/93]
- One in five American children had no contact with a doctor in 1992.
- 17 million children are uninsured for part or all of the year. [Bureau of the Census, 1990-1992 SIPP for CDF]
- Many thousands of children are locked out of the health insurance system because of pre-existing condition exclusions

MAJORITY OF UNINSURED CHILDREN IN MIDDLE CLASS FAMILIES

- 58% of uninsured children were dependents of full-time, full year workers. [Subcommittee on Children, 11/16/93]
- Approximately 30% of adolescents without insurance live in middle class families with incomes above 200% of poverty. [Subcommittee on Children, 11/16/93]

BY 2000, ONLY 50% OF CHILDREN WILL HAVE EMPLOYER-BASED COVERAGE:

- If current trends continue, only about half of the nation's children will be covered by employer-provided health insurance by the year 2000. *"For two decades, employer cost-cutting and the rising cost of health insurance have forced millions of children out of the private health insurance system."* [Children Defense Fund, 3/3/94]
- The percentage of children who were covered by employers fell from 64.1 percent in 1987 to 59.6 percent in 1992. Had the coverage percentage stayed at 1987 rates, more than 3 million additional children would have had employer-based insurance in 1992. [Children Defense Fund, 3/3/94]

MILLIONS MORE CHILDREN HAVE INADEQUATE COVERAGE TODAY:

- Millions have private insurance that fails to cover preventive services as well as special treatment needed by children with physical and emotional disabilities.
- Only about a third of health insurance policies in medium and large firms -- typically the most comprehensive plans -- covered well-baby care. [BLS, Employee Benefits Survey, 5/93]
- Only 42% of children with health insurance are covered for routine immunizations. [Subcommittee on Children, 11/16/93]

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The Mitchell Bill Provides Affordable Coverage to All America's Children

The Mitchell bill provides affordable coverage for all kids by 1997.

- Children under 19 and pregnant women will be eligible for premium subsidies. Children and pregnant women living in families with incomes below 185 percent of poverty will receive full subsidies. This will cover 6.2 million kids.

- Children and pregnant women with incomes between 185 and 300 percent of poverty will receive subsidies on a sliding scale. This will cover an additional 1.3 million kids.

So that means that a total 7.5 million children will get coverage through premium subsidies.

- In addition, unfair insurance practices that today exclude children in middle-income families from insurance will be eliminated.

By 1997, therefore, the Mitchell bill will provide affordable coverage for the 9 million American children who today have no health insurance. By contrast, under the new Dole bill, fewer than 750,000 children will gain coverage, less than one tenth the number of kids Senator Mitchell's bill covers.

The Mitchell bill provides comprehensive preventive care for kids.

- The benefits package in the Mitchell bill includes important preventive services for children. Immunizations, well-child visits and screenings will be covered at no cost.

The Mitchell bill preserves additional benefits for children with special needs.

- Children who currently qualify for Medicaid will continue to receive the additional services now covered under the Medicaid program. This will ensure, for example, that children with special needs get the additional rehabilitation services that are critical to their development.

The Mitchell bill supports essential nutrition programs .

- The Mitchell bill provides full funding for the WIC Program so that all low-income pregnant woman and children who are currently eligible for the program can be served.

MENTAL ILLNESS AND SUBSTANCE ABUSE:
The Problem Today

MILLIONS OF AMERICANS HAVE MENTAL OR SUBSTANCE ABUSE DISORDERS

- About 52 million Americans have been diagnosed with a mental or substance abuse disorder. (Washington Post, 11/2/93)

- It is estimated that the total cost of these illnesses is over $273 billion -- including direct care, lost productivity, social welfare and the criminal justice system. (Rice, D.P., et al., Economic Costs of Alcohol and Drug Abuse and Mental Illness 1985, 1990).

MANY ARE UNABLE TO GET TREATMENT TODAY

- While the prevalence of mental health and substance abuse disorders is about the same as other diseases, fewer people with mental and substance abuse disorders get treatment. Only about 11% of the population get treatment for mental and addictive disorders, with about 6% using specialty mental illness and substance abuse services. (National Institutes of Mental Health, 1992).

- Many are unable to seek treatment because of discrimination in the health insurance marketplace -- they are denied coverage because of pre-existing condition exclusions, annual day or visit limits, or lifetime limits.

    - 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 inpatient days. (Hay/Huggins 1993).

    - 95% of medium and large firms report visit or dollar limits on outpatient treatments for mental illness. (Bureau of Labor Statistics (BLS), 1991). 48% provide 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 Bureau of Labor Statistics study reported lifetime day limits, 14% reported limits on the number of treatments, and 22% reported lifetime dollar limits.

THE MITCHELL BILL ENDS DISCRIMINATION AGAINST MENTAL ILLNESS AND SUBSTANCE ABUSE TREATMENT

Eliminates insurance company discrimination.

- The Mitchell bill eliminates lifetime limits and phases out pre-existing condition exclusions that today restrict people's access to needed mental illness and substance abuse services.

- In contrast, the Dole bill leaves insurance companies in charge by, for example, limiting, but not eliminating pre-existing condition exclusions and by allowing insurance companies to decide what benefits to cover.

Requires that mental illness and substance abuse services be treated the same as other services in the benefit package.

- No longer will mental illness and substance abuse services be subject to strict day and visit limits and higher cost sharing. Instead, the National Benefits Board must design the benefits package so that there is "parity" for mental illness and substance abuse services. That means that no day or visit limits or cost sharing requirements may be applied that do not apply to other services. And that means that people can no longer be denied treatment because of arbitrary limits or prevented from getting treatment because they cannot afford it.

- Yet the Mitchell bill strikes a delicate balance. Before January 1, 2001, the National Health Benefits Board may place limits or higher cost sharing on certain mental illness and substance abuse services if the restrictions on other benefits that are needed to reach parity are too burdensome. This serves as a backstop -- people can be assured that costs will be kept under control and that other benefits will not be cut as the uninsured begin to access mental illness and substance abuse services.

- In contrast, the Dole bill allows insurance companies to offer any benefits package they want -- leaving insurance companies free to continue to deny or limit coverage of certain illnesses like mental and substance abuse disorders.

QUALITY IMPROVEMENT

America's health care system delivers the highest-quality care in the world. But, more and more, quality management means an increasing burden of paperwork and regulations for those in our hospital rooms and doctor's offices trying to provide the best care they can. And, it is too often geared toward identifying and punishing "bad apples", not toward quality improvement. With hundreds of different payers with thousands of different requirements and measurements, quality assurance has become synonymous with regulation.

Add to this poor information flow so that health plans and providers cannot judge how they stack up against their peers and consumers cannot judge one plan's quality from another, and the current system is not really a system at all.

To improve quality and ensure that patients, providers and health plans throughout the country benefit from new technologies, better treatment methods, and better information, the Mitchell bill proposes an integrated quality improvement system.

- A core set of nationally recognized quality measures gives plans and providers the feedback loop they need to improve quality and improve patient satisfaction. These measures, developed with the help of the most qualified health industry experts, practitioners and consumers replace the thousands of different measurements today's health care providers have to contend with and consumers cannot understand.

- Health plan report cards give consumers the information they need to decide among health plans based on quality and price. Health plans have to compete based on their ability to deliver high-quality care at an affordable price, not on their ability to avoid high-cost, high-risk patients.

- An expanded focus and investment in health services research, including research on outcomes, practice guidelines and quality improvement provides the building blocks needed to continually assess and update the quality measures and provides the industry with tools to improve quality.

- Quality Improvement Foundations, not-for-profit organizations, funded by competitive grants, jump start quality improvement at the local level. They provide technical assistance to providers and health plans; monitor practice patterns and patient outcomes across the population; develop programs in lifetime learning for health professionals; serve as a focal point and clearinghouse for successful quality improvement programs, practice guidelines, and research findings; and assist in developing innovative patient education systems that enhance patient involvement in decisions relating to their own care.

This integrated system replaces the existing bureaucratic and punitive approach to assuring quality with one whose focus is to give the market place the tools, the incentives and the information it needs to make quality improvement an attainable goal of every health plan, hospital and doctor's office.

QUALITY IMPROVEMENT FOUNDATIONS

The Mitchell bill establishes not-for-profit Quality Improvement Foundations (QIFs) to jump start quality improvement at the local level.

Replacing the punitive system that characterizes the "quality assurance" programs in place today, non-regulatory QIFs serve as resources to the health industry and consumers in the community.

To best meet the needs of the local community, the Mitchell bill provides broad flexibility for the structure and operation of the QIFs. In a market-oriented system, QIFs are designed to facilitate the transfer of quality-based information across plans and to improve community health by working at the local level: specifically, they offer and provide technical assistance to health care providers and plans; collect and disseminate best-practice information widely; monitor health outcomes and practice patterns. They do not regulate. They provide the assistance and information essential to improving health care quality.

Structure:

The board of directors represents the interests and concerns of the community, with its membership of consumers, providers and purchasers of health care services.

QIFs are entirely voluntary organizations - - if they perform their job well, health plans and providers will want to work with them.

A competitive grant process with competitive renewals will ensure that ineffective QIFs are supplanted.

Functions:

QIFS have 5 primary responsibilities:

- Offer and provide technical assistance to providers and health plans
- Monitor practice patterns and patient outcomes across the population to identify opportunities for improvement and establish benchmarks for quality
- Develop programs in lifetime learning for health professionals
- Serve as a focal point and clearinghouse for successful quality improvement programs, practice guidelines, and research findings
- Assist in developing innovative patient education systems that enhance patient involvement in decisions relating to their own care

The bulk of the existing activities of the Peer Review Organization will be coordinated during a transition period and ultimately integrated into the national program of quality management.

Evidence of Success:

Early working prototypes of these organizations have had success in improving patient outcomes while reducing the cost of care. QIFs build on the successes of these organizations, providing a flexible framework to take the best ideas from these prototypes and spread them across the entire country.

- By giving information to, and educating, providers, New York hospitals were able to reduce the number of unnecessary heart catheterizations from 99% to 30%, both saving money and avoiding unnecessary risk to patients.

- Northern New England Cardiovascular Disease Study Group, a consortium of surgeons, cardiologists, scientists and administrators has come together to provide information about the management of cardiovascular disease in Maine, New Hampshire, and Vermont. The consortium maintains registries on patients that have undergone different cardiovascular operations and analyzes trends in these data. Through the consortium, the health industry in the tri-state area has more of the tools it needs to better manage cardiovascular disease.

In contrast to the negative dynamic that builds up between regulatory authorities and providers, the dynamic that has grown up between these initiatives and the providers involved has been one of collaboration and trust.

QUALITY IMPROVEMENT FOUNDATIONS
QUESTIONS AND ANSWERS

Q: Aren't the QIFs too expensive?

A: No. Quality improvement and cost savings go hand in hand. As past projects have demonstrated, better information and education has led to improved quality and saved money through lowering infection rates and lowering inappropriate surgery rates, not to mention being better for patients.

Q: Aren't the QIFs too bureaucratic?

A: No. These foundations are designed to be responsive to the community's needs. The competitive grant and competitive renewal process ensures that ineffective QIFs will be supplanted. In addition, existing organizations like the PROs will be integrated into the integrated quality system, streamlining existing bureaucracy.

Q: Won't the market do this by itself?

A: No. Some areas of the country just don't have the infrastructure to obtain good quality information and benchmarks on their own. Region-wide relationships between clinicians do not exist, nor does the required technical expertise or financial support. Even in competitive areas, there need to be effective methods to identify opportunities for quality improvement and benchmark across plans. This isn't possible to do if plans work alone. The QIFs can speed the transfer of information between plans and providers about how best to improve quality and facilitate cooperation and collaboration.

RURAL COMMUNITIES AND HEALTH CARE:
The Problem Today

MILLIONS OF RURAL AMERICANS HAVE NO HEALTH SECURITY:

- 8 million -- nearly 1 in 5 -- rural Americans have no health insurance, including 25% of those living in farm families. [1992 Current Population Survey]

- 32% of rural Americans did not have health care for at least one month over a two year period. [Office of Rural Health]

RURAL AMERICANS PAY MORE FOR LESS COVERAGE:

- Farmers are particularly discriminated when it comes to obtaining affordable health coverage -- often forced to pay much higher premiums for health insurance. Rural residents have higher rates of chronic or serious illness, and many -- especially those engaged in farming, mining, and other high risk occupations -- are charged more by insurance companies and face a constant fear that their insurance will be canceled if they get sick or have an accident. Others cannot even obtain insurance when they have a pre-existing condition.

- Rural Americans who have health insurance face higher premiums than other Americans because they usually have to purchase coverage alone or through a small business. They do not have the protection of being part of a large business or purchasing group that can successfully negotiate the best premiums.

EXTREME SHORTAGE OF DOCTORS AND NURSES FOR RURAL FAMILIES:

- More than 500,000 rural Americans live in a county that does not have a single doctor and 34 million people live in rural areas with insufficient physicians to care for them. [Data 1/92, Congressional Rural Caucus, 6/9/94; Dept. of Agriculture]

- In 1988, 68 percent of rural counties did not have enough doctors. In fact, 141 rural counties had no physician at all. [Data 1/92, Congressional Rural Caucus, 6/9/94; Office of Rural Health]

- The number of rural families living in medically underserved areas increased from 37 percent in 1978 to 51 percent by 1989. In fact, in 1988, over 1 out of 4 people lived rural areas with a shortage of physicians compared to 1 out of 10 people in urban areas. [USDA, 7/20/94; Data 1/92, Congressional Rural Caucus, 6/9/94]

- Estimates in 1990 suggested a shortage of 45,000 registered nurses and nearly 1,000 dentists in rural areas. [Department of Agriculture]

- Rural Americans often must travel a long distance to get to available services. Public transportation is very scarce and more than half of low-income rural Americans don't own a car.

- The United States lost 20.5 percent of its rural hospitals from 1980 to 1992. Between 1985 and 1988, the rate of rural hospital closures was 29 percent higher than in urban areas. [USDA, 8/12/94]

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THE MITCHELL BILL EXPANDS AND IMPROVES HEALTH CARE FOR RURAL COMMUNITIES

A New Focus on Rural Health

- The Mitchell bill provides a comprehensive strategy for improving health care in rural areas. For the first time, an Assistant Secretary for Rural Health will oversee rural health policy.

Guarantees Coverage

- The Mitchell bill guarantees comprehensive benefits for all Americans -- no matter where they live. Today, rural areas have a disproportionate number of uninsured, underinsured and Medicaid recipients; hospitals in rural areas have over $1.5 billion in uncompensated care each year. By expanding coverage, the Mitchell bill will channel significant new resources into rural health care systems.

Increases Access to Care

- The Mitchell bill reduces the shortage of health professionals that plagues many parts of rural America and helps Americans in rural areas get access to the care that they need.
    - The bill provides $260 million between 1996 and 2000 for community health programs and rural delivery systems.
    - The bill funds enabling services -- like transportation, education and outreach -- to help individuals in underserved rural areas get to doctors and hospitals.
    - The bill provides significant new funding for the National Health Service Corps ($189 million in fiscal year 1996) to increase the number of primary care providers.
    - The bill automatically designates rural health clinics as essential community providers, recognizing that these facilities have traditionally served the needs of underserved populations in rural areas and that they should be assured continued participation after reform.
    - The bill encourages cooperative relationships among rural and urban providers by, for example, providing grants for network development and a rural telemedicine program.

The Mitchell Bill Provides Strengthened Protection and New Benefits For Older Americans

- **Preserves Medicare.**
- Under the Mitchell bill, Medicare will be preserved and strengthened. Older Americans will continue to receive the same Medicare coverage -- with guaranteed security. Seniors can keep seeing the doctors they see today, with expanded benefits. And doctors and hospitals will no longer be able to charge more than what Medicare pays.

- **New prescription drug coverage.**
- The Mitchell bill adds prescription drug coverage to Medicare -- providing desperately needed protection for older Americans. For less than $10 a month, older Americans will get protection against prescription drug prices that represent their highest out-of-pocket medical cost. An annual cap will be placed on out-of-pocket prescription drug costs, and above this amount, drug costs will be fully covered.

- **Covers home and community-based long-term care.**
- The Mitchell bill takes historic steps toward comprehensive long-term care coverage, creating a new, $50 billion home and community-based long-term care program. It will help Americans who need long-term care live independently at home and in their communities -- which most older Americans, people with disabilities, and their families and friends prefer.

- **Improves the quality and affordability of long term care insurance**
- The Mitchell bill creates tough new standards that all private insurers selling long-term care policies must meet. It also clarifies tax rules so that long term care services an insurance premiums can be deducted from taxable income.

- **Guarantees security to early retirees.**
- Under the Mitchell bill, American workers who retire early will not have to worry about losing their health insurance. Today many of these Americans are vulnerable -- dropped from their coverage and not yet eligible for Medicare. Under the Mitchell bill, insurance will always be secure and affordable..

- **Outlaws insurance company discrimination against older workers.**
- Today, insurance companies pick and choose whom they cover -- and they charge older workers far than younger workers. These practices will be outlawed under Senator Mitchell's bill -- insurance companies can vary premiums by no more than 2:1. And no one can deny coverage to an older worker who's once been sick.

- **Enhances medical research, including Alzheimer's research**
- The Mitchell bill creates a special fund to pay for academic health centers and medical research, which should mean increased commitment and research dollars for the fight against Alzheimer's disease.

RURAL BACKGROUND

The Health Security Act

RURAL COMMUNITIES

America's rural communities pose special challenges in health care-- both for those who need services and those who provide them. A total of 14 million people--half of them with incomes under 200 percent of poverty--live in rural areas with inadequate health care.

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

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

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

Guarantees Universal Coverage

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

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

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

Increases Access to Providers

- The Health Security Act provides a comprehensive strategy to deal with the shortages of health professionals that plague many parts of rural America. The Act sets a new national goal to greatly increase the number of primary care doctors, nurse practitioners, and physician assistants so vital to taking care of rural residents. This new primary care capacity will help serve the estimated 14 million rural citizens living in underserved areas.

- New workforce initiatives, including tax incentives, payment bonuses, and loan repayment programs, will encourage health care providers to practice in rural underserved areas.

- The Health Security Act will affect a five-fold expansion of the National Health Service Corps, from its current field strength of 1,600 over the next ten years. The Corps currently places about 60 percent of its complement of doctors, nurses and other health professionals in rural communities.

Encourages Health Networks

- Under the Health Security plan, technical and financial assistance will be provided to develop community-based networks. This will help the rural providers link-up together and to establish links with larger referral centers and academic health centers.

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

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

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

Assures Participation of Essential Community Providers

- The Health Security Act will certify certain providers and facilities that have traditionally served the needs of underserved populations as "essential community providers." This provision will assure the participation of these providers for at least the first five years after implementation.

- Health plans will be required to contract with and pay for services of all essential community providers in their service areas.

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

Coordination of Programs

- As health care reform is phased-in, the current categorical funding programs and block grants, which pay for clinical and supplemental services for the uninsured will be maintained.

- The Act will provide new public health initiatives that will offer new opportunities linking the public health and the personal health care systems. One of the new initiatives will provide for support services to help overcome non-financial barriers to ensure access to care. These "enabling" services include outreach, follow-up, home visits, and transportation.

August 12, 1994

MAJOR RURAL HEALTH PROVISIONS IN MITCHELL BILL

Section 1491 Replaces the Director of Office of Rural Health Policy with a new Assistant Secretary for Rural Health

Rural health clinics are automatic essential community providers

Sec. 1462(b) Study of Federally Certified Rural Clinics (Medicare) to examine reasons for program growth

Section 3341 Grants for development of rural telemedicine for hospitals and other health providers in a network of community based providers.

Section 3345 Establishes demos for rural telemedicine to receive Medicare reimbursement ($10 million authorized)

Section 3411 Creation of Program for Services for Medically Underserved Populations that includes rural referral centers

Section 3465 Rural Health Plan Demonstration Projects for underserved non urban areas to establish 3 demonstration projects to establish rural health plans

Section 3471 Additional Funding (FY 1996 $189 million) for the National Health Service Core

Section 3908 Border Health - President is authorized to conclude an agreement with Mexico to establish a binational commission to do a needs assessment in the U.S. / Mexico border area

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ▸ 3

To Jennifer Klein	From Emery Sharrow
Dept./Agency WH	Phone # 690-6051
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NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

Bob VH

TECHNICAL CHANGES/COMMENTS -Mitchell

Title III

Sec. 3411 Very few rural provider entities are eligible for funds under Part E which is going to make the "equitable distribution" provisions in subsection (e) very difficult to accomplish. Should the entities in subsection (c)(7) not be eligible for the enabling services program in sec. 3461, as well?

Sec. 3421 (e)(1)(B)(ii): Reference to "alliances" should be deleted.

Sec. 3441 (a)(2)makes essential access community hospitals eligible for loans and grants, but Sec. 4111(d)(1) would terminate EACH designations.

(a)(3) the reference here be to "limited service hospitals as defined in sec. 4111 of this Act" rather than "rural primary care hospitals".

Sec. 3461 (a)(1)"In general.--The Secretary may make grants to and enter into contracts with eligible entities <u>(as defined in sec. 3411)</u>to...." This would clarify who is eligible for these grants.

Part 3 Payments to hospitals serving vulnerable populations is duplicated in Title IV and should be eliminated in Title III.

Title I

Sec. 1462 (a)(2)(A) Regarding the inclusion of Medicare dependent small rural hospitals (MDHs) as Category 2 entity under ECP: It could cause significant disruption for health plans and among MDHs if there is some kind of competition among the MDHs to see which one gets a provider agreement with the plan.

Bob VanHoeck Notes on Dole

Title III

Sec. 302 requires States to designate underserved areas under rules promugated by the Secretary.

Sec. 311 allows the Secretary to conduct demonstration projects under which any public or private entity may apply for grants and waivers of any provision of Title 18 or 19 of the SSA, which may require a larger HCFA bureaucracy.

Sec. 312 establishes a new grant program (under Title XX of the SSA) for grants for planning health networks and health plans, which may require a new bureaucratic entity within the DHHS.

Sec. 313 establishes a new block grant program to States (within Sec. 330 of the PHS Act) which may require new administrative structures at both the State and Federal levels.

Sec. 321 establishes a new grant program to provide technical assistance for the development of health plans and networks which may require new administrative structures in the DHHS.

Sec. 331 establishes a new loan and loan guarantee program for developing health care delivery systems and expand sites which would require new administrative capacity in the DHHS.

Sec. 343 establishes a new grant program for FQHCs and similar organizations to expand access which may require expanded administrative capacity in the DHHS.

Sec. 345 establishes a new grant program to States to provide coordinated primary care and social services to pregnant women and children which may require expanded administrative capacity in the DHHS.

Sec. 346 establishes a new grant program for States to fund preschool and elementary school health education programs which may require expanded administrative capacity.

Sec. 349 requires the Secretary of DHHS to establish an "Interagency Task Force on Rural Telemedicine.

Sec. 350 establishes a new grant program for demonstration projects in rural telecommunications which may require expanded administrative capacity in the DHHS.

Sec. 352 establishes a new demonstration program for Medical Assistance Facilities and another for Rural Emergency Access Care Hospitals. Each program also requires the Secretary to report to Congress. Thes programs may require expanded administrative capacity in the DHHS.

Sec. 361 establishes a new grant program in Title VII of the PHS Act for States to develop emergency air transport services which may require expanded administrative capacity in the DHHS.

Sec. 371 establishes an Assistant Secretary for Rural Health in the DHHS.

Sec. 372 requires the Prospective Payment Assessment Commission to study the access of vulnerable populations to health plans, providers and services.

Sec. 373 requires the Secretary to perform a study on providing expanded benefits under plans offered to rural populations.

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TO: Jen Klein

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DATE:

RE:

PAGES: 4 5 (INCLUDING THIS COVER SHEET)

NOTES:

- "Impact" numbers are coming... (X number need met...)
- Medicare is sending me their bullets on rural
- Is this what you need? MR

What the Senate Leadership Bill Does for Rural America

Rural Residents

- Insurance Reforms expand access to care
  - expands access to coverage to 11 million rural Americans who do not have access to health care today.
  - lower rates for all Americans
  - increased choice of providers
  - guaranteed issue of community rated plans
  - no redlining of geographic areas
  - guidelines for risk adjustment for rural areas
- Significant subsidies for low income workers
- Significant subsidies for small businesses
- self employed deduct 100% of the insurance premiums
- enabling services such as transportation for access to care
- Increased access to Indian Health Service programs

Rural Providers

- Paperwork burden reduced
- Telemedicine network grants and reimbursement from Medicare
- $1.78 billion for plan and network development
- $260 million grants and loans for rural health centers and primary care hospitals
- Expansion of National Health Service Corps placing half of the providers in rural areas
- Increased coverage alleviates some of the burden of over $1.5 billion in uncompensated care in rural hospitals
- Tax credits for primary care providers serving in underserved areas ($1000 for doctors, $500 for nurses, certified nurse midwives, and Physician Assistants)
- Medical equipment depreciation credit accelerated

- Medicare bonus payments doubled for primary care providers in underserved areas

Rural Purchasing Groups

Rural Electric Cooperatives and Rural Telephone Cooperatives are able to form their own association plans and purchasing cooperatives if they cover more than 500 individuals

Option for single payer system in rural areas

Elevates Rural Health by appointing an Assistant Secretary for Rural Health Policy in the US Department of Health and Human Services

Increases Access to Care in Rural Areas

- Provides rural health centers and rural primary care hospitals grant and loan funding for the capital costs of developing community health programs and expanding rural delivery systems. (1996-2004 overall funding: $260 million)

- Develops rural plans and networks and expands rural health care sites. (1996-2004 overall funding: $1.78 billion)

- Gives rural providers additional funding for the provision of enabling services including transportation, community and patient outreach, patient education, case management, and home visiting. (1996-2004 overall funding: $1.86 billion)

- Gives rural providers additional funding for supplemental services including dental services and mental health/substance abuse services. (1996-2004 overall funding: $1.18 billion)

- Requires the Secretary to assure an equitable distribution of funds between rural and urban underserved areas for above programs.

- Establishes demonstration projects for rural health plan areas to develop a reliable supply of rural health care providers and a sound rural health delivery infrastructure.

- Establishes a rural telemedicine program to develop and expand rural health networks. In addition, provides up to $10 million from HCFA for payment of providers who provide telemedicine services.

- Expands the capacity of States to provide core public health functions and deal with environmental risks that especially affect rural populations.

- Helps States and communities target health problems in rural areas and devise local solutions to community problems.

- Encourages States and communities to establish community health advisor programs to provide outreach and health education services to isolated rural individuals.

- In most rural areas, the local school is the heart of the community. This bill uses schools to assure that children and adolescents get the health services they need.

Medicare Rural Health Physician Provisions

- Changes in Underserved Area Bonus Payments (Sec 4204): Effective 1/1/95, increase the bonus payment for primary care services in rural and urban Health Professional Shortage Areas (HPSAs) to 20 percent and eliminating the 10 percent bonus payment for non-primary care services in urban HPSAs.

- Physician Assistants and Nurse Practitioners (Sec 4212): Expands separate payment for PAs and NPs to all outpatient settings at 85 percent of the physician fee schedule, effective 1/1/97. Allows separate payment for rural NPs who refer a rural beneficiary to an urban area for treatment where the referring NP serves as the assistant-at-surgery at 65 percent of the amount that would be paid if a physician serve as an assistant-at-surgery, effective 1/1/97.

- The 1995 effective update for primary care physicians is 8.4%. This should help doctors in all areas, including rural areas.

CHILDREN BACKGROUND

The Health Security Act

CHILDREN AND FAMILIES

Over the last decade, the amount the average American family has spent on health care has more than doubled, from $1,742 to $4,296. Health care costs are projected to double again by the year 2000 if nothing is done. In addition, family coverage through the workplace is rapidly eroding: only 33 percent of employer- sponsored health plans paid for health insurance coverage of spouses and dependent children in full in 1990-- compared to 40 percent ten years ago.

- *Today 9.5 million American children have no health insurance.*
- *Thirty percent of all children under the age of two, and 50 percent of inner-city children, have not been immunized against preventable childhood disease.*
- *One in five American children had no contact with a doctor in 1992.*

Health care reform will include specific initiatives aimed at keeping children healthy.

Guaranteed Security for All Families

- The Health Security Act will guarantee every American family health insurance protection not linked to job, health, income or age.
- American families, and not their employers or insurance companies, will choose their own plans among those offered by the local health alliance or employers.

Preventive Care

- The comprehensive benefits package will include prenatal care, immunizations, regular checkups and preventive services for children including vision and dental care.

Comprehensive Health Education and School-Based Clinics

- New programs will support the special needs of school-aged youth in high risk settings. A comprehensive health education program in grades K-12 in high-risk schools will focus on behavior that results in the majority of health problems among adolescents and adults, with an emphasis on specific local needs.
- The Health Security Act will increase investments in school-bases and school linked clinics. These clinics will provide physical and mental health services and counseling in disease promotion and health prevention.

Expanded Benefits for At Risk Communities

- The Health Security Act will continue to support specific services targeted at high risk communities, including, migrant health, family planning, and maternal and child health services.

Home and Community-Based Long-Term Care

- The Health Security Act will establish a new home and community-based long-term care program, which will be made available to all people with severe disabilities without regard to age or income.

- This program will provide families the support they need to take care of children with special needs at home and give children with disabilities the opportunity to be a part of their families.

Child Health Research

- The National Institutes of health will receive additional funding to new research targeting to improving preventive medicine. Research priorities will include child health, perinatal health, birth defects, childhood diseases, unintentional injuries, learning and cognitive development and adolescent health.

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