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Health Care Reform and the HIV Epidemic Issues of Concern

Introduction: The National AIDS Policy Coordinator and staff have provided advice on policy formulation during the development of the Health Security Act (HSA). These efforts were directed towards assuring adequate care and services. As the Congress now deliberates the HSA, the Administration is making every effort to assure that modifications to the President's proposal maintain equity and sensitivity to the special needs of HIV infected individuals.

While the HIV epidemic has been thought of by the general public as an upper middle class, white gay male disease, legislators should not lose sight of the fact that the HIV epidemic has had a disproportionate impact in the inner cities where the HIV epidemic has devastated communities of color and people of limited socioeconomic status. These populations are also at high risk for the many other epidemics raging in their communities: high infant mortality, substance abuse, sexually transmitted diseases, tuberculosis, multi-resistant tuberculosis, HIV infection, violence, crime, unemployment, low educational attainment, and poverty.

The socioeconomic and health conditions which fuel these epidemics contribute to health outcomes which are financially and personally catastrophic, such as: addictions, low birth weight babies, tuberculosis, violence-related injuries, and HIV and AIDS. The high cost associated with these outcomes will be a great incentive for most health plans to find ways *not to enroll individuals from communities where these epidemics might be present*.

The practice of "cherry picking" and "red-lining" historically have been practiced in the U.S; in fact, HIV infected individuals are considered "uninsurable" today. The insurance company today is a business and like any business is driven by the profit motive. Our health care system tries to balance the insurance principles of risk and equity. The private insurance company assumes risk and attempts to maximize profits by wisely choosing only acceptable risks.

Under the HSA, the health plans will be mostly run by insurance companies whose corporate motives will be directed in large part by profits. It is with great interest that the HIV community has raised many concerns about their future health care benefits.

Background: The provisions of universal coverage, non-exclusion of pre-existing health conditions, and guaranteed lifetime coverage regardless of income represent major advances and security for all Americans. While these tenets have been put forward in the Senate Bill 1757 and House Bill 3600, the provisions of these bills will be deliberated by the 103D Congress. The details written into any new

legislation will structure the various national and state mechanism which will determine the equity and risks for both individuals and health plans.

Under the Health Security Act, all American citizens and legal residents will be guaranteed a comprehensive package of health benefits that can never be taken away. They will receive a Health Security Card entitling them to enroll in a plan. Everyone will have a choice of at least three - and in most communities, many more - health plans. And no matter which plan people choose, they will receive the comprehensive benefits package. Benefits covered under the nationally guaranteed comprehensive package carry no lifetime limits.

The package covers the following health services when they are medically necessary or appropriate including: hospital services, emergency services, services of health professionals, clinical preventive services, mental health and substance abuse services, family planning services, pregnancy-related services, hospice care (during the last six months of life), home health care, extended-care services, ambulance services, outpatient laboratory services, outpatient prescription drugs, outpatient rehabilitation services, durable medical equipment, routine ear and eye examinations (every two years) and eyeglasses and dental care for children under eighteen.

In addition, the HSA will preserve and strengthen Medicare, adding new coverage for prescription drugs. A new long-term care initiative will expand coverage of home and community-based care. This will make it possible for more elderly and disabled Americans to live in their homes and communities while receiving long-term care. The HSA will improve Medicaid coverage for people in nursing homes. It will improve the quality and reliability of private long-term care insurance and provide tax incentives for persons to buy it; and tax incentives to help individuals with disabilities work.

Community ratings, risk adjustment, re-insurance, and essential community providers are components of the HSA designed to assure services to underserved communities, and to compensate health plans for excessive health care cost. These mechanisms which are intended to guarantee equity to the most disadvantaged citizens must be carefully crafted such that they do not, in reality, create undue financial burdens which may in turn might cause health plans to promote exclusion of high risk groups as opposed to inclusion.

ONAP staff conducted a series of focus groups with PWA's and HIV organizations to ascertain their concerns related to the proposed HSA. The staff also undertook an analysis of it and identified 10 issues which related to the concerns which PWA's felt could adversely affect the HIV community: 1) Financial workings, 2) essential community provider, 3) grievance procedures, 4) long-term and home care, 4) substance abuse and Mental health, 5) equity of benefits (current

Medicaid benefits), 6) public health functions, and 7) impact on Ryan White CARE Act.

Premium Financing and Risk

Issue: Will the risk adjustment mechanism prevent "redlining" for persons with HIV/AIDS or other life threatening illnesses?

Summary: The HSA provides mechanisms which require states to spread the financial risk associated communities by adjustments which would take into account such factors, known to affect utilization of services, such as age, sex, health status and services to disadvantaged populations. The health plans have to meet specific rules on enrollment, community rating, information, grievance procedures, arrangements with providers and additional arrangements established by the National Board.

Premiums have to be community rated; that is adjusted, adjusted for individual verses family status based on the projected cost of providing the comprehensive benefits to a plans enrollees. The alliance will then risk adjust the premiums paid to each plan to account for the level of risk associate with the individuals enrolled in each plan. A plan could purchase reinsurance to cover cost beyond those covered by the risk adjustment.

By setting a rate which includes a much higher percentage of healthy people, over a larger geographical area, the rates for the less healthy will be averaged with those of the healthy. In order to assure that persons requiring greater medical care receive the necessary services without placing health plans in fiscal jeopardy, states will payer higher premiums to health plans for treating those persons. To assure that these "sicker" individuals do not cost health plans more than they can finance, the plan can purchase insurance from a national pool to further limit financial risk.

Discussion: Under the Health Security Act most of the population would obtain coverage through a regional alliance, a State-established intermediary between insurers and insurance purchasers in a defined geographic area. The alliance would contract with several plans, including managed care plans and conventional fee-for-service plans, to offer a comprehensive benefit package defined by the Act. Health plans are defined as those plans providing the comprehensive benefit package. Only State-certified health plans would provide coverage through the regional alliances. The plans would have to meet specific rules on enrollment, community rating, information, grievance procedures, arrangements with participating providers and additional requirements established by the National Health Board.

Premiums would have to be community rated, that is, adjusted for individual versus family status based on the projected cost of providing the comprehensive benefits to a plan's enrollees. The alliances would then risk-adjust the premiums paid to

each plan to account for the level of risk associated with the individuals enrolled in the plan. A plan could purchase reinsurance to cover costs beyond those protected by the risk adjustment. The following are detailed explanations:

Risk Adjustment: Alliances would risk adjust premiums to account for variations in enrollment across health plans. Any adjustment made to the premium through this process would not affect the amount paid by consumers. They would pay the premium amounts quoted at the time they chose their health plans. It would, however, affect the payments made to the plans by the alliance. The goal of risk adjustment would be to adjust a plan's premium to reflect the level of risk assumed in covering its enrolled individuals in comparison to the average population of the area. The adjustment would take into account such factors, known to affect utilization of services, such as age, sex, health status and services to disadvantaged populations. It would use the system developed by the National Health Board unless it obtained a waiver from the Board. In the early years of the alliance system, it is expected that alliances would use a reinsurance mechanism to compensate for the lack of an adequate risk adjustment methodology.

The National Board must develop a risk adjustment and reinsurance methodology by April 1, 1995.¹ The Board can make improvements to the standard methodology in order to provide for the adjustment of payments to regional alliance health plans to: 1) assure that payments to plans reflect the expected relative utilization and expenditures for services by each plan's enrollees compared to the average utilization and expenditures for regional alliance eligible individuals; and 2) protect health plans that enroll a disproportionate share of regional alliance eligible individuals whose expected utilization of health care services and expenditures for these services are greater than the average level of utilization and expenditures for regional alliance eligible individuals.²

Section 1541(a)(2) lists the factors the National Health Board must consider in developing the methodology, including: demographic characteristics, health status, geographic area of residence, socio-economic status, the proportion of enrollees who are SSI and AFDC recipients and any other factors the Board determines. There is a "zero sum" requirement in Section 1541(a)(3) which requires an assurance that the total payments to health plans by the regional alliance after application of the methodology are the same as the amount of payments that would have been made without application of the methodology.

¹ Title I, Health Care Security, Subtitle F, Federal Responsibilities; Part 1, National Board; Subpart E, Risk Adjustment and Reinsurance Methodology for Payment of Plans.

² Section 1542(b).

Section 1541(a)(4) allows for the prospective adjustment of payments to health plans. The Board does not specifically have to take into account AFDC/SSI recipients if it determines that the application of other risk adjustment factors is sufficient to adjust premiums to take into account the enrollment into plans (Section 1541(a)(5)). Special consideration can be given for adjustment for individuals with mental illness, veterans, military and Indian health plans (Sections 1541(a)(6), (a)(7) and (a)(8)). If the total payments made by a regional alliance to all regional alliance health plans in a year exceeds or is less than, the total estimated by the alliance, because of differences in the estimate and the actual distribution, the methodology must be adjusted to reduce or increase payments made by the alliance to all plans. Mandatory reinsurance is presented in Section 1541(b). If a Board determines an adequate system of prospective payment cannot be developed by an implementation date established by the National Health Board, the Board can include a mandatory reinsurance system as a component of the methodology.

Mandatory Reinsurance Mechanisms: The National Health Board (NHB) is mandated to develop risk-adjustment and reinsurance methodology by April 1, 1995. The primary purpose of both mechanisms is to protect health plans that may have a disproportionate number of "high-cost" enrollees relative to other plans; this would allow the plans to meet their higher level of expenditure with appropriately increased funding. The Mandatory reinsurance requirement³ is included as it may be necessary for states using the NHB methodology to mandate non-voluntary "transfer payments" between health plans that are within alliances, if risk-adjustment methodology cannot be developed and implemented prospectively in time to adequately control for the expected cost differentials among different enrollees within the plans. The NHB is required under the proposal to determine the type and level of coverage and operation of a mandatory reinsurance system for each state, taking into account privacy standards in order to minimize identification of individuals.

Each state that participates in the new system is required to establish a mandatory reinsurance system utilizing NHB standards. Finally, the NHB may reduce or eliminate the mandatory reinsurance system in the future if it determines that a prospective risk-adjustment methodology can be implemented successfully.

Implications for Persons with HIV/AIDS State utilization of mandatory reinsurance will probably be necessary as the methodology to do the required level of risk-adjustment is only now under development. Establishment of this provision, then, is very important for those concerned with HIV/AIDS, because the epidemiologic trend in AIDS is shifting toward the inner-city populations. Without reinsurance

³ Title I, Subtitle F, Section 1541 (c)

mechanisms, plans will be more likely to avoid "high-cost" areas such as the inner cities with greater proportion of AIDS, TB, low-birthweight babies, etc. so as not to be saddled with those higher costs during the interim period. The American Academy of Actuaries has stated that there are "tremendous" financial incentives for risk-avoidance behavior by plans in serving geographic areas within states until risk-adjustment is fully implemented, which may take, "several years".

Recommendation: Support vigorously the concept of mandatory reinsurance as laid out in the Administration plan, as a means of ensuring that "redlining" in any form (temporary or permanent) does not occur; i.e., that PWA's will not be discriminated against by health plans' avoiding places that they may live and have the best access to clinical care. This provision is the best method to make sure that plans which choose to serve PWA's are not going to suffer financially and disproportionately for that decision.

Availability of HIV Specialist, "Essential Providers"

Issue: Will HIV positive persons be able to continue using their local HIV medical specialist.

Summary: The Health Security Act establishes a special category of health care provider which is referred to as an "essential provider". Any health care provider or organization can make application to the Secretary to be certified as an essential provider. Within the HSA, a Ryan White grantee or subrecipient can be automatically certified as an essential provider. Each health plan shall enter into a written agreement with each essential provider located within its service area. The health plan shall make payment to the provider in accordance with the appropriate subsection of the HSA.

Discussion:

The Health Security Act establishes a special category of health care provider which is referred to as an "essential provider". Any health care provider or organization can make application to the Secretary to be certified as an essential provider. Within the HSA a list of organizations which can be automatically certified is included. This list consist principally of Public Health Service funded programs. One of major interest to this Office includes the AIDS providers under the Ryan White Act. Which is defined as a public or private nonprofit health care provider that is a recipient or subrecipient of a grant under Title XXVI of the Public Health Service Act.

Each health plan shall, with respect to each electing essential community provider located within the plan's service area, either (1) enter into a written provider participation agreement (described in subsection (b)) with the provider, or (2) enter into a written agreement under which the plan shall make payment to the provider in accordance with subsection (c).⁴

Under subsection (b) Participation Agreements, the health plan agrees to treat the provider in accordance with terms and conditions at least as favorable as those that are applicable to other providers participating in the health plan with respect to the following: 1) scope of services, 2) rate of payment, 3) financial incentives, 4) limits on financial risk, 5) assignment of enrollees, and 6) access to subspecialist within the plan.

⁴ Title I - HEALTH SECURITY ACT, Subtitle E - Health Plans, Part 3 - Requirements Relating to Essential Community Providers, Sec.1431 - Health Plan Requirements.

Under subsection (c) Payments for Providers Without Participation Agreements, a provider may elect to be paid at the rate as established by the regional alliance/State or by methodologies established by the Secretary which closely approximate those of Medicare. Additionally, "No application of gate-keeper limitations" may be imposed. Payment in accordance with this subsection may be subject to utilization review, but may not be subject to otherwise applicable gate-keeper requirements under the plan.

With respect to establishing a time limitation on the mandated provisions of the "Essential Provider", SEC. 1432. SUNSET OF REQUIREMENT, shall only apply to health plans offered by a health alliance during the 5-year period beginning with the first year in which any health plan is offered by the alliance.

An electing essential community provider who is aggrieved by the failure of a health plan to fulfill a duty imposed on the plan by section 1431 may commence a civil action against the plan in an appropriate State court or district court of the United States. If the court finds that the health plan has failed to fulfill a duty imposed, the electing essential community provider may recover compensatory damages and the court may order any other appropriate relief. The court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee (including expert fees) as part of the costs, and the United States shall be liable for costs the same as a private person.⁵

The HSA requires each health plan to enter into agreements with each essential provider practicing within the health plans service area. The essential providers given the option of electing one of two payment mechanisms. While it is unclear as to how these mechanisms will be implemented, there is much to be said for, "No application of gate-keeper limitations." This would be an important element in the multi-specialty requirements for an AIDS practice.

A major point of concern in the HSA is that while a Ryan White recipient (State or City) or subrecipient (community based organization) is automatically certified, the standards for certification for individual providers will be established after the passage of the HSA by the Secretary. Adequate provisions have been made in the HSA for an essential provider to seek relief in the courts.

Recommendation: That the Administration work with the Congressional liaison to include specific language defining the standard for certification of an individual as an essential AIDS provider.

⁵ TITLE V - QUALITY AND CONSUMER PROTECTION, Subtitle C - Remedies and Enforcement, Part 2 - Additional Remedies and Enforcement Provisions, Sec. 5240. CIVIL ACTION BY ESSENTIAL PROVIDERS.

Grievance Procedures

Issue: How can individuals ensure that their health plan will provide the health benefits and services they require?

Summary: The HSA is intended to provide adequate health care coverage for all citizens and residents of the United States. The Act requires States to establish health alliances which will approve each health plan before it can engage in providing health care under the Act. The law prohibits exclusions because of pre-existing conditions or through "red-lining," the practice of excluding a particular group of individuals because of perceived high risk.

The Health Security Act includes a comprehensive grievance process for any person aggrieved by acts or practices which result in denial or delay of benefits, payments. Individuals must work within the individual plan's grievance process before going to adjudication through the Complaint Review Offices set up in each state. If there is a question as to an individual's eligibility for a plan, subsidies or cost sharing, the individual may go directly to court and all costs can be reimbursed if the court finds for the individual.

The complaint office must rule in under 30 days, although a 24 hour appeal is available in cases of emergency. Appeals must be processed within 60 days. There are means of appealing, with the national board being the ultimate administrative appeal. The DHHS Secretary can also make a determination of whether a particular plan fulfills the legal requirements.

Discussion: The grievance process of the Health Security Act⁶ states that all claimants must use the plans claims process and all recourse must be exhausted before they go on to the complaint process.⁷ The plan provides for individuals to submit claims to the regional Complaint Review Offices for adjudication within 30 days. Appeals to these decisions can also be made to the regional claims office and adjudication will be made within 60 days.⁸ The regional claims office must be established by all the states that set up alliances. The Department of Labor will issue regulations for the operations of these offices.⁹ For alliances not set up by the state (i.e., corporate alliances [corporations with more than 5,000 employees]), the Department of Health and Human Services will run the claims office based on

⁶ TITLE V, Subtitle C, Remedies and Enforcement.

⁷ Section 5202(c)

⁸ Section 5201(1) and (2).

⁹ Section 5202 (a) (1).

the DOL regulations.

The HSA also provides for expedited review within 24 hrs. of claims in situations where grievous harm will occur to the claimant or the provider.¹⁰ The determinations by the claims office must specify the grounds upon which the action will be taken.¹¹ All complaints must be in writing with a sworn statement and must give notice of the nature of the complaint.¹² All claims must be filed within one year of the event that causes the claim.¹³ Individual claimants can forego the complaint process and go directly to court, can elect to participate in the Early Resolution Program¹⁴ or can obtain a hearing in the Complaint Review Office. To participate in the Early Resolution Program, the dispute must be over payment or the rendition of services and the election must be made within 15 days of the submission of the complaint.

Adjudications can be enforced by the courts. In addition to the awarded damages, the complainant will receive attorneys and other reasonable costs.¹⁵ The Secretary of Labor may impose civil penalties based on the findings of the hearing.¹⁶ In order to enforce the particular requirements of the plan, individuals must exhaust administrative remedies as described above¹⁷ or may go directly to court to obtain a ruling on issues of eligibility.¹⁸ Cases of civil rights violations can be adjudicated directly by the courts.¹⁹ The claimant can receive court costs at the discretion of the court. The HHS Secretary may make a finding that a particular plan does not comply and can ask DOJ to file suit.²⁰

¹⁰ Section 5202(c)(2).

¹¹ Section 5201(e).

¹² Section 5202(e).

¹³ Section 5202(f).

¹⁴ Section 5211.

¹⁵ Section 5202(g).

¹⁶ Section 5206.

¹⁷ Section 5237.

¹⁸ Section 5237(b)(2).

¹⁹ Section 5238.

²⁰ Section 5238(c).

Implications: The grievance procedure will be important to persons with HIV, which may be excluded from coverage by various plans. Making the grievance procedure accessible will be critical to persons living with HIV/AIDS.

Recommendation: During the implementation phase, persons requesting redress under the grievance process may not receive service as soon as necessary. For people living with HIV/AIDS, the expedited process may be necessary in all instances.

Long-term care and Home Health Care

Issue: Persons with HIV/AIDS often need home health care and long-term care services, will the Health Security Act provide those needed services?

Summary:

Home health care is included in the nationally guaranteed comprehensive package as a medically necessary or appropriate service. A new long-term care initiative will expand coverage of home and community-based care. This will make it possible for more elderly and disabled persons, including persons living with HIV/AIDS to live in their homes and communities while receiving long-term care. The Act will improve Medicaid coverage for persons in nursing homes.

The HSA will improve the quality and reliability of private long-term care insurance and provide tax incentives for persons to buy it; and tax incentives to help individuals with disabilities work.

Discussion:

Home Health Care:

Under the HSA, home health care, including skilled nursing care, physical, occupational and speech therapy, prescribed social services and home-infusion therapy after an acute illness will be covered to prevent institutionalization. Under the HSA²¹, home health care is a skilled nursing care and therapeutic services benefit. Services must be provided under the supervision of a physician or registered nurse. It would not include what is usually called "custodial care," that is, care that could be safely rendered safely and reasonably by a person not medically skilled, and that are designed mainly to help a person with daily living activities. These activities could include (not exhaustive) and would *NOT* be covered: 1) personal care such as help in walking, getting in and out of bed, bathing, eating by spoon, tube or gastrostomy, exercising, dressing; 2) homemaking, such as preparing meals or special diets; 3) moving the person; 4) acting as companion or sitter; 5) supervising medication that can be self-administered; or 6) treatment or services that any person may be able to perform with minimal instruction included but not limited to recording temperature,

²¹ Title I, Health Care Security ; Subtitle B - Benefits; Part 2 - Description of Items of Service Covered; Section 1118, Home Care defines this benefit as the items described in Section 1861 (m) of the Social Security Act (under Medicare statute) and home infusion drug therapy services described in Section 1861(II) of the Social Security Act (as added by Section 2005.)

pulse, and respirations, or administration and monitoring of feeding systems.

The "custodial care" definition is as described in the Federal Employee Health Benefit brochure (December 1993), but is generally indicative of what is not considered "skilled" care. It should also be noted that as described in the Plan, this benefit is not the same as Medicaid home health or Ryan White home services as defined in statute.

Long-term care:

Beginning in 1996, a new home and community-based care program will enable Americans with severe disabilities to remain in their own homes or with family, yet still receive the care and assistance they need.²² The HSA²³ requires States to have a plan for the home and community-based services to individuals with disabilities submitted and approved by the Secretary. No individual entitlement is established (Section 2101).

Basically, the HSA would establish a new Federal-State long-term care program for disabled persons of all ages and income levels and includes a variety of other changes in long-term care policy. The HSA would establish a new grant program to States to provide home and community-based long-term care services to the severely disabled (persons requiring assistance in three or more activities of daily living, or ADLs, such as dressing or eating), the severely mentally ill or mentally retarded, and technology-dependent children. Participation would be open to all persons meeting the disability criteria, regardless of age or income.

Low income persons not meeting the criteria but currently eligible for home and community-based services under Medicaid would continue to receive Medicaid services. However, Federal funding for these services might be limited. The program would not be an individual entitlement, like Medicare and Medicaid, under which anyone meeting eligibility criteria has a right to benefits. Instead, it would be a "capped" entitlement, with the number of participant limited to the number that could be served within the program's budget. Federal funding would be subject to an annual limit, updated for inflation and growth in the disabled population.

The formula for allocation of funds to the States would take into account the State's share of the disabled population, the State's low-income population, State

²² Title II, New Benefits; Subtitle B - Long -Term Care.

²³ Title II, Subtitle B; Section 2101, State Programs for Home and Community-Based Services for Individuals with Disabilities.

wage levels and required State contribution levels. State contributions for services could range from 5 to 22 percent of the costs of services, with higher shares paid by States with above-average per capita income. Individuals would pay coinsurance on an income-based scale. Program funding would be phased in over a 7 year period, beginning with \$4.5 billion in FY 1996 and reaching \$38.3 billion in FY 2003.

States could offer more limited services during phase-in than would be available later on; however, they could not impose means tests for eligibility. All eligible persons would receive an individual assessment and plan of care. Services would be defined by the State, but would have to include personal assistance services.

State Medicaid programs would continue to provide home and community-based services -- either additional services for persons served under the new Federal program, or services to persons not eligible under the program (because of capacity limits or because they do not meet the disability criteria). States would have the option of integrating community and institutional long-term care with fixed limits on Federal funding in place of open-ended matching funds.

The HSA would establish a system of Federal regulation of private long-term care insurance policies (including requirements that policies include inflation protection and nonforfeiture provisions) and would provide the same tax preferences for these policies that are available for regular health insurance. A new tax credit would be established to pay as much as 50 percent of costs (up to \$15,000) for personal care services for employed persons with disabilities.

Implications: The new long-term care program is the first major federal support for home care services (other than Medicaid for very low-income persons). The program is likely to be popular with the elderly, who have a strong preference for home care services. While the funding for the program is quite substantial, persons with HIV/AIDS are concerned that it raises expectations it cannot meet. In addition, the requirement that participants require assistance with three ADLs would disqualify many disabled persons who also need assistance, including persons with HIV/AIDS. A person living with HIV/AIDS would still have to impoverish themselves to obtain such services through Medicaid. In addition, there is a possibility that expenditures for the mentally retarded and developmentally disabled could potentially consume a large share of the funds. Members of Congress against the Clinton plan have specifically cited this benefit as one with great potential to become another "entitlement."

Further, the HSA measures to promote private long-term care insurance raise some concerns. The requirement that all policies include nonforfeiture provisions and offer inflation protection could significantly raise the cost over coverage. It would then not be affordable except to the wealthy.

Availability of Mental Health and Substance Abuse Services

Issue: Injecting users, a major transmission mode of HIV infection, currently have inadequate treatment and preventive services available to them, will adequate services be available to treat these individuals in order to ameliorate their additive disease and halt the epidemic?

Summary: HSA would provide some treatment for those injection drug users not now covered by any insurance. However, because of the limitations on coverage over the first years, the recidivism rate for addicts would probably remain high and the need for more intensive, prolonged treatment simply postponed. In order to make a significant difference in the rate of new infections in the injecting drug use population and their sexual partners, the public health infra-structure and funding for drug and alcohol abuse would need to be increased greatly to fill the gaps during the phase in period. The cost saving effects of limited coverage would be offset by the cost of treating more HIV infected persons and by eventually having to provide additional treatment for addictions.

Discussion: Health insurance plans which currently provide mental health and substance abuse benefits provide substantially limited services. Over the the past 10 years efforts to curtail healthcare costs have almost universally begun with cut-backs in mental health and substance abuse services. Current health plans limit benefits in a number of ways: inpatient limits, outpatient limits, dollar caps, inordinately high copayments, and denial of benefits.

Inpatient benefits are usually capped with a maximum of 30 -60 days for which benefits will be paid, copayments may range from 10-50%, and outpatient benefits are limited approximately 50% of the daily fee. It is not uncommon for the benefits to be further limited by selective payment for some of the services (i.e. payment for group therapy but not for individual counseling, etc.). Some current policies limit their payment for these services by simply placing a dollar limit on the total amount that will be paid out for services in this category. Copayments for mental health and substance abuse benefits are usually much higher than for medical benefits and many policies simply do not cover these services.

In past years , many companies, also, initiated managed care contracts which provided the same psychiatric and substance abuse benefits which are proposed in the HSA. Unfortunately, managed care companies, in order to be succesful must establish and effectively operated utilization review programs that monitor the quality of treatment and identify and minimize inappropriate use of medical services and facilities. Utilization review in many cases have meant denying the patients the type of care recommended, authorizing only a lesser intensity of care, or cutting off care before the patient had been able to obtain the maximum benefit. The result, too often being, inadequate treatment and return to disability.

The publicly funded mental health and substance abuse treatment programs that are now in place are inadequate. The quality of treatment is less than ideal, the recidivism rates are high, and the number of programs available are not adequate to provide "treatment on demand" for those who wish to access such programs. Those States with the largest number of injecting drug users who are infected or at risk of becoming infected with HIV are having the greatest difficulty adequately funding treatment programs.²⁴ The Public Health Service estimates that there are over 2 million (does not include persons with alcoholism) persons who would enter treatment if slots were available. The Nation Commission on AIDS states that every assessment of the epidemic has identified the urgent need to make treatment of addiction the highest priority in an effective public health to curtail further spread of HIV.

Using Methadone as an interim treatment for injecting drug users is controversial and only postpones the need for quality, long term treatment. Alcoholism is another disease which contributes to unsafe high-risk sexual activities that can spread HIV. Publically funded, community mental health centers do not exist in most areas where they are most needed. In addition, homeless persons and others in most need are prevented by their illness from seeking treatment. Mental illnesses which contribute to injecting and other illicit drug use, as well as alcoholism, are seldom treated.

The comprehensive benefit package describes²⁵ the following services for mental health and substance abuse illnesses: 1) inpatient and residential treatment, 2) intensive nonresidential treatment, 3) outpatient services including case management, screening and assessment, crisis services, and collateral services.

Before January 2001, 30 days of inpatient treatment is covered. A maximum of 30 additional days may be authorized if a health professional designated by a health plan determines it meets the criteria.²⁶ For every two days of intensive non residential treatment received, inpatient care is reduced by one day.²⁷ Sixty days of addition intensive treatment may be covered, cost sharing for these 60 days is

²⁴ Department of Health and Human Services, Public Health Service, PHS Response to the Nation Commission on AIDS Recommendation.

²⁵ Title I - Health Care Security, Subtitle B - Benefits, Part 2 - Description of Items and Services Covered, Section 1114. Mental Health and Substance Abuse Services.

²⁶ Section 1115 (c) (2) (D).

²⁷ Section 1115 (d) (2) (C).

25% in lower costing sharing plan and 50% in higher cost sharing plans.²⁸

Treatment for substance abuse counseling and relapse prevention is covered if a health professional designated by a health plan authorizes. Inpatient and residential days are reduced one day for every 4 days of substance abuse counseling and relapse prevention; detoxification as an out patient treatment is covered only in the context of a treatment program.²⁹

In addition to the treatment benefits appropriations for mental health and substance abuse benefits are requested in the HSA.³⁰ Authorization for appropriations are \$100M FY 1995, \$150M FY1996, and \$250M FY 1997-2000. In addition to these sums the Secretary shall establish pilot programs to demonstrate models of integrating mental health and substance abuse programs with benefits covered in Title I.³¹

Implications: The earliest description of the Health Security Act included coverage for mental health and substance abuse services which would be the equivalent of services for other medical services. As the benefit package evolved it was very quickly realized that the proposed program was going to be too

²⁸ section 1115(2)(C).

²⁹ Section 1115 (e)(2)(B,C and D).

³⁰ Title III - Public Health Initiative, Subpart F - Mental Health and Substance Abuse, Part 1 - Financial Assistance, Section 3501.

³¹ Title III, Subpart B, Section 3521.

expensive to pass Congress. Consequently, the mental health and substance abuse services are limited to the same levels as most currently available health plans for the first few years. These limits will be removed as managed care assumed responsibility for these services. This sounds like evolution in the right direction. Managed care, however, has been around in the behavioral care areas for a number of years and it has not improved access to care and has had a definitely deleterious effect on the quality of care.

The current limitations are major barriers to care for most patients with psychiatric and substance abuse illnesses. These patients are frequently in financial trouble or employment trouble at the point when they are considering treatment. These same barriers will be present under the Health Security Act. The only limited improvement in the situation will be for the individual who has no current coverage who moves into a situation where they will have extremely limited coverage.

Active addictive disease (or mental illness) because of the poor judgement involved, inability or unwillingness to practice safe sex, and the direct risk from needle use places one at higher risk of HIV infection and may well also reduce one's resistance to active disease once infected. One of the limited ways in which risk to HIV can be reduced is to identify at an early stage those who are in this high risk category and do everything possible to reduce barriers and maximize incentives to obtain competent and effective treatment. Unfortunately there is very little in the current Health Security Act which will accomplish or even move us toward this goal.

Recommendation: Work with Congress to increase substance abuse treatment and outreach preventive services for the populations at high risk for HIV infection.

Health Security Act (HSA) and Confidentiality Issues

Issue: What safeguards are envisioned for the handling of health information on HIV affected persons under the Health Security Act of 1993.

Summary: The HSA addresses the issue of how information will be handled and what penalties will be imposed for misusing information. The structure of the information sections are well thought out; however, there is a lack of specific guidelines and standards. It provide guidance level information on creation of the oversight board, users and uses of information, privacy standards, enrollee rights, outright prohibitions, training of information handlers, and comprehensive health information privacy protection. The development of the Comprehensive Health Information Privacy Protection Act does not have to be implemented until three years from the date of passage.

Discussion: The confidentiality of the information obtained by the providers and entered into a national data base under the HSA, is of great concern to all individuals. All anyone needs to do to confirm their concerns is to look at the history of surrounding the HIV epidemic. As we know, HIV status has been misused by employers, medical providers, landlords, and others and has led to a reluctance to share such information on an other than "need to know" basis.

Those familiar with the medical community, know that there is little "confidentiality" within the medical providing community, and that HIV infected patients are well known to personnel in medical settings. To compound that, the HSA now proposes to collect information on all American's enrolled in the plan, and to provide that information across state lines to any provider with whom the person will be enrolled. This, of course, raises new issues of information handling among HIV sensitive communities.

A cursory overview of the Administration's legislation follows:

Information Systems, Privacy, and Administrative Simplification is the title of Title V, Subtitle B of the HSA.³² These parts address the issue of how information will be handled, and how and with what penalty, any mishandling will be dealt.

³²Beginning as Part 1 - HEALTH INFORMATION SYSTEMS, Section 5101. Establishment of Health Information System and continuing through Part 2 - PRIVACY OF INFORMATION Section 5120. Health Information System Privacy Standards; Section 5121. Other Duties with Respect to Privacy; Section 5122. Comprehensive Health Information privacy Protection Act; and Section 5140. National Privacy and Health Data Advisory Council.

Creation of an oversight board. Within two years of passage of the HSA, the National Health Board (NHB) is to develop and implement a health information system (HIS) by which the Board shall collect, report, and regulate the collection and handling of information collected under the Act.³³ The HIS system is to be developed by the NHB and is to be consistent with the National Information Infrastructure Act of 1993 and with standards established under section 5120 of the HSA.

Users and uses of information Information collected under the HIS is to be used for planning, policy development and evaluation and for research.³⁴ Entities having access to it are Federal, State and local governments and regional and corporate alliances.³⁵

Privacy Standards. The National Health Board is to promulgate health information system privacy standards.³⁶ The NHB is to design a "unique identifier number" (UIN) as a part of the HIS³⁷, but other than a general prohibition of general access to information compiled for each holder of a UIN, there is no general guidance as to what information is to be collected or what the permissible uses of the information are to be allowed.³⁸ The most striking prohibition set forth in the principles is that no "individually identifiable health information may be provided by a health plan to a regional alliance or a corporate alliance for the purpose of setting premiums based on risk adjustment factors."³⁹ And, anyone who maintains uses or disseminates individually identifiable health information must have "administrative, technical and physical safeguards for the security of such information."⁴⁰

³³S.B.1757, hereinafter referred to as the Health Security Act or HSA at Title V, Subtitle B, Part 1, Sec. 5101 (a).

³⁴HSA at sec. 5101(d)(1).

³⁵HSA at section 5101(d)(1).

³⁶HSA at section 5103 (d).

³⁷HSA at section 5104 (a)-(c).

³⁸Section 5120 of the HSA provides for the promulgation of privacy standards. There are broadly proposed principles for such standards including unauthorized disclosure and limited disclosure to local law enforcement agencies. See HSA Title V subtitle B section 5120 (c)(1).

³⁹HSA at section 5120(c)((3).

⁴⁰HSA at section 5120(c)(4).

Enrollee rights. All enrollees have a "right to know" (a) if an individual or entity uses or maintains information on the enrollee and (b) what purposes the information is used for or may be maintained for;⁴¹ a "right to access" such information, copy such information and to correct such information⁴² and a "right to notice" ⁴³ of the purposes for which any information is provided and further underscoring the right of access set forth in paragraph (6) of the section.

Outright Prohibitions. In addition to prohibiting the use of the information for purposes of setting premiums, no information collected on the HIS can be used by a employer or prospective employer with regard to "making employment decisions."⁴⁴ Indeed, if a person were to deny or discourage employment based upon such information, might face civil penalties of up to \$50,000 per incident.⁴⁵

Training Information Handlers. The NHB is obligated under the Act to establish education and awareness programs which are designed to (a) foster adequate security practices⁴⁶; train personnel handling such information as to their duties under the Act ⁴⁷ and of informing individuals and their employers regarding their rights with respect to such information.⁴⁸ Since violations of the HSA have sanctions of up to \$10,000 per violation⁴⁹, it is assumed that information handlers will be motivated to circumscribe the sharing of information.

Comprehensive Health Information Privacy Protection Act. Finally, the HSA requires legislation within three (3) years of enactment of the HSA for the NHB to submit to the President and the Congress a detailed proposal for legislation to provide a comprehensive scheme to protect individually identifiable health

⁴¹HSA at section 5120(c) (5)

⁴²HSA at section 5120(c) (6) .

⁴³HSA at section 5120(c) (7) .

⁴⁴HSA at section 5120(c) (9) .

⁴⁵HSA at sections 5412(a) (3) and 5412(b) (1) .

⁴⁶HSA at section 5121(c) (1) .

⁴⁷HSA at section 5121(c) (2) .

⁴⁸HSA at section 5121(c) (3) .

⁴⁹HSA at section 5141(a) (3) .

information.⁵⁰ The proposed legislation would cover information which is inappropriately shared whether verbally or written.⁵¹

Implications: With regard to the two years of delay between the passage of the HSA and the implementation of the health information system (HIS), there is a time-lag problem. The increasing number of HIV infected populations within the United States is concentrated in minority populations including women, children, the homeless and prison populations. Many of these individuals will be under-enrolled: i.e. they will not be caught up in the first rush to register. The homeless are often difficult to locate and their first "experience" of registration will probably be reserved for "emergency room" visits. Prison populations are not even being currently considered for coverage. They are, in fact, excluded under the Act. Thus, information may, or may not, be collected on these populations. If it is, the populations themselves may lack the will to challenge the mishandling of such information. They may not even be aware of a mechanism for redress of grievances under the Act.

Once collected, there should be serious concern as to the users of the information. Use of collected and reported data for health care planning, policy development, policy evaluation, and research are good public health functions and objectives in and of themselves. But users of the information are not just traditional users such as government suppliers of services (i.e. federal, state and local government entities) but also regional alliances and corporate alliances. This places information on people within the care, custody and control of private or quasi-private entities, which may or may not be monitored for information processing, handling, and disseminating. Having the information in their hands leads to questions of what is to be done with it once it is there.

Increased pressures for access to the information will be acute since one goal of collecting such information is the "managing and containing costs at the alliance and plan levels".⁵² Plans and alliances of Ryan White Title I cities will be particularly interested in such statistics for purposes of initially qualifying or continuing qualification for Title I funds. The key to information control may be limiting the access to such information by curbing who will have person-specific access and having all other uses be epidemiological (i.e. number counts as opposed to name counts).

The legislation contemplates "unique identifier numbers" for each enrollee of the

⁵⁰HSA at section 5122.

⁵¹HSA at section 5123(3).

⁵²HSA at section 5101(d)(8).

plan, much like the social security number provided to each American now. This does not mean that wanton misuse of the information will prevail. For example, no use is to be made of the information for denying benefits or by employers for denying jobs. This clearly addresses two grave concerns of HIV positive people: loss of coverage and loss of employment. Of more than general interest is the provisions within the Act to train information handlers as to their duties and responsibilities under the act as well as the provisions for actively educating enrollees as to what their rights are: rights of knowing, accessing, correcting and of being told when information is held on a person.

The chief weakness as the legislation currently stands is the lack of specific guidelines or standards of the types of information collected, restrictions on that information, and clearly articulated standards of who should receive such information and when they should receive it. The "heaven in the details" will evidently be at the guidance of the proposed Comprehensive Health Information Privacy Protection Act which is to come within three years of the Acts passage.

Recommendations: The following recommendations should be considered for tightening up the proposed legislation as it pertains to confidentiality issues:

- 1) There is no need to delay for three years of development from the date of passage a Comprehensive Health Information Privacy Protection Act as envisioned by the Act. The public, which will lack confidence in the accumulation of such information pools, let alone the experience-driven HIV populations, will be demanding privacy protection from the beginning. Such protection should be developed parallel to the refinements of the Act.
- 2) It is unclear whether the provisions of such an Act would be pre-emptive of State or local laws governing medical records. Would the Federal law be a floor, setting minimum standards of handling health care records; would it set a ceiling, or would it set exclusive standards that could not be modified by other entities. This point needs to be lobbied.
- 3) The intersection of "handicap" protection as allowed under the Americans With Disabilities Act for HIV sensitive communities and the Comprehensive Health Information Privacy Protection Act needs to be carefully reviewed. If someone mishandles information, does a private right of action spring into existence or is one relegated to a government forum for resolving the matter?
- 4) Conflict resolution mechanisms in HCR need to be carefully reviewed as to the timeliness of their resolution for fatally infected individuals. The two and three year judicial time lines of the past, which often lead to the plaintiff's death before resolution, Resolutions for such populations needs to be expedited by placement on fast-tracks for arbitration or judicial resolution. The conflict resolution sections

of HCR recognize these needs and provide for most resolution within 30 days⁵³ of complaints being filed, and in some cases, within 24 hours.⁵⁴ However, claimants must use the plan's claims process and all recourse must be exhausted before the claimant goes on to the complaint process. It is these kinds of requirements that need to be carefully reviewed since they will most often be the cause of delay.

5) Along with the rights to know, to have access and to obtain notice, a "right to treatment" might also be considered. This is much more political in scope, but many people who are turned away by medical providers now might be more willing to buy into the proposed legislation if they know that part and parcel of universal health care coverage is the assurance that they have a "right to treatment" which cannot be denied.

⁵³HCR section 5202(c).

⁵⁴HSA section 5201(c)(2).

Health Care Reform and the Ryan White CARE Act

Issue: Will the financial restructuring of the health care system assure the delivery of health care services appropriate to the needs of vulnerable populations whose access problems go beyond lack of insurance.

Summary: to be written

Discussion: In August of 1990, Congress passed the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The purpose of the CARE Act was to provide emergency assistance to States and localities for the delivery of essential services to individuals and families affected by HIV disease. Further, the CARE Act was created to establish services for persons with HIV/AIDS who would otherwise have no access to care. Finally, it was intended to provide emergency relief funding to communities with the highest number of reported AIDS cases.

Congress funded the CARE Act at \$221 million in fiscal year (FY) 1991, \$276 million for FY 1992, \$338 million for FY 1993, and \$579 million for FY 1994. As health care reform is undertaken, its affect on clients served by the CARE Act must be assessed. Several key issues such as guaranteed benefits and wrap-around services, financing mechanisms, essential providers, and access to specialty services must be explored.

Persons living with HIV have special needs often exacerbated by other physical, social and economic factors, e.g. substance abuse and homelessness. Needs that are best served by the provision of a complex array of social as well as preventive and primary care services. Further, these individuals often require extensive outreach and efforts to modify the behaviors that both put them and others at risk and make them averse to seeking care in a timely manner.

The Administration is currently stating that federal categorical such as the CARE Act will be "offset" by the cost of services estimated to be provided in guaranteed benefits in the health care reform package. The comprehensive benefit package may not provide many essential services for persons with HIV/AIDS. These supportive and enabling services, and their cost, must be identified to ensure that comprehensive care for persons with HIV/AIDS is sustained with CARE Act dollars. Conversely, a variety of services currently provided by the CARE Act would be covered by a comprehensive benefits package. These would include primary care services, medications, assistance for health insurance coverage, home-based services, and case management.

An evaluation of CARE Act expenditures for these categories is necessary to determine CARE Act funds "freed" as a result of health care reform. These funds might be utilized to support HIV-specific supplemental insurance for wrap-around

services, "infrastructure" grants for coinsurance, copayment, etc., other health care reform provisions or the deficit.

It may be necessary to utilize CARE Act funds to subsidize the supplemental and client's share of insurance premiums, co-payments, deductibles, and expenditures that exceed spending caps. With health care reform there will be a need for persons living with HIV to have access to specialty HIV care that may only be provided outside a health alliance. This need may be met with the designation of all providers under the CARE Act as "essential providers." However, questions remain about: 1) what defines essential community providers, e.g. primary medical, social service provider, etc.; 2) whether there are gatekeepers that would limit access to essential providers; and 3) how this provision would play out in rural or low-incidence HIV communities.

Recommendation: 1) To work through the Administration to assure that the CARE Act is not discarded after health care reform; and that it continues to serve as a critical resource to sustain health care delivery systems, comprehensive health and support services those infected with HIV.

2) To work through the Administration to assure that any "savings" of CARE Act funds which may be realized as a result of services provided under the HSA not be used as an "off-set" but used to provide grants to additional eligible metropolitan areas.

Public Health Core Functions/Research

Issue: What is the nature of the funding for research on behavior, health services and Core Functions of Public Health Programs?

Summary: Although the Health Security Act will provide funding for health care for all Americans, there are research and public health initiatives that will have to be provided by the Public Health System. Behavioral research into those behaviors that may cause or contribute to disease will be conducted by the National Institutes of Health. The Act will also provide funding for strengthening the public health core function of states, including those components related to diseases of public health significance.

Discussion: The Act includes coverage for all individuals for medical services and prevention. The Act also makes provisions for improving the quality of services provided by the states and for public health initiatives that constitute primary prevention. These functions are reinforced with behavioral and health promotion research.

The Act provides for additional biomedical and behavioral research on prevention and health promotion at NIH and for research on the impact of health care reform. In addition, the Act provides for grants to states to improve the core function of the public health system and grants to state/local governments, non-profits and public/private partnerships to conduct national prevention programs. Funding for all these initiatives is in addition to other funding that may be provided for these activities through other appropriations.

These programs are included under Title III, Subtitle C, Health Research Initiatives NIH will conduct biomedical and behavioral research. Sec. 3201, amending Section 402(f) of the Public Health Service Act. Research will consist of child and adolescent health, chronic and recurrent health conditions, reproductive health, mental health, elderly health...infectious diseases... and to resource development related to such research. NIH will receive \$400M in FY95, \$500M in FY96-2000. Sec. 3211(a).

Research on the impact of Health Care Reform shall be conducted by the Administrator of Agency for Health Care Research. Sec. 3202, amending section 902 of the Public Health Service Act. This research will be conducted under the direction of the National Board. Research will concentrate on the quality of care, consumer choice, health delivery, risk adjustment, access to health care and others. The PHS Initiatives Fund will receive \$150M in FY95, \$400 in FY96, \$500 in FY97 and \$600 for FY98-2000.

Core functions of Public Health Programs: funding will be given to the states to improve the following: communicable disease prevention, accident prevention, toxic hazard exposure, identify and control outbreaks of infectious diseases, public information campaigns, develop new prevention strategies. Sec. 3311. Funding will consist of \$12M in FY95, \$325 in FY 96, \$450 for FY97, \$550 for FY98, \$650 for FY99 and \$750 for FY2000. Sec. 3301(a). Grants will go to states to improve data collection, to protect the environment, investigation and control of health conditions, public information campaigns, evaluation, public health laboratory services, training and education, policy development and administration. Sec. 3312(b)(1 – 8).

National Initiatives Regarding Health Promotion and Disease Prevention: Grants will go to state/local governments, non-profits and public/private partnerships to carry out projects to provide health promotion and disease prevention. Sec. 3331. Priorities will be set by the DHHS Secretary once a year. Sec.3332(a). The grants will be made by DHHS based on the following: programs must take into account the needs of the affected populations, are targeted to the most needy population, examine links between preventable diseases and increase links between agencies rendering programs. Sec. 3331. Grant applications must be submitted to DHHS. Sec. 3333.

Implications: Although the Health Security Act will provide for primary care, there are research and public health core functions that must be supported with continued funding. These will not be funded through reimbursement mechanisms that will be used for HSA. The behavioral research component will be instrumental in impacting behaviors that put persons at risk for HIV, enhance survivability and improve quality of life. The core function funding will enhance the public health structure to better deal with illnesses of public health significance.

Recommendations: These provisions must be supported. Whenever possible, this funding must be maintained or increased. HSA will not be able to provide sufficient funding for the public health functions that are necessary to support the general welfare.

Supplemental Services under Medicaid and the New Health System: Implications for HIV/AIDS Populations

Discussion: Optional services under Medicaid are those which directly or indirectly allow access of patients to the health care system or are certain patient care services which are not required under the standard Medicaid insurance plan. There are 33 different services that states may opt to provide, including transportation, social work, child care, case management, hospice and home health. These are provided by seven states (medical social worker and christian science nurse services) to 50 states (optometric, clinic, prescription drug, prosthetic, and nursing facilities for the mentally retarded). These are provided in all states. Numbers of services per state range from 14 (Louisiana and Wyoming) to 30 (Minnesota, New Jersey and Wisconsin).

This optional services are supported by federal matching funds ranging from 50-80% (inversely related to state per capita income) for any of the 33 services states opt to elect (Federal Financial Participation [FFP]). These services are mandated for many of the 16 million Medicaid-eligible children regardless of state option (enforced match). Medicaid is currently estimated to provide coverage of direct and indirect services for approximately 90% of children with HIV/AIDS. In addition, significant, though smaller, amounts of supplemental services are currently funded through other non-Medicaid means (federal grants [e.g. Ryan-White], state, third-party and out-of-pocket funds).

Under the Administration's Health Security Act adult Medicaid beneficiaries who receive cash assistance (9 million beneficiaries) would be main streamed into the new system, but would not have to pay premiums. Further, they would be entitled to join a new state and federally-matched program providing wrap-around services similar to those listed above. Children less than 18 years old who are currently or would be Medicaid beneficiaries, with eligibility for wrap-around services (primarily based on poverty level), would be provided those services through a new fully federally funded, state-administered program, regardless of their cash assistance status.

However, adult Medicaid beneficiaries who are not on cash assistance and the estimated 37 million currently uninsured would only be able to receive supplemental services at state option, without federal entitlement support. In FY92, there are an estimated 6 million Medicaid adult non-cash beneficiaries with an annual total (direct/indirect services) payout of at least \$25 billion.

A proposal for funding enabling services through federal grant mechanisms is mentioned in the Public Health Initiative part of the HSA, and would be authorized for \$200 million in FY 96, \$300 million in FY97-99, and \$100 million in FY 2000.

Categorical grant programs (e.g., Ryan-White) would continue under the proposal, funding "essential community providers", so that there would still be provision of significant support from PHS for enabling services in states and localities. However, there would likely be an "offset" (latest percentage quoted for Ryan-White is 25%) reduction of funds to account for the clinical services portion that would instead be provided through the benefits package.

Implications on access to care

More children/adolescents who are in need of financial assistance will have greater (more nationally uniform and easily obtained) access to supplemental services under the new proposals than under the current system. Given Medicaid's current coverage of almost all (90%) children with HIV/AIDS, this proposal would continue to allow that high level of support for enabling services.

Adults on cash assistance (9 million), who require significant support services in order to successfully access the health care system, will continue to have these paid for by state and federally matched entitlement funds. This plan will continue entitlement support for access services in those groups where there is a high rate of increase of HIV/AIDS.

Adults who are NOT on cash assistance (including the 6 million from Medicaid as well as those from the estimated 37 million uninsured), however, will be provided only those supplemental services that states choose to continue in the face of being unable to receive matching federal entitlement funds. A significant financial burden may therefore be placed on states that wish to (continue to) provide wrap-around services to these adults.

The impact on HIV/AIDS populations could be very significant, as adults in this group who are financially strapped but not on welfare could potentially lose, let alone not gain, additional services that give them access to the care provided by the plan. The Public Health enabling services initiative and the proposed continuation of the categorical grant programs (especially Ryan-White) would assist in lessening the financial predicament described above. However, they are not even authorized at levels to supplant the potential loss of benefits that may result due to the Medicaid modifications. Further, as these are categorized as discretionary spending, they may be subject to significant budget constraints in future years, due to deficit-reduction initiatives.

Policy Options: A. OPTIMAL Support the Administration proposal to establish broader medical coverage for children and continued coverage for cash-assisted adults under the Medicaid program, due to the significant concerns regarding increasing HIV rates in these age and risk groups. Advocate that

requirements for provision of federal entitlement matching funds for supplemental services be established for all formerly Medicaid AND uninsured adults, whether on cash assistance or not, in order to assure appropriate access to care for these individuals.

The major difficulty with this approach is that a very significant (potentially multi-billion dollar) increase in federal financing would be required for the additional millions of formerly uninsured who could need (and definitely use if available) these services.

B. OPTIMAL/REALISTIC Support the Administration proposal to establish broader medical coverage for children and continued coverage for cash-assisted adults under the Medicaid program, due to the significant concerns regarding increasing HIV rates in these age and risk groups. Advocate that the Public Health enabling services initiative be legislated as entitlement spending in order to prevent it from being subject to the annual appropriations process, which could very likely result in its being less than fully funded. Advocate the same policy for categorical grant programs of particular relevance to HIV/AIDS (inc. Ryan-White, up for reauthorization).

However, given the federal government's experience with the increasing mandatory financial obligations of entitlement programs, it is unlikely that it would want to establish new ones, particularly with deficit-reduction as a prioritizing principle.

C. REALISTIC Support the Administration proposal to establish broader medical coverage for children and continued coverage for cash-assisted adults under the Medicaid program, due to the significant concerns regarding increasing HIV rates in these age and risk groups. Support within the Administration and in Congressional hearings establishment of, and promises of full funding for, the Public Health enabling service initiative and categorical grant programs like Ryan-White that financially support provision of the supplemental services that PWA's particularly require for care. Advocate funding equivalency at least between the gain expected through the public health initiatives and the loss encumbered through the Medicaid program revisions. As a previous step, support the prioritization by the Department's analytic group of conducting a study on determining the financial gains/losses on supplemental services under health reform. Evaluation of supplemental services need by the currently uninsured could be advocated as an additional step.

October 19, 1993

TO: Carlos Velez, Director, HIV/AIDS Prevention, NAPO
Alice Litwinowicz, Planning and Information Group, NAPO

FROM: Sandy Howard and Linda Sanches
Division of Public Health Policy, ASPE

RE: HIV/AIDS and Health Care Reform: Questions and Answers
-- Information Copy

At the request of Patsy Fleming (OS) we developed the attached compilation of questions and answers on HIV/AIDS care in health care reform. As a basis for the questions we used memos prepared by you and addressed to Ben Merrill, which describe issues raised at meetings with people with HIV/AIDS and the community-based organizations serving them.

We hope that these questions and answers are useful to you. Please feel free to call us at 690-6102 should you want updates on these points.

HIV/AIDS AND HEALTH CARE REFORM

QUESTIONS AND ANSWERS

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October 19, 1993
PHP/ASPE

BENEFITS -- WHO DECIDES?

QUESTION:

Who will determine what is covered under the plan? Who establishes the standard of care?

ANSWER:

- ▶ Initially, the guaranteed benefit package will be provided in the legislation. The National Health Board will then have the authority to review benefits in light of changing technology.

BENEFITS -- HIV SERVICES

QUESTION:

Will services for HIV patients be covered under the plan?

ANSWER:

- ▶ Yes. A comprehensive package of services will be available to all Americans regardless of their medical condition or the disease with which they suffer.
- ▶ Under today's insurance rules, people who are HIV-positive may be dropped from coverage, or their rates may skyrocket. Under reform, all Americans have the security of health coverage that's always there. Plans cannot charge more to people with preexisting conditions and they cannot drop them.

KEY INFORMATION:

- ▶ Experimental drugs and therapies will not be covered services, regardless of the medical disease a person has. The guaranteed benefit package includes coverage of routine medical services provided as part of an investigational treatment during an approved research trial because the costs of these services would be incurred anyway.

LIFE-THREATENING ILLNESSES

QUESTION:

Is there language in the plan that specifically addresses life-threatening illness?

ANSWER:

- ▶ Life-threatening illnesses are specifically addressed by the plan. However, medically necessary care will be provided to everyone, whether or not the illness is life-threatening. In addition, the guaranteed health benefits include hospice services, home health care and extended care services.

BENEFITS -- EXPERIMENTAL PROCEDURES

QUESTION:

How does the plan treat experimental treatments? Does the Health Board decide coverage for these procedures?

ANSWER:

- ▶ The guaranteed benefit package includes coverage of routine medical services provided as part of an investigational treatment during an approved research trial because the costs of these services would be incurred anyway.
- ▶ Experimental procedures that have not been shown to be safe and effective through scientific studies and are not provided as part of an approved research trial will not be included in the benefit package.
- ▶ The National Health Board will have the authority to add new procedures and treatments to the covered benefits as those procedures are demonstrated to be safe and effective.

KEY INFORMATION:

- ▶ Experimental drugs and therapies will not be covered services, regardless of the medical disease. (Experimental drugs, when administered as part of an approved clinical trial, are normally provided free of charge to the patient.)

CHOICE OF DOCTORS

QUESTION:

Will the government choose the doctor one uses in the plan?

ANSWER:

- ▶ No. Everyone will choose their own doctors. Each individual will be able to enroll in a traditional fee-for-service plan, join a network of doctors and hospitals, or join an HMO. An individual can choose a plan that provides the providers and services he or she prefers. If required services are not available through providers within the plan, the plan must make referral arrangements for their members.

ACCESS TO HIV SPECIALISTS

QUESTION:

Since there are few doctors with expertise in HIV, how can we be sure that HIV patients have access to these providers?

ANSWER:

- ▶ Individuals are free to choose the health plan that best serves their needs and preferences. Essentially all doctors will be available through one type of plan or another. Fee for service plans should include any doctor who is not willing to participate in an HMO or PPO type plan.
- ▶ MEDICAID: In many regions of the country, organized delivery systems have little experience providing care to severely disabled persons. During a transition period it is important that disabled Medicaid recipients have access to a fee-for-service plan, and additional subsidies will be made available to secure this access. Further, deductibles and copayments will be subsidized for disabled Medicaid recipients in fee-for-service plans.

OUT OF PLAN SERVICES

QUESTION:

Will consumers have access to out-of-plan services or services available only in another area (e.g. out-of-plan physician visits, or services at an out-of-area specialty clinic, such as the Mayo Clinic)?

ANSWER:

- ▶ Plans will determine coverage policies for out-of-plan and out-of-area services that are not urgently needed, and individuals may select plans that include the services they desire. Urgently needed medical services must be provided.
- ▶ The Department of Health and Human Services, in cooperation with States and health alliances, will identify rare diseases, specialized procedures and treatments for which health plans will be required to establish contractual relationships with academic health centers.

CONFIDENTIALITY -- HEALTH INSURANCE CARD

QUESTION:

Please clarify the use of the health insurance card. What types of information would it contain?

ANSWER:

- ▶ Every American will receive a national health security card to assure access to needed health services throughout the United States. Much like ATM cards, the health security card will allow access to information about health coverage through an integrated national network. The card itself would contain a minimal amount of information, probably limited to basic information to verify identity and plan enrollment.

CONFIDENTIALITY OF HEALTH RECORDS

QUESTION:

How will confidentiality of health records be assured?

ANSWER:

- ▶ Currently, no uniform, comprehensive privacy standards related to health care information exist. The Federal government will establish national privacy safeguards covering all health records, based on the Code of Fair Information Practices. For example, the Code stipulates that individuals who are the subject of data collected:
 - ▶ Have the right to know about and approve the uses to which the data are put;
 - ▶ Are assured that no secret data systems are permitted to exist;
 - ▶ Have the right to review and correct data about themselves;
 - ▶ Have adequate assurance that data may be collected and used only for legitimate purposes.
- ▶ A national privacy panel will be created under the National Health Board. It will focus on privacy protection as applied to health care information.
- ▶ The Federal government will develop effective mechanisms for enforcement, including significant penalties for breach of legal requirements.
- ▶ The Department of Health and Human Services is continuing to identify and resolve various privacy concerns.

CONFIDENTIALITY OF MEDICAL INFORMATION

QUESTION:

The plan calls for integration of medical information into PHS surveillance efforts. How will confidentiality be protected if information is aggregated for surveillance and epidemiological purposes?

ANSWER:

- ▶ The national privacy policy will explicitly forbid the linking of aggregated health care and other information through the unique individual identifier for participants in health plans.
- ▶ Uniform and comprehensive confidentiality protection will apply to all individually identifiable health care information, whether it is part of the new health care system or exists outside it, regardless of the form in which records are kept, their location, owner, user, or repository. The same level of protection will be available for all illnesses and diseases.

DISCRIMINATION -- SAFEGUARDS

QUESTION:

Many Americans currently face non-financial barriers to care, including discrimination based on race, ethnicity, sexual orientation, age, or gender. Who is responsible for ensuring that providers and plans do not discriminate?

ANSWER:

There are several points of responsibility to ensure that discrimination is not a barrier to receiving health care.

- ▶ First, the Health Security Plan will put and end to cherry picking (offering low rates only to groups of young, healthy low-risk persons) and redlining (denying coverage to certain industries or geographic areas perceived as high risk).
- ▶ Enforcement of Title VI of the Civil Rights Act will preclude discrimination and provide protection both to providers and recipients.
- ▶ The National Quality Management Program under the National Health Board develops a core set of measures of performance that apply to all health plans, institutions and practitioners. It will publish annual performance reports on each health plan, creating a public system of accountability for quality.
- ▶ States must develop and implement plans to meet enrollment, access and quality standards. States must also report on the performance of alliances, plans, providers and practitioners.
- ▶ Alliance must resolve consumer complaints, grievances and requests to leave a health plan. Alliances must also issue reports on the quality of health plans, providers and practitioners.
- ▶ Health plans are responsible for reporting on, maintaining and improving the quality of care delivered by providers and practitioners.

DISCRIMINATION --LOW INCOME

QUESTION:

Will low-income people be segregated into separate plans?

ANSWER:

- ▶ The important thing to remember is that low-income people are guaranteed access to a quality plan.
- ▶ States can require plans to serve populations in all areas.
- ▶ We are continuing to model subsidy schedules to explore their impact on patient choice and program costs and will work with you on this.

DISCRIMINATION -- CAN PLANS CONTROL WHO'S COVERED?

QUESTION:

Can a plan draw its own area and fix it so that it only serves the wealthy? Also could the plan draw its district so that it doesn't have an essential access provider in its area? How are you going to ensure that minority providers aren't locked out?

ANSWER:

- ▶ First, Title VI of the Civil Rights Act will preclude discrimination and provide protection both to providers and recipients.
- ▶ In addition, States may require plans to establish service areas to ensure that eligible populations are covered.
 - ▶ However, financial incentives will reinforce these rules. Plans that do manage to draw a more favorable enrollment--either by luck or by design--will be paid a risk adjusted premium that offsets the case-mix advantage.
 - ▶ Alliances may not subdivide a primary metropolitan statistical area and may not discriminate against health plans or providers on the basis of race, gender, ethnicity, religion, or organizational arrangement.
- ▶ Health plans may not discriminate against providers on the basis of race, ethnicity, gender, religion, mix of health professionals or patient population.

PRESCRIPTION DRUGS -- OFF LABEL DRUG COVERAGE

QUESTION:

Will off-label use of prescription drugs be covered?

ANSWER:

- ▶ All uses (approved and unapproved) of drugs, biologicals, and insulin are covered, however plans are allowed to establish formularies.
- ▶ The National Health Board may intervene to require plans to cover certain unapproved uses for specified serious or life threatening illnesses.
- ▶ The Secretary may recommend to the National Health Board that certain unapproved uses should not be covered by plans.

NEWLY-APPROVED DRUGS

QUESTION:

Some current insurance plans exclude newly-approved drugs. Will new drugs be automatically covered?

ANSWER:

- ▶ The comprehensive benefit package will provide access to FDA approved prescription drugs. However, health plans may use formularies to restrict coverage to an approved list of drugs.

KEY INFORMATION:

- ▶ The drug benefit is still under discussion.
- ▶ Under Medicare, the Secretary may:
 - ▶ Exclude certain drugs from coverage if they are determined to be excessively priced and an appropriate rebate cannot be negotiated.
 - ▶ require prior approval before certain drugs may be dispensed. These include medications that are not cost-effective or are subject to inappropriate use.

NON-APPROVED DRUGS AND DRUG IMPORTATION

QUESTION:

Are non-approved drugs and drug importation policy addressed under the plan?

ANSWER:

- ▶ Only FDA approved drugs and biological products are covered under the plan.

Co-payments for Prescription Drugs

QUESTION:

How will co-payments work under the plan for prescription drugs?

ANSWER:

- ▶ Co-payments for prescription drugs will vary according to the type of health plan the beneficiary is enrolled. The minimum copayment will be \$5 per prescription for beneficiaries enrolled in managed care plans. For beneficiaries enrolled in other types of plans (e.g., indemnity plans), the copayment will include a \$250 deductible with a 20% coinsurance.

SUPPORT SERVICES

QUESTION:

Are transportation and other support services critical to people with HIV covered by the plan?

ANSWER:

- ▶ In the existing health care system, major financial and non-financial barriers reduce access for many populations, including individuals with severe health problems such as HIV infection and AIDS. The comprehensive benefits package will significantly improve access to needed treatment services.
- ▶ Transportation and support services are not part of the comprehensive benefits package. However, activities designed to enable, enhance and ensure access to care for vulnerable groups will be supported through public health service access initiatives.
- ▶ Successful programs such as Ryan White and community health centers, will be expanded.
- ▶ New grant programs will support outreach and enabling services (e.g., transportation, translation), linkage of individuals to health plans and community health and social services, and other supplemental services.

AIDS COMMUNITY-BASED PROGRAMS

QUESTION:

What will happen to current community-based programs that serve people with HIV? Will those additional services be cut?

ANSWER:

- ▶ The current public health programs vital to serving vulnerable populations will remain and be expanded. The Ryan White Care programs will continue.
- ▶ Existing community providers that are federal grantees serving special populations will be designated "Essential Community Providers", meaning that health plans will be required to contract with and reimburse them for care for five years. Independent providers may apply for designation as essential providers.

COORDINATION WITH COMMUNITY-BASED PROGRAMS

QUESTION:

How will the new health plans coordinate with existing community-based programs serving people with HIV?

ANSWER:

- ▶ Designation of "Essential Community Providers" will assure access and continuity of care by requiring health plans to contract with established community-based providers. By the end of five years, essential providers either become integrated into health plans or join together to create new, community-based health plans.
- ▶ Plans must be able to demonstrate to DHHS that they can provide low-income and other vulnerable enrollees with access to care at least as effectively as essential provider in order to discontinue contracting or reimbursement arrangements with essential community providers.

COMMUNITY-BASED MENTAL HEALTH SERVICES

QUESTION:

How will the President's plan affect mental health and substance abuse services currently provided by community-based organizations?

ANSWER:

- ▶ The Health Security plan provides benefits for substance abuse and mental health services delivery in a variety of settings, including provider offices and clinics, residential treatment programs, intensive day programs, and intensive home-based services. Some of these services are currently provided by community-based organizations. Plans will have the flexibility to include a wider variety of providers than is typically available currently, because often coverage is restricted to hospitals and provider offices.

MENTAL HEALTH BENEFITS

QUESTION:

Are the proposed substance abuse and mental health benefits in the President's plan adequate to support the long-term psychosocial needs of HIV-positive individuals?

ANSWER:

- ▶ The President's plan does not treat HIV-positive individuals differently than anyone else in need of mental health and substance abuse treatment services. Health plans will be prohibited from denying coverage and benefits based on pre-existing conditions, including HIV-positive status.
- ▶ The President's plan will give States the flexibility until the year 2001 to design and implement health care reform to meet the mental health and substance abuse treatment needs of their citizens, including HIV-positive individuals.
- ▶ The President's plan gives States the flexibility to fold their expenditures for public mental health and substance abuse programs into funding available to health alliances and move to an integrated system for acute care for mental illness and substance abuse disorders.

CHRONICALLY MENTALLY ILL--LONG TERM CARE

QUESTION:

Chronically mentally ill need extensive services; will those services be covered?

ANSWER:

- ▶ Some of the needed services will be included in the guaranteed benefits package, e.g., mental health benefits.
- ▶ In addition, many of the chronically mentally ill will qualify for the new home and community based long-term care program, through which additional services will be available.
- ▶ And current Medicaid programs for the chronically mentally ill will continue for those on cash assistance (AFDC or SSI).
- ▶ Grant programs for community mental health centers will continue to provide further services.

LONG-TERM CARE

QUESTION:

Is long-term care part of the guaranteed benefit package?

ANSWER:

- ▶ The plan includes a new long-term care home and community based program for severely disabled persons, regardless of age or income. This program will benefit about 3 million people.
- ▶ This program will be separate from the guaranteed benefits available from alliance health plans, and there are no plans to add these benefits to the guaranteed benefits package, which are paid in part through employer contributions.
- ▶ By 1996, a demonstration will be initiated to promote the integration of acute care with long-term care outside of alliance health plans.
- ▶ The plan also includes several additional proposals that will enhance long-term care benefits.
- ▶ Private long-term-care insurance will be improved through the adoption of new federal standards.
- ▶ And tax deductions will be permitted for private long-term care policies.
- ▶ MEDICAID: Current Medicaid home and community based long-term care programs will continue, providing an additional means of enrollment for those not enrolled in the new program.
- ▶ The plan also enhances the current Medicaid institutional long-term care program, benefitting an additional 1.2 million people.
 - ▶ People with \$12,000 in assets will qualify for benefits, an increase from \$2,000.

LONG-TERM CARE -- CAPPED PROGRAM

QUESTION:

If the home and community based program is capped, how will you ensure that those who are eligible for it will get enrolled?

ANSWER:

- ▶ Budgets have been estimated to cover the costs of the entire population likely to be eligible for these benefits.
- ▶ In addition, current Medicaid home and community based long-term care programs will continue for those on cash assistance programs, providing an additional means of enrollment for those not enrolled in the new program.
- ▶ States will need to submit a plan to the Department of Health and Human Services outlining how their program will work and how their individuals will get services. This plan will need to be approved before they receive federal money. States will have the flexibility to design their programs and allocate funds in ways that best meet the needs of their populations served.

LONG TERM CARE -- ENTITLEMENT?

QUESTION:

Is the long term care program an entitlement? What happens to a severely disabled person if the state cannot afford to provide services?

ANSWER:

- ▶ The new long term care benefit is a capped entitlement to the States to expand home and community based services to individuals with severe disabilities. It is not an entitlement program for individuals.
- ▶ While this new benefit does not guarantee that every eligible disabled individual will have access to a wide array of home and community based services, the substantial increase in Federal dollars should improve the availability of these type of services for most eligible disabled individuals.

DISABILITY BENEFITS

QUESTION:

Will individuals be able to retain their disability benefits even when they recover enough to work again?

ANSWER:

- ▶ The SSI and the SSDI programs for disability do not change as a result of health care reform.
- ▶ If a person works in spite of a disability, there are return-to-work provisions, which allow an SSI beneficiary to return to work and retain Medicaid coverage for a period of time. If a person truly recovers from a disability, (e.g., a broken leg), and is able to return to work, then disability benefits would normally be terminated.
- ▶ One of the biggest obstacles for a disabled person returning to work is obtaining health care coverage. Universal access and coverage of pre-existing conditions are the MOST important factors which facilitate return to work under health care reform.

SPECIAL SUBSIDY FOR SSI DISABLED?

QUESTION:

Does the plan provide a special subsidy for the SSI disabled population that is unavailable to other Medicaid or low income enrollees?

ANSWER:

- ▶ We are concerned about continued access to very highly specialized services now used by the severely disabled population on SSI. Currently these services are available only in the fee-for-service insurance sector.
- ▶ We are considering options that would guarantee access to these services during the transition when other health plan arrangements evolve to provide them.
- ▶ One option is to provide the SSI disabled with a special subsidy that would pay for coverage under the lowest cost fee-for-service plan, regardless of the relationship of that plan's premium to the average premium in the Alliance.
- ▶ We also are considering time limiting this special treatment to end when other types of plan demonstrate a capacity to serve this population.
- ▶ As we weigh these options, your suggestions will be most appreciated.

DISABILITY PAPERWORK

QUESTION:

Will the paperwork required to qualify for disability and other benefits be reduced? If one moves will the same services be available without a lot of paperwork and forms?

ANSWER:

- ▶ There is no immediate change from current policy for SSI and SSDI. Now, some patients do not have treating physicians and about 40% require evaluation by consultative physicians paid for by SSA. Under the plan, everyone would have a physician, and this would speed up the process of disability determination.
- ▶ If a person moves, there may be differences among the States in supplemental benefits available, and there may be additional paperwork involved in such cases.

DISABILITY WAITING PERIODS

QUESTION:

What happens with disability waiting periods and coverage under the plan?

ANSWER:

- ▶ The comprehensive benefit plan covers all medically necessary services without a waiting period.
- ▶ MEDICARE: There are no changes in the waiting period for Medicare coverage under SSDI.
- ▶ MEDICAID: The Medicaid program will continue to make payments on behalf of AFDC and SSI recipients. Cash assistance recipients, just like other members of the alliance, will choose from among plans participating in the regional alliance.
- ▶ Supplemental services for cash recipients (e.g., vision care, non-emergency transportation) will remain as in current law.
- ▶ Medicaid benefits and payments will continue to supplement Medicare as under current law.

NON-TRADITIONAL FAMILIES

QUESTION:

How will members of non-traditional families be able to access health care?

ANSWER:

- ▶ All individuals will be covered by a health plan. The plan provides for separate premiums for individuals, married couples, single parents and married two-parent families. The premium for couples is the same cost as two individual premiums. The plan does not provide family premiums for families of unmarried individuals.

HEALTH REFORM AND THE TERRITORIES

QUESTION:

How will the population of the Territories be treated under health reform? Will they participate in health reform as does the mainland population?

ANSWER:

- ▶ The policy regarding the Territories is currently under development. The current plan envisions residents of the territories being guaranteed the same comprehensive benefit package available in the States. Because the territories have special problems, it has always been the policy of the federal government to allow them maximum flexibility in determining their health systems. Within broad limits, this will probably continue. They will be allowed to continue their health plans much as they exist currently.
- ▶ Puerto Rico, for example, has a system of walk-in clinics. While they wish to change this for a health insurance system similar to that of the mainland, they are experimenting with such a system in one municipio only. The remainder of the commonwealth will continue with their current system of clinics which will have to offer the health reform benefit package.
- ▶ The Territories will probably also benefit from health reform by getting additional federal funds. A working group is modeling the subsidy each territory would get if it participated fully in health reform. Having estimated the amount of the subsidy, the share of the subsidy to be paid by the federal government will be the subject of federal/territory negotiations. It is felt that the territories will receive additional federal funds as a result of those negotiations.

CLAIMS PROCEDURE

QUESTION:

Will there be uniform claims procedures across all plans and all alliances rather than letting each plan/alliance establish its own?

ANSWER:

- ▶ The legislation will establish uniform claims procedures for both corporate and regional alliances.
- ▶ The new rules will rely heavily on the development of alternative dispute resolution procedures to reduce costs and increase the efficiency of the grievance process by setting specific deadlines for resolution and providing for early review of disputes by neutral third parties.

LEGAL STANDARD FOR REVIEW OF CLAIMS

QUESTION:

What is the legal standard?

ANSWER:

- ▶ In those cases requiring interpretation of the benefits package there will be a de novo review of the entire case.

FORUM FOR ADJUDICATING HEALTH CLAIMS

QUESTION:

Will a forum, such as a new health benefits court, be created to hear these claims?

ANSWER:

- ▶ We are currently examining methods to provide consistent interpretations of the legislation but have yet to establish just what type of forum this will involve.

PRIVATE CAUSES OF ACTION

QUESTION:

Will there be private causes of action for participants?

ANSWER:

- ▶ If the new system of alternative dispute resolution procedures does not resolve the conflict the participant will be free to pursue additional remedies including a private right of action.

PROCEDURES FOR ARBITRATION OR MEDIATION

QUESTION:

Will there be clear procedures for arbitration or mediation?

ANSWER:

- ▶ The legislation will provide the parameters and additional details will be developed in the regulatory process.

AIDS Action Council Draft List of Amendments

Poverty/affordability/disability issues

1. Those who are on Medicaid and disabled should have premiums and coinsurance covered for fee-for-service.

Rationale: People with HIV disease must be able to pull together a team of care providers that is not restricted to a single network, since often the range of expertise needed is not available within a closed group, especially in smaller communities. The Administration recognized this when it included this option in the original draft of the plan.

2. Subsidy for poor disabled should cover fee-for-service premium and out-of-pocket expenses.

Rationale: The same as above. Unless the coinsurance and out-of-pocket expenses are subsidized, developing an appropriate team of providers may not be possible if limited to one list of providers.

3. Cash assistance recipients pay 20% of standard co-payments; however, providers absorb the difference creating a financial disincentive to serve these patients. Require the alliance to reimburse the plans/providers for these co-payment differentials. (This creates complexity re billing and does not solve the problem of allowing the provider to know who is subsidized; are there better ideas?)

Rationale: One of the strengths of the Clinton plan is that it tries to eliminate the distinctions between those on Medicaid and those who are not. While the same fee schedules will now apply, providers may use the lower co-payment schedule as an excuse to provide less quantity or lower quality care to those who are on Medicaid.

4. Currently, premium and cost sharing assistance is on a sliding scale for those between 100 and 150% of the federal poverty line; fully subsidize people to 150% of poverty; implement sliding scale for people from 150 to 200%.

Rationale: 150% of poverty is still a very low income level; a sliding scale above 150% would eliminate disincentives for those who are high users of health care from earning just above the 150% level.

5. Make explicit that premium expenditures are capped at 3.9% of income for *any plan selected* for people earning \$40,000 or less. (not just up to the average cost plan)

Rationale: This would assure that those who opt for fee-for-service plans because the closed networks cannot provide the same quality care would not be penalized.

6. Medicare disabled can opt into regional alliance.

Rationale: Medicare has disadvantages for high users of the system, especially the fact that there are no limits on out-of-pocket expenses.

7. Out-of-pocket payments should be pro-rated on a monthly basis.

Rationale: While a \$1,500 maximum in out-of-pocket expenses might seem manageable over the course of a year, many people with HIV disease may actually reach that maximum in a few months because they can be such high users of the system. Therefore, a pro rated maximum out-of-pocket cap would help mitigate that burden without costing the system more.

8. Include the mental health and substance abuse expenditures in out-of-pocket cap.

Rationale: Without this inclusion, accessing mental health and substance abuse care, which may be critical for people with HIV, may be financially impossible since they will also be incurring significant out-of-pocket costs for primary health care at the same time.

9. Include the following expenditures in the out-of-pocket: long term care; covered services beyond the amount, duration, and scope in the benefits package.

Rationale: This would mitigate any burden imposed by the failure to cover certain important benefits within the plan.

10. Modify "primary care provider" definition to include specialty expertise for certain chronic diseases.

Rationale: Very often, persons with disabilities will see specialists for all their primary care. Requiring these individuals to have to use a generalist as a gatekeeper at all times is wasteful, since a referral is more than likely to be made anyway.

11. Because the risk adjustment methodology may prove difficult to develop, it is important to make the interim reinsurance methodology as effective as possible in creating incentives for plans to accept expensive enrollees. It is currently conceptualized as reinsurance for expensive diseases. This could be augmented by including basic SES and demographic factors: below 200% poverty; SSI; residing in designated medically underserved areas; over 65; other.

Rationale: This would address, after the fact, all the elements intended to be in the risk adjustment mechanism, which would adjust prior to use of services. This will reduce even further any incentive for providers to risk select among clients.

Coverage/Inclusiveness

12. Expand coverage to all residents of the U.S., including undocumented.

Rationale: Without full coverage, burden of uncompensated care and on safety net will continue; disproportionately high levels of HIV infection in undocumented population -- without integration into health care system, opportunities for prevention diminished.

13. Expand coverage to include incarcerated individuals.

Rationale: Health care is very poor in prisons, especially for people with HIV. Better care will lower long-term costs, will assure appropriate continuity of care for individuals as they are released.

Consumer Rights/Protections

14. Require any plan certified by any alliance to accept enrollees from anywhere in the alliance area. This does not mean that all plans must be infinitely large. There is already language allowing plans to declare themselves "full".

Rationale: If it is legal to restrict plan enrollment to certain geographic areas, there could well be a legal form of redlining -- plans could choose to operate only in wealthy areas or avoid gay neighborhoods without violating the law. This could have the effect of weakening those plans serving those poorer or sicker neighborhoods. This could result in financially weaker plans and/or a new version of Medicaid mills.

15. This "full" declaration should be better specified to preclude its use to risk select. For example, perhaps plans could file and be certified only up to an annual maximum number of enrollees. They could not declare themselves "full" until this number was reached; when reached, they could accept no more enrollees. The secretary or board develop criteria for determining reasonable capacity limits.

Rationale: This is designed to avoid use of a "full" declaration to avoid high-cost patients. A well-run plan should be able to estimate in advance its capacity.

16. A plan must automatically be investigated for decertification if disenrollment patterns are not reflective of the demographic distribution of those enrolled in the plan.

Rationale: This is borrowed from the Cooper bill. This would highlight any discriminatory practices or poor quality in delivery of care.

17. Define "major life events" (permitting mid-year plan change) to include diagnosis with a

terminal or life threatening disease or condition.

Rationale: People moving or recently divorced, etc. have the right to switch plans. As long as everyone cannot be in a fee-for-service plan, an adjustment for a new diagnosis that requires a different kind of care than the plan is expert in should be permitted.

18. Health plan boards and regional alliance boards must include high utilizers. Health plan boards must have one-third consumer representation.

Rationale: This is to assure both consumer representation generally, and that those who are sick will have a voice in the kind of choices plans and alliances make -- rather than making financial and care decisions based only on the needs of the healthy.

19. In Title I cities, Ryan White Planning Councils guaranteed representation on alliance board.

Rationale: The Clinton plan is relatively weak in trying to integrate existing public health/care delivery structures into the decision making and planning associated with the regional alliances. This would be one way of assuring, in high incidence communities, that the needs of people with HIV are addressed and integration with existing programs might occur.

20. Essential community providers given minimum percentage representation on provider advisory councils in each regional alliance.

Rationale: This is another way of assuring input from advocates for the underserved and to make sure that essential community providers are treated as partners in the regional alliance.

21. Definition of family should be more broadly defined to include "families of choice" or some such definition for collateral services under substance abuse benefit; that broader definition could then be standardized later to extend the definition of family throughout the legislation.

Rationale: This is not just a backdoor approach to domestic partner coverage. Particularly in substance abuse care, the support needed by those close to someone in treatment can be critical to the success of that treatment, and this is very often not one's biological family.

22. Definition of eligible family must include any family as defined by the states.

Rationale: It must be made clear that the federal government is not overriding any decisions by the states to recognize domestic partners, if they so choose.

23. Add sexual orientation to protected classes in discrimination sections.

Rationale: This is to prevent the use of sexual orientation as a surrogate for HIV risk.

24. National health board must assure access to services for out-of-school and runaway youth prior to implementation date.

Rationale: This is an important group at risk to HIV; the plan does require that the board develop a system, but there is currently no timeline.

25. Cap marketing budgets of health plans (and regulate marketing)

Rationale: Marketing of plans should be based on quality measures, not "feel good" messages that are currently dominating advertising.

26. Require consumer information to be available in languages other than English in areas where a significant amount of the population does not speak English.

Rationale: If consumers are to make a rational choice in health care, they should have accessible information.

27. Prohibit provider reimbursement schemes that allow providers in managed care settings to benefit financially from decisions regarding care.

Rationale: This relates both to rewarding providers for limiting visits or referrals and to profiting from referrals. Decisions regarding care should be based on patient need, not financial incentives.

Essential Community Providers

28. Essential community providers be considered "in network" by all plans (adjust requirement for contractual or Medicare reimbursement arrangement to contractual).

Rationale: For essential community providers to be true partners, they must be in network; without this designation, patients will be discouraged from seeking what may be more appropriate care because of added costs. Essential community providers may be forced to absorb some of the out-of-pocket costs of their patients if they are being seen out of network, without any reimbursement scheme to help them.

29. Academic medical centers should be considered "in network" by all plans.

Rationale: To be assured that those with the most knowledge about HIV will be available to provide care, arrangements must be possible with any academic health center (including those out of state). If the relevant academic health center is out of network, accessing the care will be prohibitively expensive. Not all academic health centers have expertise in all diseases; by limiting access to health centers some diseases will have less access to state of the art treatment.

30. Community based substance abuse providers should be added legislatively to the list of automatic essential community providers.

Rationale: This would help compensate for the relatively poor coverage of substance abuse in the basic benefit. In all likelihood most of these programs will become eligible under the criteria to be established by the Secretary; immediate inclusion is more efficient and will communicate to regional plans the need to commit to full access to substance abuse treatment. Moreover, the health care system has little experience in treating substance abusers. Community providers offer the plans critical expertise in outreach and treatment to ensure the plans' ability to offer the basic benefits package.

Prevention benefit

31. Add HIV testing (age 13 and above) as prevention benefit with no copayment and not part of deductible.

Rationale: This is an important part of basic preventive services. Existence of this benefit should not result in reduced funding for anonymous test sites since many at-risk individuals will still be seeking testing from alternative sites -- and no point of access to HIV testing should be cut off.

32. Increase frequency of PAP smear covered as preventive benefit for those with HIV infection.

Rationale: Underlying HIV infection requires more frequent PAP smears; the primary care physician should be permitted to order more frequent testing as part of the preventive benefit (preventing cervical cancer is still the goal) for HIV-infected women.

Drugs

33. Cost of experimental treatments not part of a clinical trial must be covered by a plan if charges incurred through a treatment IND.

Rationale: The Clinton plan makes coverage of experimental treatments optional for plans. Generally, companies do not charge for the drugs available through a treatment IND. If they do, it must be the cost of production only; this should be covered to make access to experimental treatments equitable.

34. Cost of associated care for experimental treatment not part of a clinical trial must be covered by a plan if for a treatment available under an FDA approved expanded access protocol for life-threatening diseases.

Rationale: If the FDA determines that a drug is promising enough to be part of an expanded access protocol, then plans should be required to cover the associated care costs (usually additional tests; the drug is usually made available at no cost). These protocols are most often only for those who have failed or are intolerant of any approved treatment. All patients should have equal access to this kind of therapy.

35. Require drug price transparency -- that all companies publish their price lists -- to allow large buying groups to comparison shop, as is required in Medicare.

Rationale: We would prefer some kind of price controls. In their absence, forcing companies to disclose their prices will create a level playing field for all plans and might even embarrass a company or two.

36. Formularies for drugs covered shall be determined at the federal level.

Rationale: The plan currently permits plans to develop formularies. Unless these are determined at the federal level, there will be discrepancies in coverage from plan to plan, region to region, and state to state. All patients, regardless of plan or place of residence should have access to the same drugs.

Long-term care benefit

37. Long-term care benefit exempt from three ADLs limitation in last 24 months of life.

Rationale: This would permit access to the long-term care benefit for people with end-stage AIDS but not be an open-ended cost. Access to this care for people with AIDS actually reduces hospitalization time and other care associated costs.

38. Adopt a standard of palliative care that would allow ongoing non-curative treatments into the hospice benefit that is part of the comprehensive benefits package.

Rationale: Access to the hospice benefit should permit treatment or prophylaxis of opportunistic infections. For example, an end-stage patient in hospice care should be permitted to receive treatment for CMV retinitis to prevent blindness, even though this will not prolong life expectancy.

39. Alter the formula for distributing the long term care funds between states to include a factor for actual case counts for specific diseases (like HIV/AIDS and Tay-Sachs) whose incidence varies by demographic factors other than the ones in the proposed formula.

Rationale: This will result in a more realistic distribution of funds based on actual usage.

Public health programs

40. Retain separate funding streams for Ryan White CARE Act, community and migrant health centers, STDs, TB, family planning, substance abuse block grant, etc.

Rationale: These programs will continue to be essential services; because of the special outreach these programs do to bring people into care and because the trust relationships they have developed with their clients.

41. Create a clear earmark for HIV services (care, prevention) so not folded into a general public health block grant.

Rationale: We are concerned that health departments, left to their own priority setting, will channel resources into more "popular" programs and not make choices based on public health needs (especially in lower incidence states with poorly organized HIV constituencies).

Note: Separate memo on confidentiality/anti-discrimination forthcoming.

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THE WHITE HOUSE

WASHINGTON

**Health Care Reform and the HIV Epidemic
Top Ten Issues**

For those infected with HIV, the assurance of comprehensive health insurance is an essential public health goal.

The Office of the National AIDS Policy Coordinator has provided advice on policy formulation during the development of the Health Security Act (HSA). These efforts were directed towards assuring adequate care and services for people with HIV/AIDS. As the Congress now debates the HSA, the Administration is making every effort to assure that modifications to the President's proposal maintain equity and sensitivity to the special needs of HIV-infected individuals.

Private insurance companies, like other businesses, seek to maximize profits by choosing only "acceptable" insurance risks. Under the HSA, universal coverage is guaranteed. Universal means everyone! What does Health Security mean to you?:

- **Universal coverage - HIV status or other health conditions do not prevent you from getting coverage.**
- **Community ratings prevent persons with HIV infection from being charged more for premiums.**
- **Prescription drugs will be covered.**
- **Ryan White CARE Act services will not be lost.**
- **Any form of discrimination is prohibited.**
- **Essential providers - specialists in treating HIV and AIDS will be available to all people who need them.**

Based on a series of focus groups with people with AIDS and HIV/AIDS service organizations, a list of "top ten" concerns for the HIV community were identified. Information regarding these concerns is attached for your review.

I hope this information will be helpful to you. If I can be of further assistance or provide any additional information, please contact me or Andrew E. Barrer, Ph.D. at (202) 632-1090. Thank you.



Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

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1. Premium Financing and Risk Adjustment

Issue: Will the risk adjustment mechanism prevent "redlining" for persons with HIV/AIDS or other life threatening illnesses?

Summary: Yes. Redlining, or any attempts to limit access to people with HIV or AIDS is clearly prohibited. The HSA provides mechanisms which require states to spread the financial risks associated with special communities by adjustments which would take into account such factors known to affect utilization of services, such as age, sex, health status and services to disadvantaged populations. The health plans have to meet specific rules on enrollment, community rating, information, and grievance procedures.

2. Availability of HIV Specialist, "Essential Providers"

Issue: Will HIV positive persons be able to continue using their local HIV medical specialist?

Summary: The Health Security Act establishes a special category of health care provider which is referred to as an "essential provider". Any health care provider or organization can make application to be certified as an essential provider. Within the HSA, a Ryan White grantee or subgrantee can be automatically certified as an essential provider. Each health plan must enter into a written agreement with each essential provider located within its service area.

3. Long-term Care and Home Health Care

Issue: Persons with HIV/AIDS often need home health care and long-term care services. Will the Health Security Act provide those needed services?

Summary: Home health care is included in the nationally guaranteed comprehensive benefits package. A new long-term care initiative will expand coverage of home and community-based care. This will make it possible for more elderly and disabled persons, including persons living with HIV/AIDS to live in their homes and communities while receiving long-term care. The Act will improve

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transportation, and outreach. It may be necessary to utilize Ryan White CARE Act funds "freed up" by the provision of these services under HSA to subsidize the supplemental and client's share of insurance premiums, co-payments, deductibles, and expenditures that exceed spending caps.

The CARE Act is not a "band-aid" that can be discarded after health care reform. The Act will serve as a critical resource to sustain health care delivery systems and insure the continued delivery of essential and comprehensive health and support services to those infected with HIV.

6. Medicaid and Medicare Funding and Program Transition Issues

Issue: What impact will the HSA have on funding for the Medicaid and Medicare programs? What programs will be available during the transition from the old system to the one provided under the HSA?

Summary: Under the HSA adult Medicaid recipients who now receive cash supplements (currently 9 million beneficiaries) would be enrolled in the new system, but would not have to pay premiums. Further, they would be entitled to join a new state and federally-matched program providing wrap-around services similar to those now available under the Medicaid program. Children less than 18 years of age who are currently eligible or would be Medicaid recipients, with eligibility for wrap-around services (primarily based on poverty level), would be provided those services through a new federally funded (but state administered) program, *regardless of their cash assistance status*.

The Medicare program will be preserved and strengthened under the HSA, which will add new coverage for prescription drugs and expanded coverage of home and community-based care.

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Medicaid coverage for persons in nursing homes.

The HSA will improve the quality and reliability of private long-term care insurance and provide tax incentives for persons to buy it; and tax incentives to help individuals with disabilities work.

4. Availability of Mental Health and Substance Abuse Services

Issue: Mental health needs in the HIV/AIDS community tend to be greater than the average. What will HSA do to provide these services? Injecting drug users, at high risk of HIV infection and transmission, currently have inadequate treatment and preventive services available to them. Will adequate services be available to treat these individuals in order to ameliorate their additive disease and halt the epidemic?

Summary: A base level of mental health services will be provided to all persons through the Health Security Act. We know that viable mental health services are part of a good program of health care and especially beneficial to HIV infected persons.

In order to make a significant difference in the rate of new infections in the injecting drug use population and their sexual partners, the HSA will provide substance abuse treatment to everyone.

5. Health Care Reform and the Ryan White CARE Act

Issue: Will the financial restructuring of the health care system assure the delivery of health care services appropriate to the needs of vulnerable populations whose access problems go beyond lack of insurance?

Summary: The comprehensive benefits package provided by the HSA may not provide all essential services for persons with HIV/AIDS. Conversely, a variety of services currently provided by the CARE Act would be covered under the HSA benefits package. These would include primary care services, medications, assistance for health insurance coverage, home-based services, case management,

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7. Health Security Act (HSA) and Confidentiality Issues

Issue: What safeguards are envisioned for the handling of health information on HIV affected persons under the Health Security Act ?

Summary: The HSA addresses the issue of how information will be handled and what penalties will be imposed for misusing information. The HSA will provide guidance level information on creation of the oversight board, users and uses of information, privacy standards, enrollee rights, outright prohibitions, training of information handlers, and comprehensive health information privacy protection. The development of the Comprehensive Health Information Privacy Protection Act will be implemented within two years from the date of passage.

8. Grievance Procedures

Issue: How can individuals ensure that their health plan will provide the health benefits and services they require?

Summary: The HSA is intended to provide adequate health care coverage for all citizens and legal residents of the United States. The Act requires States to approve each health plan before it can engage in providing health care under the Act. The law prohibits exclusions because of pre-existing conditions or through "red-lining," the practice of excluding a particular group of individuals because of perceived high risk.

The Health Security Act includes a comprehensive grievance process for any person aggrieved by acts or practices which result in denial or delay of benefits or payments. Individuals must work within the individual plan's grievance process before going to adjudication through the Complaint Review Offices set up in each state. If there is a question as to an individual's eligibility for a plan, subsidies or cost sharing, the individual may go directly to court and all costs can be reimbursed if the court finds for the individual.

The complaint office must rule in under 30 days, although a 24 hour appeal is available in cases of emergency. Appeals must be processed within 60 days. There are means of appealing, with the national board being the ultimate administrative appeal.

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9. "State Options"

Issue: What impact will "State Options" have on coverage under the HSA? What impact will it have on services, availability, and affordability?

Summary: Some states cover additional services under federally matched Medicaid programs. Under the HSA, a number of programs will become available at each state's option. To assure that there is not a loss of services to the person with AIDS, Ryan White will continue to act as the safety net to assure needed services reach all people in need. The expanded use of case management, will help follow individual needs and assure services are provided.

10. Public Health System Core Functions

Issue: What is the nature of the funding for research on behavior, health services and Core Functions of Public Health Programs?

Summary: The Health Security Act will provide funding for AIDS specific research and public health initiatives that will have to be provided under the authority of the Public Health System. Behavioral research into those behaviors that may cause or contribute to disease will be conducted by the National Institutes of Health. The Act will also provide funding for strengthening the public health core function of states, including those components related to diseases of public health significance. This support will allow communities to maintain strong programs to prevent the spread of HIV, tuberculosis, and other conditions of public health importance.

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HIV/AIDS AND THE HEALTH SECURITY ACT

TALKING POINTS

- **Benefits:** Services for people with HIV or AIDS will be covered under the plan. A comprehensive package of services will be available to all Americans regardless of their medical condition. These benefits include hospital and health professional services, mental health, outpatient rehabilitation, home health care and extended care services.
- **Provider Choice:** People will be able to choose their own doctors and their own health plans. Each individual will be able to enroll in a traditional fee-for-service plan, join a network of doctors and hospitals, or join an HMO. And all health plans must offer a point-of-service option, so that members are not restricted to the plan providers. If required services are not available through providers within the plan, the plan must make referral arrangements for their members.
- **Access to Expertise in HIV:** In the Health Security Plan patients with HIV will have access to providers in their area with expertise in HIV disease. All plans will be required to contract with academic medical centers to provide care for their members. Individuals are free to choose the health plan that best serves their needs and preferences. Doctors can affiliate with more than one health plan.
- **Confidentiality:** The health plan includes a national privacy policy that will establish uniform, comprehensive privacy standards. The policy forbids the linkage of individual identifiers with information aggregated for population-wide surveys. Privacy protection as applied to health care information will be a continuing focus of the National Health Board.
- **Discrimination:** Under today's insurance rules, people who are HIV-positive may be dropped from coverage, or their rates may skyrocket. Under reform, all Americans have the security of health coverage that's always there. There are no lifetime limits to coverage. Health plans are required to offer annual open enrollment, and they cannot charge a higher premium to people with preexisting conditions nor drop individuals from coverage.

The Health Security Plan will put an end to cherry picking (offering low rates only to groups of young, healthy low-risk persons) and redlining (denying coverage to certain industries or geographic areas perceived as high risk). States and alliances are both responsible for assuring that no one faces barriers to care based on race, ethnicity, sexual orientation, age, gender or disability.

- **Drugs:** The prescription drug benefit of the health plan covers all FDA approved uses of drugs, biologicals, and insulin. Unapproved uses recognized in certain medical compendia or peer-reviewed literature are also covered.

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- **Hospice:** The guaranteed health benefits include hospice services.
- **Cash Assistance:** The SSI and the SSDI programs for disability do not change as a result of the Health Security Plan.
- **Medicaid:** Medicaid beneficiaries will now receive the same health care benefits through the same health plans as every other person. The stigma and barriers to access that many Medicaid recipients now experience will no longer exist. All children who would have been eligible for Medicaid will be eligible for a new federal program of wrap-around services that supplement the comprehensive benefits package. Adult Medicaid recipients will continue to receive wrap around services (e.g., vision care, non-emergency transportation) at the state option; however, states will receive federal matching payments only for adults receiving AFDC or SSI and dual eligibles (Medicare and Medicaid). Medicaid long term care services remain unchanged, for all Medicaid eligible individuals.
- **Medicare:** An outpatient prescription drug benefit is added to the Medicare program. This benefit is identical to the Health Security Plan drug benefit.
- **Home and Community Based Long Term Care:** The Health Security Act includes a major expansion of home and community based services (HCB) for individuals with severe disabilities. The HCB program is administered by states and is separate from the alliances and health plans. This new long term care program will offer significantly increased federal funding to help states to offer a wide array of personal assistance and related supports to people at home, in the community.

Eligibility for this program is based on functional criteria and is not limited by age, type of disability, or income. When this program is fully phased in, approximately \$38.5 billion new federal dollars will be available to help people who have significant needs for assistance with activities of daily living, including those with AIDS, to live more independent lives.

- **Public Health Programs--Research:** The Health Security Act expands biomedical and behavioral research on health promotion and disease prevention supported by the National Institutes of Health. This initiative gives priority to research in certain areas, including infectious diseases such as HIV and TB. For the entire research program the bill authorizes \$400 million in FY 1995, and \$500 million for each of the Fiscal Years 1996 through 2000.
- **Public Health Programs--Outreach & Support services:** Existing programs that provide the support services that are so critical for people with HIV will continue unchanged. Public health access programs, such as Ryan White and the Community Health Center program, that provide outreach and enabling services (e.g., transportation), case management and other supplemental services will be expanded. To increase the capacity of medically underserved individuals to utilize

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the services included in the comprehensive benefits package, the Plan will extend support for enabling services to new provider types.

- **Mental Illness and Substance Abuse:** Mental illness and substance abuse treatment services are guaranteed elements of the comprehensive benefits package. By 2001 there is expanded mental illness and substance abuse coverage which includes elimination of day and visit limitations and higher cost sharing provisions.

Mental illness and substance abuse treatment benefits covered by the Health Security Plan (within certain guidelines and criteria):

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|---------------------------|--------------------------------------|
| -screening and assessment | -inpatient and residential treatment |
| -crisis services | -intensive non-residential treatment |
| -outpatient treatment | -collateral services |
| -case management | |

These benefits include:

- Outpatient diagnosis, crisis services and medical management without limit.
- Thirty visits for outpatient psychotherapy and collateral services annually (additional visits at health plan discretion to prevent hospitalization or facilitate earlier hospital release)
- Thirty days annually of inpatient or residential treatment (an additional thirty may be approved by the health plan under specified circumstances)
- Outpatient substance abuse counseling and relapse prevention treatment (at health plan discretion an individual may receive by exchanging inpatient/residential days for outpatient visits on a 1 inpatient day to 4 outpatient visits basis until the 30 day inpatient annual limit is reached)
- Following residential or intensive non-residential substance abuse treatment, 30 group therapy sessions for counseling and relapse prevention.

The Health Security Plan provides for benefits in a variety of settings, including offices and clinics, residential treatment and intensive non-residential programs. This benefit offers a wider variety of services than is typically available currently.

The Health Security Act provides for public health grants to states for activities related to mental illness and substance abuse, including increasing access to services, improving State and local service systems, and integrating public and private systems for treatment. By October 1, 1998, states must submit a plan to HHS showing how the state will integrate state and local mental illness and substance abuse services with the services included in the comprehensive benefit package.

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