MEMORANDUM

TO: Jen
FROM: Jesselyn
DATE: October 17, 1994
RE: Meeting with Sara Rosenbaum

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The students have the official summary of the health reform plan that you have worked on. The instructions ask that you describe in about 15 minutes the major features of the plan and how it affects public health. Some plans deal explicitly with these issues, some have implicit effects. Suggested topics to cover include:

* Screening services
* Preventive services
* Public health professional education
* Infectious diseases
* Reproductive health

Explain that the Clinton plan does have an explicit title on public health -- Title III on Public Health Initiatives -- and that you will run through this. However, many provisions that have an important impact on public health, such as the topics mentioned above, appear in other titles. For example, clinical preventive services -- which include immunizations and screening tests -- are described in Title I, Subtitle B on Benefits.

Although Sara discussed the political in-fighting that occurred over many provisions in Title III, I only included mention of this problem where it seemed really relevant. You might want to start out your discussion with a disclaimer that this Title is difficult to describe in terms of one major overriding "theme." It is more of a catch-all section of subtitles that are not knit together particularly well. (Sara said that, overall, this was poor policy-making. The Title III sections did not hang well together. The subtitles were politically naive or substantively incorrect.)

However, Title III is significant for its keeping with the Health Security Act's main themes of universal coverage, cost containment, and prevention as a guiding principle. A lot of the public health measures were proactive (e.g., emphasis on research, prevention, screening, education). A much smaller number of the public health measures were reactive/remedial (e.g., improving the situation for medically underserved areas).

Title III

SUBTITLE A: WORKFORCE PRIORITIES UNDER FEDERAL PAYMENTS

* This is a funding provision. The Act includes programs to promote the full utilization of the professional educational and clinical skills of advanced practice nurses and physician assistants. It recognizes that more primary care physicians are needed -- especially to provide preventive care and especially in medically underserved areas. The Act includes provisions that would increase the number of primary care physicians and encourage those providers to practice in urban and rural underserved areas.

* Sara did not discuss this.

Main Theme: To provide more health care professionals in urban and rural underserved areas.

SUBTITLE B: ACADEMIC HEALTH CENTERS

* Academic health centers deliver specialized care, train health professionals, and drive advances in medical science. The Act provides support for academic health centers by requiring health plans to contract with them to provide specialized services and by providing funding for the additional institutional costs incurred by these centers. In addition, the Act expands federal funding for clinical prevention research and health services research.

* Sara said that this was not particularly important and did not discuss it.

Main Theme: Funds academic health centers and ensures that health plans will contract with them.

SUBTITLE C: HEALTH RESEARCH INITIATIVES (See p. 562)

* The Act expands funding for biomedical and behavioral research, targeting illnesses such as Alzheimer's disease, breast cancer, heart disease and AIDS. A significant investment is made in health promotion and disease prevention research. Finally, a new health services research initiative includes quality and outcome measurement, the development of clinical practice guidelines and evaluation of primary care services.

* Designed to prioritize certain kinds of research activities.

* Clinical trials to measure effectiveness.

1) outcomes - in the past, performance was being measured by looking at claims forms off of general population measures of health and well-being. Now we'll look at effectiveness of variations in interventions.
2) clinical ports
3) consumer knowledge-how consumers make choices/informed choice
4) risk adjustment

AHCPR would come out with guidelines that health plans would absorb because it is in their market interest to do so.

Main Theme: This is the John Wenberg stuff. It is significant because there are tremendous variations among practice procedures and thus a need to develop more uniform clinical practice guidelines.

SUBTITLE D: CORE FUNCTIONS OF PUBLIC HEALTH PROGRAMS; NATIONAL INITIATIVES REGARDING PREVENTIVE HEALTH

* Under this provision, public health would return to its pristine form. This provision would reshape public health agencies so that public health would no longer be part of personal health.

* Strength: More resources to core public health/population efforts.

* Weakness: There still will be people who will need personal health services and will fall through the cracks.

Bent towards increased surveillance, monitoring, etc. Model was state entitlement that would entitle states to the money. State would negotiate with fed. over money (grant-in-aid).

Main Theme: This is most significant in its separation of public health and personal health. Public health had become very focused on the delivery of personal health services. This provision returns public health care to its original function . . . but may leave stranded some of those people in need of personal health services.

SUBTITLE E: HEALTH SERVICES FOR MEDICALLY UNDERSERVED POPULATIONS

Theory:If everyone had insurance, you would only need public funding for 2 things:

1) public capital investment funds

2) funding for enabling services usually offered by public groups, but not by private doctors (e.g., translation, transportation, etc.)

*The Act authorized $600 million in new funds for community and migrant health centers over fiscal years 1994 through 2000.

* A new capacity expansion program ($2.7 billion over fiscal years 1995 to 2000) would be available to community and migrant health centers as well as other providers in medically underserved areas to build new health care facilities, support capital improvements for existing facilities, and link current primary care providers with inpatient institutions through information systems and telecommunications.

* The enabling services program ($1.2 billion over fiscal years 1996 to 2000) would be available to community and migrant health centers as well as other providers in medically underserved areas to provide translation, transportation, child-care and outreach services.

* Expansion of the National Health Service Corps ($950 million over fiscal years 1995 to 2000) would increase the supply of practitioners available to serve in community and migrant health centers.

Problem - No underwriting support/operational funding. (Energy & Commerce would have changed this. It did get into Gephardt. Gephardt threw HSA Subtitle E away and it became an operating subsidy program.) Operational subsidy very important.

Part IV: An entitlement. But way below the amount reasonable needed to carry out uncompensated care activities. We had only 20% of the money we should have had.

Main Theme: This was meant to improve health services for medically underserved populations, but was underfunded.

SUBTITLE F: MENTAL HEALTH; SUBSTANCE ABUSE

* By 1996, every person would have some mental health and substance abuse coverage. The service system capacity to deliver would be achieved through a phase-in period that would be completed by 2000. The existing public system of treatment services would be continued during the phase-in period.

* The Act would outlaw denial of coverage based a wide range of mental and substance abuse disorders that are today often deemed "preexisting conditions."

* Psychotherapy visits limited to 30 per year.

* But people with severe or clinical mental illness will have unlimited visits for "medical maintenance" of their conditions.

* Encourages innovative alternatives to inpatient treatment: partial hospitalization, day treatment, psychiatric rehabilitation, ambulatory detoxification, home-based services, and behavioral aide services.

* Encourages preventive care: outpatient services, brief office visits for medical management, substance abuse counseling, early intervention.

* Collateral treatment for family members of an individual receiving mental or substance abuse services.

* Supplement to current Title 19.

* States had to do an audit of their programs to still get federal money.

* Sara said that this section was a compromise and that mental illness community killed a lot of this off in future bills.

Main Theme: The proposal envisioned a phase-in of more comprehensive and managed mental illness and substance abuse services so that eventually coverage of such benefits are comparable to other benefit services.

SUBTITLE G: COMPREHENSIVE SCHOOL HEALTH EDUCATION; SCHOOL-RELATED HEALTH SERVICES

* The primary objective of health education is to target and reduce the health risk behaviors accounting for the high morbidity and mortality rates among youth and adults. Emphasis on safety and the prevention of injuries; tobacco, alcohol, and other drug abuse; sexual behaviors that increase risk of infection of HIV and other sexually transmitted diseases; and dietary patterns and sedentary lifestyles that lead to disease.

* Provision for sequential age-appropriate health education programs. Two agencies -- DOE and HHS -- fighting over what kind of programs to provide. The issue: comprehensive school health education programs vs. school-related health services programs. Health education won out over health services.

* This provision is not for clinics + direct health care delivery in schools. Rather, it is similar to subtitle C, an authorized appropriation.

* See Section 3612 - general authority to HHS to waive some programs' money to use for other things. (For example, the Drug Free School Act had a lot of money.) Authorized number was low, but there was this backdoor funding. So the other big fight became who got the money.

Main Theme: This is for health education in school rather than for health services in school.

COMPREHENSIVE BENEFIT PACKAGE

The Act would require each health plan to provide coverage for the following service so long as they are medically necessary or appropriate. There would be no lifetime dollar maximum limit placed on coverage under the plan (except for orthodontia):

* hospital and emergency care
* the services of physicians and other health professionals
* specified clinical preventive services (including immunizations and tests) — screening - e.g. mammography
* mental illness and substance abuse services
* family planning
* pregnancy-related services
* hospice care
* home health care
* extended care services
* outpatient laboratory and diagnostic services
* outpatient prescription drugs
* ambulance services
* outpatient rehabilitation services
* durable medical equipment
* prosthetic and orthotic devices
* vision and hearing care
* dental services for children
* health education classes

It is interesting to note that a number of provisions assume universal coverage. Subtitle D, which returns public health agencies back to doing public health work -- rather than personal health care delivery -- would be virtually impossible without universal coverage. Subtitle E is another example. It provides public funds for public capital investment and enabling services. Again, however, the theory rests on the assumption that everyone would have insurance, so public funding would no longer be needed in this area.

Once the Health Security Act was fully implemented, most everyone would be required to obtain a standardized, comprehensive benefit package (above) from large insurance purchasing cooperatives. Without universality -- which provides basic private coverage for everyone -- many public health provisions which shifted monies and functions back to the public realm would unravel. Yet the principle of universal coverage, which had always been the bedrock of reform rather than an "optional" mechanism, became one of the more controversial issues during Congressional debate. The misleading debate over whether "universal coverage" means 91 or 95 or 98 percent eclipsed the broader issue of how universal coverage could make all the other reforms -- particularly those involving public health -- possible.

To Howard Cohen (October 20 or 27)
Ellen Doneski (October 27)
Jennifer Klein (October 20) ✓ 456-2878
Mary McGrane (October 20 or 27)
Susan McNally (October 20)
Andy Schneider (October 27)
Marty Sieg-Ross (October 27)
From Your Friends, Ruth and Tim TMV
Re: Teaching at Our Hopkins Class
October 15, 1994

Thanks for agreeing to talk to our class on Public Health and Health Reform. Here's a little background for you.

The Class

The class is made up of about 35 people, most of them seeking a Masters in Public Health. Many of them already have graduate or professional degrees. They come from a wide variety of backgrounds, but most have some familiarity with health issues already (e.g., reporters for health newsletters, employees of the Public Health Service or the GAO, employees of interest groups, practicing physicians, etc.). They are a smart group, usually with lots of questions.

The Course (to date)

We're making the course up ourselves; there's no textbook and (to our knowledge) no precedent. It's turning out to be a survey of the variety of Federal programs that deal with public health--both directly and indirectly. Classes to this point have been on Congressional process, the budget and budget process, Federal public health programs, Federal poverty clinic programs, and Federal and private health finance programs--all with a slant toward public health effects. We have also had other guest speakers talking about everything from AIDS education to dietary supplements.

Your Class

For the class that you will be speaking to, we have given the students the official summary of the health reform plan that you have worked on. Some are very brief, some are extensive, but then you knew that.

On October 20, we will have people talking about the four original health plans--Clinton, Michel, Cooper-Grandy, and Rowland-Bilirakis. On October 27, we will have people talking about the four compromise bills--Gephardt, Bipartisan, Mitchell, and Mainstream. (Our Rowland-Bilirakis speaker has cancelled; we're looking. It may be Tim, but don't tell Waxman.)

We would ask that you describe in about 15-20 minutes the major features of the plan and how it affects public health. Some plans explicitly deal with these issues, some have implicit effects. Some topics that you might consider are screening services, preventive services, public health professional education, infectious diseases, reproductive health, etc.

After each of the night's four speakers has presented, we'll take a break (as we do every class) and then come back for questions (from students, from us, and from you guys).

Vital Statistics

The class takes place from 7 to 10. It begins with students doing 1-minute speeches on public health topics--usually about 10 to 15 a night. If you want to see these, get there at 7; if you don't, get there at 7:15.

The class takes place in the Benjamin Rome Building, which is in the 1600 block of Massachusetts Avenue, NW. As you are heading toward Dupont Circle, it is on the right hand side, just after 16th Street. There's no offstreet parking, and it's sometimes very difficult; allow time for that. If you'd rather cab it, we think that Johns Hopkins will reimburse speakers. The classroom is on the Second Floor. Typically, we don't know the room number, but when you come off the elevator, you'll step into a small lobby; the classroom is off the lobby to the left.

Finally, people regularly bring sandwiches to the class. Feel free.

Thanks

Thank you. Thank you. Thank you.