



Give

Ability

A

Chance



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The Health Security Act

AMERICANS WITH DISABILITIES

Americans with disabilities are a large and diverse population. Of the estimated 35 to 43 million people with physical or mental impairments, a significant portion are of working age. For many, their disability status -- compounded by the lack of available and affordable assistance -- renders them unable to get health insurance, and hurts their job prospects. Meanwhile, families with insurance are reluctant to change jobs or move for fear of being denied health insurance coverage. Passage of this Act will cure this significant gap in the protections of the landmark Americans With Disabilities Act.

In a health insurance industry that competes by insuring only the healthiest people, Americans with disabilities are often discriminated against, dubbed "high risk" applicants because they may have higher health care costs. Those who are able to obtain insurance are often forced to pay the highest rates in the market, and are still faced with a lifetime limit on benefits. After that, they're on their own.

Guaranteed Comprehensive Benefits

- Under health reform, all Americans -- including those with disabilities -- are guaranteed a comprehensive package of benefits at the community rate. Like all other Americans, persons with disabilities will be able to choose their doctor and health plan.
- There will be no lifetime limits on care -- a change that will free many Americans with disabilities to go to work without fear of losing the health benefits they now get through Medicaid or through private coverage.
- Benefits will include not only acute-care services, but also certain rehabilitative services in both inpatient and outpatient settings.
- The guaranteed benefits package, protections from discrimination in health care, and new services will substantially improve access to health services for Americans with disabilities.

Community-Based Long-Term Care

- A new community-based long-term care benefit will aid Americans of all ages with severe physical or mental disabilities, regardless of income. This new program, which is in addition to existing Medicaid programs of long-term care, will benefit substantial numbers of Americans with disabilities and will be reimbursed at rates of federal participation almost 30 percentage points higher than under existing programs.
- Children under the age of six with severe disabilities or chronic medical conditions who would otherwise require hospital or institutional care will be able to receive assistance in their homes and communities.
- Through the new home and community-based program, a broad range of personal assistance services will be available to children and working age adults with severe disabilities.
- States will have the flexibility to design their own approaches to community-based care. States may expand their programs beyond personal assistance to include case management, homemaker and chore services, home modifications, respite services, assertive technology, adult day care, and rehabilitation services.
- For low-income persons with lesser levels of disability, states will be able to continue their home and community-based programs under Medicaid.

New Tax Credit

- Under the Health Security Act, employees with disabilities who require personal assistance with daily tasks will be eligible for new tax credits covering 50 percent of their personal care service costs -- up to a maximum of \$15,000 each year.

Improved Medicaid Coverage

- Residents of nursing homes and intermediate care facilities for the mentally retarded will be able to retain \$70 per month as a living

allowance (compared to the \$30 per month ceiling at present).

- Single residents of such facilities will be able to retain up to \$12,000 in personal assets under eligibility determinations (compared to \$2,000 at present).

November 10, 1993

SUPPORT FROM GROUPS OF PEOPLE WITH DISABILITIES

"Health care reform that will provide universal, comprehensive and affordable health care to all Americans regardless of their health or disability status is a priority to the American Council of the Blind. President Clinton is proposing a system that would be a major improvement over what exists today. The guarantee that no one will be denied health insurance for any reason and the elimination of pre-existing condition exclusions are two critical components in ensuring access to health care for all people. **We commend President Clinton in this historic effort to enact comprehensive, universal health care coverage for all Americans, particularly for those who need it most: individuals with disabilities.**

American Council of the Blind

"The Arc strongly supports President Clinton's initiative in making reform of health and long-term services a top priority for his administration. The Arc measures all proposals against a set of five principles from a disability perspective: non-discrimination, comprehensiveness, appropriateness, equity and efficiency. In many ways the Clinton proposal measures up to these principles. **The Clinton proposal includes important new initiatives in long-term services and supports creating new community-based support services to serve people of all ages with the most severe disabilities who need long-term support. These two new initiatives are an important step toward achieving independence, integration, and productivity for people with mental retardation and toward fulfilling the promise of the American with Disabilities Act.**

"The Arc believes that President Clinton is proposing a system which will greatly improve health coverage for people with mental retardation and their families. The proposal lays a foundation for a universal system in which everyone will have access to comprehensive health care regardless of age, income, or health status and people will have improved access to long-term supports necessary as a result of their disabilities or age."

The Arc, a National Organization on Mental Retardation

"We are pleased that the Clinton proposal would eliminate both medical underwriting and caps on lifetime coverage maximums, includes an outpatient prescription drug benefit for everyone, and provides protection against catastrophic out-of-pocket costs. We believe that the sort of system that President Clinton is proposing would be a significant improvement over the status quo, and one that would improve access for those who are most in need of services, people with disabilities and chronic health conditions."

Epilepsy Foundation of America

"We are pleased that the President's proposal includes important new initiatives in the area of long-term services and supports, including personal assistance services."

The Consortium for Citizens with Disabilities

(These quotes are as of 9/23/93)

CHILD WITH DISABILITIES

Today:

Alec Moore is a 10-year-old child with severe cerebral palsy. He lives at home with his parents. Both of Alec's parents work outside the home, but because of his condition they cannot afford health insurance. Today, Alec receives Medicaid coverage because his state provides Medicaid coverage to "medically needy" individuals who, although they do not meet the normal income criteria for Medicaid, have medical expenses that are very high.

Reform:

Under reform, Alec will continue to receive all of the services he is eligible for today. His parents will obtain health insurance through their employers, and their policies will cover him for all services included in the comprehensive benefits package.

Both their employers and Alec's family will gain from health reform: Alec will have the guarantee of health security with no lifetime limits on coverage. His parents will know that they will never confront a situation in which they will be unable to obtain coverage because of his condition. Their employees will not be faced with the dilemma of unusually high premiums caused by having someone with high medical costs in their health insurance group.

Assuming they choose an average cost plan, Alec's parents will pay 20% of the premium for a family plan, \$872 a year, or \$73 a month.

Report To
America

Health Security Plan

Issues of Concern to People with Disabilities

The President's Committee on Employment of People with Disabilities has prepared this document to assist the disability community in understanding the President's health care reform proposal. The information provided focuses on issues of primary concern to this constituency and does not include information on all aspects of the plan. This summary is based on the most recent information available to the Committee.

President's Committee on Employment of People with Disabilities

Health Security Plan

Overview

The Health Security Plan will guarantee all Americans and legal residents a comprehensive package of health benefits with no lifetime limits, a choice of health plans, and the security of having lifetime coverage. Types of plans that will be available include the traditional fee-for-service selection of individual doctors, a preferred provider network, and the HMO.

People who are employed will be able to sign up for a health plan at work. State governments will set up health alliances to give consumers and small businesses the ability to buy affordable care. Individuals will enroll through a health alliance unless they are covered under government-sponsored programs such as Medicare, Department of Defense, Department of Veterans Affairs, and the Indian Health Service. Individuals eligible for Medicaid receive coverage through regional health alliances.

Security

Every American will receive a Health Security Card that guarantees a comprehensive package of lifetime benefits, regardless of employment or health status.

All plans must meet national standards on benefits, quality and access, but each state may tailor the new system to local needs and conditions.

All employers contribute to health care premiums for employees; both employers and employees share the responsibility. Individuals who are self-employed or unemployed will buy health coverage from the regional alliance. The self-employed individual will be able to take a 100% tax deduction for the cost of the premiums. Discounts will be provided for low-income people.

There are limits on out-of-pocket payments, and discounts to ease the burden on low-income individuals and small employers.

The plan includes a comprehensive benefit package with no lifetime limits on medical coverage in order to guarantee access to a full range of medically necessary or appropriate services.

Individuals who are elderly or disabled and eligible for Medicare will receive coverage for outpatient prescription drugs.

Americans are guaranteed a choice of health plans and providers.

No health plan may deny enrollment to any applicant because of health, employment or financial status, nor may they charge some individuals more than others because of age, medical condition or other factors related to their health status.

status, disability or employment status.

Q. How will the plan ensure continuity and portability of coverage, especially in times of change such as geographic move or new employment status?

A. The Health Security Plan guarantees that you will never lose your health coverage. If you switch jobs and/or move, you remain covered by your current plan until you are enrolled in a new one. If you lose your job, you are still guaranteed health coverage.

Q. How will the plan provide, and what will be the scope of, allowable preventive services, including services to prevent worsening of a disability?

A. The Health Security plan provides for a comprehensive benefit package, including preventive services. Medical coverage guarantees access to a wide range of medically necessary or appropriate services. While the guaranteed benefit is primarily focused on post-acute illness, in the context of disability this could include health care services that might prevent secondary disability or deteriorating function, assist in establishing and maintaining maximum independence and functional ability, and assist in promoting physical and psycho-social well-being.

Q. How will the plan cover access to and coverage for diagnostic services?

A. Diagnostic services and outpatient laboratory services will be part of the comprehensive benefit package guaranteed by legislation.

Q. How will the plan cover long term home and community based services?

A. The plan will increase federal authority to provide home and community based services to individuals with the most severe disabilities without regard to income or age. This will be accomplished through innovative state and federal partnerships. Benefits will include comprehensive personal assistance services defined as assistance (including supervision, standby assistance and cuing) with activities of daily living.

States will have the flexibility to define and design home and community based services, including personal assistance services, case management, homemaker and chore assistance, home modifications, respite services, assistive technology, adult day services, habilitation and rehabilitation, supported employment and home health services not otherwise covered by Medicaid, private insurance, or through the basic health plans.

States will be able to offer vouchers or cash directly to eligible individuals.

Co-insurance will be paid by eligible individuals to cover cost of services according to a sliding scale with those below 150% of the federal poverty standard only having to pay a nominal fee. A tax credit of 50% of the costs up to \$15,000 for assistance with activities of daily living will be available for employed individuals with disabilities.

Q. How and to what extent will the plan cover mental health, counseling and substance abuse?

A. Initially, the plan will provide 30 days per episode, with 60 days annually for inpatient or residential treatment of mental health problems; 30 visits per year for outpatient psychotherapy; and 120 days per year for intensive non-residential treatment services.

By the year 2001, a comprehensive, integrated benefit structure with appropriate management replaces prescribed limits on individual services. By 2001 the management of treatment will determine the length of inpatient care. Limits on, and cost-sharing for, outpatient treatment and non-residential treatment services will be eliminated.

Further Information

To obtain a 30-page summary of the Health Security Plan, contact the Superintendent of Documents, P. O. Box 371954, Pittsburgh, PA 15250-7954, and request item number 040-000-00632-0. Cost is \$2.50. To order by phone, call 202-783-3238 (Voice). Individuals who are deaf or hearing impaired may access this number through their State Relay System or by calling 1-800-877-8339.

As with other major legislation related to disability or employment issues, the President's Committee will monitor this bill as it moves through Congress and will issue periodic "Legislative Updates." If you wish to receive these updates, please send your name and address to: Office of Public Affairs, President's Committee on Employment of People with Disabilities, 1331 F Street, NW, Washington, DC 20004.

THE HEALTH SECURITY ACT: BENEFITS FOR CHILDREN

"Family values alone cannot nourish a hungry child, and material security alone cannot provide a moral compass. We must have both."

President Clinton

AMERICA'S CHILDREN TODAY

Fears and Violence

In a recent survey, **the number one fear among American children 10 to 17 involved violent crime.** The **number two** fear reported involved **parental job loss.** The **number three** fear reported involved not being able to afford **health care.**

56% fear that a member of their family will be the victim of a violent crime.

53% fear that a parent will lose his or her job.

51% fear not being able to afford a doctor.

Newsweek & the Children's Defense Fund

Insurance

In 1991, **12.6%** of American children went **uninsured** throughout the year.
20.3% were covered under **Medicaid.**

Of the uninsured children in America in 1991:

66.4% came from **non-poor** families.

68.3% came from families headed by **married couples.**

Current Population Service, Bureau of the Census

Immunizations

In 1991, **46%** of American children did not receive their **Polio** vaccination.
18% of American children did not receive their **measles** containing vaccination.
31% of American children did not receive their **DTP/DT** vaccination.
(These represent three of the most crucial vaccinations.)

National Health Information Survey.

HEALTH SECURITY FOR AMERICA'S CHILDREN

Under the Health Security Act, all children are guaranteed comprehensive health care coverage. That means 9.5 million children under age 18 who are currently uninsured will be covered.

Comprehensive Coverage:

The Health Security Act provides a comprehensive benefits package which includes a broad range of physical and mental health services.

Encourages Preventive Care:

Numerous studies have shown that mothers who receive early and continuous prenatal care are more likely to give birth to healthy babies. The Health Security Act invests in keeping Americans healthy by providing complete prenatal care at no cost to families.

The Health Security Act benefits include full coverage of well-baby care, immunizations and preventive services, also at no additional charge, to help ensure that our children get off to a healthy start. Today, these services are covered by only about one-third of private insurance plans.

Protects Low-Income Children:

While our current system provides coverage for many low-income women and children through Medicaid, many have difficulty finding providers who will treat them for the low rates paid by the Medicaid program. Under the Health Security Act, low-income families have the same choice of plans as other families in their area. Families who today receive health care through Medicaid will join the alliance. They will receive discounts on premiums to ensure that their insurance is affordable. Those families who continue to receive Medicaid will receive assistance with cost-sharing.

Children who continue to be covered by Medicaid will receive the comprehensive benefits package through their alliance. In addition, they will receive any wrap-around services they are currently eligible for under Medicaid but that are not included under the comprehensive benefits package. This will preserve coverage for medically necessary services, such as eyeglasses, and maintain coverage for support services such as transportation and case management.

The Health Security Act also calls for additional funds for a program which has proven successful. The supplemental food program for women, infants and children (WIC). The President's proposal authorizes \$250 million for WIC in 1996, increasing to \$411 million

by the year 2000. This new funding is part of the Act's overall emphasis on preventing illness before it happens. Good nutrition is integral to good health.

School Health Initiatives:

The Health Security Act includes two new grant programs: one to support school health education programs, and a second to help fund school health services.

Under the Health Security Act, \$50 million per year will go to support the planning and implementation of comprehensive school health education programs for children in kindergarten through grade 12.

The President's plan also provides \$100 million to fund school health services including preventive health services, mental health and social service counseling, substance abuse counseling, care coordination and outreach, management of simple illnesses and injuries and referral and follow-up for more serious conditions. These funds will be targeted to adolescents and communities most in need of support.

Improvements in Public Health Efforts:

Significant new funding will help support public health initiatives of special importance to the health of children including immunizations, lead poison screenings, health education, and violence prevention.

The Health Security Act will expand current programs that serve children in high-risk and underserved communities and provide grants and guaranteed loans to community-based providers and institutions to help them develop community-based health plans to serve these regions.

Investments in Primary Care:

The Health Security Act will expand the National Health Services Corps and encourage primary care doctors including pediatricians, obstetricians and general family physicians to ensure that children and expectant mothers will not lack for appropriate medical care. Through increased incentives offered to doctors, primary care providers will be more available than ever before in underserved urban and rural areas.

SUPPORT FROM PROVIDERS

"At a time when one in every three children in the United States depends either on Medicaid or on charity to pay for health care, we commend the President's effort to move the nation toward comprehensive health care reform. We believe reform will enhance both medical security for the nation's 65 million children and peace of mind for their parents. We are especially impressed by the commitment of the First Lady to ensuring that all children have access to appropriate health care, because it is such an important investment in the nation's future."

National Association of Children's Hospitals and Related Institutions, Inc.

"The Clinton proposal has identified the right elements needed to ensure a healthier future for our children, including: a strong emphasis on prevention and primary care; guaranteed access to a one-tier system of care; health insurance reforms that would finally do away with pre-existing conditions, and; a solid basic benefits package, including comprehensive coverage for immunizations. The Clinton proposal also makes unprecedented effort to reach out to adolescents, an often forgotten population, to bring them into the health care system where they can get the guidance they need to make responsible health choices."

American Academy of Pediatrics

"The Administration's national health reform plan contains historic gains for children, according to the Children's Defense Fund (CDF), which applauded the plan's commitment to end the nightmare of insecurity that millions of parents feel when their children get sick. According to CDF, the plan gives health coverage to nearly nine million children who are currently uninsured and dams the flood of millions of children who lose employer-based insurance at some point every year. Finally, we have a viable plan to reorganize the health system that would guarantee every American child a healthy start in life. For the first time, parents will be able to make decisions about their jobs based on their families' needs rather than on a child's pre-existing medical condition."

Children's Defense Fund

"Child advocates must not allow this opportunity to be wasted."

Marian Edelman, President, Children's Defense Fund

REVISED

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A DISABILITY PERSPECTIVE ON HEALTH CARE REFORM: EVALUATION OF CLINTON HEALTH PLAN BASED ON CCD HEALTH TASK FORCE PRINCIPLES

by

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This analysis is based on a preliminary draft of the President's health reform proposal dated September 7, 1993 unless otherwise specified. The Consortium for Citizens with Disabilities (CCD) adopted five principles as the basis for a disability perspective on health care reform (see Appendix #1). These are: (1) non-discrimination; (2) comprehensiveness; (3) appropriateness; (4) equity; and (5) efficiency. (The numbers in the "strengths" column correspond to the numbers in the "weaknesses" column.)

I. NON-DISCRIMINATION

Strengths

1. All legal U.S. residents in the U.S. would be covered by 1997

2. No exclusions or waiting periods for pre-existing conditions.

Weaknesses

1. Many persons would be uninsured during the next three years, and another Presidential election will occur before this mandate is implemented. Hillary Clinton has already been quoted in the *Washington Post* (Sept. 22, 1993) as saying that if Congress wants to stretch out the timetable for ensuring that all Americans are covered, the 1997 target date "is open to discussion." Persons who are not citizens or legal residents would not be eligible for the federally guaranteed health care benefits even if their employers are contributing to the premiums.

- 2a. The plan proposes that states create **financial incentives** to ensure access to appropriate health care for "certain population groups that face barriers to access because of geographic location, income levels, racial or cultural differences." The plan does not recognize that **persons with disabilities are a disadvantaged group that require civil rights protection to prevent discrimination.** The plan assumes that a risk-adjustment mechanism can be created that would provide private insurance plans with an enhanced premium from the regional alliance for enrolling a disproportionate number of persons with higher health care needs and thereby remove the existing financial incentives to discriminate against people with disabilities.

I. NON-DISCRIMINATION

Strengths

5. National standards for benefits, quality, and access to care established by the National Health Board.

Weaknesses

5. The exclusion of certain health-related services like outpatient rehabilitation for persons with congenital conditions is comparable to "re-inventing" the use of pre-existing condition exclusions. The arbitrary exclusion of certain health-related services like hearing aids from the federally-guaranteed benefit package, appears to violate the non-discrimination requirements of the Americans with Disabilities Act when other forms of durable medical equipment and prosthetic devices are provided to treat comparable functional impairments; moreover, the determination of whether a particular service is medically necessary and appropriate to provide should depend on the unique health conditions of the individual which reflect the interaction of many factors. What may not be medically necessary for the so-called "average patient" may be medically necessary for a person with a disability or a chronic illness.

II. COMPREHENSIVENESS

Strengths

1. An independent National Health Board would determine the guaranteed benefit package that all plans would have to offer subject to approval by the President and Congress. An insurance plan could not terminate, restrict or limit coverage for the federally guaranteed benefit package in order to contain its costs.
- 1a. National Health Board consists of seven members appointed by the President with the consent of the Senate, with experience in: "health care financing and delivery, state health systems, consumer protection, business, law or delivery of care to vulnerable populations."
2. Federally guaranteed benefit package would include some prevention, mental health, out-patient prescription drug benefit, rehabilitation, home health care and short term nursing home care which are often absent from existing private insurance plans.

Weaknesses

1. Access to benefits beyond federally guaranteed minimum will depend on ability to pay.
- 1a. There is no requirement that any of the seven members of the National Health Board or the advisory committees that they establish are persons with disabilities or knowledgeable about the health care needs of persons with disabilities.
- 1b. **The Clinton plan does not specify the criteria or process that the National Health Board would use to decide when to add or eliminate a medically necessary service from the federally guaranteed benefit package.** Many people with disabilities, whose lives depend on medical breakthroughs and pioneering uses of new procedures, such as persons with cancer, AIDS, transplants, and rare disorders, are concerned that decisions of the National Health Board might limit pioneering research and diffusion of innovations that could improve the quality of health care.
2. **Prevention services for preventing secondary disabilities and functional deterioration, maintaining health, and increasing function of persons with disabilities are not recognized as prevention services and are limited in the acute care benefit.**

II. COMPREHENSIVENESS

Strengths

2. Federally guaranteed benefit package would include some prevention, mental health, out-patient prescription drug benefit, rehabilitation, home health care and short term nursing home care which are often absent from existing private insurance plans.

Weaknesses

- 2a. The President's health care reforms do not address whether and how Medicaid payments for early intervention, special education "related services", and early and periodic screening diagnosis and treatment (EPSDT), which many children with disabilities are eligible for now, will be continued. These publicly-funded prevention services provide low income children with disabilities many essential health-related services that are either not included in or may be beyond the limits of covered services specified in the federally guaranteed benefit package.

Many children with disabilities will lose access to certain medically necessary health care services (such as hearing aids, restorative dental care, and certain types of mental health, rehabilitation services and assistive technology) under the Clinton plan that they are currently entitled to under Medicaid through the federal mandate for Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

The President's plan would also withdraw Medicaid coverage from nearly seven million children who currently receive Medicaid but do not receive cash assistance for SSI (Supplemental Security Income) or AFDC (Aid to Families with Dependent Children) and cover them under the employer mandate.

Reduction or elimination of this Medicaid entitlement will significantly undermine Medicaid financed coverage under other federal programs, including the federally mandated early intervention programs for providing services to infants and toddlers with disabilities and their families (Part H of the Individuals with Disabilities Education Act), and the Maternal and Child Health funded Programs for Children with Special Health Care Needs (Title V) of the Social Security Act.

II. COMPREHENSIVENESS

Strengths

2. Federally guaranteed benefit package would include some prevention, mental health, out-patient prescription drug benefit, rehabilitation, home health care and short term nursing home care which are often absent from existing private insurance plans.

Weaknesses

continued

- 2a. Although the President's plan promises to provide a supplemental benefit package for Medicaid eligible children who receive SSI or AFDC cash assistance, states will have discretion over the amount, duration, and scope of these supplementation services which they do not have now under the current federal EPSDT mandate, and states will be permitted to eliminate Medicaid coverage for educationally related services for other children with disabilities under the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act. This reduction or elimination of Medicaid coverage will severely undermine the capacity of special education programs to serve children with disabilities and provide the health related services that are necessary for a child to receive a free appropriate public education in the least restrictive school environment.

Many of these children have enrolled in Medicaid, even if they have some form of private health insurance, because Medicaid provides coverage for the rehabilitation therapies (e.g. physical therapy, occupational therapy, speech-language pathology services) and equipment (e.g. specialized devices, hearing aids) that private health insurance seldom covers and that they cannot afford to pay for themselves. Private health insurers often refuse to cover these services because they do not deal with acute care needs or because they are considered "developmental" or "educationally related" since they are identified in school. Even if the Clinton plan were to continue the current EPSDT benefit, this would perpetuate a two-tier system where low income children in Medicaid get a more comprehensive benefit package than children with disabilities in moderate income families.

II. COMPREHENSIVENESS

Strengths

- 2b. Durable medical equipment, prosthetic and orthotic devices will be covered if they improve functional abilities or prevent further deterioration in function; covered services include training for use of these items.

Weaknesses

- 2b. **Durable medical equipment, prosthetic and orthotic devices:** Even though all prosthetic devices, most orthotic devices, and many forms of durable medical equipment are customized, such as customized seating and positioning in many power wheelchairs, "custom devices" are supposedly excluded from the federally guaranteed benefit package. Prosthetic devices are covered only if they replace the internal body organ rather than the function of the internal body organ [this criterion is straight out of the acute care oriented Medicare program which HCFA Administrator, Bruce Vladeck, has recently described as reflecting 1965 medical practice]. It is not clear whether insurance companies will interpret this federally guaranteed benefit to cover various forms of assistive technology, such as augmentative communication devices or environmental control devices. In the past these devices have arbitrarily been considered luxury items and not "medically necessary," a decision reflecting an acute care bias in the health care system, even though they can significantly improve functional abilities. There is no requirement that insurance companies must take into account "**functional necessity**" in determining which types of durable medical equipment, and prosthetic and orthotic devices will be covered. There are no assurances that persons with disabilities will be able to choose specialized prosthetists, orthotists and other rehabilitation technicians outside of an insurance plan's network, in order to purchase the most appropriate prosthetic and orthotic devices. It is not clear whether the consumer will have the option to "upgrade" the durable medical equipment, prosthetic or orthotic device that an insurance plan is prepared to pay for, and whether these out-of-pocket expenses will count toward the threshold of their stop-loss protection.

II. COMPREHENSIVENESS

Strengths

- 2c. Federally-guaranteed benefit package will include outpatient rehabilitation services, including occupational therapy, physical therapy, and speech-language pathology services to **restore** functional capacity or minimize limitations on physical and cognitive functions as a result of an **illness or injury**.

Weaknesses

continued

- 2b. after which the insurance plan covers 100% of their out-of-pocket costs.
- 2c. **Outpatient rehabilitation services including occupational therapy, physical therapy, and speech-language pathology services** are covered only to restore functional capacity or minimize limitations on physical and cognitive functions as a result of an **illness or injury**. There is no mention of outpatient rehabilitation for minimizing limitations due to a **birth disorder or the process of aging**. Moreover, insurance plans are expected to re-evaluate the need for continued therapy at the end of each 60 days of treatment to decide whether function is sufficiently improving to justify additional rehabilitation therapy. **There is no recognition that outpatient rehabilitation may be medically necessary and appropriate to prevent functional deterioration.**
- 2d. **Home health care is covered but only as an alternative to institutionalization for illness or injury** and subject to 60 day re-evaluation; there is no mention of respiratory therapy.
- 2e. **Extended inpatient care services in skilled nursing home or rehabilitation facility reflects acute care bias by being covered only after an acute illness or injury as an alternative to continued hospitalization; there is no mention of restoring functional capacity or minimizing limitations as a result of a birth disorder or the process of aging;** inpatient care service are subject to a limit of 100 days per calendar year.
- 2f. **"Custodial care" and personal comfort services and supplies** are excluded from the federally guaranteed benefit package, reflecting the acute care bias in the existing system. Insurance companies have traditionally used the terms custodial care, personal comfort services, and

II. COMPREHENSIVENESS

Strengths

2. Federally guaranteed benefit package would include some prevention, mental health, out-patient prescription drug benefit, rehabilitation, home health care and short term nursing home care which are often absent from existing private insurance plans.

Weaknesses

continued

- 2f. convenience items as excuses for not covering services that aren't "essentially medical."
- 2g. **Disposable medical supplies** required for many chronic health conditions do not appear to be covered in the federally guaranteed benefit package even though many are covered by Medicare and private health insurance and are very cost-effective for preventive care. This includes better surgical dressings for pressure ulcer treatment, ostomy supplies, and tracheostomy supplies that may be prescribed by a physician and can cost several thousand dollars a year for on-going chronic health conditions. It also includes incontinence supplies and medical support garments that may be required for persons with different forms of cancer or persons who have experienced bad burns. Some types of disposable medical supplies may be covered if used in connection with a covered item of durable medical equipment.
- 2h. **Experimental treatments** are excluded from the guaranteed benefit package unless they are part of an approved research trial. It is not clear whether an insurance plan can unilaterally decide that a specific treatment is "experimental." The federally guaranteed benefit package will only cover routine medical costs associated with an "investigational treatment" if it is part of an approved research trial.
- 2i. **Adult dental care** is excluded from the federally guaranteed benefit package care until the year 2001, and then will it only phase in preventive dental care and restorative dental care, and cover orthodontia only to avoid reconstruction therapy.

II. COMPREHENSIVENESS

Strengths

2. Federally guaranteed benefit package would include some prevention, mental health, out-patient prescription drug benefit, rehabilitation, home health care and short term nursing home care which are often absent from existing private insurance plans.

Weaknesses

- 2j. **Outpatient drug benefit** will require a \$5 per prescription co-payment for the low-cost sharing option or a \$250 per year separate deductible and 20% copayment for the high cost-sharing option subject to the out-of-pocket spending limit of \$1500 per individual or \$3000 per family, adding to the financial burden on low and moderate income families who require prescription drugs. Health insurance plans are also permitted to establish formularies to restrict drug choices, and impose mandatory generic substitution in order to contain drug costs. There is no assurance that generic substitution must have the informed consent of the consumer and the treating physician to avoid adverse reactions often found with anti-seizure or psychiatric prescriptions.

In addition, the outpatient drug benefit appears to arbitrarily limit coverage for immunosuppressive drugs to only three years, even though these medications are all required for life by persons who have received an organ transplant. This arbitrary exclusion from the federally guaranteed benefit package means that not only will transplant recipients have to pay for these life-saving drugs on their own, but their out-of-pocket expenses will not be counted towards their stop-loss protection for these medically necessary expenses.

- 2k. **Mental health and substance abuse services** are provided initially for a maximum of 30 days per episode of inpatient or residential treatment with a 60 day annual limit which will be expanded to an annual maximum of 90 days by 1998. Outpatient psychotherapy is limited to 30 visits per year while medical management, evaluation, and assessment, and substance abuse counseling are not limited. Intensive non-residential treatment services including partial hospitalization, day treatment, psychiatric rehabilitation, ambulatory detoxification, home-based

II. COMPREHENSIVENESS

Strengths

3. A new non-Medicaid Home and Community Based (HCB) services program targeted for persons with the most severe disabilities would create an entitlement to intake, eligibility determination, and a plan of care based on functional need rather than on income, family composition, age, or diagnosis. The new program which will be funded separately from the employer mandated health insurance premium contributions would be phased in over 5 years. Individuals with severe disabilities will no longer have to impoverish themselves or their families in order to become **eligible** for the HCB services they need.
- 3a. Eligibility criteria are: (1) needing personal assistance with three or more deficits in activities of daily living; (2) needing constant supervision because person poses a significant danger to self or others, has multiple and significant behavior problems, or is unable to administer prescribed medications; (3) has a diagnosis of severe or profound mental retardation measured by an IQ of 36 or less on a standard intelligence test; or (4) is a child under the age of six who is dependent on technology and otherwise requires hospital or institutional care.

Weaknesses

- 2k. services, and behavioral aide services are limited to 120 days per year. By the year 2001, a comprehensive mental health and substance abuse benefit will be phased in without limits on individual services.
- 2l. **Eyeglasses and contact lenses** for adults are excluded from the federally guaranteed benefit package, even if one has had cataract eye surgery.
- 2m. The expansion of other benefits such as preventive dental care for adults and eliminating limits on mental health coverage by the year 2001 depends on unspecified savings from reform and unknown budget constraints.
3. If inadequately funded by the federal government or poorly implemented by the state, this new HCB program will fail to provide the support that people with the most severe disabilities need to live in their own homes and communities and will end up in institutions at much higher costs. This new HCB program represents a significant departure from current long term care policy by shifting from an entitlement based on the combination of income and disability to a capped program based exclusively on measures of severity of disability without regard to income or other measures of need.
- 3a. Eligibility criteria for HCB benefits could disqualify a majority of SSI recipients with disabilities from receiving long term care services they currently need and may receive under Medicaid if they do not meet the highly restrictive functional impairment tests. The use of IQ of 36 or less as an eligibility criterion for this new long term care benefit is a redundant measure of eligibility because most persons with this low IQ level will also have three or more deficits in activities of daily living. In fact, **severity of disability is not the only appropriate indicator of need for**

II. COMPREHENSIVENESS

Strengths

- 3b. HCB benefits in all states must cover: assessment, planning and personal assistance with activities of daily living; but can also include case management; homemaker and chore assistance; home modifications; respite services; assistive technology; adult day services; habilitation and rehabilitation; supported employment; and home health services.

The new HCB program requires states to offer both consumer-directed and agency-administered personal assistance services, and states may elect to offer vouchers or cash directly to eligible individuals or to capitate benefits to health plans or other providers.

- 3c. Cost-sharing for long term care benefits includes: (1) nominal cost sharing below 150% of poverty at state option; (2) 10% co-insurance for individuals between 150-249% of poverty; (3) 25% co-insurance for individuals between 250-399% of federal poverty level; and (4) 40% co-insurance for individuals over 400% of the federal poverty level.
- 3d. Federal matching funds of 75-95% (approximately 20-25% higher than current Medicaid matching rates) will be allocated to states based on: (1) estimated number of individuals with severe disabilities; (2) age and gender distribution in the population; (3) prevalence of poverty in the state; (4) average wage for individuals in service occupations in the state. Federal funding allocations will be phased in 20% per year between FY 1996-2000 and are estimated to reach \$28 billion when fully implemented in FY 2000. As a measure of

Weaknesses

continued

- 3a. long term care services. For example, it is likely that persons with mental retardation who have a higher IQ are likely to need a higher level of personal assistance and supervision in long term support services than persons with an IQ of 36 or less.

- 3b. **There are no minimum benefit levels specified in the Clinton HCB proposal.** State flexibility in defining how to use a capped federally funded block grant for HCB services could undermine existing Medicaid funded long term care services; states will continue to be able to set their own more restrictive eligibility criteria, service options, and service limits for community-based long term care services. Personal assistance services defined as assistance with activities of daily living is the only service category mandated by the new HCB program.

- 3c. Significant cost-sharing for low income persons will impose a substantial financial obstacle to purchasing long term care services for many persons with disabilities. There is no stop-loss on cost-sharing for long term care services which will impose a substantial financial hardship on middle income families with children with disabilities, resulting in impoverishment as often occurs today.

- 3d. Without federal guidelines insuring that persons with intensive HCB needs receive at least a certain percentage of the federal funding for HCB, states may choose to distribute these scarce funds in a way that serves as many people as possible, discriminating against persons with the most intensive HCB needs. States will have a financial incentive to move people from Medicaid waiver HCB services to the new HCB program with a higher federal match and potentially lower benefit levels.

II. COMPREHENSIVENESS

Strengths

continued

- 3d. the Administration's commitment to increase resources for Home and Community Based Long Term Care which is currently only \$3.5 billion federal dollars for all Medicaid HCB waivers, the federal government will actually increase federal dollars for HCB benefits to \$5 billion by the end of the first year of implementation.
- 4. States will have the option of continuing to provide Medicaid community LTC services to low income persons and "Katie Beckett" children who do not meet the functional eligibility criteria for the new HCB program for persons with the most severe disabilities. It is hoped that middle class children with disabilities who avoid institutionalization with the support of "Katie Beckett" Medicaid waivers will meet the severity eligibility criteria for the new HCB program for persons with the most severe disabilities.
- 4a. Eligibility would be set by the state based on: (1) functional eligibility standards; (2) financial eligibility standards between the SSI eligibility level and the federal poverty standard or the State Supplemental Payment level, whichever is higher; and (3) resource limits at least \$2,000 and up to \$12,000 per individual.
- 4b. Benefits are to be determined by the state and can include any community long term care services previously funded under Medicaid.
- 4c. Federal funding for Medicaid LTC program for low income persons will occur at the current Medicaid Federal matching rate; states will be required to continue to serve at least the same number of low income individuals as they served in their FY 1993 Medicaid community LTC program.
- 4d. Federal expenditures for the new HCB program for persons with severe disabilities and Medicaid LTC program for

Weaknesses

- 4. There are no federal mandates requiring states to continue providing optional Medicaid services, including Medicaid HCB waivers, rehabilitation services, etc. In fact, states may well move state dollars used for Medicaid matching funds to obtain the higher federal match for the new HCB program for persons with severe disabilities. Although the Clinton plan requires protection for all current Medicaid HCB waiver service recipients, the lack of a waiver maintenance of effort mandate will deny future services to many currently eligible Medicaid recipients who will not be eligible for the new HCB program.
- 4c. States will not be required to provide the same services or even the same dollar amounts in their combined long term care programs, but are only required to serve at least the same number of low income persons as they served in their FY 1993 Medicaid community LTC program.

The new HCB program represents a significant departure from current federal LTC financing policy by shifting from an

II. COMPREHENSIVENESS

Strengths

continued

- 4d. low income persons will eventually be capped at the state level.

5. States will have the option of combining into a single capped program the new HCB program expenditures for persons with severe disabilities, former Medicaid community funding, and Medicaid institutional expenditures for any or all categories of recipients of LTC; states can set financial or functional eligibility standards for this new, separate HCB program.

- 5a. Under pressure from Congressman Henry Waxman to safeguard current Medicaid mandates, the Administration reportedly decided on September 14th to *temporarily* allow current Medicaid LTC policies to continue independently of new state HCB expenditures caps and to make recommendations for the integration of the Medicaid LTC services and the new HCB expenditures cap one year after the creation of the new HCB program.

Weaknesses

continued

- 4c. open-ended federal financial entitlement for states to a capped federal financial entitlement to states based on the estimated number of individuals with severe disabilities, age and gender distribution in the population, prevalence of poverty, and the average wage for individuals in service occupations in the state.

5. Current federal mandates to ensure that low income persons on Medicaid receive LTC services could be eliminated by this new HCB program creating an entitlement for an unspecified HCB benefit level to persons regardless of their ability to pay.

- 5a. The Medicaid savings that were anticipated by the Federal government by shifting resources from current Medicaid LTC services to the new HCB program will have to be made up by other Federal funding sources if current Medicaid long term care policies are **temporarily** allowed to continue without change. Earlier drafts of long term care proposals for the Clinton plan had included various proposals for incremental Medicaid reforms that would have expanded flexible community-based long term care services and the populations eligible for them. **One incremental change** which is not included in this draft of the Clinton plan would allow states to fund Medicaid home and community-based waiver services as a regular state plan option, rather than a cumbersome 3 year application and 5 year renewal process.

A **second proposal** would have allowed states to create a single budget for long-term care expenditures for certain Medicaid eligible populations, such as persons with mental retardation or

II. COMPREHENSIVENESS

Strengths

5a. Under pressure from Congressman Henry Waxman to safeguard current Medicaid mandates, the Administration reportedly decided on September 15th to *temporarily* allow current Medicaid LTC policies to continue independently of new state HCB expenditures caps and to make recommendations for the integration of the Medicaid LTC services and the new HCB expenditures caps one year after the creation of the new HCB program.

6. Medicaid coverage for institutional care would be expanded by requiring all states to establish a medically needy program for all residents of a nursing home or an ICF-MR facility; residents of nursing homes or ICF-MR would be permitted to retain \$100 per month as a personal needs allowance which would be protected from spend down obligations to qualify for Medicaid coverage; residents of nursing homes and ICFs-MR could retain up to \$12,000 in personal assets without jeopardizing eligibility for Medicaid coverage.

Weaknesses

continued

5a. developmental disabilities to encourage states to reverse the existing Medicaid institutional bias.

A **third proposal** would have extended Medicaid institutional income eligibility rules to Medicaid-funded home- and community-based services expanding eligibility for individuals with incomes up to 300 percent of poverty to qualify, permitting spousal impoverishment protections for married individuals in the community, and allowing individuals to spend down to the federal poverty level instead of the lower SSI level.

In addition, states would be able to require cost sharing for individuals with incomes between 100 and 300 percent of poverty, after taking into account individual maintenance needs allowance, family/spousal allowances, and other medical expenses. A **fourth proposal** would have required states to clarify how they will ensure consumer participation in health, safety, and quality assurance for all of the home and community-based services and measure consumer satisfaction with the services.

6. Long term care reform in the Clinton plan will continue to have an "institutional bias" by capping the new federal HCB services for persons with severe disabilities while placing no caps on available federal matching funds for ICFs-MR or skilled nursing facilities.

III. APPROPRIATENESS

Strengths

1. Consumer chooses insurance plan based on objective report card on quality provided by regional alliance.

Weaknesses

- 1a. It is unlikely that a report card on the quality of health care provided by different health plans within a regional alliance will provide *sufficiently specific information* for persons with a disability or chronic illness to decide which health plans are best able to meet their needs.
- 1b. The federally guaranteed benefit package contains **arbitrary limits** on certain covered services including durable medical equipment, prosthetic and orthotic devices, rehabilitation therapies, home health care, immunosuppressant drugs, and mental health services, etc. Moreover, exclusions for outpatient rehabilitation therapies appear to discriminate against persons with congenital disabilities which recreates the use of pre-existing condition exclusions and may violate the Americans with Disabilities Act.
- 1c. Managed competition creates a major incentive to under-serve consumers by providing a fixed payment to a health plan in exchange for its obligation to provide all medically necessary and appropriate covered services to its enrollees. This disincentive to serve is often reinforced by financial incentives for individual physicians who receive financial bonuses from the managed care plan for not exceeding certain utilization levels and who may be financially penalized for exceeding those utilization targets even when they are providing medically necessary care.
- 1d. The regional alliance is not required to force the state certified health plans which it contracts with to disclose the financial incentives which they have created for their health care providers which may affect their willingness to provide medically necessary and appropriate care.

III. APPROPRIATENESS

Strengths

1. Consumer chooses insurance plan based on objective report card on quality provided by regional alliance.

Weaknesses

- 1e. Health plans are not required to refer enrollees out to specialists or to centers of excellence, even when the enrollee has cause to believe that the health plan's providers cannot provide as high a quality of health care as an outside specialist or center of excellence. Choice of provider is probably the most important quality assurance mechanism for a person with a disability to ensure that he or she receives appropriate health related services. It is unlikely that many health plans in a regional alliance will have on staff a qualified developmental pediatrician, pediatric rehabilitation therapist, child psychologist or child psychiatrist, or an orthotist and prosthetist who can provide the quality of care that many persons with disabilities depend on to maintain their health and maximize their functioning and quality of life. This problem is magnified for persons with certain rare disorders for whom there may be only two or three centers in the entire country with experienced specialists to treat them. It is not uncommon for HMOs to resist referrals to specialists outside of their network, even for persons with rare disorders, in order to contain their costs. This problem must be addressed to enable persons with disabilities to seek appropriate health care from specialists, even if they are at distant medical facilities, in order to receive the most effective care. Some specialized programs have attempted to serve persons with rare disorders by negotiating costs with their HMOs that are comparable to the prices that the HMO would have paid for local medical services. It is essential that this quality assurance mechanism is protected by federal standards and is not left to the discretion of a health plan struggling to contain its health care costs. It is also crucial that financial obstacles do not prevent persons from disabilities from seeking the qualified health care that they need.

III. APPROPRIATENESS

Strengths

1. Consumer chooses insurance plan based on objective report card on quality provided by regional alliance.
2. Consumer can disenroll from insurance plan at any time for cause.
3. Fee for service option is supposed to be available through regional alliance if consumer can afford it.

Weaknesses

- 1f. Individuals with work-related injuries covered under workers' compensation insurance are able to get better services from health insurance plans than persons with disabilities enrolled in the same health plan.
2. The reasons that a consumer can disenroll from an insurance plan for "cause" are not specified (e.g., change in health status, lack of appropriate specialists in the plan, difficulty in getting a referral to specialists out of the plan); other insurance plans may create similar problems in responding to certain health care needs; that is why ADA protections must be enforced as federal civil rights law to correct discrimination.
3. Fee-for-service option may be waived by regional or corporate alliance. This could greatly limit the choice of provider for persons with disabilities who often depend on specialized services for meeting their basic health related needs. Financial barriers must not be allowed to block access to the most appropriate health care for persons with disabilities.

Although President Clinton has said repeatedly that managed competition will not interfere with the ability of individuals to choose their own physicians even if they are attached to different health plans within a regional alliance, it may be in the interests of the competing health plans to limit the clinical practices of the physicians whom they employ. Some health care analysts predict that the largest health plans will have the capacity to game the system through marketing, subtle risk selection, and capitation creep, and they will have the clout to extract discounts from hospitals and doctors by threatening to withdraw a significant proportion of their business. This could have the effect of shifting costs to smaller plans driving up their premiums and causing their enrollees to shift to the larger HMO plans.

III. APPROPRIATENESS

Strengths

4. The responsibility for access to health insurance and access to appropriate health care in a geographical region lies with the regional alliance which represents employers and consumers but not insurers and providers.

Weaknesses

continued

3. One result of this competitive strategy is that small scale, non-HMO providers may be driven out of business unable to compete for patients who will be forced into large scale low cost HMOs with long waits, hurried care, and clinical decisions driven by cost containment strategies. Already, ten insurers control 70% of the HMO market nation-wide.
- 4a. If the regional alliance is dominated by employers seeking to minimize their premium contributions or by state officials seeking to minimize the taxes they impose, it is less likely to protect consumers from reduction in quality of health care due to cost containment pressures on the insurance plan.
- 4b. There are no assurances that persons with disabilities will be represented among the consumers on the regional alliance monitoring the quality of health care services provided by the for-profit health plans. The Clinton plan needs strong governance provisions to constrain the high degree of state flexibility, or else strong federal requirements to protect vulnerable populations, like persons with disabilities.
- 4c. There are no federal requirements for persons with disabilities having any specified planning roles in helping states develop appropriate policies for the new Home and Community-Based program for persons with severe disabilities. This ignores the important precedent of the Rehabilitation Act with mandated involvement of persons with disabilities in policy direction for the largely federally funded, state-administered Vocational Rehabilitation program. In addition, there is an important precedent of mental health councils' including persons with disabilities in developing state mental health plans which are then submitted to and approved by governors before being submitted to

III. APPROPRIATENESS

Strengths

4. The responsibility for access to health insurance and access to appropriate health care in a geographical region lies with the regional alliance which represents employers and consumers but not insurers and providers.

Weaknesses

continued

- 4c. the federal government.

States should be required to establish an independent state policy board on Long Term Services which includes a majority of consumers and is representative of the broad disability community, including people of all ages. The State Policy Board should develop a consumer-driven long-range strategic plan for community and institutional services that addresses how the state will assure that the needs of all the diverse groups of eligible persons will be appropriately served in keeping with the policy values of the Americans with Disabilities Act. This calls for the full integration and inclusion of Americans with disabilities of all ages into every aspect of American community life. The state plan should be prepared by the State Policy Board and approved by the Governor before being submitted to the federal government. By allowing persons with disabilities to develop the initial plan before it is submitted to the Governor for approval or modification, this provides an important degree of public accountability that would otherwise be lacking in a plan originally proposed by the state government.

- 4d. The regional alliance may be reluctant to exclude an insurance plan that provides poor quality care to low income persons if other plans in the region are over-enrolled, and there are no other insurance plan providers that think they can make a profit by replacing the poor quality plan.

III. APPROPRIATENESS

Strengths

5. To maximize cost containment, a for-profit health plan is authorized to limit the number and type of health care providers who participate in the health plan, require participants to obtain health services (other than emergency services) from participating providers or from providers authorized by the plan, and to use single source suppliers for pharmacy, medical equipment and other health products and services.
6. Quality assurance is supposed to be protected by grievance procedures within each insurance plan, an ombudsman at the regional alliance level, and the consumer's right to sue.
7. Recognizing that competing health plans face many financial disincentives to reach out to vulnerable populations in underserved areas (including "individuals with certain severe health problems, such as HIV infection, AIDS, chronic mental illness, substance abuse or serious disability,") the federal government will finance separate public health service access initiatives that expand the health care capacity and remove barriers to access and improve quality of health care in underserved areas. These include: (1) expansion of the National Health Service Corps to reduce the shortage of primary care practitioners in underserved areas; (2) funding for community and migrant health centers, family planning clinics, health care for the homeless program, and various maternal and child health programs; (3) new grants and loans for start up and operating funds to essential community

Weaknesses

5. There is a fundamental contradiction between cost containment pressures at the level of the health plan and the requirement to serve people who may need expensive health care services.
6. **The Clinton plan does not explicitly state that ADA protections apply to the National Health Board, regional and corporate alliances, and health plans.** It is crucial that federal civil rights laws are available to protect vulnerable populations, like persons with disabilities, from the inevitable contradiction between cost containment at the level of the health plan and the requirements to serve persons who may require expensive health care services.
7. The Public Health Service Access Initiatives are woefully under-funded to build health care capacity in the underserved areas. It is not clear how an additional \$1-4 billion federal dollars by the year 2000 will begin to create equal access to medically necessary health care for all persons in underserved poor urban and rural areas. Health plans will have five years to either demonstrate their capacity to provide access for all participants or continue contracting arrangements with "essential community providers" in underserved areas at a capitated rate no less than that paid to other providers for the same services or to reimburse them at Medicare payment rates. This is likely to perpetuate a two-tier system.

III. APPROPRIATENESS

Strengths

continued

7. based providers and public and non-profit health care institutions; and (4) new formula grants to the states to cover outreach and enabling services (e.g. transportation, translation /interpretation, child care), supplemental services, advocacy and follow-up services to low-income, underserved, hard-to-reach, and otherwise vulnerable populations.
8. The National Health Board will set national standards for the administration of the new health system by states, and interpret and update the nationally guaranteed benefit package to reflect changes in technology, health care needs, and methods of service delivery. The Board will also establish and enforce baseline budgets for all alliances, and manage a performance-based system of quality management and improvement which health plans are required to use in their annual quality performance reports.

Weaknesses

8. There are no assurances that the National Health Board and its advisory committees, which include representatives of states, health providers, employers, consumers, and affected industries, will be able to protect the access of persons with disabilities to medically necessary and appropriate services in the private health plans. The health security of persons with disabilities will depend not only on the expansion of federally-guaranteed benefits in the health plan, but resistance to a reduction in needed benefits generated by the inevitable pressure for cost containment. Unless the National Health Board resists this pressure to cut benefits, it will be difficult to squeeze the excess capacity, administrative waste, and excess profits from the health care system.

IV. EQUITY

Strengths

1. Premium subsidies for the federally guaranteed benefit package will be available for low income persons with incomes up to 150 percent of the federal poverty level (approximately \$10,500 for a single individual or \$21,500 for a family of four) and to small employers (under 50 employees) for whom the premium costs would be a financial burden; if a subsidized individual or family cannot enroll in a plan at or below the average premium, the alliance will raise the subsidy to permit them to enroll in the lowest-cost plan above the average. Part time and seasonal employees may be eligible for a public premium subsidy if their family incomes are less than 250% of poverty.
- 1c. Supplemental services (beyond the federally guaranteed benefit package) for SSI and AFDC recipients will remain a state option depending on the state's Medicaid optional services. Under consideration is conversion of supplemental services payments for cash and non-cash recipients (i.e. medically needy persons whose income before medical expenses make them ineligible for cash public assistance) into a block grant and providing states greater flexibility in targeting and delivering these services.
2. Health plans would have to charge the same community-rated premium to every individual within a regional alliance regardless of health status, age, etc.

Weaknesses

- 1a. **Choice of health plans will be based on ability to pay.** In the absence of information about the amount of the public subsidy that the Clinton plan will provide to persons at different income levels under 150% of poverty, it is impossible to evaluate the extent to which the Clinton plan discriminates against persons on the basis of income.
- 1b. **Only persons with disabilities on Medicaid will be eligible for a public subsidy for a fee-for-service plan** so that they can enroll in the lowest price fee-for-service plan without additional out-of-pocket payments for premiums, deductibles or co-payments; this protection during an unspecified transition period to be determined by the National Health Board is supposed to ensure "high quality care for the disabled."
- 1c. Limits on the federally guaranteed benefits will require supplemental private insurance. Certain health-related services like home health care, rehabilitation therapies, and durable medical equipment, prosthetic and orthotic devices, will only be available to persons who can afford supplemental insurance.
- 2a. Community-rated premium for all individuals within regional alliance is not as progressive as a financing mechanism that used an income tax or payroll tax to ensure that financing was based on ability to pay. This would ensure that persons with higher incomes paid a higher rate or a higher amount for health care than persons with lower incomes.

IV. EQUITY

Strengths

3. Providers will be prohibited from balance billing (i.e. charging consumers more than the standard fee negotiated with the regional alliance).
4. No lifetime caps on medically necessary or appropriate covered services (with the exception of orthodontia) for the federally guaranteed benefit package.
5. The limit on out-of-pocket costs for deductibles and co-payments is \$1,500 for an individual and \$3,000 for a family per year, after which a stop-loss protects against additional out-of-pocket expenses for covered services.

Public subsidies to cover co-payments and deductibles are available to individuals with family incomes less than 150% of poverty, if the regional alliance is not served by a plan with low cost sharing and a premium at or below the average premium in the alliance.

Weaknesses

- 2b. Cost-sharing requirements for deductibles and co-payments (such as \$10 per office visit or \$5 per prescription drug in the low-cost sharing plan) will discourage many low income persons from getting the timely, medically necessary health care that they or their family members need.
4. Limits on covered services in the guaranteed benefit package are arbitrary ways to contain health care costs.
5. A self-employed person with an income over 150 percent of poverty (i.e., \$10,500) would be required to pay both the employer and employee share of the community-rated premium, in addition to deductibles and co-payments up to a cost-sharing stop-loss of \$1,500 for an individual. Although the employer's share paid by the self-employed person would be capped at the same percentage applied to small business (e.g. 3.5% of payroll), this represents a significant percentage of his or her pre-tax earnings which would be a highly regressive way to finance health care.

IV. EQUITY

Strengths

6. Financing for this national health care program will not require the federal government to impose new broad-based taxes. The Clinton plan proposes to pay for the estimated cost of covering uninsured and low-income wage workers in small firms through: (1) new taxes on cigarettes (\$12 billion to \$16 billion per year); (2) Medicaid and Medicare savings from enrollees whose health care premiums would be partially covered by employers (estimated revenue \$19 billion per year); (3) Medicaid savings for individuals who would be covered under the plan (estimated total revenue \$40 billion to \$50 billion per year); (4) taxable profits as companies' health care premium contributions are slowed (\$2 billion to \$15 billion per year by the year 2000).
7. Employers are expected to pay 80 percent of average premiums in the regional or corporate alliance depending on the type of the employee's family (e.g. single individual, couple, single-parent family, or two-parent family with one or more children); no employer will be required to pay more than 7.9 percent of payroll for health coverage annually, while employers with fewer than 50 employees will be eligible for a cap on the employer's contribution to premiums varying from 3.5 percent (for average wages under \$12,000 per full-time worker) to 7.9 percent of payroll (for average wages greater than \$24,000).

Weaknesses

6. Cuts in Medicare and Medicaid are proposed to finance subsidies during transition period. A number of health care analysts have questioned whether the Medicaid growth rate can be reduced from 16.5% to 4.1% and the Medicare growth rate can be reduced from 11.6% to 4.1% within a five year period without sacrificing the health security of Medicaid and Medicare beneficiaries. Among persons with disabilities who would likely be harmed by these proposed reductions are the tens of thousands of persons currently on waiting lists for a variety of Medicaid waiver programs who may not be eligible for the new HCB program for persons with the most severe disabilities. As a result they may never have access to any Long Term Support services in the community and thus be forced to "choose" institutional care.
- 7a. **Non-profit employers who do not qualify for a tax deduction on their contributions to health insurance premiums of their employees and dependents are not protected from the financial burden of meeting this employer obligation even if they face difficulty raising their prices through local and state government contracting.**
- 7b. Some public subsidies to employers, like the proposal under review in the Clinton plan for the federal government to allow employers to shift their obligations to pay early retiree health benefits to the federal government, reinforce existing inequities in the employer-sponsored health insurance system by favoring employers and employees with early retiree health benefits when many other individuals are in need of public subsidies to provide equal access to medically necessary health care.

IV. EQUITY

Strengths

8. Families contribute the difference between 80% of the average premium and the price of the insurance plan they choose.
9. A new individual income tax credit for 50 percent of personal assistance services, to be defined by the Internal Revenue Service (IRS), up to a maximum of \$15,000 per year, would be available to employed individuals with disabilities who require personal assistance services and have a tax liability equal to or greater than the size of the tax credit.
10. There is a graduated cost-sharing requirement for the new Home and Community Based (HCB) program for persons with severe disabilities from a nominal cost sharing below 150% of poverty up to at least 25% co-insurance for individuals above 250% of the federal poverty level.

Weaknesses

8. There is no cap on the amount of the individual's or family's contribution to their health insurance premium in relation to their income, only a cap on employers' and government's costs.
9. Although a tax credit for personal assistance services spreads only half the cost throughout the population, it does provide an important financial mechanism for this critical enabling service which reduces a major disincentive for some persons with disabilities.
10. There is no cap on out-of-pocket expenses for the new HCB program which can be very expensive for middle class families expected to pay at least 25% of the cost in copayments.

V. EFFICIENCY

Strengths

1. Competition among plans for providing guaranteed benefit package is supposed to reduce health care costs.
2. Requiring plans to contract with regional alliance is supposed to increase negotiating power of consumers.
3. National Health Board will set premium caps for each regional alliance from year to year to control health care expenditures.

Weaknesses

- 1a. Competition among a few large for-profit insurance companies within a regional alliance may very well result in price-fixing rather than cost containment.
- 1b. Competition among plans is unrealistic in many sparsely populated areas of the country or in underserved urban areas with high levels of poverty.
- 1c. Maintaining differences in health plans increases administrative costs and discriminates against lower income persons who cannot afford to enroll in the quality plan they need.
2. Regional alliance is likely to be dominated by employers who want to minimize their premium contributions and by state officials who may want to reduce taxes rather than by consumers who want access to highest quality of care available for whatever health care need they have.
- 3a. Premium cap may increase cost containment pressures within health plan that erodes quality of care in providing covered services. For persons with disabilities, this may lead to secondary disabilities and other preventable medical complications that ultimately require more expensive acute care and contribute to Social Security, welfare and other dependency costs outside of the health care system.
- 3b. Clinton plan makes use of global budgeting at the level of the insurance plan rather than at the level of society that other countries have found to be highly effective in containing health care costs in a publicly accountable way.

V. EFFICIENCY

Strengths

4. Health plans will decide how to provide covered services in the most cost-effective way.
5. Consumers would be taxed (ten years after enactment of the Clinton plan) on premium contributions above the average cost plan in their region whether paid for by employer or deducted from earnings.
6. Standardization of forms will reduce administrative waste.

Weaknesses

4. Clinical judgment of health care providers is likely to be constrained by cost-containment pressures on health plan providers who receive a pre-paid community-rated premium to provide covered services to all enrollees. As a result, cost containment pressures will be handled as private rationing decisions within the health care marketplace rather than as public policy decisions.
5. Taxing health insurance premiums above the average cost plan will encourage consumers not to seek the most comprehensive health care package that they might need.
6. Preserving a role for private health insurance industry in restructured health insurance marketplace creates forms of administrative waste that would not be required by a single payer system (e.g. risk-adjusted premiums to protect insurance plans from open enrollment); the U.S. General Accounting Office originally concluded that a single payer system could save \$67 billion dollars in administrative waste which was approximately 10 percent of total health care expenditures in 1990; the Congressional Budget Office has recently concluded that the single payer bill (H.R. 1200) introduced in the 102nd Congress would cover all of the uninsured, reduce administrative waste, and control national health care expenditures better than the version of managed competition (H.R. 5936) introduced by the members of the Conservative Democratic Forum in the last session of Congress (CBO, July, 1993).

V. EFFICIENCY

Strengths

8. Medical malpractice reforms are designed to reduce costs.

Weaknesses

continued

8. awards will be reduced by the amount of recovery from other sources that compensate an individual for an injury. Demonstration pilots will be created in which a physician able to demonstrate that his professional conduct or treatment complied with appropriate practice guidelines would not be liable for medical malpractice.

This evolving analysis of strengths and weaknesses in the Clinton Health Plan from a disability perspective will be revised as new developments occur. We hope this analysis will be helpful in focusing attention on the impact of specific features of health care reform on persons with disabilities and on the "temporarily able-bodied" population. It is important that persons with disabilities are recognized as a litmus test embodying the health care needs of the total population rather than as a special interest group seeking to promote its special interest. Readers are encouraged to share their thoughts, insights, concerns, and recommendations for improving access to health care for persons with disabilities or chronic illness by contacting Bob Griss, Senior Health Policy Researcher, or Allan Bergman, Director of State-Federal Relations, United Cerebral Palsy Associations, 1522 K Street, N.W., Suite 1112, Washington, D.C. 20005; telephone: (202) 842-1266 or 1-800-872-5827.



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President Offers Health Reform Plan



J. Edward Beck (l), member of the National Easter Seal Society Board of Directors, and Robbie Friedner, member of the National Easter Seal House of Delegates, participated in a White House rally for national health care reform.

On Sept. 22, President Clinton introduced his plan for reforming America's health care system. The plan emphasizes six basic principles: security, savings, simplicity, choice, quality, and responsibility. For people with disabilities and their families, the proposed American Health Security Act is an encouraging first step

toward comprehensive, affordable, guaranteed access to health care and related support services.

The following day, the President invited approximately 1,000 leaders representing business, labor, medical, consumer, and other key interests to the south lawn of the White House for a rally to launch his public bid for national health care reform. The National Easter Seal Society was represented at this event by national board member J. Edward Beck, house of delegates member Lewis "Robbie" Friedner and Office of Public Affairs staff Randall Rutta and Judith Shaw.

Reaction to the President's plan in the disability community was generally favorable. The National Easter Seal Society and other groups applauded President Clinton's commitment to health care reform, particularly his efforts to bring about universal access to health care and to eliminate pre-existing condition exclusions. Responding to the Clinton plan, the national society reiterated its health reform principles and encouraged reforms that strengthen access to nonprofit home and community-based services, and that maintain access to existing disability-related services. Easter Seal viewpoints were also expressed in statements issued by the Consortium for Citizens with Disabilities and the National Leadership Coalition for Health Care Reform. Copies of these statements are available from

the Office of Public Affairs.

Within a week of the President's speech, Hillary Rodham Clinton was back on Capitol Hill promoting the Administration's plan in a series of House and Senate hearings on health care reform. Sixteen congressional committees have jurisdiction over health care financing and delivery, with four committees — Senate Finance, Senate Labor and Human Resources, House Ways and Means, and House Energy and Commerce — likely to take the lead in crafting health care reform legislation. Congressional hearings

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