Risa met with him

6/28.

- single payer
- what controversial

215-898-1537

Myrna

215-843-9875

cc: Melanne, Patti, Jennifer

LOUIS STOKES
11TH DISTRICT, OHIO

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June 16, 1994

Mrs. Hillary Rodham Clinton
First Lady
White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20000

Dear Mrs. Rodham Clinton:

As Chairman of the Congressional Black Caucus (CBC) Health Braintrust, I am enclosing a copy of the document entitled the **"African American Community's Requirements for Health Care Reform: Consensus Provisions and Legislative Priorities".** This document represents over a year's collective efforts of the CBC Health Braintrust to define and outline the African American community's concerns with regards to health care reform.

In discussions that you and I have had regarding the President's commitment to ensuring health care for all Americans, the issue of the special needs of minority Americans has been a prominent concern. It is my hope that this document provides you with a clear understanding of the health needs and requirements of the African American community, and serves to guide the Administration and the Congress in formulating strategies with respect to our community.

I would appreciate the opportunity to meet with you to discuss this document and its subject matter. Thank you for your willingness to work with the Congressional Black Caucus on this very important issue.

Sincerely,

LOUIS STOKES
Member of Congress

LS/lla

EMBARGOED UNTIL C.O.B. ON 6/23/94

CONGRESSIONAL BLACK CAUCUS

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

CONSENSUS PROVISIONS AND LEGISLATIVE PRIORITIES

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CONGRESSIONAL BLACK CAUCUS

KEY AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Universal coverage, universal access and comprehensive benefits.

- Health care reform legislation must provide for universal coverage by a date certain and universal access to quality, affordable, non-discriminatory health care that is portable and includes a comprehensive benefits package. The package also must include provisions necessary to respond to African American women's health care needs, and provide coverage for adult dental care upon the statute's effective date. Overall, the benefits package must be at least as comprehensive as that proposed in H.R. 3600, and must maintain the level of benefits currently provided to Medicare and Medicaid recipients, where the benefits may be more comprehensive than those proposed in H.R 3600.

One tier of health care for all that allows free choice of provider.

- There must not be a two-tier health care system that provides a lower quality of care for the poor and the sick. There should be no significant financial barriers, such as deductibles and copayments, that limit choice of provider for the poor and low-income Americans. Consumers, not employers, must be able to choose their own doctors and health plans.

Fair financing.

- The financing of health care should be based on one's ability to pay to ensure that it is affordable to all persons, including the poor and low-income Americans. Employers should be asked to pay their fair share of the cost of health care, with significant subsidies provided to the smallest businesses.

Significant expansions in assistance to minority and medically-underserved communities and providers.

- The legislation must preserve and expand the African American health care infrastructure. This includes ensuring an adequate supply of health care providers and specialists; reinvigorating public and community hospitals, public health clinics, neighborhood and community health centers, and community pharmacies; expanding the concept of essential community provider to include individual health care providers with a history of service in underserved areas; and providing

set-asides funds to strengthen Historically Black Colleges and Universities.

Strong quality assurance mechanisms.

- The legislation must strengthen consumer protections through expanded and enhanced quality assurance provisions that include patient satisfaction as an indicator of quality care, ensure access to culturally sensitive health care providers, and encompass the necessary securities for patient data collection and information management.

Substantially increased business and employment opportunities for African American health providers and workers.

- The legislation must ensure that business and economic opportunities are provided on a leveled playing field that facilitates the empowerment of African American communities by providing access to entrepreneurial opportunities, and to the capital needed to implement them. It must ensure that set asides are provided and are tagged to the percentage of African Americans that exist in a region as opposed to in the country as a whole. It must provide appropriate worker protections that include retraining of displaced workers.

Strong consumer role in the administration of the program and strong anti-discrimination protections.

- The legislation must strengthen civil rights and affirmative action provisions to ensure African Americans equitable representation on all health care governing bodies at the federal, state and local levels. Representation is to reflect the number and percentage of African Americans in the region. It must ensure that affirmative action provisions are federally mandated, and include federal authority for enforcement and oversight with regard to state implementation of of health care reform.

State single-payer option.

- The legislation must include provisions to allow states to opt for a single payer system.

LEGISLATIVE PRIORITIES

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Universal Coverage

There must be a single standard of care not varied or limited by race, ethnicity, economic status, geographic location or pre-existing condition.

Everyone shall have the same basic comprehensive benefit package.

Families shall be defined to include grandparents who are raising grandchildren.

All Americans shall be eligible for coverage under any health reform legislation.

Prisoners must be eligible under health reform legislation.

Undocumented immigrants must be eligible under health reform legislation.

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Universal Access

Health care (not just health insurance) is available to all covered individuals.

Quality health care services must be convenient to consumers in terms of location, hours of service, waiting time, and [adequate and reasonable] provider-patient ratios.

Care must be offered by culturally sensitive health professionals and workers.

> The best way to assure access to culturally sensitive health care providers is to increase the number of African American professionals and health care workers; to preserve the roles of those who are currently working in communities; and to make funds available to strengthen their capacity and build health care networks and establish health plans.

Discrimination prohibitions protecting patients and providers shall be written into law.

Consumers must continue to have access to those providers who traditionally have given them quality care.

Federal authorities (e.g. Secretary of DHHS, National Board) shall develop and require health plans to meet measurable, feasible standards assuring access and quality, including standards specifically addressed to meet the needs and improve the health of historically underserved and vulnerable populations.

Whether the area is inner-city or rural, standards shall include without limitation:

- maximum distances and times for travel;
- waiting times;
- ratios of clinician to patient;
- health care process and outcome measures;
- health promotions and disease prevention;
- outreach and consumer education;

- consumer satisfaction; and

- methods for assuring that all enrollees who do not speak English as a first language will have access to culturally and linguistically appropriate services.

This provision shall not be construed to preempt other State or Federal remedies or standards that provide additional protection to consumers.

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Quality Issues

The Secretary of DHHS or other appropriate federal authority shall promulgate standards to assure measured improvements in the health status of consumers.

Aspects of consumer's health status that will be subject to measured improvement include:

- infant mortality;
- early and continuous prenatal care;
- children's immunizations;
- children's dental care;
- cancer;
- cirrhosis;
- diabetes;
- heart disease;
- stroke;
- homicide; and
- accidents.

As a condition for approval of State health plans and continued designation as a participating State, each State shall set forth its plan for improving the health status of consumers, particularly the traditionally underserved, and will report to the Secretary or designated Federal authority regarding implementation of this plan.

To enforce quality and access standards set by Federal authorities, there must be the following enforcement provisions:

- Aggrieved consumers should have a private right of action to remedy and seek compensation for health plans' violations of federal or state standards.
- Health plans that violate quality or access standards should be barred from enrolling new consumers at least until such violations have been rectified.

- When consumers are adversely affected by poor quality care or inadequate access to care, they should be permitted to change plans, with compensation from the health plan that harmed them (e.g. continued payment for their care at the new plan).

There must be uniform race- and income-specific data collection and reporting requirements, and mandatory consumer surveys, including those specifically targeted to underserved or vulnerable populations. Data shall be collected on participation and health outcomes.

States must be required to monitor and enforce health plan compliance with quality performance and outcome standards established by the designated federal authority.

To ensure quality of care, the legislation must protect and promote health care consumers' legal rights with regard to possible negligence and malpractice. State medical boards must provide for significant consumer input, and consumers must have access to information regarding provider practice patterns, such as that contained in the National Practitioner Data Bank.

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Affordability

Eliminate cost-sharing for individuals and families with incomes below 200% of the Federal poverty level.

Medicaid eligibles shall not be required to make copayments higher than those currently allowed under the Medicaid program.

Any health reform legislation shall fully subsidize premiums for individuals and families with incomes below the Federal poverty level. From the Federal poverty level up to 200% of the poverty level, there shall be a sliding-scale cap placed on premiums based on individual or family income. For those with incomes at and above 200% of poverty, the premium cap would be locked in at 3.9% of income.

In order to provide access for low-income consumers with legitimate needs to go outside a managed care network, point-of-service copayments (if any) should be reduced to the level of in-plan copayments.

There must be provisions to blend Medicaid and other premium payments so that health plans receive the basic amount for each participant, regardless of economic status.

Health care reform must not be funded by reductions in Medicare and Medicaid expenditures which result in cutting or eliminating services currently available.

Low-income persons in need of long-term care must be provided the same stop-loss protection that exists for acute care services.

Apply the same discounts for copayments to any stop-loss on total out-of-pocket costs.

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Comprehensive Benefits Package

The comprehensive benefits package recommended in H.R. 3600 (Subtitle B, Part 1) can be supported with the following clarifications and amendments:

Women's health benefits

- Mammograms every 2 years for women age 40 to 49; annual mammograms for women age 50 or older, (no copayments or deductibles).
- Annual clinical breast exams for all women, (no copayments or deductibles).
- Annual pap smears for all women who have reached childbearing age (no copayments or deductibles).
- Free family planning visits for all women, and free contraceptive drugs and devices for women with a family income of 200% of poverty or below.
- Reproductive health services including prenatal care, post-partum care, contraceptives, the full range of pregnancy related services and family planning services.
- Annual pelvic exams for women of childbearing age.
- Annual screening for chlamydia, gonorrhea, other fertility related infections, and sexually transmitted diseases for women of childbearing age [including those over the age of 50].
- Contraceptive drugs and devices must be covered for all women with no copayments and deductibles.

Infants and Children

- Well-baby services.
- Immunizations for childhood diseases.
- Teen pregnancy prevention.
- Women's, Infants' and Children's nutrition program should be continued.

- Medicaid wrap around coverage for children under the age of 22 who are in families with incomes below 200% of poverty.

Mental Health and Substance Abuse
- Mental health services,including 60 days inpatient services and 60 day outpatient services.

Long-term Care
- Long-term care services.

Adult dental services (for persons 18 and older):
- Should be provided upon the effective date of the statute, and include:

- Diagnostic (including oral cancer screening); emergency care; preventive (including prophylaxes); basic restorative services (fillings); and periodontal maintenance (limited scaling and root planing).

Children's dental services (up to age 18 years) including:
- Diagnostic, preventive (including sealants, prophylaxes, fluoride treatment, sports mouth guards); orthodontic treatment (up to 21 years); emergency care; basic restorative care (fillings); periodontal maintenance (limited scaling and root planing); and endodontic services.

AIDS/HIV
- HIV testing for persons age 13 and older added to covered preventive services with no cost-sharing.

Pharmaceuticals
- Coverage and access regarding all pharmaceuticals, as prescribed by physicians, should be assured, with the same deductible and copayment requirements (if any) as other medical treatments.

- Access to all prescription drugs approved by the Food and Drug Administration.

- No restrictions on the number of prescriptions and the available medication for Medicaid and Medicare recipients.

- Contraceptive drugs and devices must be covered for all women with no copays or deductibles.

Enabling Services
- For underserved persons, essential benefits must include outreach, prevention education and health

promotion, transportation, and translation services in order to assure access to health care.

State Minimum

- State minimum benefit requirements shall be preempted unless they exceed the level of benefits provided under Federal health care reform statute.

Pre-Medicare Population

- Coverage for early retirees in the 55-64 age group should be retained as outlined in H.R 3600.

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Medicaid and Medicare

- Health care reform bill must not reduce or eliminate any health services or supplemental benefits currently offered by the **Medicaid and Medicare** programs for both cash and non-cash recipients and eligible recipients.

- Supplemental benefits must include:
  - services for pregnant and postpartum women;
  - dental care;
  - physical therapy, occupational therapy and chiropractic services;
  - mental health and substance abuse services; and
  - critical enabling services that include outreach, transportation, and translation.

- There must be other essential Medicaid services including:

  - respiratory care services [as defined under Section 1902(e)(9)(C) of Title XIX of the Social Security Act];

  - such care and services as were provided to individuals described in section 1902 (a)(10)(A)(i) of Title XIX of the Social Security Act by the majority of States including the District of Columbia, under State plans in effect on October 1, 1992;

  - early and Periodic Screening Diagnostic Treatment program; and

  - adult vision care and eyeglasses,

- There must be no reduction or diminution of long-term care benefits available to low-income persons under Medicaid.

- There must be Medicaid wrap around coverage for children under the ages of 22 who are in families with income below 200% of poverty.

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Graduate Medical Education

Endorse the concept of 3000 by the year 2000. By the year 2000, the percentage of African Americans graduating should be 15 percent of all graduates in medical, dental, nursing, pharmaceutical, and allied and public health professions.

- In order to accomplish these goals, funds shall be set aside for enhancing existing or establishing new scholarships; loan forgiveness programs, mentoring, recruitment, and retention programs; and faculty development at health professions schools.

- Provide such sums as may be necessary for the training of African American physicians, nurses, pharmacists, dentists, and allied health professionals.

    - $10,000 per annum grants to African American and Hispanic students who enter or are enrolled in a graduate health care program at an HBCU or Hispanic-Serving Institution for academic years 1994-2000; and who agree to work for no less than three years after graduation in an underserved area; and

    - $5,000 per annum grants to African American and Hispanic students who enter or are enrolled in a graduate health care program at a majority institution for academic years 1994-2000; and who agree to work for no less than three years after graduation in an underserved area.

- Federal authorities should establish annual goals for the enrollment of African Americans, as a condition of funding, when making allocations to approved physician, dentist and other health professional training programs.

- In making these awards, the Secretary shall consider whether an institution has an established track record for training and graduating African American health professionals.

Preserve, enhance and expand the number of African American and other minority, and disadvantaged health care providers by reauthorizing the Disadvantaged Minority Health Improvement Act of 1993 (H.R.3699) which was introduced by Congressman Louis Stokes during the 103rd Congress.

Historically Black Colleges and Universities (HBCU's)

- Provide HCBUs and other minority health professions schools increased and targeted financial support, including:
  - graduate medical education payments; and
  - funding for strengthening recruitment,
  - community outreach,
  - research programs, and
  - institutional support.
- Annual appropriation of such sums as necessary.
- Institutions which should be funded for these purposes include:
  - Charles R. Drew Postgraduate University of Medicine and Science
  - Central State School of Water Resources Management and the Environment
  - Hampton University School of Nursing
  - Howard University Colleges of Medicine, Dentistry and Public Health
  - Florida A&M University College of Pharmacy
  - Meharry Medical College Schools of Medicine and Dentistry
  - Morehouse School of Medicine
  - Texas Southern University
  - Xavier University of Louisiana College of Pharmacy
  - Tuskegee University School of Veterinary Medicine
  - Morgan State University Schools of Mental Health and Psychology
  - Southern University National Sickle Cell Anemia Research Center

African American Academic Medical Centers

- Exempt African American academic medical centers from mandates requiring that at least 55% of individuals participating in graduate medical education programs be trained in primary care. Allow these institutions to continue to produce specialists prepared to practice in the inner city and rural areas.
- Exempt African American academic medical centers from any law mandating a national percentage requirement for primary care and medical specialists.

- Prohibit any reductions in indirect medical education payments.

Provisions must be adopted to address the potential funding shortfall (estimated at $2.71 billion annually for undergraduate medical education, transition to generalist and ambulatory care training, and the overall medical school infrastructure).

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Incentives to Practice in Underserved Areas

- Health care reform legislation should provide credits against Federal income taxes of $1,000 per month for up to 60 months.
  - Eligible providers should be those who provide medical and support services on a full-time basis in health professional shortage areas (HPSAs).
  - Providers must provide care to underserved patients in HPSAs who seek care.
- Give access to tax credits to physicians who are repaying a PHS loan through service in HPSAs at the end of their PHS commitment.
- Provide grants for medical equipment to providers establishing a practice in the amount equivalent to proposed tax incentives for their first year of practice.
- Make provisions for tax incentives for specialists who are members of medical teams required to provide emergency medical services under the Public Health Act.
- Provide tax relief for the purchase of equipment and property owned and used by providers in HPSAs.
- Provide low-cost (e.g. 3%) interest housing and business loans to health providers willing to reside in underserved areas.
- Dentists providing basic care in HPSAs should be eligible for primary care tax incentives.

The Secretary of the Department of Health and Human Service shall provide an annual report on the inclusion and status of African American physicians, dentists, nurses, and allied health professionals in managed care organizations. The Secretary also shall provide reports on managed care plans and other health plans performance on various quality measures by race and ethnicity.

The National Health Service Corps must be expanded, with placements in urban and rural areas that include:

- medical and dental specialties; and
- setting specific goals and timetables to recruit, train and place African Americans.

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Ensuring Future Supply of Providers

Provide funds for career counseling and orientation programs for schools (K through 12) and community-based organizations.

Health care reform legislation must provide funding for scientific enrichment programs starting at the elementary school level to increase the numbers of minority students able to enter health care careers and professions.

Develop new school-to-work programs and/or provide health care-related linkages with existing school-to-work programs.

Preserve, enhance and expand the number of African American and other minority, and disadvantaged health care providers by reauthorizing the Disadvantaged Minority Health Improvement Act of 1993 (H.R.3699) which was introduced by Congressman Louis Stokes during the 103rd Congress.

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Building Capacity: Public and Community Hospitals and Other Health Facilities

Designate African American- owned and -operated hospital facilities as "essential community providers."

Disproportionate Share Hospitals

- To maintain needed services to the underserved, and institutional viability, phase-out disproportionate share (DSH) payments commensurate with the pace of universal coverage, for hospitals now receiving these payments.

- Continue for a minimum of five years after the effective date of the Act disproportionate share hospital funding under the Social Security Act.

- All African American hospitals shall remain eligible for disproportionate share adjustment payments regardless of bed size. [i.e. even if under 100 beds.]

- Eliminate subsidy caps for hospitals serving vulnerable populations.

Capacity-Building

- Provide grants and contracts to African American hospitals, Historically Black Colleges and Universities with health schools, public health clinics, neighborhood and community health centers, community pharmacies and other community-based organizations for purposes related to capacity- and network-building such as:
  - capital financing and reserves;
  - management information systems;
  - appropriate medical technology;
  - personnel recruitment and training;
  - internal management systems; and
  - costs to maintain and establish operations.

- Designate Federally Qualified Health Centers and rural health clinics as "essential community providers."

- Fund at a minimum 50 demonstration projects to establish community-based networks and African American managed care plans. Funds authorized for this purpose should be such sums as necessary.

Historically Black Colleges and Universities

Make Historically Black Colleges and Universities with health professions schools eligible for "essential community provider" infrastructure grants.

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Essential Community Providers

Essential community providers shall be defined to include:

- Historically black hospitals,
- Federally qualified health centers,
- Rural health clinics,
- Family planning clinics,
- Maternal and child health providers,
- AIDS providers under the Ryan White Act,
- Hospitals receiving disproportionate share payments, and
- Rural primary care hospitals.
- Individual health providers who:
  - serve one or more than one Medically Underserved Areas or Health Professions Shortage Areas for a total of at least 20 hours per week, or a neighborhood or community in which persons reside who are at-risk of under-service and spend at least 20 hours per week at the principal site and are available to patients evenings and weekends at the principal site; and
  - if the individual provider is a physician, he or she must also be [i] board certified, or board eligible [ii] hold hospital staff privileges, or [iii] is affiliated with one or more physicians holding staff privileges.

Provisions protecting essential community providers.

- It is mandatory that any health reform legislation must include a provision that requires health plans serving either medically underserved or health professional shortage areas [as defined by Health and Human Services under 330 and 332 of the Public Health Service Act] to contract with "essential community providers" or demonstrate that they can provide the same health care delivery system that would be provided by the essential community providers.
- Health plans shall be required to contract with essential community providers on terms as favorable as those under contracts with other providers.

- Health plans shall be required to reimburse essential community providers no less than the reasonable costs rates required by 1833[a] of the Social Security Act.

- The "essential community provider" contracting requirement shall remain in effect for ten years.

- At the end of the ten years, the Secretary of DHHS shall provide a report on the program to the Congress.

Standards for qualifications and regulations

- The Secretary of the Department of Health and Human Services shall be required to set standards for qualifications of providers not automatically certified, consistent with the Act.

- The Secretary of the Department of Health and Human Services [DHHS] shall be required to develop regulations implementing the program and establishing certification and health plan notification procedures within six months of enactment.

- Essential community providers shall be eligible for construction bond guarantees under FHA 241 and 242 programs jointly administered by DHHS and DHUD.

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Consumer Protection, Participation, and Advocacy

Health reform legislation shall include a "Consumers' Bill of Rights," declaring the sense of Congress that the health care system should not operate so as to impair the right of any consumer to:

(a) affordable health insurance;
(b) a comprehensive package of health care benefits;
(c) personal choice of health care providers and health plans;
(d) quality health care which is equal to that received by all other consumers;
(e) confidentiality of, and access to, one's own medical records; and
(f) effective participation in the process of improving the delivery and quality of health care.

All non-profit hospitals shall have representation on their policy-making boards of no less than one-third consumers, selected by the board from among consumers served by the hospital who have no conflict of interest. All privately-owned hospitals shall have consumer representation on their boards, selected by the board from among consumers served by the hospital who have no conflict of interest. The purpose of these provisions is to serve as a safeguard against bureaucratic abuse and private sector exploitation.

Information

- Health plans must inform an enrollee of all medically accepted treatments or services available for an illness or condition for which the enrollee seeks treatment, without regard to whether the health plan authorizes a doctor or other health provider to provide any of the treatments or services.

- If a health plan has defined authorized treatments or services for particular conditions, that information must be provided to the enrollee in writing.

Health Plan Claims Review

- Health plans must be required to create a complaint review procedure to reconsider any denial of an enrollee's claim for a service or treatment.

- Denials of service or treatment should be defined to include both written or verbal claim denials, without regard to whether a doctor is denied authorization to provide the

services or treatment or whether an enrollee is denied reimbursement for or preauthorization for the treatment.

- If a health plan denies a claim for a non-urgent service or treatment, it must do so within 5 days of the date of the decision and not later than 30 days from the date of the claim.

- If a doctor requests, either orally or in writing, approval to provide a treatment or service to an enrollee that a "gatekeeper" denies, the same notice requirements must apply.

- Notice of denial of a claim must state the reasons for the denial and whether any treatment or service, other than that requested by the enrollee or their doctor, was authorized.

- Notice must include a statement of the enrollee's right to appeal the denial to the health plan, or pursue a State complaint review process or to initiate proceedings in State or Federal court.

- Notice must be written in a language calculated to be understood by the enrollee, taking into account limited English proficiency.

Appeals

- If a health plan denies a claim, the enrollee, or the health care provider who requested payment for the treatment or service, shall have the option of appealing the denial in a health plan procedure or seeking review of the denial in a State complaint review procedure or in State or Federal court.

Health Plan Appeal

- A health plan shall be required to create a de novo review procedure, conducted by someone other than the person or people who originally denied the claim and who is authorized to approve the claim.

- The health plan appeal shall be decided within 30 days of the request for review and written notice of the decision provided to the enrollee.

  Notice of the denial of the appeal must contain the reasons for the denial, state whether any other service or treatment is authorized, and shall be written in a language calculated to be understood by the enrollee, taking into account limited English proficiency.

State Administrative Review Procedure

- The State shall be required to create a complaint review office to review appeals from denials of claims by health plans that must conform with regulations to be promulgated by the U.S. Department of Health and Human Services [DHHS].

- The State shall be required to have hearing officers, who meet DHHS established qualifications and requirements.

  Hearing officers shall issue and serve upon health plans, a copy of any complaint and notice of a hearing date within "5 days" of the filing of the complaint.

- A health plan shall pay for second opinions given by "out-of-network" doctors for enrollees who qualify for Federal premium subsidies or reductions in cost-sharing prior to the hearing date set by the hearing officer.

- Hearing officers shall have the power to compel a health plan to pay for the "out-of-network" second opinion.

- Hearing officers shall have the power to compel the attendance of witnesses by subpoena.

- Hearing officers shall be required to apply a "preponderance of the evidence standard."

- A complainant shall have the burden of demonstrating that he or she is entitled to the benefit sought.

- A health plan shall bear the burden of demonstrating that it was not required to provide for the treatment or service.

- If the hearing officer rules in favor of the complainant, the hearing officer shall have the power to order that the health plan cease and desist from an act or practice, to order that the health plan provide benefits, to pay the enrollee prejudgment interest on any costs the enrollee incurred in obtaining the treatment or service at issue and to require the health plan to pay any service at issue and to require the health plan to pay any reasonable costs, including attorney's fees, incurred in connection with the hearing.

- The State shall provide interpreters for all stages of the complaint and hearing process in the event complainant is limited English proficient, or severely hearing impaired.

State or Federal Court Action

- State and Federal courts shall have jurisdiction over denials of claims.

- No amount-in-controversy requirement shall apply to Federal court jurisdiction.

- The courts shall review the denial of a claim on de novo.

- If the court finds for the plaintiff, the court shall have the power to enjoin the health plan from an act or practice causing the harm, to order that the health plan provide benefits, to pay the enrollee prejudgment interest on any costs the enrollee incurred in obtaining the treatment or service at issue and to require the health plan to pay any reasonable costs, including attorney's fees and expert witness fees, incurred in connection with the case.

Review Procedure for Denials of Claims for Preauthorization for Urgent Care

- Urgent requests for a treatment or service shall be defined as those that if not provided would place the health of the enrollee in serious jeopardy, risk the serious impairment of bodily functions or the serious dysfunction of a bodily organ, but would not be considered an emergency procedure.

- If an enrollee or a health care provider seeks preauthorization for a claim for urgent care, a health plan must notify the enrollee of the denial of the claim within "24 hours."

- A health plan's failure to provide timely notice of denial shall result in the automatic grant of the claim.

- Upon a denial of the claim, a complainant shall be permitted to seek an expedited review process in the State complaint review process or could seek a temporary restraining order in a court of appropriate jurisdiction.

- The state shall be required to provide an expedited hearing on an urgent request for a treatment or services. A hearing shall be scheduled within "24 hours" of the filing of the complaint.

- Because of the serious nature of the services or treatment involved, the enrollee shall be able to seek an injunction from the hearing officer for immediate provision of the treatment at issue.

- If the complainant qualifies for a premium subsidy or reduction in cost-sharing and the health plan should be required to pay for an out-of-network second opinion.

Emergency Services

- A health plan shall be required to pay for emergency services.

- A health plan shall be prohibited from requesting a preauthorization for an emergency service.

Retaliation

- A health plan shall be prohibited from terminating insurance coverage or contract for services with providers during the review and appeal process.

- A health plan shall be prohibited from denying an enrollee, in any way, benefits of the health plan in retaliation against the enrollee for pursuing any right or remedy.

Regulations

- A private right of action must exist against any Federal agency or Federal officials for failure to promulgate timely regulations under the legislation and for failure to enforce the legislation or regulations promulgated under it.

Resources for Consumer Advocacy

- Require the Secretary of Labor and the Secretary of Health and Human Services to designate through a competitive selection process, on a state-by-state basis, a non-profit organization to operate that state's new Office of Consumer Advocacy for Health. The nonprofit organization would be one with consumer advocacy and health care expertise. The Office would assist consumers in resolving grievances (which do not involve filing suit) stemming from such problems as the lack of accessibility of services and the lack of availability of premium and cost-sharing subsidies.

- Require all health plans to establish and maintain at least one Independent Consumer Advisory Committee per community-rating area. Committee members would be volunteers who represent the diversity of the health plan's enrollees. The Committee's functions would include conducting regular meetings of health plan enrollees and health plan representatives to facilitate the communication of consumer grievances. Each Committee also would submit an annual report to the state Office of Consumer Advocacy for Health outlining the Committee's recommendations for improvements in the health plan's delivery of health care.

- Provide for the establishment of a National Consumer Technical Support and Training Center, designed to give technical assistance and training to the states' Offices of Consumer Advocacy for Health. The Secretary of Labor and the Secretary of Health and Human Services, shall designate

a nonprofit, national consumer organization to serve as the Center through a competitive selection process.

- Provide all states' Offices of Consumer Advocacy for Health, all Independent Consumer Advisory Committees, and the National Consumer Technical Support and Training Center with a permanent source of funding: 0.25% of health plans' annual premiums in each state. Of that amount, 1/4 would be dedicated to the Independent Consumer Advisory Committees, and nearly 3/4 would be dedicated to the states' Offices of Consumer Advocacy for Health. The Secretary would reserve at least $5 million of the .25% for the National Consumer Technical Support and Training Center.

  Require the Secretary of Labor (in consultation with the Secretary of Health and Human Services) to designate through a competitive selection process, on a state-by-state basis, a nonprofit organization to operate that state's new Office of Consumer Advocacy for Health which has demonstrated consumer advocacy, and health expertise.

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Data Collection, Information Systems, and Reporting

Data Collection and Health Information Systems

- Health care reform requires the development and implementation of a health information system that will collect, analyze, report and regulate the collection, analysis, and reporting of data on the health care system.

- African American HBCUs, research organizations and other institutions and agencies shall participate in all phases of the health information system, including system design, collection, analysis, reporting and interpretation of data.

- Data collection results for both urban and rural communities shall be reported by health care providers including health plans, hospitals, and clinics, by race, ethnicity, national origin, sex, language, income, age, and residence. Data shall include:

  - enrollment and dis-enrollment,

  - clinical encounters, and other items and services provided by health care providers,

  - health outcomes in inner city and rural areas, and

  - grievances, including subject matter of the grievances, filed at the health plan level, administrative agency level or any court actions, and the outcome of the grievance proceedings.

- Data collection shall also include administrative and financial transactions and activities of participating States, alliances [if legislation creates them], carriers, health plans, health care providers, and employers necessary to determine compliance with the legislation.

- Demographic characteristics of employees and enrollees of health plans, terms of agreement between health plans and health providers, payment of benefits in cases in which benefits may be payable under the plan and utilization management by health plans and health care providers shall also be part of the information system.

- The information system shall include any other data regarding fraud and abuse and compliance with the legislation.

- The data collection and reporting provisions shall not be subject to existing laws governing data collection, [including the Paperwork Reduction Act].
- The information system shall be operating within 2 years of enactment of the legislation.
- Interim measures for data collection shall be developed.

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Privacy

The information system shall utilize a unique numerical identifier [other than a social security number] for each eligible individual to protect an individuals's privacy.

Any transmission of information between or among health plans, carriers, health care providers and any Federal agency shall use the unique numerical identifiers.

The Federal agency shall be required to ensure that a unique numerical identifier cannot be used to connect individuals with health information that is collected.

Enrollees shall not be identifiable, nor shall past, present, or future physical or mental conditions or treatment for the provision of or payment of health care service be discoverable.

Unauthorized disclosure of individually identifiable health information shall be unlawful, unless the enrollee requests disclosure in writing or the disclosure is made to a Federal, State or local law enforcement agency for enforcement of the legislation.

Any authorized disclosure must be restricted to the minimum amount of information necessary to accomplish the purpose for which the information is being disclosed.

Any individual or entity that maintains, uses or disseminates individually identifiable health information shall adopt administrative, technical and physical safeguards for the security of the information.

Enrollee must have a right to access such information including the right to review or copy the information.

It shall be unlawful for any employer to make employment decisions based on identifiable health information.

The Federal agency shall devise protection against an employer from using identifiable health information for employment decisions.

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Outreach, Education and Consumer Satisfaction

Outreach and Education

- Funds should be authorized to support community-based outreach and education efforts directed to low-income underserved and unserved populations, in appropriate languages and culturally appropriate manner. Information to be disseminated would include:

  - How to access the health care system;
  - Rights and responsibilities;
  - Health promotion and disease prevention; and
  - Costs, identity, location, qualifications and availability of participating providers.

Consumer Satisfaction Surveys

- Any health reform legislation shall require a Federal agency to periodically collect data on consumer satisfaction.
- A Federal agency shall be required to develop consumer surveys to be disseminated and collected by health plans and other providers.
- Consumer satisfaction data shall also include collection of complaints filed before any State or Federal administrative agencies or in State or Federal court, the nature of the complaints and the health plans against which the complaints have been lodged.
- Consumer satisfaction data shall be collected and analyzed for each health plan and made publicly available.
- The consumer survey system shall be operational within one year of enactment of the legislation.

The public must have access to practitioner-specific disciplinary and malpractice records contained in the National Practitioner Data Bank. This information should be made available on a semiannual basis to public libraries. A hot line should be established for updated information.

Economic Development and Business Opportunities

Data Base Development

Undertake a major research and data base development effort that compiles baseline information on current African American participation in the health care industry. Such data would contain statistical information on the number of African American individuals and firms involved, the level and extent of their participation in terms of employment, revenue dollars and categories of participation, and the capacity and potential of this African American business sector to exploit expanded opportunities in health care delivery and related products and services. Grants and/or contracts would be awarded to African American nonprofit organizations, HBCUs, and African American for-profit research and consulting firms to conduct the various aspects of this research and data base development effort.

Minority Health Enterprise Zones (MHEZs) Program

Designate certain urban and rural demographic areas as Minority Health Enterprise Zones (MHEZs) that will be served by local entities (e.g. alliances) managed and controlled by racial and ethnic minorities. Determination of the areas to be designated as MHEZs will be based on the health status of the minority population in the region as measured by mortality and morbidity statistics and by the prevalence of selected risk factors in the specific geographic area/region.

Specifically, the Minority Health Enterprise Zones (MHEZs) Program would:

- Provide resources for horizontally and vertically integrated community-based health delivery systems;
- Foster the involvement of essential community providers and other providers, public hospitals, community-based organizations, churches, historically black colleges and entrepreneurs from underserved minority groups; and
- Provide substantial grant/contract as well as low-cost loan support for development, capital financing, management information systems, appropriate medical technology, personnel recruitment and training, internal management systems and such other costs that may be required to establish and maintain operations.

- Provide capital resources and administrative support for a demonstration health-related empowerment program targeted to underserved populations. Such a demonstration program would foster the design and testing of optimum systems and approaches to ensure maximum participation in economic development and business opportunities by minority individuals and firms.

- Design and test mechanisms to encourage and support the participation of African Americans in information superhighway efforts as they relate to health care delivery.

- Provide grant/contracts to African American organizations, non-profits, for-profit companies and HBCUs to develop culturally sensitive, culturally relevant health education programs. These programs should include but not be limited to those on nutrition, family planning, prenatal care, smoking cessation, hypertension, substance abuse, heart disease, AIDS, and diabetes; and also they should help African Americans learn to negotiate the health care system as reform evolves and changes it.

Set Aside Programs

- Incorporate mandatory affirmative action, prime, subcontracting and business set-aside provisions in which African Americans in the health care industry would participate. The provisions would be applicable to every level of administration and health care delivery, including the National Health Board, states, health alliances (regional and corporate), health plans, other boards, councils and committees.

- Set aside opportunities should include at least the following categories:

  - providers, provider services and networks;

  - health care alliance professionals (management consultants, cost analysts, legal services, etc.);

  - allied health services (testing facilities, laboratories, satellite services, etc.);

  - related products and services (equipment, linen/supplies, food service, medical supplies, transportation, etc.);

  - computer technology and data base management firms, including procurement, billing and medical records services;

  - pharmaceutical companies and distributors;

- construction and construction-related companies;

- consumer and health education specialists (outreach specialists/trainers, graphics consultants, public relations specialists, etc.); and

- insurance and financial services.

- Set aside provisions would be based on and tagged to the percentage of African Americans and other minorities that exist in a region as opposed to the country as a whole.

- Under these set aside provisions, African American and other minority business enterprise (MBE) goals and women's business enterprise (WBE) goals would be decoupled.

- A special category of set asides would be provided for HBCUs and teaching hospitals with predominantly African American enrollments to ensure their participation in every aspect of health care and to ensure an adequate supply of health care providers in the future.

- The set aside provisions would utilize specific incentives and sanctions to ensure that these business goals are met. (Precedents include P.L. 95-507, the Small Business Administration's Section 8(a) program and P.L. 99-661, Section 1207, the Department of Defense Five Percent Contracting Goals, and Executive Order 11246.)

Capital Formation, Equity Development and Tax Incentives

- Develop an equity development program, such as the Small Business Investment Corporations (SBICs) and the Minority Enterprise Small Business Investment Corporations (MESBICs).

- Create a quasi-public entity (like Fannie Mae) to provide financial resources and services to African American individuals and firms located in designated underserved areas.

- Provide for tax incentives, such as investment tax credits similar to those available to encourage investment in enterprise zones in urban and rural areas, to stimulate capital formation for African American business participation in the health care industry.

- Provide for the issuance of revenue bonds (similar to Industrial Revenue Bonds) as a source of capital for the renovation, expansion and construction of health care facilities in African American communities.

- Amend the Community Reinvestment Act (CRA) to add requirements for capital investments in African American health-related businesses.

Health Care Trust Fund

- Establish a Trust Fund as a source of capital loans, grants, and contracts related to infrastructure enhancement, development and expansion.

- The Trust Fund would begin an **immediate** program of grants and contracts to involve, develop, strengthen and expand the capability and capacity of community-based organizations to establish integrated health delivery systems to provide services to African Americans in urban and rural areas.

- This Trust Fund would also be the permanent instrument for capital support of those infrastructure, information technology and system requirements that come out of the MHEZ Demonstration Program, as well as the support for capital needs outside of that Program.

Bonding and Financial Assistance Programs

Establish special bonding and short-term lending programs for African American firms needing bonding and financial assistance in order to participate in health-related construction opportunities. The Bonding Assistance Program would enable such firms to obtain bid, payment and performance bonds for projects involving health care and related facilities. The Short-Term Lending Program would enable such firms to obtain short term working capital at prime interest rates for health-related projects. Comparable programs in existence are the DOT Bonding Assistance and Short Term Lending Programs.

Job Training, Retraining and Educational Awareness

- Provide for vigorous federal monitoring and enforcement so as to ensure that the participation of African Americans in training and job opportunities provided under health care reform is proportional to their representation in the population of the region.

- Provide for appropriate protections for African American workers that include training and retraining of those workers displaced by corporate restructuring attributable to health care reform.

- Develop and support programs of school awareness of health care-related career opportunities for African American youth (K through 12).

Impact of Various Health Care Delivery Financing Options

- Provide adequate tax credits or subsidies, as well as cost phase-ins, to African American businesses so that they will not be disproportionately impacted by employer-mandated health care costs.

- Provide a tax credit or subsidy to African American businesses, and other businesses whose employee pool is consistently higher than 51% African American, if these companies provide more than the mandated comprehensive benefits package to their employees. This tax credit should be scaled so that the greatest tax credit will go to companies providing the most number of benefit options. In addition, credit should also be given to companies offering comprehensive prevention services.

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Representation and Affirmative Action

Equitable representation of African Americans must be assured at every decision-making level and in all health care governing bodies at federal, state and local levels.

Representation is to reflect the number and percentage of African Americans in the region.

Health care reform legislation must contain standards for the inclusion of providers, consumers, community-based organizations, educators, entrepreneurs and other affected parties at every decision-making level - federal, state and local.

Representation standards shall apply to the National Health Board, states, health alliances, health plans and all other boards, councils and committees created under health reform legislation.

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Anti-Discrimination

General Provisions

- The Office of Civil Rights in the Department of Health and Human Services shall be elevated to the Assistant Secretary level.

- Any health reform legislation shall include a general anti-discrimination provision applicable to any person or entity, territories or Puerto Rico.

- Health plans or activity related thereto including but not limited to those receiving Federal financial assistance, shall be prohibited from engaging in any activity, either directly or through contractual arrangements, that has the effect of discriminating against any individual on the basis of race, national origin, gender, age, religion, language, disability, sexual orientation, income, health status or anticipated need for health services.

- All Federal payments to any health program or activity without regard to how it is collected or disbursed, shall be treated as Federal financial assistance for the purposes of this Section and Title VI of the Civil Rights Act of 1964.

- Legislation shall contain a provision stating that an aggrieved person under this provision may commence a civil action in an appropriate State or district court of the United States.

- A health plan may be provided a business necessity defense to a claimed violation of the anti-discrimination provision.

- A business necessity defense shall not apply to cases of intentional discrimination.

- In a case of unintentional discrimination, a health plan, if it demonstrated that the act sued upon is required to meet a compelling business necessity, is narrowly tailored to meet that compelling business necessity and is the least discriminatory alternative available to the health plan, would not be liable under the provision.

- An aggrieved party shall be provided an opportunity to rebut any evidence of a business necessity introduced by health plan as a defense.

- If the court finds that the person or entity has failed to comply with the anti-discrimination provision, the aggrieved person shall be permitted to recover compensatory and punitive damages and the court should have the power to order any other appropriate relief.

- The court shall also have the discretion to allow the prevailing parity, other than the United States, a reasonable attorney's fee (including expert fees and other out-of-pocket expenses) as part of the costs, and the United States shall be liable for the costs the same as a private party.

Enforcement

- All Federal agencies with regulatory responsibility over any health program or activity are empowered to extend Federal financial authority to enforce the anti-discrimination requirements.

- Federal agencies shall issue rules, regulations or orders of general applicability and should include discretion to withhold Federal financial assistance until the violation ceases.

- Federal agencies shall be permitted to refer a violation to the United States Attorney General for further action.

Anti-Discrimination Provisions Applicable to Health Plans
Minority Providers

- Any legislation shall expressly prohibit health plans from discriminating against providers of the health services for membership in provider networks.

- Health plans shall be prohibited from discriminating in the terms and conditions of membership in provider networks.

- It shall be unlawful for a health plan to engage in any activity that has the effect of discriminating against a provider on the basis of race, national origin, gender, language, age, religion of disability of the provider or on the basis on the race, national origin, gender, language, age religion, socioeconomic status, disability, health status, sexual orientation or anticipated need for health services of a patient of patients of the provider.

- The same rights, remedies and defenses available under the general anti-discrimination provision shall be applicable to this provision.

Marketing and Advertising

- Health plans shall be prohibited from marketing or advertising in a way that has the effect of discriminating.

- Health plans shall have affirmative obligations to market and advertise services in all portions of their service areas.

- Health plans shall be required to promote the availability of the health plans on an equal opportunity basis in all marketing and advertising materials.

- All marketing and advertising material shall be made available to limited English proficient consumers in their respective languages if they belong to single language minority, consistent with the anti-discrimination provisions of the legislation.

- A health plan shall be prohibited from using marketing or advertising materials that use human models that are not fully representative of the population in the area served by the health plans, consistent with the anti-discrimination provisions of the legislation.

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

State Flexibility

Health plan certification

- States shall have express Federal requirements for health plan certification.
- States' criteria for health plan certification must be published.
- Federal certification requirements shall include the following criteria:
  - the quality of the plan,
  - the financial stability of the plan,
  - the plan's capacity to provide access to health care services mandated by the Act to enrollees in manpower shortage areas, minority communities, low-income communities and rural communities,
  - the terms and conditions under which plans have contracted with minority providers, community health clinics or other essential community providers located in or practicing in their marketing and service areas as defined by the Secretary of the Department of Health and Human Services, and
  - the plan's compliance with or ability to comply with the anti-discrimination provision of the Act and all applicable civil rights laws.
- Any legislation shall expressly prohibit certification of any health plan if,
  - the plan has an outstanding alleged violation of any anti-discrimination provision of this Act or any applicable Federal civil rights law;
  - the plan is not in compliance with any anti-discrimination provision of this Act or any applicable civil rights law;
  - the plan cannot demonstrate that it has a sufficient number of participating primary care providers actually available to furnish primary care services to enrollees so that the ratio of patients to primary care providers is no longer greater than 2,000:1; and

- the plan has not demonstrated its compliance with requirements that it contract with "essential community providers."

Any legislation shall contain an express requirement that any plan that is found in violation of the anti-discrimination provisions of the legislation or of any applicable Federal civil rights law be decertified, unless it comes into compliance within 120 days of the violation.

The Secretary of Health and Human Services shall have the power to conduct a civil rights compliance review of State certified health plans.

- If the Secretary determines that a State certified health plan is in violation of any anti-discrimination provision of the legislation of any applicable Federal civil rights law, the Secretary shall be permitted to inform the State of the violation, and withhold any Federal financial assistance to the health plan in the event that the violation is not corrected.

- The Secretary shall also be permitted to refer the matter to the U.S. Attorney General for further action.

- The Secretary of Health and Human Services shall be permitted to create additional criteria for health plan certification and shall be directed to promulgate regulations under the provision.

- The Secretary of Health and Human Services shall be required to promulgate regulations consistent with this provision, in a timely fashion.

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Civil Rights Compliance and Enforcement Review

Any health reform legislation shall contain a provision requiring the Secretary of the U.S. Department of Health and Human Services to require States to submit civil rights compliance plans that must be approved by the Secretary prior to approval of the plan or release of any Federal financial assistance.

The Secretary shall determine the form of the plan to be submitted by each State, but shall include a compliance plan to ensure compliance with the anti-discrimination provisions of this legislation and Title VI of the Civil Rights Act of 1964, Title VII of the Civil Rights Act of 1964, 24 U.S.C. 1981, Section 504 of the Rehabilitation Act of 1974 and any other relevant civil rights law the Secretary determines must be included.

- In the event that the Secretary determines that a State is in violation of any anti-discrimination provision or applicable civil rights laws, the Secretary shall inform the State of the violation and provide the State 120 days to devise and submit a plan to correct the violation.

- If the violation continues or the Secretary disapproves the plan, the Secretary shall be permitted to assume operation of the State health system as a whole or the entity in violation of the relevant provisions or laws, withhold Federal financial assistance and refer the matter to the U.S. Attorney General for further action.

- The Secretary shall be required to conduct annual compliance reviews, with regard to whether the State has any reported violations.

- The Secretary shall be required to promulgate regulations under these provisions.

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Single Payer Option

Provisions that should be supported that will enable states to utilize the single-payer option are:

- A change in the waiver language to require only one waiver for the purpose of consolidating Medicare beneficiaries under the single-payer plan.

- States choosing the single-payer options should be eligible for all subsidies for which the state would be eligible had it not chosen the single-payer option.

- States should be allowed to finance their single-payer systems with whatever revenues meet their needs and are approved within that state.

- Any savings that result from greater administrative efficiencies under single payer should not result in reduced subsidies to states, but instead, should be available to that state for expanding benefits or reducing cost-sharing or other financing requirements.

In addition, Federal implementation funds should be available to all states, no matter what option they choose. These funds include planning grants, financial support for start-up of single payer entities (including for regional health alliances that may be the state single payer) and for technical assistance in drafting legislation and regulations, data collection and automating information systems.

States should be able to use planning grants to conduct an independent fiscal analysis of the most cost-effective reform option.