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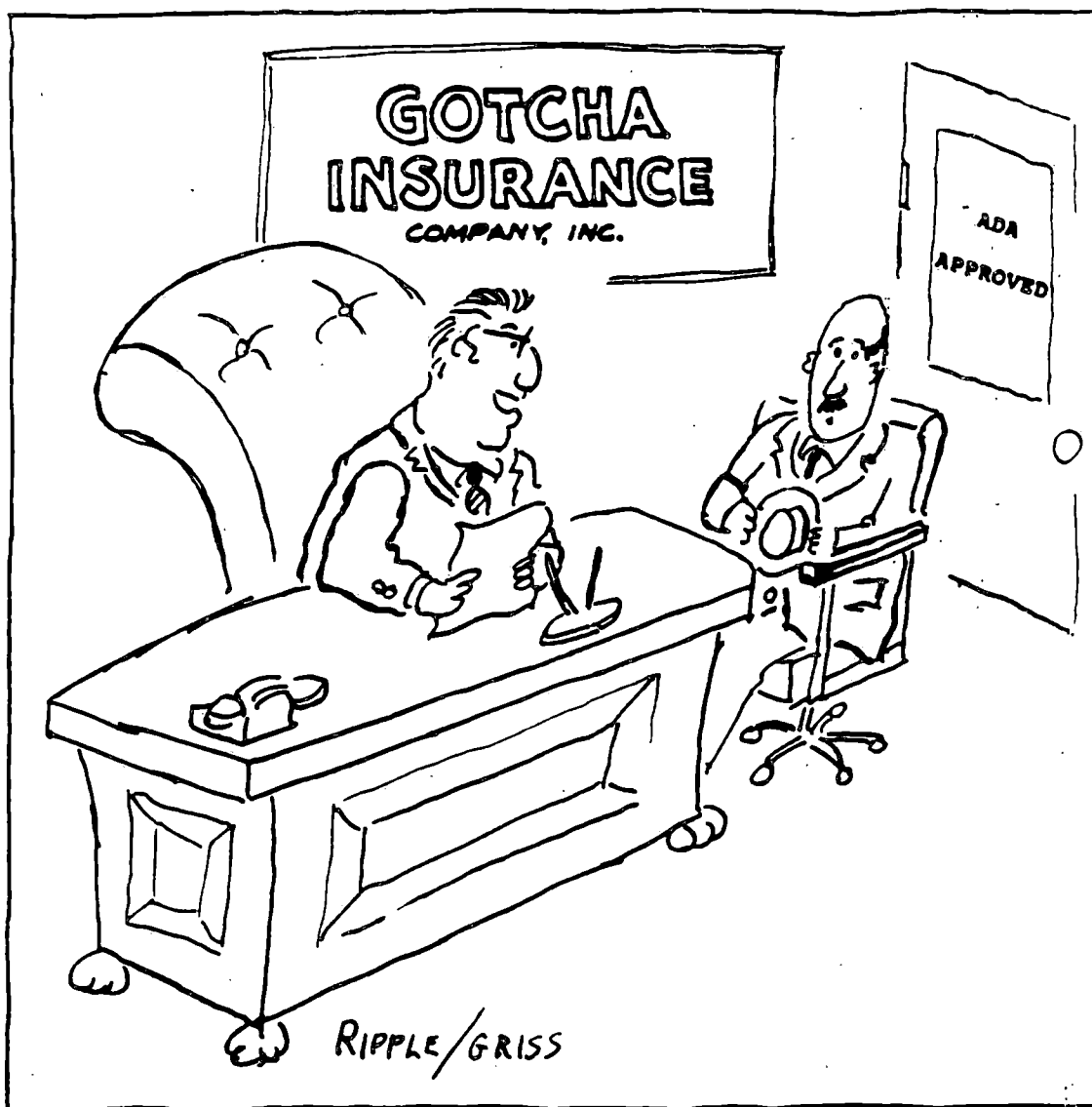
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Diagram 10:



**"BASED ON OUR FICTITIOUS ACTUARIAL TABLES,
WE CONSIDER YOU 'MEDICALLY UNINSURABLE',
BUT WE WOULD BE HAPPY TO SELL YOU A HEALTH
INSURANCE PLAN THAT PERMANENTLY EXCLUDES
COVERAGE FOR ANY PRE-EXISTING CONDITIONS."**

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Insurance-Liability Curb Poses Problem for Bush

NEW YORK, TUESDAY, MAY 19, 1992

p. A12

By ROBERT PEAR
Special to The New York Times

WASHINGTON, May 18 — A bitter dispute has broken out within the Bush Administration over whether to support or oppose a decision by a Federal appeals court allowing employers to revoke the health insurance coverage of employees who develop costly illnesses like AIDS.

The case involves a man with AIDS whose company severely limited his medical payments after he told company officials that he had the disease and filed his first claims. His lawyer has appealed the ruling to the Supreme Court, contending that the company illegally discriminated against the man, John W. McGann, by stripping him of health insurance benefits at the moment he needed them most.

The Court has asked the Administration for its views on whether the Justices should hear the case. It makes such requests in difficult cases involving issues of concern to the Government or the public. The Justice Department, in its response, usually indicates its views on the merits of the case.

The issue poses a problem for the White House in a political year when it has stoutly defended the private insurance system against calls for a program of national health insurance financed by the Government.

Dueling Departments

The Labor Department, which regulates employee benefit plans, generally supports the appellate court ruling. It maintains that the Government should not interfere with employers' prerogative to cut costs by reducing health insurance benefits.

But the Department of Health and Human Services says the Court should overturn the decision on the ground that if employers are allowed to renege on their commitments it will undercut the system of private health insurance, on which more than two-thirds of all the nation's workers depend.

Moreover, governors fear that the Government and the states will incur huge new costs if gravely ill workers, denied coverage through private insurers, turn to Medicaid and other public programs to pay their bills.

"If private insurers, under cover of Federal law, are allowed to dump people with catastrophic illnesses, those people will wind up in public programs," said Alicia S. Pelrine, director of human resources for the National

Governors' Association. "We view that trend with some alarm."

In letters to the Labor Department and the Justice Department, Mark E. Haddad, a lawyer for the American Medical Association, said the appellate court decision "may adversely affect the tens of millions of Americans who receive health insurance as a benefit of employment" from companies serving as their own insurers.

The American Association of Retired Persons, the National Governors' Association and groups advocating better treatment of people with AIDS are also seeking a reversal of the decision.

The Supreme Court has invited Kenneth W. Starr, the Solicitor General of the United States, to present the Administration's views. He is trying to thrash out differences among the Labor and Health and Human Services

Private coverage vs. catastrophic illnesses.

departments and the White House, which may ultimately have to resolve the dispute. While there is no deadline, Justice Department lawyers want to file their views by early June.

In the pending case, the United States Court of Appeals for the Fifth Circuit, in New Orleans, ruled that employers who underwrite their own health insurance, as most big companies do, may change their policies and sharply reduce coverage for workers who develop costly illnesses like AIDS, cancer or Alzheimer's disease.

Mr. McGann, the plaintiff in that case, died of AIDS in June 1991. But the executor of his estate has appealed to the Supreme Court, arguing that Mr. McGann's employer, the H & H Music Company of Houston, illegally stripped him of health insurance benefits.

Coverage Converted

The company had a conventional group health insurance plan. But after Mr. McGann told the company that he had AIDS and filed his first claims in early 1988, the company converted its coverage to "self-insurance" and slashed the lifetime limit on payments for AIDS-related expenses to \$5,000, from the prior limit of \$1 million. The change did not affect any other employee or any other disease.

Self-insured companies assume the financial risk of health insurance for their workers and use their own assets to pay claims. More than half of all employees now work for self-insured companies, the Health Insurance Association of America says.

The Labor Department is writing the first draft of the Government's brief because it has primary responsibility for enforcing the 1974 law that regulates employee health insurance and pension plans. The department argues that employers must be free to cut back or end health benefit plans without interference by the Government. If they are not, the department says, they will be less willing to offer such benefits to employees in the first place.

The Department of Health and Human Services and the A.M.A. agree that employers may revise the terms of their health insurance plans, but insist that such changes must not be made so as to punish or retaliate against a person who has suddenly become ill and has filed claims.

Promoting Private Insurance

A major goal of President Bush's health policy is to expand the role of private insurance and to fend off demands for national health insurance financed by the Government. "The goal here is to promote private insurance, and the question is, what's the best way to do that?" said Michael J. Astrue, general counsel of the Department of Health and Human Services.

Kirk B. Johnson, senior vice president and general counsel of the A.M.A., said: "It is patently unfair for an employer to retroactively deny health insurance benefits to employees after they get sick and make a claim. We concede that there is no particular level of coverage that employers have to offer. But having offered it and having encouraged employees to rely on it, the employers cannot backtrack."

Thomas B. Stoddard, a former executive director of the Lambda Legal Defense and Education Fund who represents Mr. McGann's estate, said, "If an employer can cut workers out of a health plan after they become ill, health insurance is just an elaborate shell game."

But David G. Ball, Assistant Secretary of Labor for pension and welfare benefits, said there was a public interest in allowing employers to revise health benefits.

"It's a voluntary system," Mr. Ball said in an interview. "Employers don't have to offer benefits at all. An employer is much more likely to offer benefits if he has an opportunity to cut them back at a later date. Profitability is unpredictable. Employers are generous in good times, and in bad times they may need to reduce health benefits to preserve jobs and to protect the corporate entity."

Ann L. Combs, a Deputy Assistant Secretary of Labor, said that if Congress thought the results of the appellate court decision was "unacceptable from a policy perspective" it could amend the 1974 law. But she said the Labor Department was not recommending such a change now.

**Table 5: Conditions For Which Health Insurance Coverage Is Denied
(Examples From the Underwriting Guide of a Major Company)**

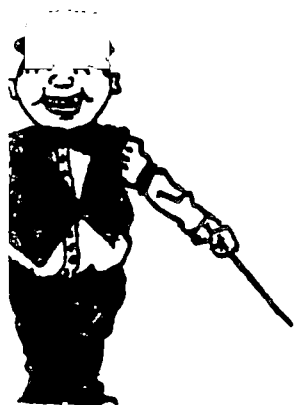
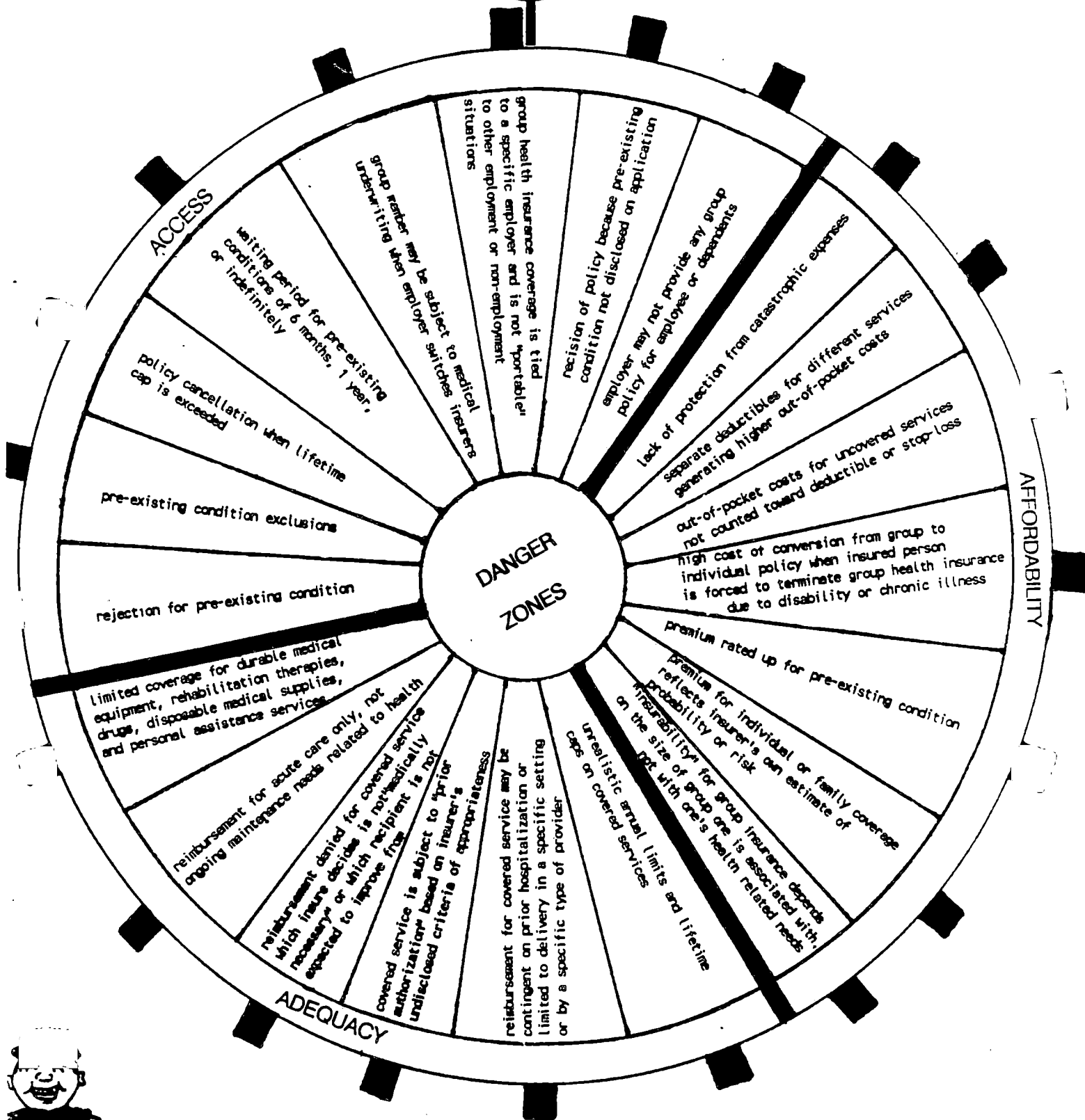
1. Addison's Disease	34. Gonorrhea (w/n 5 yrs)
2. Adrenal Insufficiency	35. Heart Pacemaker
3. A.I.D.S.	36. Hemophilia
4. Alcoholism	37. Hepatitis, Chronic
5. Alzheimer's Disease	38. Herpes Simplex, Within 5 yrs
6. Aneurysm (unoperated)	39. Hodgkin's Disease (treated w/n 10 yrs)
7. Anorexia Nervosa	40. Intestinal Bypass
8. Anxiety (present or treated w/n 1 yr)	41. Kidney Dialysis
9. Arteriosclerosis, Peripheral	42. Leukemia
10. Arthritis, Juvenile	43. Lupus Erythematosus
11. Black Lung	44. Mongoloidism (Down's Syndrome)
12. Brain Concussion, With central nervous system residuals	45. Multiple Sclerosis
13. Brain Tumor, Unoperated or incomplete recovery from operation	46. Muscular Dystrophy
14. Bright's Disease	47. Myasthenia Gravis
15. Brittle Bones	48. Narcolepsy
16. Bronchiectasis, With other chronic respiratory tract diseases	49. Nephritis, Chronic
17. Bulimia	50. Nervous Breakdown (w/n 5 yrs)
18. Burger's Disease	51. Pancreatitis, Chronic
19. Cancer, Other Than Skin, If o	52. Paralysis of both arms and both legs
20. Cancer, Other Than Skin, Treated w/n 5 yrs	53. Parkinson's Disease, Diagnosed age 50 or under
21. Cancer, Melanoma, Treated w/n 5 yrs	54. Peripheral-Vascular Disease
22. Cerebral Palsy	55. Personality Disorder
23. Cirrhosis	56. Pregnancy
24. Condyloma (present or treated w/n 5 yrs)	57. Polycystic Kidney Disease
25. Congestive Heart Failure	58. Psychosis/Psychoneurosis
26. Chronic Obstructive Eye Disease	59. Raynaud's Disease
27. Cushing's Disease or Syndrome	60. Rectal Bleeding, Cause Unknown
28. Depression (present or treated w/n 2 yrs)	61. Rheumatic Fever, Within 1 year.
29. Diabetes Away, Juvenile Onset	62. Schizophrenia
30. Down's Syndrome	63. Skull Fracture, Still Under Treatment
31. Drug Addiction	64. Syphilis (w/n 5 yrs)
32. Emphysema, Severe or with other resp. tract or cardiovascular disease.	65. Transplants
33. Epilepsy, Grand Mal	66. Warts, Venereal (present or treated w/n 5 yrs)
	67. Wheelchair Dependent

Note: Insurance companies will not insure individuals with these conditions.

Source: Medical Underwriting Guide of a major health insurance company.

from Health Insurance at Risk: The Seven Warning Signs,
Citizen Fund, Washington, D.C., June 1991, p. 15.

Diagram 3: HEALTH IN \$URANCE ROULETTE



"Step right up to the finest protection that voluntary private health insurance can offer!"

"I THOUGHT I WAS COVERED": Obstacles to Reimbursement for Consumers who supposedly are Insured

1. **Lifetime caps** (e.g. AIDS cap case); 79% employer-sponsored plans had lifetime maximum in 1989 (BLS); 42% had \$1 million+
2. **Annual limits** (e.g. 60 days rehabilitation; 20 visits for outpatient mental health; \$500 for durable medical equipment)
3. **Pre-existing condition exclusions**
 - a. permanent (e.g. 16.6%) based on BPA/WID Consumer Survey
 - b. waiting periods
 - (1) repeated exposure everytime change in insurer
4. **Uncovered services**
 - a. prescription drugs, biologicals, medical foods
 - (1) off-label use of drugs
 - b. experimental treatments (e.g. not FDA approved)
 - c. prevention (e.g. well-person care; prenatal care)
 - d. on-going rehabilitation therapies
 - e. "custodial care"
 - f. assistive technology related to impairments
 - g. other (e.g. organ transplant, hearing, vision, dental)
5. **Excuses for non-coverage of "covered services"**
 - a. definitions of medical necessity vs. comfort or convenience item (what is a medical purpose vs. functional purpose to overcome impairments?)
 - b. eligibility for public program (e.g. Special Education; Medicaid; Vocational Rehabilitation; Medicare)
 - c. no "reasonable expectation" of significant progress within limited period of time (e.g. 60 days in federally qualified HMO)
6. **Allowable costs** (user is responsible for difference between provider charges and 80% of insurer's determination of allowable costs)
7. **Managed care**
 - a. prior authorization requirements
 - b. approved list of products, list of providers,
 - c. case-by-case decisions (extra-contractual)
8. **Recission**
 - a. policy cancellation for non-disclosure on application if reasonable person would have known that a pre-existing condition existed
 - b. implications of genetic screening for determining medical uninsurability
 - c. function of Medical Information Bureau (MIB)
9. **Premium increases based on group or individual "experience" which exceed threshold of affordability and lead to reduction in benefits or policy cancellation**
10. **Lack of catastrophic protections or stop-loss in some plans**
 - a. 17% of group plans (BLS, 1989) ___% of individual plans
 - b. deductibles discriminate against health care users
 - c. copayments supposedly discourage unnecessary care but actually discriminate against low income persons
11. **Differential impact of self-insured employer plans; HMOs; bare-bones insurance plans; Oregon Medicaid rationing plan.**

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Consortium for Citizens with Disabilities

CONSORTIUM FOR CITIZENS WITH DISABILITIES HEALTH TASK FORCE

"PRINCIPLES FOR HEALTH CARE REFORM FROM A DISABILITY PERSPECTIVE"

December, 1991
(updated February, 1993)

ON BEHALF OF:

AIDS Action Council
Alliance for Genetic Support Groups
American Academy of Physical Medicine and Rehabilitation
American Association for Counseling and Development
American Association of University Affiliated Programs
American Association on Mental Retardation
American Civil Liberties Union
American Congress of Rehabilitation Medicine
American Foundation for the Blind
American Occupational Therapy Association
American Physical Therapy Association
American Psychological Association
American Speech-Language-Hearing Association
The Arc, Association for Retarded Citizens of the United States
Epilepsy Foundation of America
Immune Deficiency Foundation
International Association of Psychosocial Rehabilitation Services
Learning Disabilities Association
National Alliance for the Mentally Ill
National Association for Music Therapy
National Association of Developmental Disabilities Councils
National Association of Medical Equipment Suppliers
National Association of Private Residential Resources
National Association of Protection and Advocacy Systems
National Association of Rehabilitation Facilities
National Association of State Mental Retardation Program Directors
National Council for Independent Living
National Council of Community Mental Health Centers
National Easter Seal Society
National Head Injury Foundation
National Mental Health Association
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Parent Network on Disabilities
National Recreation and Parks Association
National Rehabilitation Association
National Transplant Support Network
Spina Bifida Association of America
The Association for Persons with Severe Disabilities
United Cerebral Palsy Associations, Inc.
World Institute on Disability

DISABILITY PERSPECTIVE ON HEALTH CARE REFORM

Non-Discrimination People with disabilities of all ages and their families must have access to health care which:

- prohibits pre-existing condition exclusions;
- prohibits rating practices that discriminate against higher users of health care;
- ensures that all persons, regardless of income or health status, have access to all needed health-related services; and
- ensures continuity and portability of coverage.

Comprehensiveness In addition to acute care hospital and physician services, comprehensive health-related services include:

- preventive services, including services to prevent the worsening of a disability;
- health promotion/education services;
- diagnostic services;
- long and short term home and community-based services;
- prescription drugs, biologicals and medical foods;
- mental health and counseling services;
- rehabilitation services, including audiology, occupational therapy, physical therapy, respiratory therapy, speech-language pathology services, cognitive, vision and behavioral therapies, and therapeutic recreation;
- personal assistance services and independent living services; and
- durable medical equipment and other assistive devices, equipment, and related services.

Appropriateness Services must be provided to persons with disabilities on the basis of individual need, preference and choice which:

- ensures consumer choice in relation to services and provider;
- ensures a range of service settings through an integrated delivery system;
- ensures appropriate amount, scope and duration of services; and
- ensures the availability of trained personnel.

Equity People with disabilities and their families must be ensured equitable participation in the nation's health care system and not burdened with disproportionate costs. An equitable system:

- limits out-of-pocket expenses and cost sharing requirements for participants;
- provides access to services based on health care need, not income level or employment status; and
- ensures adequate reimbursement for service.

Efficiency The health care system should provide maximum appropriate effective quality services with minimum administrative waste. An efficient system:

- reduces administrative complexity and minimizes administrative costs;
- allocates resources in a more balanced way between preventive services, acute care, rehabilitation and chronic care management;
- maintains effective cost controls so that all people can get the health care services which they need.

CCD HEALTH TASK FORCE OBJECTIVES FOR 1993

I. Health Care Reform Objectives

- (1) Deny approval for the revised Oregon Medicaid rationing plan.
- (2) Assure that any proposal for national health care reform promotes the CCD Health Task Force goals of nondiscrimination, comprehensiveness of benefits, appropriateness, equity and efficiency.
- (3) Examine all options for national health care reform, including a single-payer health care system and different versions of "managed competition" to measure their effectiveness in meeting these five goals.
- (4) Oppose small group insurance reform as an alternative to comprehensive health care reform.
- (5) Ensure the establishment of safeguards to protect people with disabilities in existing and proposed managed care arrangements so that their health care needs are not sacrificed to cost containment objectives.
- (6) In particular, oppose mandatory participation in managed care for Medicaid recipients.
- (7) Address inequities in the Medicaid program including the continuing ineligibility of many low income people, the arbitrarily restrictive benefit packages, and the low reimbursement levels which discourage health care providers from serving Medicaid eligible people.
- (8) Define comprehensiveness of health care benefits to include prevention of secondary disabilities, ongoing rehabilitation therapies, and health-related assistive technology.
- (9) Define the relationship of personal assistance services and long-term supports and services to comprehensive health care benefits.
- (10) Establish criteria for coverage of health-related assistive technology.
- (11) Remove obstacles to insurance regulation based on the Supreme Court's 1986 interpretation of the Employee Retirement Income Security Act of 1974 (ERISA). (Ref: Pilot Life case).

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	Bill Schmidt [EFA]	(301) 459-3700
	Steve White [ASHA]	(301) 897-5700

II. Task Force Activities for 1993

To achieve our "Health Care Reform Objectives" for 1993, the CCD Health Task Force will undertake the following activities:

- (1) Examine different versions of "managed competition" as a framework for achieving all of the CCD Health Task Force principles. Identify problems for persons with disabilities associated with different versions of "managed competition" represented by Paul Starr's single-sponsor approach; Alain Enthoven's Jackson Hole approach; and the Conservative Democratic Forum's approach. Evaluate the strengths and weaknesses of these approaches in relation to a single payer approach and advocate for the approaches which best fulfill CCD principles;
- (2) Recognize the use of ADA and other civil rights laws to ensure access to health care for persons with disabilities, and develop strategies for using ADA as a "bridge" for promoting the right to health care for all persons;
- (3) Oppose proposals which ration health care for cost containment purposes by legitimating the withholding of medically necessary services from persons who could benefit from them when it is possible to ration excess capacity, excess profits, and administrative waste in the health care system;
- (4) Clarify the changes which are needed in the health care delivery system to more effectively and efficiently serve persons with disabilities;
- (5) Promote awareness of problems with managed care under the existing system which must be addressed by "managed competition";
- (6) Sensitize Members of Congress and their staff to a "disability perspective on health care reform" so that the health care needs of people with disabilities are viewed as a **litmus test** for the effectiveness of all health care reform proposals;
- (7) Develop strategies for member organizations to promote national grass roots mobilization for health care reform based on their organizational positions on health care reform and the CCD Health Task Force Principles;
- (8) Increase Task Force efficiency by establishing a coordinated method of covering Congressional hearings and communicating with CCD organizations so that Task Force members have access to all current information on the health care debate.

Consortium for Citizens with Disabilities

December, 1992

THE CONSORTIUM FOR CITIZENS WITH DISABILITIES HEALTH TASK FORCE

PROBLEMS AND SAFEGUARDS FOR PEOPLE WITH DISABILITIES IN MANAGED CARE

The CCD Health Task Force "Principles for Health Care Reform from a Disability Perspective" were developed to assess the ability of various major health care reform measures to meet the needs of people with disabilities. Since many reform proposals utilize some form of managed care, the CCD has applied these principles and identified a number of major problems in managed care systems.

This document identifies these problems and makes recommendations to improve the ability of managed care systems to better meet the needs of people with disabilities. The CCD believes that it is critical for health care policy makers to recognize that there are at least 43 million Americans with disabilities and a large number of others with special health care needs. This includes individuals of all ages with physical and mental impairments, conditions or disorders, that are severe, acute, or chronic and limit or impede their ability to function.

Problems with/Recommendations for Improvement

Managed care systems often include financial incentives to restrict access, limit or deny care, or provide poor quality care. This is especially detrimental to children and adults with disabilities and those with special health care needs.

- A. Capitated managed care systems must have the flexibility necessary to permit primary care physicians to refer participants with disabilities to specialists without being financially penalized.
 - B. Primary care physicians in managed care plans must be adequately compensated and not placed at inordinate financial risk.
 - C. Methods for ensuring the financial solvency of managed care entities, particularly capitation models, must be considered. These may include financial solvency requirements for HMOs, mandatory reinsurance, state reinsurance for Medicaid managed care programs, stop-loss coverage, and mandatory capitalization requirements.
- I. Managed care systems often do not include the array of comprehensive health related services needed by children and adults with disabilities.
- A. Managed care programs must offer a comprehensive benefits package that meets the needs of people with disabilities and special health care needs. This includes such basic benefits as prescription drugs, rehabilitation services, durable medical equipment, such as wheelchairs and other assistive technology, and mental health services.
 - B. Managed care programs must not include disincentives, financial or otherwise, to the provision of services in home and community-based settings when appropriate.
 - C. Specific services should be provided not only to treat acute and chronic conditions but also to promote and maintain health and optimum functioning and prevent deterioration and secondary complications.

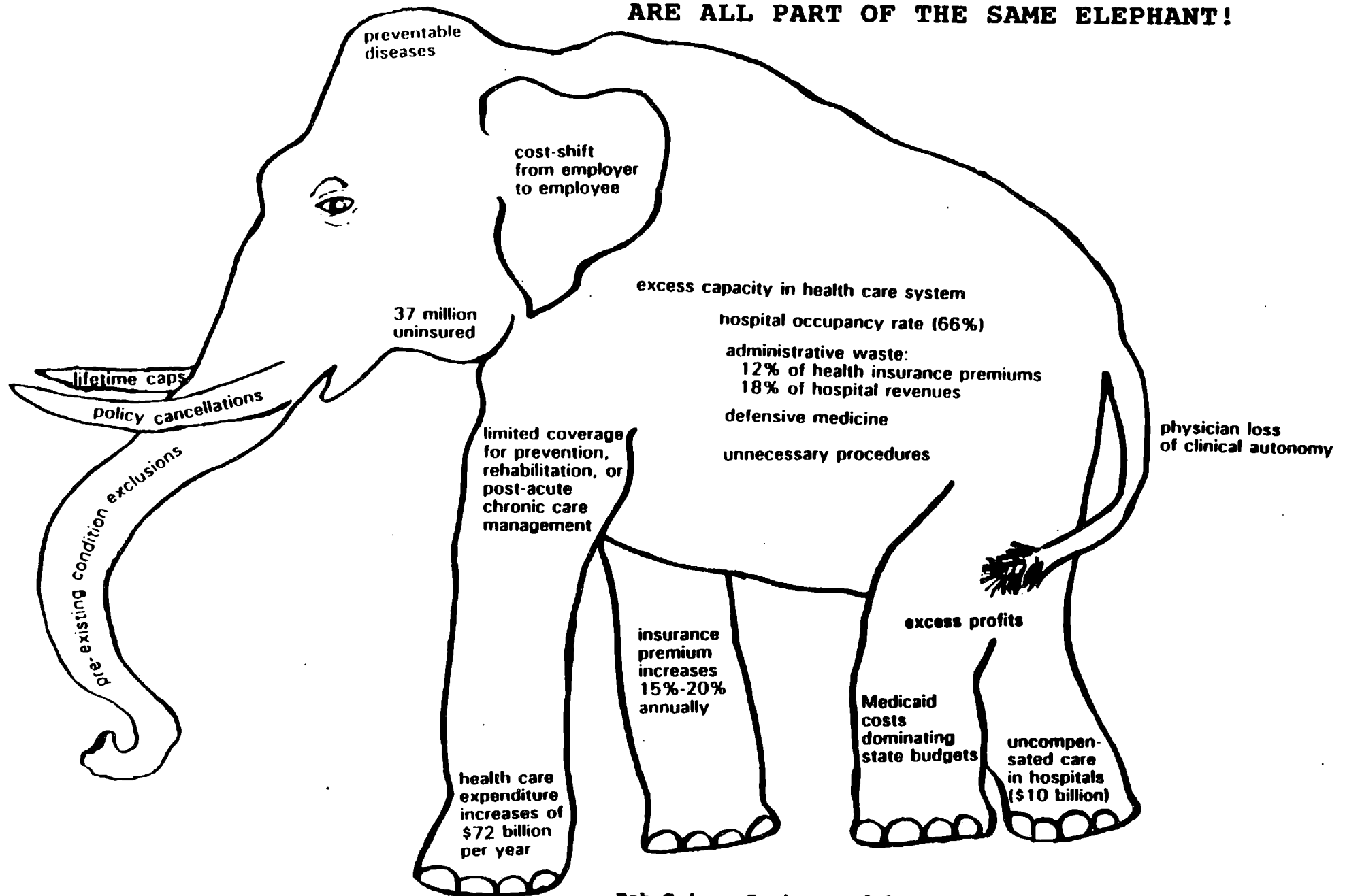
- III. Managed care systems often have limited experience in providing comprehensive services to children and adults with disabilities because of a systemic emphasis on primary care. This leads to limited access to needed specialized services, delays in services, and a lack of continuity of care needed by children and adults with disabilities.
- A. Managed care systems must offer people with disabilities and special health care needs the option of having a specialist as their "gatekeeper" in the system. This specialist would provide both necessary specialized care (at the specialized rate) and primary care (at the lower primary care reimbursement rate).
 - B. Managed care entities must have specific limits on waiting times for first appointments and for speciality referrals. To assure geographic accessibility of services, there must also be established standards on travel times and distances to both primary and specialized services.
 - C. Managed care systems must be structured to ensure continued, appropriate access to health and health-related services for children and adults with disabilities.
- IV. Managed care systems lack adequate quality assurance mechanisms, as well as effective grievance policies and procedures designed to ensure access to appropriate health services.
- A. Managed care systems must provide participants with clear information on policies, procedures, and grievance mechanisms and must ensure consumer participation in the establishment of such procedures. All reviews must be conducted in a timely manner. An independent ombudsman program should be required.
 - B. Managed care systems should be required to provide health care service in accordance with nationally accepted prevention and treatment protocols, e.g. protocols for prenatal care, well-baby care, and childhood immunization schedules.
 - C. Managed care systems must have in place timely procedures for obtaining independent second opinions when covered benefits are denied for any reason, including a judgement that they are not "medically necessary" or when a consumer challenges the appropriateness of a proposed treatment. These second opinions must be considered in any grievance review.
 - D. Managed care systems must include the option to disenroll for those participants who are not receiving adequate and timely services.
 - E. Managed care programs must have strict quality assurance provisions that require internal and external audits by independent assessors and the results of these audits should be available to consumers to assist them in choosing a managed care program. Outcome reviews should be a component of this process.
 - F. Additional protections which must be included are satisfaction surveys of enrollees and disenrollees, including current and former providers.

For additional information contact: Co-Chairs of the CCD Health Task Force

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Diagram 1:

**SYMPTOMS OF THE HEALTH CARE CRISIS
ARE ALL PART OF THE SAME ELEPHANT!**



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DIAGRAM 4: SOURCES OF FUNDS FOR PERSONAL HEALTH CARE IN 1990

Source of payment	Total	Hospital care	Physician services	Dentists' services	Other professional services	Home health care	Drugs and other medical nondurables	Vision products and other medical durables	Nursing home care	Other personal care
Amount in billions										
Personal health care expenditures	\$585.3	\$256.0	\$125.7	\$34.0	\$31.6	\$6.9	\$54.6	\$12.1	\$53.1	\$11.3
Out-of-pocket payments	136.1	12.8	23.5	18.0	8.8	0.8	48.2	8.2	23.9	--
Third-party payments	449.2	243.2	102.2	16.0	22.8	6.1	14.4	4.0	29.3	11.3
Private health insurance	186.1	89.4	58.2	15.1	12.8	0.5	8.3	1.3	0.6	--
Other Private	21.3	13.8	0.0	--	3.6	0.5	--	--	1.0	2.2
Government	241.8	149.0	43.9	0.9	6.4	5.1	6.1	2.7	27.7	9.1
Federal	177.2	104.6	35.1	0.5	4.9	4.1	3.0	2.4	17.2	5.5
Medicare	108.9	68.3	38.8	--	3.1	2.9	--	2.2	2.5	--
Medicaid	40.6	16.2	3.1	0.4	1.2	1.2	2.9	--	13.7	2.8
Other	27.7	20.1	2.0	0.1	0.7	--	0.1	0.2	1.0	3.5
State and local	64.6	35.3	8.8	0.4	1.6	1.0	3.1	0.3	10.5	3.5
Medicaid	30.7	12.3	2.1	0.3	0.9	1.8	2.1	--	10.5	1.6
Other	33.9	23.0	6.7	0.1	0.7	0.0	1.0	0.3	0.1	2.0
EXHIBIT: Total Medicaid	71.3	28.5	5.2	0.7	2.0	2.2	4.9	--	24.1	3.6
Percentage distribution										
Personal health care expenditures	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Out-of-pocket payments	23.3	5.0	18.7	53.0	27.7	12.1	73.6	67.3	44.9	--
Third-party payments	76.7	95.0	81.3	47.0	72.3	87.9	26.4	32.7	55.1	100.0
Private health insurance	31.8	34.9	46.3	44.5	40.4	7.3	15.3	10.4	1.1	--
Other Private	3.6	5.4	0.0	--	11.5	7.1	--	--	1.9	19.9
Government	41.3	54.7	35.8	2.5	20.4	73.5	11.1	22.3	52.1	80.1
Federal	30.3	40.9	28.8	1.4	15.5	58.6	5.5	19.5	32.3	48.7
Medicare	18.6	26.7	23.9	--	9.7	41.8	--	17.8	4.7	--
Medicaid	6.9	6.3	2.5	1.2	3.7	16.8	5.3	--	25.7	18.1
Other	4.7	7.9	1.6	0.2	2.1	--	0.2	1.7	2.0	30.7
State and local	11.0	13.8	7.0	1.1	4.9	14.9	5.6	2.8	19.8	31.3
Medicaid	5.2	4.8	1.7	0.9	2.8	14.6	3.8	--	19.7	13.8
Other	5.8	9.0	5.3	0.2	2.2	0.3	1.8	2.8	0.1	17.5
EXHIBIT: Total Medicaid	12.2	11.1	4.2	2.2	6.5	31.4	9.1	--	45.4	31.9

NOTES: 0.0 denotes less than \$50 million. Medicaid expenditures exclude Part B premium payments to Medicare by States under "buy-in" agreements to cover premiums for eligible Medicaid recipients. Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Diagram 21:

THE HEALTH CARE TRAIN IS LEAVING THE STATION.
WHICH DIRECTION IS IT GOING, AND ARE THERE
DISABILITY CARS ABOARD?

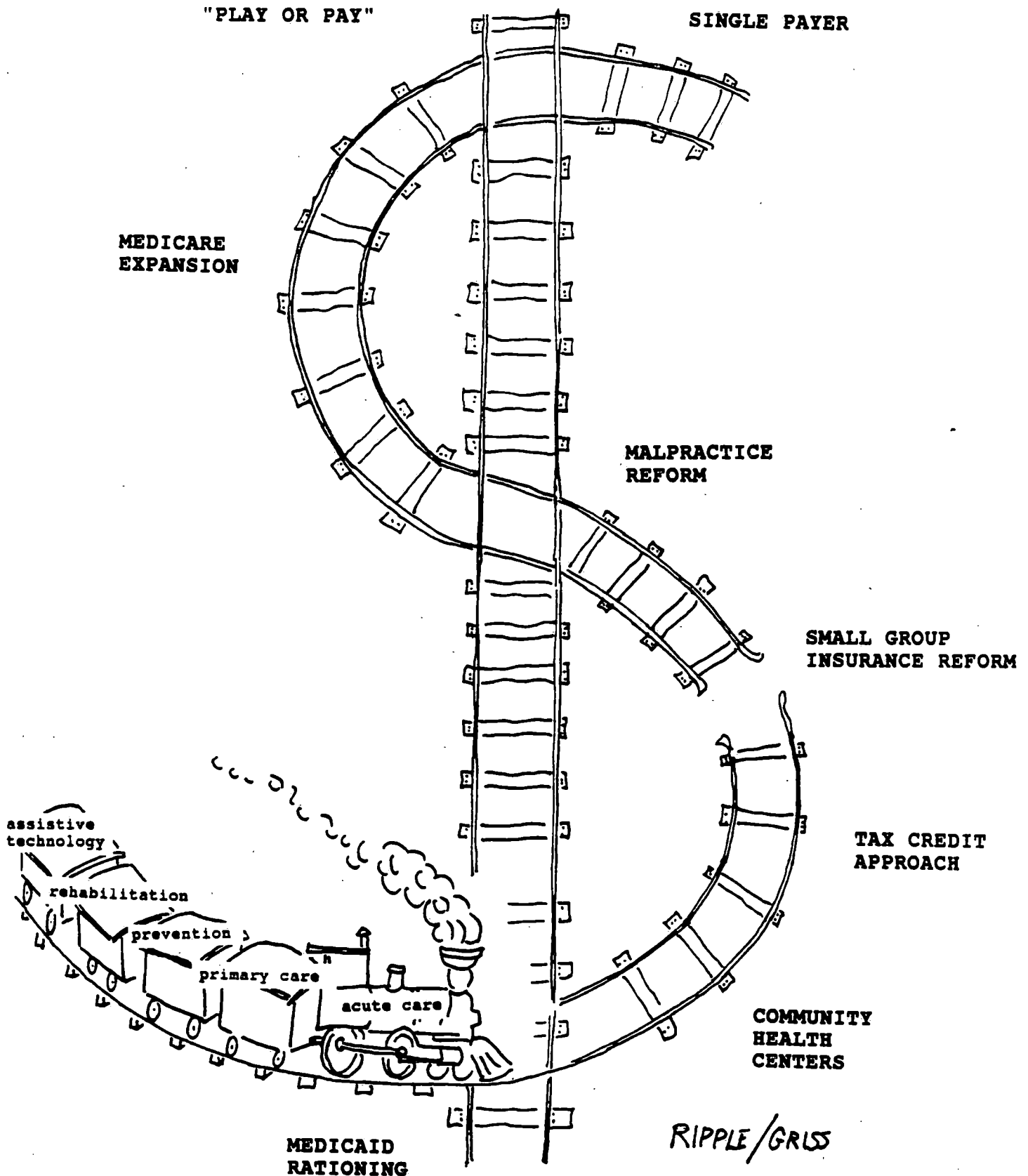
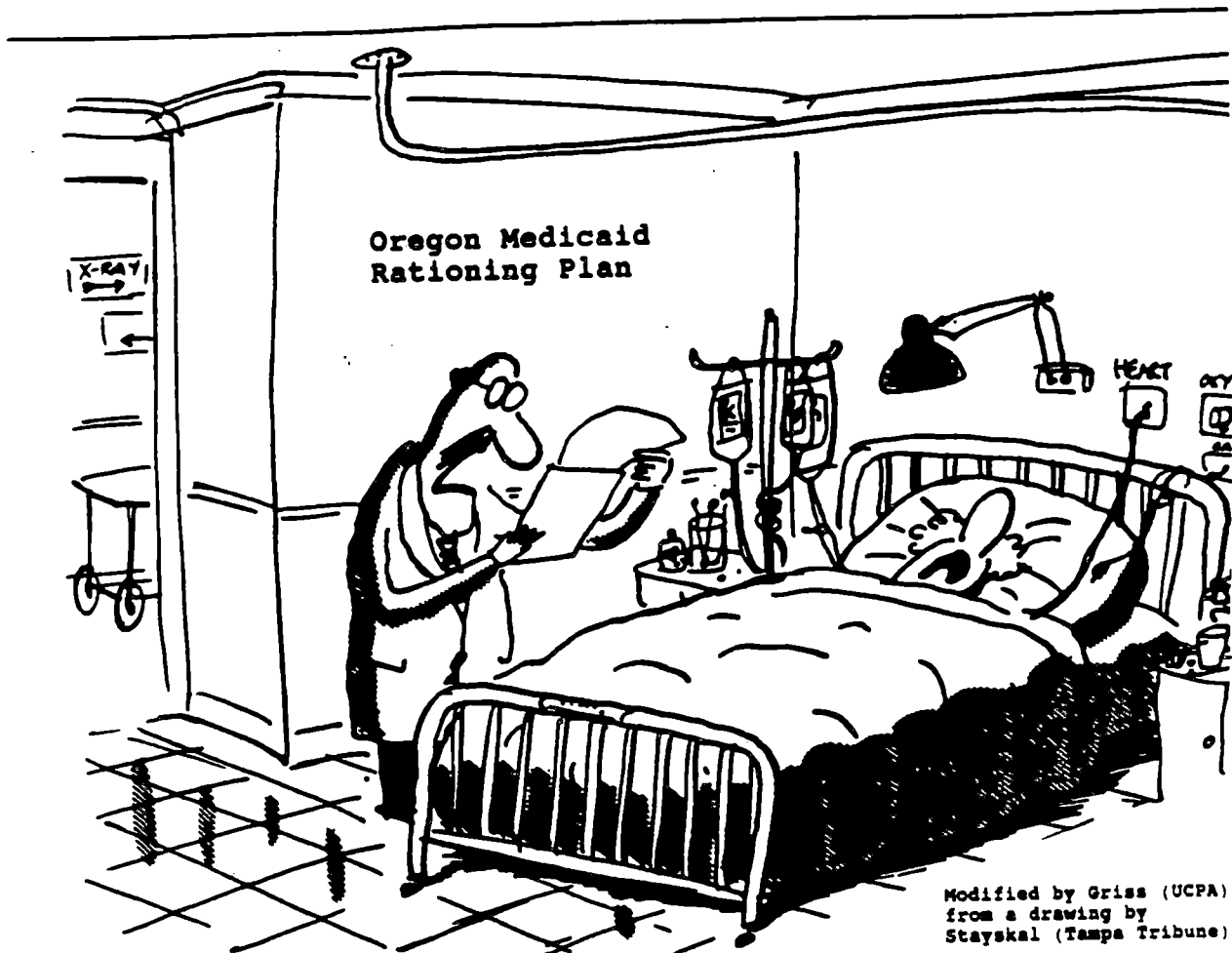


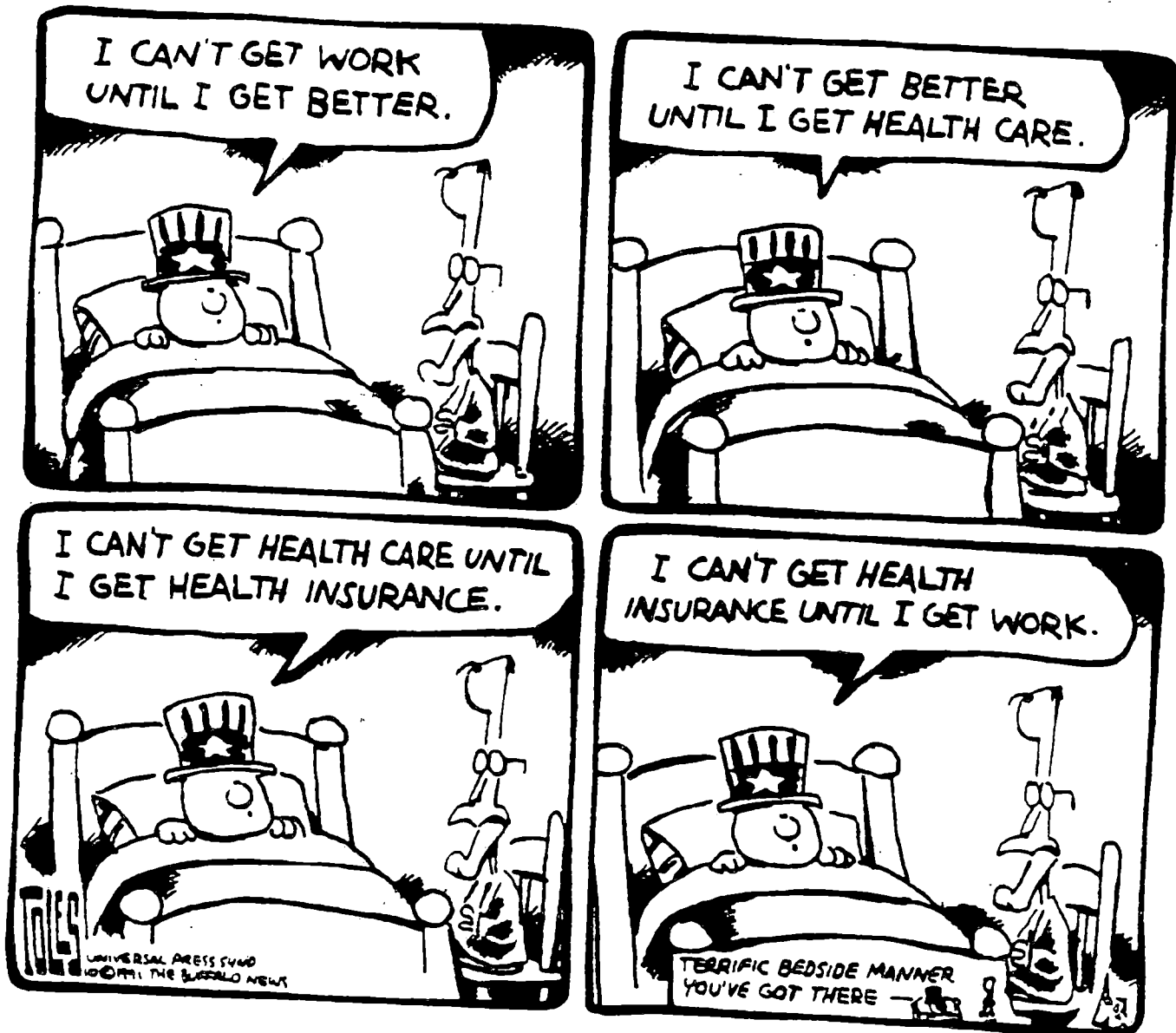
**Diagram 18:
Physician as Gatekeeper:
Taking the Pulse of the Treasury**



"Due to fluctuations in the state budget, your condition has been downgraded from Serious to No One Really Cares."

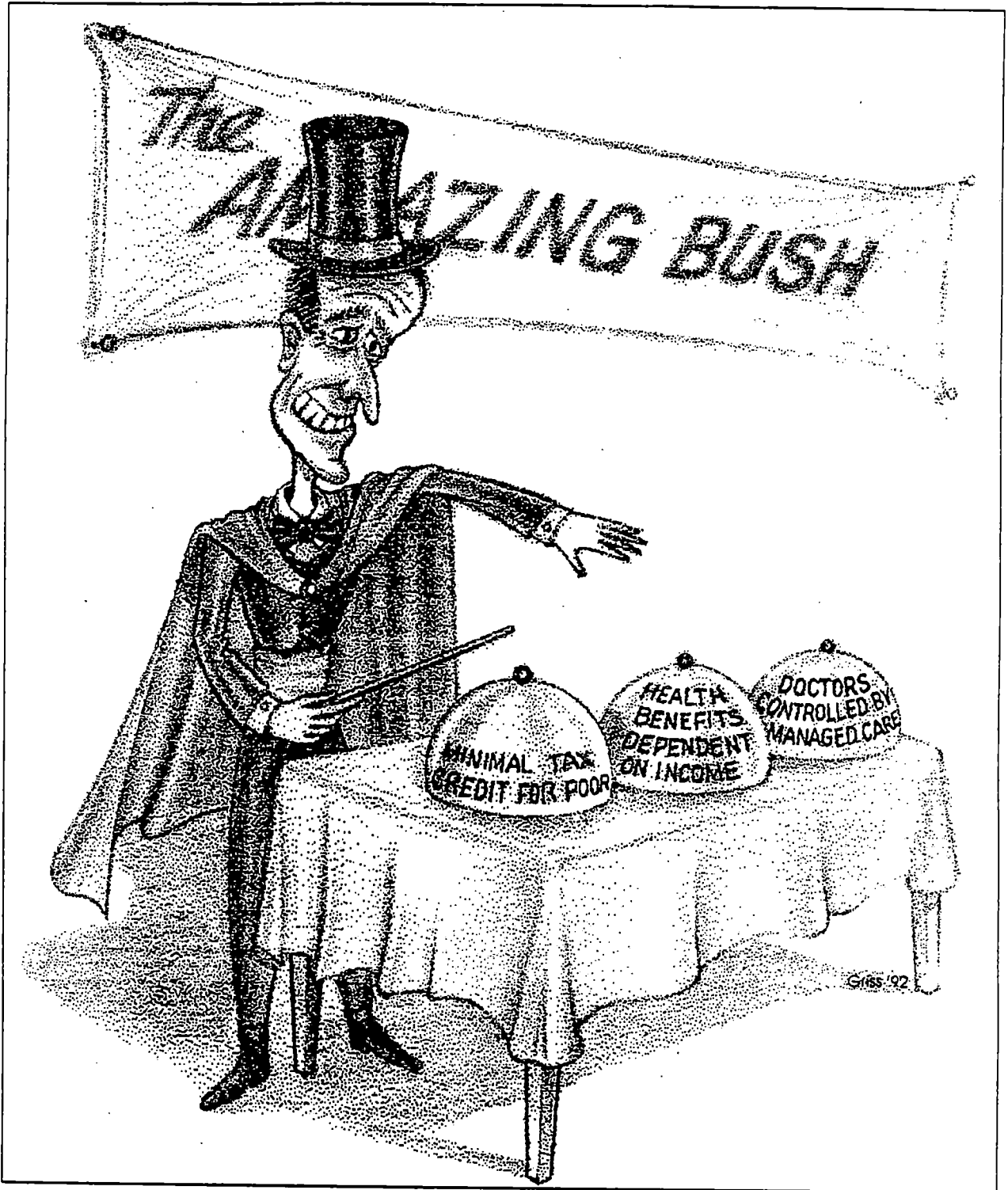
Diagram 19:

CONTRADICTIONS OF U.S. HEALTH CARE FINANCING POLICY

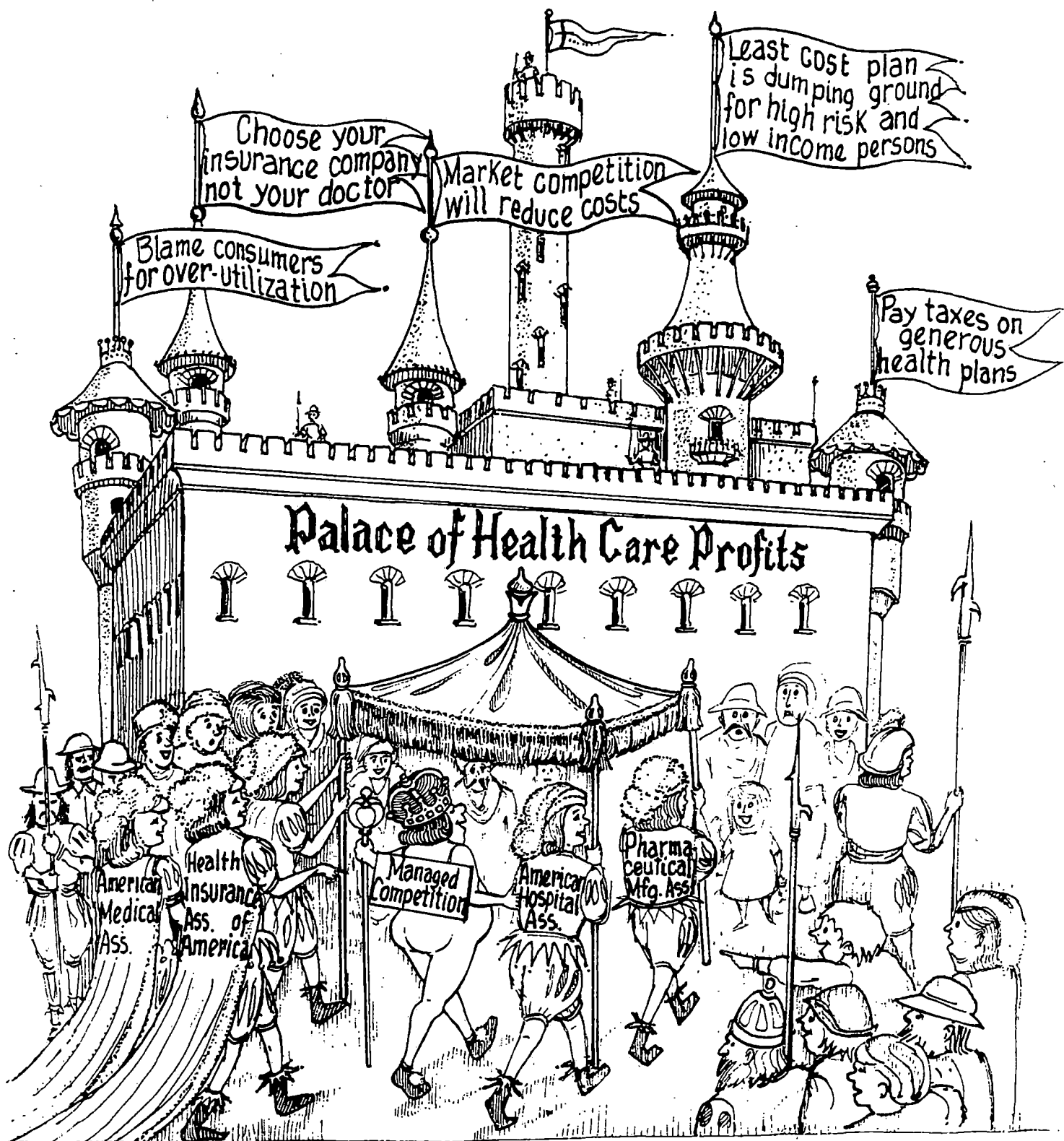


from Toles with The Buffalo News

MEDICAL DARWINISM: SURVIVAL OF THE RICHEST



Tax credit approach would enable you to choose your insurance company, but not your doctor!



"The Emperor doesn't have anything on!" Private insurers will still be able to deny needed care by limiting providers, creating financial disincentives for treatment, or delaying appointments in order to maximize their profits. Outcomes data will not help consumers who do not have the money to choose plans based on quality.

MANAGED COMPETITION VS. SINGLE-PAYER: A Comparison

MANAGED COMPETITION

SINGLE-PAYER

BASIC CONCEPT

A Multi-Tiered System of "Managed Care"; All health coverage is provided for through either:

- o a health insurance "purchasing cooperative" of employers ("sponsors") who contract with an approved network of providers;
- o an approved private "health plan";
- o a government-"sponsor" plan selected by a state/locality;
- o Medicaid and/or Medicare.

Keeps the current systems of fragmented, incomplete coverage intact, including private insurance, Medicaid, Medicare, and self-insurance.

A Unitary System of Consumer-controlled Care; all health coverage is provided through a state plan approved by the national government.

The thousand of different types of coverage through private insurance, self-insurance, Medicaid, and Medicare would be eliminated.

UNIVERSALITY OF COVERAGE

In theory, everyone would have to "buy" a coverage plan:

- o Workers employed by "big" employers would buy from the employer who would contract with an approved plan;
- o Workers employed by small employers would buy from their employer who would buy from a purchasing cooperative which would buy from an approved plan;
- o Workers not covered by an employer-based plan would be eligible to purchase coverage from the government-sponsor, if they could afford to do so;
- o The disabled and elderly would continue to purchase coverage through Medicare;
- o The poor would be covered through Medicaid.

Everyone is covered, all residents.

COVERED BENEFITS

A minimum benefits package would be defined which all plans would be required to offer. If more benefits than the basic plan are desired, employers may purchase additional coverage from private insurers, but employees would suffer tax penalties on these benefits as "taxable income".

The minimum benefits package has not been defined. However, if current managed care programs are any indication, then home care, respite care, mental health care, rehabilitation services, durable medical equipment, prescription drugs, and other services will either not be covered at all or subject to limitations on the amount of service offered.

Everything is covered, from primary and preventive care to long-term care, including dental, eye care, mental health rehabilitation, home care, respite care, special needs, drug treatment, prescription drugs, durable medical equipment, and experimental, investigational, and complementary medicine.

OUT-OF-POCKET EXPENSES; PREMIUMS, DEDUCTIBLES, AND CO-PAYMENTS

Plans would offer only minimum benefits. Consumers would pay up to 20% of premiums, and 20% co-payments for covered services and deductibles. Consumers would pay for any coverage not offered by the basic plan, and would be taxed on these additional benefits as "taxable income".

None. Providers may not charge more than approved rates.

CHOICE OF PROVIDERS

Limited by requiring people to enroll in HMOs or other managed care plans. Access to care would be controlled through a general practitioner gatekeeper.

Consumers have full freedom of choice of providers.

(- over -)

[This chart is a draft prepared for the New York State Health Care Campaign by Susan Dooha, National Transplant Support Network, and Mark Hannay, ACT UP/NY.]

MANAGED COMPETITION**COST
CONTAINMENT
MECHANISMS**

Managed competition has not been tried, anywhere. In theory, managed care plans would compete based on price for contracts with employers/sponsors, purchasing cooperatives, or government-sponsors.

It would contain costs by:

- o forcing everyone into managed care plans;
- o limiting benefits to a minimum package;
- o imposing an intensive review of individual practitioner decisions in order to eliminate alleged consumer overuse.
- o retaining premiums, deductibles, and co-payments to maintain discourage consumers from seeking access to alleged "unnecessary care".

It would leave our current multiple-insurer/payer system and its administrative and marketing costs intact, and would add a new layer of administrative bureaucracy: sponsors.

**FINANCING
MECHANISM**

Health care would be paid for by:

- o Employer and employee contributions in the form of premiums, co-payments, and deductibles for the basic managed care plan, and out-of-pocket fee-for-service for additional coverage.
- o The Medicaid system would continue to be financed by taxes and co-payments.
- o The Medicare system would still be paid for by taxes, premiums, co-payments, deductibles, and supplementary private insurance.

SINGLE-PAYER

Global budgets are set for institutions and fee schedule for providers.

The major source of inefficiency within the current health care system is administrative waste and marketing; these costs are eliminated by ending the role of private insurance and self insurance.

Health care would be paid for in a more progressive manner through a choice of public funding (to be determined), including payroll taxes and general revenue.

WHY A SINGLE-PAYER SYSTEM IS THE ONLY REAL SOLUTION TO HEALTH CARE REFORM

- **Universal access:** Everyone is covered regardless of employment status, income, or amount of services needed. (Managed competition limits access by linking coverage to employment, by retaining premiums, deductibles, and co-payments for the basic package of benefits, and by adding tax liability for additional coverage purchased.)
- **Comprehensive coverage:** A full array of services is guaranteed to all consumers, and the same benefits for everyone. (Managed competition only offers a basic package of benefits; additional coverage will depend upon ability to pay, and incur tax liability.)
- **Freedom of choice:** The consumer retains control of his/her health care decisions. (Managed competition limits choice of providers via managed care networks and general practitioner gatekeepers.)
- **Rational decision-making:** Health care decisions are made based upon need and appropriateness, not ability to pay. (Under managed competition, health care decisions are still made based upon cost and financial ability.)
- **Costs are controlled:** All providers and institutions are put on global budgets, and fee schedules are set for procedures. (Managed competition relies upon "the market" to control costs through competition among managed care plans.)
- **The system is streamlined:** Administrative inefficiencies are minimized by eliminating the cost of administrative waste and marketing of the current multi-payer system, thereby freeing up (literally) billions of dollars per year for health care. (Managed competition retains the entire current administrative and marketing system, and adds new layers of bureaucracy: managed care plans and sponsors.)
- **Health care is treated as a social good:** The health care system is primarily financed through a progressive payroll tax and other general revenue funds. (Under managed competition, health care is still treated as an economic commodity whereby costs, out-of-pocket expenses, and tax liabilities determine health care decisions.)

COMPARISON OF MAJOR HEALTH CARE REFORM MODELS

TYPE	SINGLE PAYER	SINGLE SYSTEM WITH COM- PETITION	MANAGED COMPETITION
Model/Proponent	Canadian-style	Garamendi, Starr	Enthoven, Jackson Hole Group, Conservative Democratic Forum
PRIMARY RESPONSIBILITY AND ACCOUNTABILITY	PUBLIC	PUBLIC	PRIVATE
Change In Financing System	major	moderate	minimal
Change In Delivery System	minimal	moderate	major
How it works for patients:			employer chooses "sponsors" it can afford; patient choosing the one he/she likes and uses its facilities
a. average patient	patient gets health card, can use it anywhere for any service with no copayment	patient chooses "sponsor," gets its card; can use at its facilities with minimal copayments	family switches to public spon- sor
b. In case of unemployment	no effect	family stays with same sponsor	low income patients may be segregated into poorer plans
c. low income patients	same access as everyone	sponsors required to enroll a proportionate % of low income patients	no controls on differences among plan premiums; likely to vary widely
d. well-to-do patient	purchase supplemental insurance for uncovered services	purchase extra insurance; limits on difference among plan premi- ums	capitation and competition
Method of Cost Containment	public budget allocation price regulation/control	"risk adjusted capitation" to all providers (some price regulation)	
Incentives to hospitals	global budgets control costs	not clear if hospital prices may vary among purchasers	"competition" to lower prices
Incentives to Providers	fee-for-service tends to increase services performed	capitation controls services	capitation and competition
Role of Insurance Companies	transitional; in Canada, they were slowly phased out	moderate role, market heavily regulated	major role, market minimally regulated
Business Support	minimal	moderate	major

COMPARISON ON UHCANI PRINCIPLES

TYPE	SINGLE PAYER	SINGLE SYSTEM WITH COMPETITION	MANAGED COMPETITION
1. Universal coverage based on residency, not employment	yes	yes	no; employer may choose high co-insurance plan that employee unable to afford - what then?
2. One plan for all, comprehensive benefits	yes	partial; guaranteed plan is supposed to be comprehensive, like HMO benefits	no; base plan likely to be "bare bones"; cap deduction for insurance benefits to make people pay out of pocket for better care
3. No cost sharing barriers to care	yes	mostly yes; no deductibles, no copayments above 200% of poverty; copayment allowed on some services	no; copayments allowable to differentiate between plans
4. Administrative simplicity, as in single payer	yes	some simplification	less simplification because of more plan-switching and use of copayments
5. Freedom to choose caregivers, not insurance plans.	yes	no; but choice of plan totally up to consumer	no; consumer choice of plan determined by employer's prior choice
6. a. Progressive financing b. Public accountability	probable yes	probable/possible yes	probably not no
7. Budget limits	yes	yes	no; strong ideological aversion to limits; counts on market competition to keep total expenditures down

*Draft prepared by Ken Frisof, Jan.
1993*

PRINCIPLES AND APPROACHES TO HEALTH CARE REFORM

<u>PRINCIPLES</u>	<u>SINGLE-PAYER</u>	<u>PAY-OR-PLAY</u>	<u>INSURANCE</u>
Universality	All residents covered under single plan. Breaks link between employment and health coverage.	Coverage thru private/public plans, with penalties for non-coverage. Relies on employer-based system.	Expanded access to insurance, some bills impose penalties for non-coverage. Relies on employer-based system.
Comprehensiveness	Benefits include wide range of preventive and acute care, including prescription drugs. Some plans include long-term care.	Benefits are limited to a basic package, usually not including prescription drug coverage or long-term care. Maximum benefit limits often allowed. Without maintenance of effort requirement, could result in reduction in benefits for currently-insured.	Benefits are expected (and in some cases required) to be limited. Without maintenance of effort requirement, could result in reduction in benefits for currently-insured.
Non-discriminatory	All residents have equal access in plan. Additional benefits available thru collective bargaining, private insurance.	All plans include same basic benefits cost-sharing requirements can limit access.	Plans may be required to include basic benefits. Cost-sharing requirements can limit access.

<u>PRINCIPLES</u>	<u>SINGLE-PAYER</u>	<u>PAY-OR-PLAY</u>	<u>INSURANCE</u>
Freedom of Choice	All residents guaranteed freedom of choice of providers with no financial penalties.	Employers and public plans can limit freedom to choose providers through financial penalties.	Employers and public plans can limit freedom of choice through financial penalties. They are often encouraged to do so.
No financial obstacles to care	Prohibits or limits cost-sharing. Prohibits balance billing.	Allows cost-sharing and balance billing, usually with limits on deductibles, copayments and sometimes limits on balance billing. Prohibits cost-sharing for the poor, limits for the near-poor.	Allows cost-sharing and balance billing. Sometimes provides subsidies or tax credits for small businesses, poor or the non-poor.
Public accountability	Single payer entity is publicly-accountable. Includes mechanisms for consumer, provider participation.	Retains current multi-payer, employer-dominated system.	Retains current multi-payer, employer-dominated system.
Single payer	Uses single-payer to increase efficiency, prevent discrimination and gain simplicity.	Retains multi-payer structure.	Retains multi-payer structure.

<u>PRINCIPLES</u>	<u>SINGLE-PAYER</u>	<u>PAY-OR-PLAY</u>	<u>INSURANCE</u>
Non-profit administration	Single-payer is a non-profit entity, providers may be for-profit.	For-profit insurance companies continue in operation. In some cases, private coverage is encouraged.	For-profit insurance companies continue in operation and private coverage is encouraged.
Limits on insurance companies	Insurers are only allowed to sell supplemental coverage.	Insurance companies remain in operation but are subject to added regulation: guaranteed issuance and renewal, rate bands or community rating, annual premium increase limits, limits on pre-existing condition exclusions.	Insurance companies remain in operation but are subject to added regulation: guaranteed issuance and renewal, rate bands or community rating, annual premium increase limits, limits on pre-existing condition exclusions.
Cost Containment -- administrative costs	Reduces costs through single-payer, uniform billing, global budgets.	Reduces costs through purchasing networks, uniform billing forms.	Reduces costs through purchasing networks, uniform billing forms.
Cost Containment-- hospital costs	Reduces costs through global budgets, separate capital budgets, CON.	Some bills require all-payer rates based on DRGS.	Relies on managed care.
Cost Containment-- physicians	Reduces costs through negotiated annual rates, CON.	Some bills require all-payer rates.	Relies on managed care.

<u>PRINCIPLES</u>	<u>SINGLE-PAYER</u>	<u>PAY-OR-PLAY</u>	<u>INSURANCE</u>
Cost Containment-unnecessary procedures	Promotes outcomes research and practice guidelines, global budgets.	Outcomes research and practice guidelines	Outcomes research and practice guidelines
Cost Containment-duplicative technology	Uses global budgets, separate capital budgets, health planning	None -- could use CON	None -- could use CON
Cost Containment-overall	Sets annual expenditure caps	May set annual expenditure caps, in some cases for covered services	None
Portability	Coverage maintained without regard to change in income, employment, health status, etc. Bills may require that state purchase indemnity plans for persons moving out-of-state	Specific coverage can change with change in income, employment, health status, etc.	Specific coverage can change with change in income, employment, health status, etc.

<u>PRINCIPLES</u>	<u>SINGLE-PAYER</u>	<u>PAY-OR-PLAY</u>	<u>INSURANCE</u>
Progressive Financing	Prohibits or limits point-of-service cost-sharing. Usually relies on combination of payroll and income taxes. May include "sin" taxes.	Does not prohibit but may limit point-of-service cost-sharing. Relies on premiums which may vary according to income up to a prescribed limit (usually 200% of poverty).	Does not prohibit point-of-service cost-sharing. Relies on premiums but may vary tax subsidies according to income up to a prscribed limit (usually 200% of poverty).

insurance accounts for less than one-third of health care expenditures (see *WfW*, Jan./Feb. 1991, p. 24). Moreover, policymakers are seeking to facilitate a political solution to the multi-sided health care crisis among the major stakeholders in the health care system. Given the constellation of political interests poised to influence national health care policy on Capitol Hill, policymakers have tended to favor a restriction on the scope of health care coverage as a way to maximize cost-containment, while extending basic coverage to the 37 million uninsured persons, rather than restructuring the health care system.

Unless the disability community can help refocus the goals of the health care debate from extending the present system of inadequate acute care to 37 million currently uninsured persons to one that expands the definition of "health", the national health care policy which Congress adopts will continue to ignore many of the health-related needs of persons with disabilities or chronic illness. The disability community can warn the American public and our policymakers about the **major barriers to access, adequacy, and affordability** in the existing private and public health insurance systems.

Strategic Role of Disability Movement:

The disability movement could be a powerful force in reexamining health care financing policy for several reasons. **First**, people with disabilities are highly vulnerable to the limitations of both public and private systems as they are squeezed between a private system which is designed to charge according to an assessment of risk and a public system which subsidizes health care according to age, poverty status, family structure, and an **inability to work**.

Secondly, people with disabilities know better than anyone else the limitations of trying to address their chronic health care needs in a health care financing system that was historically developed and remains principally organized to deliver acute health care.

Thirdly, disability cuts across class lines encouraging all people to consider what kinds of health care they would want for themselves and their family members when they become disabled or develop a chronic health condition and no longer view themselves as "temporarily able-bodied" (TABs).

Fourthly, the disability movement is the most logical consumer group to make health care the civil rights issue for the 1990's. **Access to health care and personal assistance services are the two critical issues needed to assure full implementation of the promise of ADA.** Unions have a tendency to see rising health care costs as a threat to their wages, and employers view it as a threat to their profits and to their ability to compete with other employers who face lower health care costs either in this country or abroad. But people with disabilities and chronic illness understand how obstacles to health care can

prevent participation in employment, limit community activities, and disrupt family life.

Obstacles to Overcome:

Before the disability movement can be taken seriously in the health care debate, it will have to overcome several obstacles. One is that different disability organizations must not focus just on their specific health care needs, but must be as united as we were in the passage of the ADA and must support the changes which are critical to the health care needs of other groups as well. For some groups the most critical health care takes the form of mental health services, while for others it is rehabilitation therapies, prescription drugs, or assistive technology. **We cannot allow ourselves to be "divided and conquered."**

Secondly, the disability organizations must join forces with chronic illness organizations who happen to represent a far larger constituency of persons who are equally vulnerable in our acute-care oriented health care system. Thirdly, the disability movement must recognize that, however effective it has been in advocating for categorical solutions to other problems facing persons with disabilities, the national health care crisis requires a generic solution.

One of the reasons that the disability movement has not played this role is the long-standing aversion in the Independent Living movement to the "over-medicalization" of services. There is also a mistaken impression that most persons with disabilities are primarily dependent on public insurance. Approximately two-thirds of all persons with disabilities have some form of private health insurance. [This includes 64.2 percent of children with cerebral palsy and 49.3 percent of adults with cerebral palsy.] And those who are dependent on public programs, like Medicaid, face major cut-backs in their benefits as illustrated by the Oregon Medicaid rationing plan (see accompanying *WfW* article).

Another reason is that the disability community, like the larger society, is greatly divided into the "haves" and the "have-nots" with each individual concerned about his or her own health insurance plan. In addition, many national voluntary associations are afraid to alienate the medical community which has traditionally opposed national health insurance.

Confronting Dilemmas:

Because the current health care financing system is so unfair, almost any reforms look good by comparison, at least for some people. This creates a real dilemma for people with disabilities: **Should we support a change that is less than ideal because it is better than the existing system, or withhold our support in favor of more far-reaching changes that would better address the needs of persons with chronic health conditions, even if there is a smaller chance that those changes will be adopted.**

While the status quo is unlikely to continue because of the massive contradictions in the current health insurance system, the greatest danger from a disability perspective is in legitimating the rationing of health care before the structural changes have been made. This may take the form of permitting "barebones" health insurance policies which are masquerading at the state level under the banner of small business insurance reform or of rationing under-funded public programs on the basis of quality of life like the Oregon Medicaid rationing plan.

Shaping the Health Care Debate:

Recognizing that the disability movement cannot influence health care policy without the support of other groups, it is important to consider how the disability movement can have its greatest impact. Certainly, every effort should be made to expose the inequities in the current system and the hidden costs which they impose on:

- (1) persons with and without disabilities as families struggle to pay out-of-pocket for necessary health care;
- (2) employers who cannot afford the health care that their employees and their dependents deserve;
- (3) under-funded government programs which serve as a safety net for persons who have been dumped out of the private health insurance system; and
- (4) the society in general when secondary disabilities are not prevented, or when people with disabilities are afraid to risk working because it might jeopardize their only access to health care.

But at the same time our greatest contribution may be in clarifying the principles which should guide our health care system. These include: (a) expanding the definition of "health" to include prevention services, rehabilitation therapies, assistive technology, and on-going health-related maintenance services; (b) distributing all health related expenses equitably throughout the population; and (c) restructuring our health care delivery system to more effectively support consumer-directed chronic care management.

The U.S. is at a crossroads. Our health care policy will either legitimate retrenchment by rationing services to those least able to pay, or it will restructure our priorities so that more resources will be devoted to managing chronic health conditions and less will be consumed by administrative waste, excess capacity, and "medical recidivism" which consume vast quantities of acute care services for health needs which could have been prevented.

UCPA has prepared a detailed critique of the "play or pay" approach from a disability perspective which will appear in subsequent issues of *WfW*. For

those who would benefit in seeing it now, it is available on request. Contact Bob Griss, United Cerebral Palsy Associations, Inc., 1522 K Street, N.W., Suite 1112, Washington, DC 20005. Tel: (800) USA-5UCP or (202) 842-1266.

Rationing Health Care For Low Income Persons in Oregon

by Bob Griss

On August 9, the State of Oregon hosted a conference to demonstrate support for their Medicaid rationing plan which determines a process for deciding which "medically necessary" services will be funded by Medicaid on the basis of the availability of state revenues. The conference featured many of the architects of this Medicaid rationing plan and representatives of the U.S. Department of Health and Human Services from Washington, D.C., whose approval of Oregon's Medicaid waiver application would be necessary for Oregon to be able to avoid certain Federal requirements for the use of Federal Medicaid dollars.

Although the conference was called to celebrate the "Oregon Solution" to cost containment, several organizations including the Oregon Catholic Conference, the Oregon Human Rights Coalition, the National Association of Social Workers, and Families, U.S.A., held a press conference in the rain outside of the conference to express their opposition to the Oregon Medicaid rationing plan.

In Oregon, UCPA's affiliate, UCP of Oregon and Southwest Washington, in Portland, OR, was the only disability organization in the state to publicly oppose the Oregon rationing plan. Below is UCPA's statement which explains why we fear the broader implications of the Oregon Medicaid rationing plan.

"THE IRRATIONALITY OF OREGON'S MEDICAID RATIONING PLAN: A DISABILITY PERSPECTIVE"

by Bob Griss and Allan I. Bergman

The Oregon Medicaid Rationing Plan attempts to establish a rational basis for allocating scarce State matching funds for Federal Medicaid dollars among the population of current Medicaid recipients and low income persons who are uninsured in Oregon. The Medicaid rationing plan reflects the State's budget constraints and recognizes the importance of providing preventive services and primary health care for many people who are currently uninsured.

HEALTH CARE FACT SHEET**BACKGROUND:**

Driven by cost containment concerns as personal health care expenditures increase by over \$72 billion each year, health care reform has become a major federal domestic policy priority. The health care debate has tended to focus on the 37 million uninsured persons, health care premiums which are rising between 15-20% each year, and the elusive potential savings from managed care.

The health care debate has largely ignored a disability perspective focusing instead on the interests of employers, insurers, health care providers, and the government which is the largest payer of health care, accounting for over 41% of total health care expenditures in 1990. Health care policy has historically been shaped in the U.S. by the capacity and willingness of employers to pay for employee premiums, the power of providers to set their own rates, and the necessity to maintain the profitability of some 1500 private insurers, although private health insurance accounts for less than one-third of total health care expenditures. The Health Task Force of the Consortium for Citizens with Disabilities (CCD) has endorsed five principles for a disability perspective on health care reform, including: nondiscrimination, comprehensiveness, appropriateness, equity, and efficiency.

Nondiscrimination means that all persons, regardless of income, age, health, disability, or employment status have access to all needed health related services. Research indicates that as many as 16.6 percent of persons with disabilities have permanent pre-existing condition exclusions on their private health insurance plans, and that persons with certain chronic conditions are often routinely denied coverage when they apply individually or in small groups, even though a majority are actually low users of health care. Many persons are vulnerable to medical underwriting when they become unemployed, change their jobs, or their employer changes insurers, and many persons become captive of their jobs when they cannot get a child or spouse covered by a new health insurance plan because of a so-called pre-existing condition. Despite passage of The Americans with Disabilities Act (ADA), access to health care is still NOT A RIGHT for children and adults with disabilities or for any other Americans.

Comprehensive health care for persons with disabilities must include prevention, rehabilitation, assistive technology, psychological counseling, prescription drugs, and chronic care management as well as hospitalization and physician services. Most health insurance plans only cover acute care even though a majority of Americans have chronic health conditions. In the absence of access to comprehensive health care many preventable conditions occur, and many persons are deprived of the health related services that would enable them to maintain their health and make a maximum contribution to society.

Appropriateness means that consumers can choose their own health care providers, and that the health care financing system ensures

that appropriate services are available. Managed care approaches to control health care costs can interfere with consumer choice of provider, which is very important to persons with disabilities and chronic illness.

Equity means that health care costs are equitably distributed throughout the population, and that persons with disabilities or chronic illness are not required to pay a disproportionate share of their income for health related needs. Blue Cross-Blue Shield used to use "community rating" which enabled all insured persons to pay the same premium, but for-profit insurers developed a competitive advantage by resorting to "experience rating" which charged groups different premiums based on anticipated health care utilization.

Efficiency means that administrative waste is minimized; that health care resources are rationally allocated among preventive services, acute care, rehabilitation, and chronic care management; and that mechanisms exist for effective cost controls. According to the U.S. General Accounting Office, "if the universal coverage and single payer features of the Canadian system were applied in the United States, the savings in administrative costs alone would be more than enough to finance insurance coverage for millions of Americans who are currently uninsured. There would be enough left over to permit a reduction, or possibly even the elimination of copayments and deductibles, if that were deemed appropriate." (June 1991)

LEGISLATIVE DESCRIPTION:

Over 35 national health care bills have been introduced in the 102nd Congress which represent four primary approaches to health care reform:

Small group insurance reform proposes to eliminate medical underwriting for certain size groups (e.g. 2-50 employees) and to limit how much insurers can increase premiums for a small group on the basis of age, sex, and health status; however, it encourages "bare-bones" coverage, wipes out state benefit mandates, does not control health care costs, and does not require employers to contribute to the health insurance of their employees or dependents.

Tax credit approach as proposed by the Administration would provide a limited tax credit or voucher of up to \$3750 for the purchase of private health insurance for a family of three or more persons with an income under 100% of poverty, but the quality of the benefit plan would depend largely on the amount that one can afford for the premium, and cost controls would take the form of managed care.

"Play or pay" approach proposes to require employers to contribute to the health insurance of their employees and dependents according to certain Federal minimum standards, or else pay a certain percentage of their payroll into a public plan that would provide health insurance benefits that also meet those minimum standards; however, to avoid overburdening employers, the Federal minimum standards do not require coverage for such basic services as prescription drugs, rehabilitation, and durable medical equipment, etc.; managed care would determine which services will be

reimbursed; many people would receive poorer services in the public plan than some employers can afford to provide; and although a Federal Health Expenditure Board would be established to set national expenditure goals and negotiate reimbursement rates, the "play or pay" approach lacks effective mechanisms to allocate resources among different sectors of the health care system.

Single payer approach proposes to provide universal coverage to all citizens through a **government funded** health care system that ensures access to comprehensive health care services with consumers choosing their own providers. Financing occurs through progressive income taxes and corporate taxes which enable health care costs to be distributed equitably throughout the population. **The health care system is administered at the state level**, and most health care providers would remain in the private sector. The leverage of the single payer approach ensures effective cost controls through uniform fee setting for specific types of services, and a global budget would be allocated to different services in the health care system according to a publicly accountable plan that minimizes administrative waste and unnecessary excess capacity.

CURRENT STATUS:

The two immediate threats to comprehensive health care reform are small group insurance reform represented by Senator Lloyd Bentsen's (TX) bill (S. 1872) and the Oregon Medicaid rationing plan which is being considered for approval by the U.S. Department of Health and Human Services which seeks to ration Medicaid payments for health care on the basis of cost, cost-effectiveness, and presumed quality of life, as measured by a telephone survey of a random sample of Oregonian residents. The Senate Democratic Leadership has endorsed a "play or pay" approach (S. 1227). Meanwhile, the primary single payer approach to National Health Insurance is H.R. 1300 in the House, and S. 2320 in the Senate.

UCPA RECOMMENDATIONS:

- o UCPA opposes small group insurance reform;
- o UCPA supports the development of a single payer system as the most effective and efficient way to achieve comprehensive health care reform goals;
- o UCPA is willing to consider other options and may support certain features of a "play or pay" approach to the extent that they promote the goals of comprehensive health care.

These actions are consistent with UCPA's Legislative Priorities for health care access in the 102nd Congress which states: "to assure universal access to health care for all citizens" including "elimination of the use of pre-existing condition exclusions" and "denials"; "minimum federal standards for comprehensive coverage; and progressive financing"...

RELEVANT COMMITTEES:

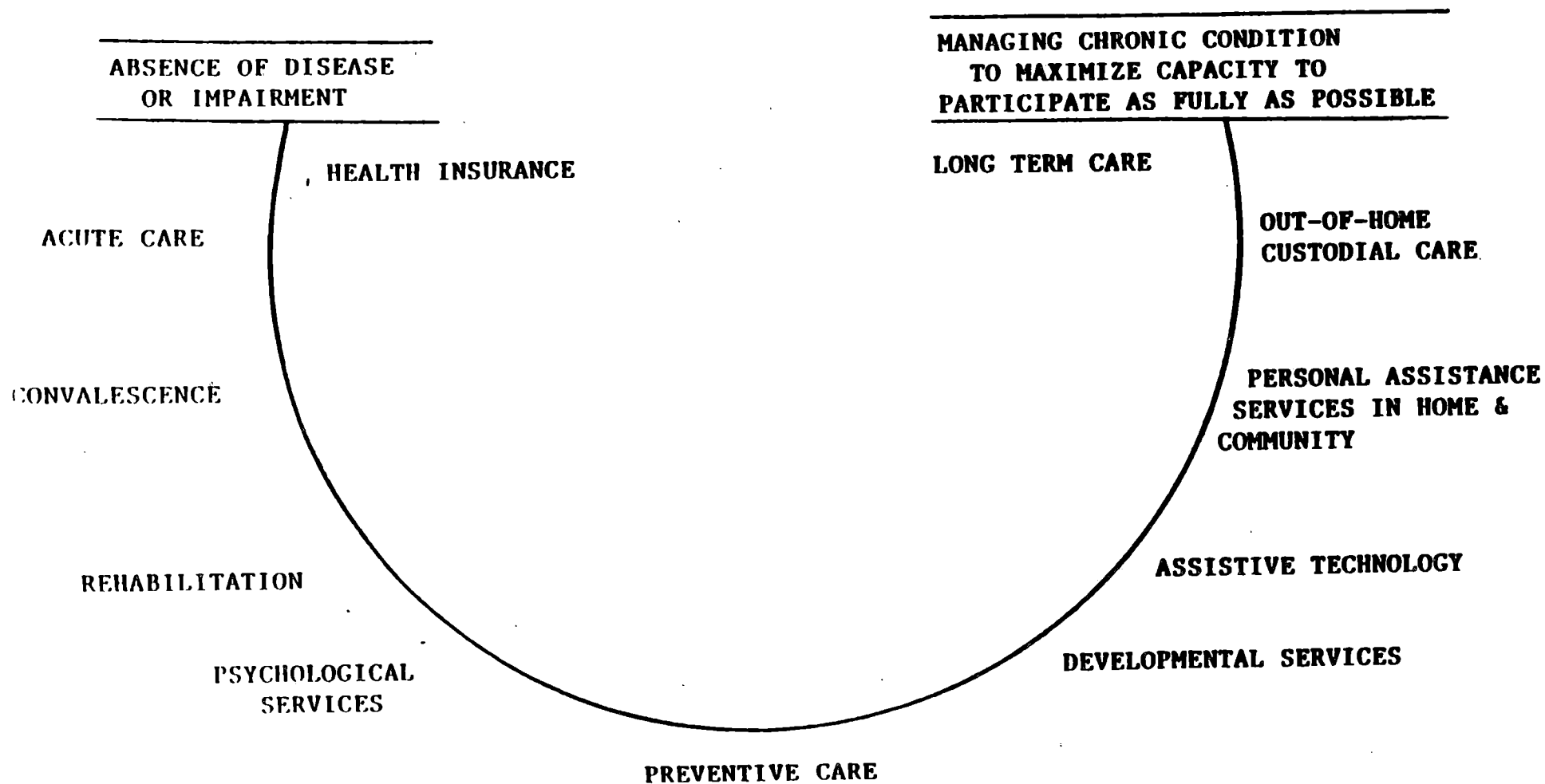
Senate Finance Committee

Senate Labor and Human Resources

House Ways and Means Committee

House Energy and Commerce

Diagram 2: CONTINUUM OF HEALTH RELATED NEEDS



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HEALTH CARE UTILIZATION AMONG TEN SELECTED CHRONIC CONDITION GROUPS OFTEN IDENTIFIED AS "MEDICALLY UNINSURABLE" BY PRIVATE HEALTH INSURANCE MEDICAL UNDERWRITING GUIDES

Table 1: PERCENT OF WORKING-AGE PERSONS WITH SELECTED CHRONIC CONDITIONS BY VARIOUS INDICATORS OF LOW HEALTH CARE UTILIZATION

A. % NOT HOSPITALIZED IN PAST YEAR (HIS, 1983-86)			
1.	epilepsy	79.2%	
2.	diabetes	73.4%	
3.	multiple sclerosis	74.4%	
4.	enteritis & colitis	83.8%	
5.	cancer (e.g. breast-female)	86.1%	
6.	mental retardation	85.1%	
7.	cerebral palsy	76.9%	
8.	complete paralysis of entire body	62.6%	
9.	ischemic heart disease	68.1%	
10.	rheumatoid arthritis	83.5%	
11.	all persons in excellent health	96.2%	
B. % WITH 3 OR FEWER PHYSICIAN OFFICE CONTACTS IN PAST YEAR (HIS, 1983-86)			
1.	epilepsy	40.5%	
2.	diabetes	39.7%	
3.	multiple sclerosis	49.0%	
4.	enteritis & colitis	50.2%	
5.	cancer (e.g. breast-female)	34.5%	
6.	mental retardation	59.7%	
7.	cerebral palsy	69.7%	
8.	complete paralysis of entire body	15.9%	
9.	ischemic heart disease	40.4%	
10.	rheumatoid arthritis	41.9%	
11.	all persons in excellent health	85.1%	
C. % SELF-REPORTING "EXCELLENT" OR "VERY GOOD" HEALTH STATUS (HIS, 1983-86)			
1.	epilepsy	35.9%	
2.	diabetes	20.0%	
3.	multiple sclerosis	11.8%	
4.	enteritis & colitis	43.6%	
5.	cancer (e.g. breast-female)	47.9%	
6.	mental retardation	27.0%	
7.	cerebral palsy	46.1%	
8.	complete paralysis of entire body	14.6%	
9.	ischemic heart disease	19.8%	
10.	rheumatoid arthritis	24.1%	
D. % OF SSDI BENEFICIARIES WITH NO MEDICARE CHARGES FOR INPATIENT SERVICES OR OUTPATIENT SERVICES IN 1985 (HCFA)			
		No Inpatient	No Outpatient
1.	epilepsy	75.1%	35.5%
2.	diabetes	57.9%	25.7%
3.	multiple sclerosis	74.7%	35.3%
4.	enteritis & colitis	64.4%	29.6%
5.	cancer (breast-female)	59.7%	24.9%
6.	mental retardation	86.0%	49.7%
7.	cerebral palsy	83.7%	44.9%
8.	spinal cord injury	74.6%	43.6%
9.	angina pectoris	71.1%	28.9%
10.	rheumatoid arthritis	71.9%	30.9%

* Figure has low statistical reliability or precision (relative standard error exceeds 30 percent)

Source: Robert Griss and Stuart Hanson, Accessibility, Adequacy, and Affordability of Health Insurance for Persons with Disabilities or Chronic Illness, preliminary draft of Report to Congress, National Institute on Disability and Rehabilitation Research, Washington, D.C. July 1990.

Table 2: PERCENT OF WORKING-AGE PERSONS WITH VARIOUS INDICATORS OF HIGH HEALTH CARE UTILIZATION

A. % HOSPITALIZED AT LEAST TWICE IN PAST YEAR (HIS, 1983-86)				
1.	epilepsy	7.5%		
2.	diabetes	8.3%		
3.	multiple sclerosis	19.5%		
4.	enteritis & colitis	5.8%		
5.	cancer (e.g. breast-female)	7.7%		
6.	mental retardation	7.2%		
7.	cerebral palsy	2.4%		
8.	complete paralysis of entire body	15.9%		
9.	ischemic heart disease	14.9%		
10.	rheumatoid arthritis	3.7%		
11.	all persons in excellent health	0.4%		
B. % WITH 6 OR MORE PHYSICIAN OFFICE CONTACTS IN PAST YEAR (HIS, 1983-86)				
1.	epilepsy	45.5%		
2.	diabetes	43.9%		
3.	multiple sclerosis	39.5%		
4.	enteritis & colitis	34.4%		
5.	cancer (e.g. breast-female)	52.4%		
6.	mental retardation	23.6%		
7.	cerebral palsy	22.1%		
8.	complete paralysis of entire body	58.9%		
9.	ischemic heart disease	40.8%		
10.	rheumatoid arthritis	47.6%		
11.	all persons in excellent health	8.6%		
C. % SELF-REPORTING "FAIR" OR "POOR" HEALTH STATUS (HIS, 1983-1986)				
1.	epilepsy	38.1%		
2.	diabetes	48.6%		
3.	multiple sclerosis	61.3%		
4.	enteritis & colitis	23.1%		
5.	cancer (e.g. breast-female)	25.5%		
6.	mental retardation	37.9%		
7.	cerebral palsy	20.9%		
8.	complete paralysis of entire body	45.7%		
9.	ischemic heart disease	50.4%		
10.	rheumatoid arthritis	41.2%		
D. PERCENT OF TOTAL MEDICARE CHARGES AMONG SSDI BENEFICIARIES WITH SELECTED CHRONIC CONDITIONS ACCOUNTED FOR BY TOP 5% AND 10% OF USERS WITH THOSE CHRONIC CONDITIONS IN 1985 (HCFA)				
		Top 5%		Top 10%
		Inpatient	Outpatient	Inpatient Outpatient
1.	epilepsy	29.6%	31.4%	45.7% 46.5%
2.	diabetes	26.4%	47.5%	40.9% 61.2%
3.	multiple sclerosis	26.6%	27.8%	42.6% 43.1%
4.	enteritis & colitis	30.9%	56.5%	47.0% 64.6%
5.	cancer (e.g. breast-female)	20.1%	27.8%	35.2% 43.5%
6.	mental retardation	34.1%	36.1%	50.1% 50.6%
7.	cerebral palsy	32.5%	36.3%	48.4% 51.9%
8.	spinal cord injury	29.7%	31.4%	49.1% 45.8%
9.	angina pectoris	28.9%	29.5%	46.3% 45.5%
10.	rheumatoid arthritis	28.9%	30.2%	44.2% 44.0%

WASHINGTON VIEWS

UCPA's Position Statement on National Health Care Reform

Guided by a well-formulated disability perspective on health care reform, UCPA has anticipated the various dilemmas in the health care crisis and taken a leadership role in communicating with Congress, with the Federal government, with other disability and chronic illness groups, and with persons with disabilities at the community level. UCPA's position statement on National Health Care Reform is reprinted below.

UCPA POSITION STATEMENT ON NATIONAL HEALTH CARE REFORM

- UCPA opposes small group insurance reform initiatives as inadequate for and possibly diverging from comprehensive health care reform goals;
- UCPA supports the development of a single payer system as the most effective and efficient way to achieve comprehensive health care reform goals;
- UCPA is willing to consider other options and may support certain features of a "play or pay" approach to the extent that they promote the goals for comprehensive health care.

— Adopted by UCPA's Executive Committee, February 1, 1992

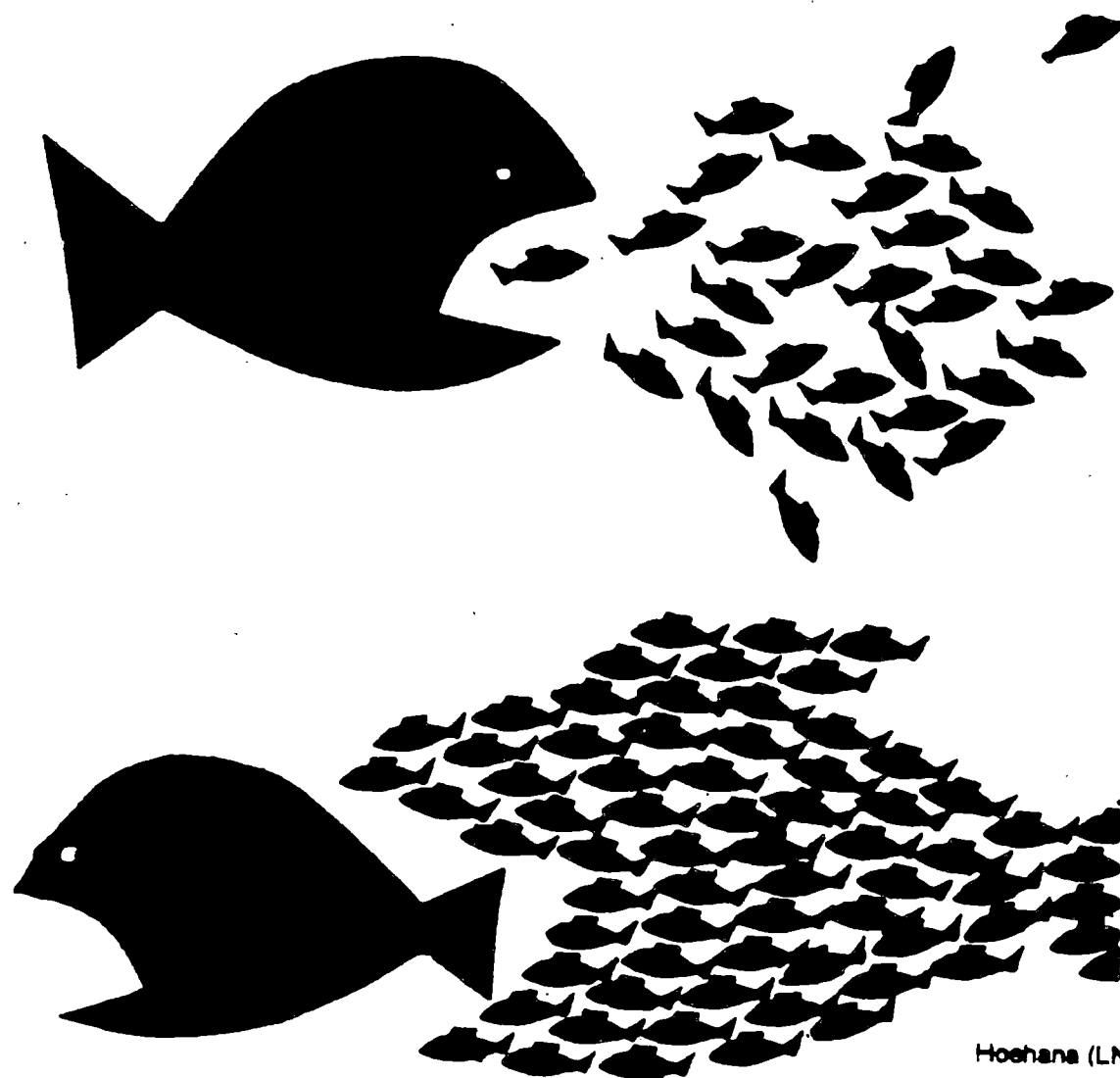
We affirm UCPA's commitment to comprehensive health care reform established by the Members of the Corporation in its Resolution on Access to Health Care on May 4, 1991. Persons with disabilities or chronic illness are increasingly vulnerable in the voluntary private health insurance marketplace and in the existing residual public health insurance programs under the growing pressure of cost containment in the health care financing system. We support the enactment of comprehensive health care reform which ensures:

- (1) universal access for all persons regardless of income, health status, employment status, disability, age, race, sex or geographic residence;
- (2) comprehensive coverage for all needed health related services including but not limited to

hospital and primary care; preventive care and health education; rehabilitation services, including physical therapy, occupational therapy, audiology, speech-language pathology services, respiratory therapy, cognitive and behavioral therapies, psychiatric rehabilitation, and therapeutic recreation; assistive technology; home care; mental health and counseling services; prescription drugs (including the use of off-label and "experimental" drugs if that is what one's doctor recommends as the best treatment), biologicals and medical foods; personal assistance services and independent living services; and care coordination services which ensure appropriate and cost-efficient health care;

- (3) freedom of choice for users to choose their own health care providers;
- (4) effective cost containment measures which reduce unnecessary costs, constrain inappropriate utilization, but provide adequate reimbursement to ensure the availability of competent personnel;
- (5) avoidance of rationing by emphasis on reduction in administrative waste associated with voluntary private insurance, and reduction in excess capacity by shifting resources from high tech acute care to prevention, rehabilitation, and chronic care management;
- (6) health care costs distributed equitably throughout the population rather than relying on experience rating or the use of high deductibles and copayments which penalize persons who need health care;
- (7) continued support for basic biomedical and mental health research that will improve the delivery of cost-conscious quality health care;
- (8) quality assurance standards for all health care providers with federal and state responsibility for data collection, evaluation, and monitoring of appropriate treatment and utilization.
- (9) delivery of health care services for chronic health conditions in a way that minimizes interference with normal activities;
- (10) protection of patients' rights and assurance that health care users have full participation in decision-making at all levels of government which affect health care policy.

— Adopted by UCPA's Governmental Activities and Advocacy Committee, January 26, 1992



Hochana (LNS)



United
Hospital Fund

Shaping New York's Health Care
Information, Philanthropy, Policy

Press Release

September 1992

Old Snake Oil in New Bottles

Managed competition is a grand design for the complete reorganization of the American health care system, but it speaks only tangentially to the most important problem in health care in the United States."

The good news is that health care and the reform of health care financing appear to be near the top of the list of issues in this year's presidential election. The bad news is that, thanks to the energy of a handful of policy promoters and the unbridled enthusiasm of the editorial board of the *New York Times*, much of the debate is likely to revolve around the purported virtues of "managed competition," this year's magical mystery cure for all that ails America's troubled health care system.

For those who missed the publicity blitz, managed competition, according to its advocates at the *Times*, is a system under which

...consumers would be combined into large groups and represented by sophisticated sponsors. The sponsors would negotiate with doctors and hospitals, forcing them to provide high-quality treatment at reasonable cost. Sponsors would pay providers a fixed fee for each patient, independent of how much care the patient turned out to need, thus encouraging doctors to keep patients healthy and provide the most efficient care when they are sick. (Editorial, August 2, 1992)

It sounds too good to be true.

In fact, managed competition is a grand design for the complete reorganization of the American health care system, but it speaks only tangentially to the most important problem in health care in the United States today—the fact that one in seven Americans

lacks the financial means to get the health care he or she needs—and offers only untested theory (most of it contrary to actual experience) as a solution for the other central problem, the continuing upwards spiral in the costs of health care. Indeed, one has to be only moderately cynical to suspect that much of the appeal of managed competition lies in the recognition of its capacity to divert attention from these more important, and thus more contentious, issues.

With its promise of unmitigated benefit, managed competition may be this decade's intellectual and moral equivalent of the Laffer Curve, the construct which purported to demonstrate that cutting federal taxes would increase federal government revenues, inspiring George Bush to coin the phrase "voodoo economics." Of course, most responsible economists now agree that the Laffer Curve never had much empirical basis and that the public policy developed by its advocates is a major source of the unmanageable, continuing federal budget deficit. In a similar attempt to find a painless solution to a difficult policy problem, the advocates of managed competition propose to create a "market" in health care coverage through an extraordinarily complex regulatory scheme.

Blaming the Victim

Proposals for managed competition in health care, such as those advanced by Professor Alain Enthoven of Stanford University or the "Jackson Hole Group" led by Dr. Paul Ellwood, are rooted in two basic propositions, which purport to explain much of what

"A trip to the doctor is not like a trip to Cape Cod, a colonoscopy is not like a haircut, and a lens procedure is not like getting a new TV."

is wrong with the American health care system. The first proposition—widely accepted although largely inaccurate—is that health care in the United States costs so much because Americans use too much health care. According to the proponents of managed competition, Americans are overinsured, at least in part because the value of employer-provided health insurance benefits is exempted from taxable income. Because people have so much health insurance, the argument then goes, they are inadequately "sensitive" to the price of health care at the point of service, and thus use more than they otherwise would.

This "excess" demand for health care, according to the proponents of managed competition, is the major source of the extraordinary, continuing inflation in health care costs. Thus, most full-fledged managed competition proposals start with the abolition or limitation of tax exemption for employer-provided health insurance. The most comprehensive managed competition proposals then use the new tax revenues derived from reducing the benefits available to most of the population to finance coverage for some of the uninsured.

It certainly is true that the tax exemption for fringe benefits is one of the more regressive features of the Internal Revenue Code: not only are such exemptions worth more to people in higher tax brackets, but higher paid employees tend to get more generous health insurance coverage. But the significant cuts in income taxes in the early 1980s (remember the Laffer Curve) did not reduce demand for health insurance, as this theory would seem to predict. Nor is there any actual experience that demonstrates that real people, with the exception of a few highly paid employees, pay any attention at all to the relatively minor tax implications when thinking about health insurance cover-

age. More to the point, the sorts of health insurance coverage to which advocates of managed competition most strenuously object—first-dollar coverage for an unlimited range of services at the consumer's option—largely disappeared from the private sector during the latter half of the 1980s, not because of any changes in the tax code, but because, in real life, employers couldn't afford them any more.

Still more pernicious is the underlying assumption that cost inflation in health care is largely a problem of excessive discretionary utilization by consumers. Again, the facts do not support this interpretation. During the 1980s, a period in which real health care costs grew faster than at any time in history, the average American used considerably fewer health services than in the decade before. Total hospital days fell 15 percent, and physician visits per capita, the service over which consumers exercise the most discretion, also fell. To be sure, consumers received more services, especially high-technology services, per hospital day or physician visit in the 1980s than they had in the past, but they paid for a greater share of them out of pocket. And those services are largely initiated by providers, not consumers. A trip to the doctor is not like a trip to Cape Cod, a colonoscopy is not like a haircut, and a lens procedure is not like getting a new TV.

International comparisons are always dangerous, as anyone watching the current policy debates will quickly conclude, but it is not inappropriate to point out that in the other Western nations that have both universal health insurance coverage and lower costs than we do—that is to say, all other Western nations—consumers use more health care than we do. They go to the doctor more often, are hospitalized more often, and stay much longer once they are hospitalized. (They also live longer, which may or may not be

related.) It's also worth noting that the absence of copayments and other out-of-pocket liabilities for health care consumers in those nations is the principal reason that the administrative overhead in their health care systems is so much less than ours.

Reforming the Market

The other proposition underlying arguments for managed competition is more soundly based, even if its implications are not necessarily those managed competition advocates would identify. Put most simply, the current "market" for health services doesn't work because of the fundamental imbalance in power between buyers and sellers. Most consumers don't want to worry about the price when they need, or think they need, health care for themselves or their children; that's why they have insurance. Indeed, most of the time people seek health care, they don't even know what they need; they are paying health professionals to tell them and are rarely in a position to evaluate independently what they are told. Indeed, most Americans think there is something faintly immoral about forcing people who are acutely ill or in serious pain or experiencing a life-threatening illness to weigh financial considerations when deciding what to do.

The way to redress this fundamental imbalance in the health care marketplace is indeed, as the advocates of managed competition contend, to aggregate the buying power of consumers and to employ sophisticated organizations with the consumers' best interests at heart to work as their agents. It doesn't necessarily follow, however, that those agents should be big insurance companies or big health maintenance organizations or similar "sponsors."

There are many ways to redress the absence of consumer market power without forcing all consumers into a small number of

self-appointed, unaccountable insurance plans. One could imagine, for example, a public or quasi-public price-setting mechanism, as we now have for electric and gas service and are about to recreate for that most vital of all public services, cable television. In fact, prices for more than a third of health services—those rendered to Medicaid and Medicare patients—are already set by government. Proponents of managed competition oppose such price-setting mechanisms: the academic economists believe that government will set the prices too high, while the provider groups think they will be too low.

Given our national distaste for government, other alternatives should also be considered. One possibility might be to create a narrowly drawn exemption to antitrust law permitting private insurers to bargain collectively about prices with organized providers—as is, in effect, now done in Germany and the Netherlands. Or one could pursue the proposal already floating around in the Congress to permit, but not require, private insurers to pay physicians and hospitals the same prices Medicare pays. Or one could develop some sort of arbitration strategy in which, for example, a neutral third party heard claims from payers and providers and then made a binding decision, not that such a strategy has worked terribly well in controlling the prices paid for major league shortstops.

But the reason proponents of managed competition have rejected these options is because they are after more than prices. They want to reform medical care at the same time. This is where their first proposition reappears—and with a considerable tinge of moralism, as demonstrated by the *Times's* choice of such locutions as "consumers would be combined" and "forcing" doctors and hospitals. Proponents of managed competition—pursuing a theoretically efficient system at the expense of theoretically wasteful patients and

"The debate on managed competition becomes a smokescreen, distracting us from what should be the first priority: coverage for everyone."

health care providers—would limit the kinds of insurance people could choose, require them to participate in "managed care" arrangements that would severely restrict their choices of doctors and hospitals and put them at enormous risk of underservice, and impose extraordinarily detailed oversight of professional practice in order to "force" high quality care, all in the name of eliminating the overuse of service and making the health care system more "efficient."

First Principles

In other words, while much of the current discussion of health care reform is driven by the need to find a way to get the uninsured and underinsured into the health care system, proponents of managed competition insist on a thoroughgoing reshaping of that system first. Of course, we can't afford to cover the uninsured unless we can control costs; we can't even continue to cover those who currently have insurance unless we can control costs. But neither can we afford to wait a generation or so to rebuild the system, particularly when what the proponents of managed competition are seeking to fix may not be broken.

One cannot simultaneously control health care costs, protect the economic interests of all health care providers, and extend universal health insurance coverage. If managed competition really controlled costs, providers (as well as consumers) would be substantially worse off; the reason so many providers support managed competition is because they don't believe its cost containment mechanisms will really work, and they're afraid the mechanisms in other pro-

posals for health care reform would. In this way, the debate on managed competition becomes a smokescreen for the most important issues, distracting us from what should be the first priority: coverage for everyone.

One way or another, we're going to have to figure out how to control the costs of health care—by taking away revenue from providers, taking away freedom to choose from consumers, or quite possibly both. But that's only an economic problem. The fact that American citizens who are sick can't get health care because they don't have health insurance is also, I would suggest, a moral problem. In fact, it's a disgrace.

There are many ways to get health insurance coverage to those who don't now have it. The president has proposed part of a plan to do so. So has Governor Clinton. So have lots of other people. I have my preferences, but that's almost beside the point. Let's get everybody covered, now. After that, we can fight about money. Indeed, we might even find that insuring everyone could be the impetus for solving the cost problem.



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DEFINITIONS

MANAGED COMPETITION:

System for offering health care coverage which is governed by national rules promulgated by a national health board with services delivered through network (see definition in attached AARP article as possible resource).

GLOBAL BUDGETING

A nationally established overall "Budget" - amount to be spent on health care at state and national levels.

MANAGED CARE

Care provided through "networks" that "manage" utilization of services provided based on a subjective set of criteria of what will be paid for under what circumstances: HMO, PPO, IPO, etc.

PORTABILITY

Health care plan follows the consumer rather than staying with the job.

COVERAGE

(This is one you all need to decide how you want to handle - re CCD principals, limits, etc?) The issues all agreed upon were portability and community rating

FINANCING

Government - Feds: Medicare, Medicaid, Veterans, Head Start, rehabilitation, etc
State & local: Medically needy, hospitals, clinics, and Medical schools.
Private - Insurance & Individual Pay

COST CONTAINMENT

Various strategies for limiting expenditures - the one recommended by ILRU Seminar is: _____

CASE MANAGEMENT

Assertive community based treatment (LL & K - this was what was in my notes - couldn't find on the tapes didn't sound right. I believe, Kym that this was your suggestion. Can you help here?). - providing support and advocacy for consumers

PREVENTION

Any services that reduce likelihood of additional and/or more costly treatment - social, educational, nutritional, and medical.

CONTINUUM OF CARE

Service availability from prevention (health education, nutrition through medical services) to long term services - which allows for integration and coordination of care

COMMUNITY RATING

Mechanism used by Insurance company to determine premium rates - based on community claims experience rather than individual or employer groups.

The principles for evaluation criteria that the seminar came up with were:

1. A paradigm shift from sickness to wellness model
2. A cost effective model (the most comprehensive, least intrusive approach with maximum consumer involvement)
3. Universal access mandated coverage
Under mandates one of the concerns was mandates for employee and/or household and under coverage, the extent physically, the extent mentally, and the extent under rehabilitation?
4. Appropriate and comprehensive services and the CCD list was the recommended framework.
5. Equitable financing (you may want to talk to some of the participants about getting some of their thinking on equitable. The notes and the tapes were a little sketchy and I didn't feel there was a real clear guideline.
6. Cost containment - The need for services at both ends - from preventive services, to long term services. Today, too much of the prevention is defined as immunization and prenatal. Before one gets into the system, health education, health promotion activities, wellness activities, nutrition is a key to the front end services. Of course at the back end - rehabilitation services, long term support services, the maintenance services that again, contribute to the quality of one's life.

HEALTH CARE REFORM PROPOSALS

	NAM	Heritage Foundation	National Leadership Commission	AEI/Pauly	Health Equity Action League (HEAL)	American Medical Association (AMA)	Blue Cross/Blue Shield Association
COST CONTAINMENT	Encourages employer/employee cost-sharing; assessment of spending levels vs. health status improvement; incentives for managed care; improved public program efficiency	Higher cost-sharing encouraged through tax policy	Encourages organized delivery systems (ODs) to manage quality and cost	Competitive health care plans	Encourages market-based system; incentives for government providers and insurers to pursue innovative purchasing techniques	Reduce excessive paperwork; information to consumer at point of service to encourage cost-consciousness	Incentive for insurers to contract for high quality, cost effective services and for employers and individuals to choose such carriers; adequate funding of public programs
Reduce state barriers to managed care and UR	X	NA	NA	NA	X	NA	X
Preempt state benefit mandates	X	NA	X	NA	X	X	X
Tax treatment of health benefits	NA	Replaces tax exclusion and deductions with refundable tax credit for individuals and families	NA	Limits tax subsidy for employer-paid health benefits	NA	Limit amount of employer-provided health benefits that are tax free	NA
Global budget	NA	NA	X	NA	NA	NA	NA
Federal commission	NA	NA	National Health Review Board to set budget and payment rates	NA	NA	NA	NA
State agency	NA	NA	State Health Review Board to administer state budgets	NA	NA	NA	NA
Medicare payment rates	NA	NA	Optional	NA	NA	NA	NA
Medical liability: federal tort reform	Federal tort reform, limits on attorney fees, periodic payment for large amounts, offsets for collateral awards, statute of limitations	NA	Demonstrations on ADR, new credentialing for health care professionals, considerations of tort law reform	NA	X	X	X
Negotiated payment system	NA	NA	All-payer system	NA	NA	NA	NA

	NAM	Heritage Foundation	National Leadership Commission	AEI/Pauly	Health Equity Action League (HEAL)	American Medical Association (AMA)	Blue Cross/Blue Shield Association
QUALITY							
Practice guidelines and outcomes research	Encourages purchasers to buy-on value	NA	X	NA	X	X	X
Nation strategy for quality improvement	X	NA	X	NA	NA	X	X
ACCESS							
Universal public insurance	NA	NA	NA	NA	NA	Coverage mandate on employers; permits state to require self-insured employers to participate in risk pools through employer mandate	NA
Medicaid expansion	With buy-in	With buy-in	Optional public program	Replaces Medicaid with private coverage through tax credit	NA	Phased-in coverage	X
Pay or play	NA	NA	X	NA	NA	NA	Large employers must offer to help finance benefits; small employers must offer, but not pay for benefits; noncontributing small employers assessed a surcharge
Individual mandate	Encourages coverage	X	NA	X	NA	NA	NA
Small group insurance reform	X	NA	X	NA	X	Incentives for states to set up pools for small businesses	X
Small employer purchasing group	X	NA	NA	NA	NA	NA	NA
100% deductibility for self-employed	X	NA	NA	NA	X	NA	X
Tax credit for small business to offer coverage	NA	NA	NA	NA	NA	NA	Tax incentives for small employers

	NAM	Heritage Foundation	National Leadership Commission	AEI/Pauly	Health Equity Action League (HEAL)	American Medical Association (AMA)	Blue Cross/Blue Shield Association
Tax incentives for all businesses to offer dependent care and managed care	NA	NA	NA	NA	NA	NA	NA
Portability: both insured and self-insured must comply with pre-existing condition requirements	NA	NA	NA	NA	NA	NA	Require employer open enrollment period for family members who lose coverage due to employment change; eliminate pre-existing condition exclusions

X = addressed by proposal

NA = not addressed

National Association of Manufacturers
January 1992

HEALTH CARE REFORM PROPOSALS

	Mitchell/Kennedy (S.1227)	Rostenkowski (H.R.3205)	Rostenkowski (H.R.3626)	Bentsen (S.1872)	Chafee (S.1936)	Russo (H.R. 1300)	Kerry (S. 1446)
COST CONTAINMENT							
Reduce state barriers to managed care and UR	X	NA	NA	X	X	NA	NA
Preempt state benefit mandates	X	After 1/1/93 pre-empts state mandates that exceed requirements of benefits package	X	X	X	NA	NA
Tax treatment of health benefits	NA	NA	Subsidy for low-income individuals	NA	NA	NA	NA
Global budget	X	X	NA	NA	NA	X	X
Federal commission	Sets national rates	Establishes health care cost containment commission to negotiate spending target and rates	Study health care spending; Sec. establishes uniform claims and reporting forms	Study health care spending; make recommendations on uniform claims and reporting forms	NA	Federal administration of rate-setting	Federal administration of rate-setting
State Agency	Administers state rate- setting program	X	NA	NA	NA	Optional	X
Medicare payment rates	NA	NA	Require providers to accept as payment in full; private payers may voluntarily adopt system	Study use of Medicare rates for all payers	NA	NA	NA
Medical Liability; federal tort reform	State grants to encourage tort reform	NA	NA	NA	Federal tort reform, limits on attorney fees, periodic payment for large amounts, offsets for collateral awards, statute of limitations	NA	National commission to study tort reforms; state grants
Negotiated payment system	All-payer system	All-payer system	NA	NA	NA	Single-payer system	Single-payer system
QUALITY							
Practice guidelines and outcomes research	X	NA	NA	Increased authorizations	NA	X	X

	Mitchell/Kennedy (S.1227)	Rostenkowski (H.R.3205)	Rostenkowski (H.R.3626)	Bentsen (S.1872)	Chafee (S.1936)	Russo (H.R. 1300)	Kerry (S. 1446)
Nation strategy for quality improvement	X	NA	NA	NA	X	NA	State commissions on quality
ACCESS							
Universal public insurance	NA	NA	NA	NA	NA	Federal	State/federal
Medicaid expansion	Replaced by AmeriCare	Replaced by Public Plan	NA	NA	X	Replaced by public plan	NA
Pay or Play	X	X	NA	NA	NA	NA	NA
Individual mandate	NA	NA	NA	NA	NA	NA	NA
Small group insurance reform	X	X	X	X	X	NA	NA
Small employer purchasing groups	NA	NA	NA	State grants	Establishes nonprofit small employer purchasing groups; incentives to join	NA	NA
100% deductibility for self-employed	X	X	X	X	X	NA	NA
Tax credit for small business to offer coverage	X	NA	NA	NA	X	NA	NA
Tax incentives for all business to offer dependent care and managed care	NA	NA	NA	NA	Tax incentives and establishes managed care advisory board to set standards	NA	NA
Portability: both insured and self- insured employers must comply with pre-existing conditions requirements	NA	X	X	X	NA	NA	NA

X = addressed by proposal
NA = not addressed

Health Care Reform Bill Analysis

February 12, 1992

Mitchell (S.1227)
As Introduced June 5, 1991

Russo (H.R. 1300)
As Introduced March 6, 1991

Bentsen (S.1872)
As Introduced October 24, 1991

Rostenkowski (H.R.3626)
As Introduced October 24, 1991

Description	▶ "HealthAmerica: Affordable Health Care for All Americans Act" ▶ Universal coverage ▶ Employer mandated coverage; enroll each employee and family in a health benefit plan or contribute a percent of payroll to public plan (AmeriCare) ▶ Medicaid is replaced with a Federal/State program called AmeriCare which is administered by States subject to national standards for eligibility, reimbursement, and coverage ▶ Non-binding expenditure targets negotiated between providers and payers	▶ "Universal Health Care Act of 1991" ▶ Universal coverage- ▶ National, single payer system ▶ Employment/private insurance replaced with publicly-administered program ▶ Freedom of choice of providers ▶ No cost sharing ▶ Annual budgets tied to growth in GNP and a national fee schedule	▶ "Better Access to Affordable Health Care Act of 1991" ▶ Covers small businesses employing 2-50 persons who work at least 30 hours per week. ▶ Sets requirements for insurance policies sold to small businesses based on NAIC or HHS standards.	▶ The Health Insurance reform and Cost Control Act of 1991 ▶ Covers small employers who typically employ 2-50 persons for an average of 17.5 hours/wk
Benefits	▶ Inpatient and outpatient hospital and physician services ▶ Diagnostic tests ▶ Prenatal and well-baby care ▶ Preventive services, limited to well-child care, pap smears, and mammograms ▶ Limited mental health benefits ▶ Provision for actuarial equivalent package of benefits states that employers may offer plans that do not meet minimum standards as long as the employer contribution is actuarial equivalent to what would be provided under the basic plan. Basic services must still be covered without limits on scope and duration, except as specified in the basic plan, but the level of cost-sharing can be adjusted.	▶ Inpatient hospital services ▶ Nursing facility services ▶ Home health services ▶ Hospice care ▶ Medical and other health services and professional medical services furnished by health care professionals who are authorized to provide such services under State law (includes limited mental health services) ▶ Prescription drugs and biologicals ▶ Preventive health services, including prenatal and postnatal care and preventive care for children ▶ Home and community-based services for specified, qualified individuals	▶ Insurers must offer 2 plans: A Basic Plan includes inpatient and outpatient hospital and physician care; diagnostic services; prenatal, well-baby and well-child (thru age 6) care; pap smears, mammograms and colorectal screening. A Standard Plan includes the above benefits plus limited outpatient psychotherapy and counseling.	▶ Same as Medicare, except no day limit for children and full maternity coverage ▶ Medicare also expanded to include colorectal screening, some immunizations, well-child care, and mammograms.
Role of Managed Care	▶ National standards developed for the promotion of managed care and gives favorable treatment of managed care plans; preempts State legislative barriers to managed care. Businesses with fewer than 30 employees are given guaranteed access to managed care	▶ None specified	▶ Within two years after enactment, HHS would promulgate requirements for certification for managed care and utilization review programs. ▶ States would be limited immediately in their authority over those programs.	▶ None specified
Coverage	▶ Certification of coverage is required to receive health care services and other benefits provided or sponsored by the government (eg food stamps, loans) or to claim an individual as	▶ Automatic enrollment at time of birth or at time of lawful resident status or immigration ▶ NHI card issued ▶ Residents, citizens, nationals and	▶ Business may require a minimum period of service before worker is eligible for coverage. ▶ No eligible employee, spouse, or dependent may be excluded from coverage	▶ Business may require a minimum period of service before worker is eligible for coverage. ▶ No eligible employee, spouse, or dependent may be excluded from coverage

Mitchell (S.1227)
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Coverage (Cont'd)	- a personal exemption for tax purposes - Coverage under public program is phased-in for children and pregnant women first, followed by employees sponsored by their employers, and finally others not covered	lawful resident aliens of US eligible	once minimum service requirements have been met.	once minimum service requirements have been met.
Adminis- tration	- A single State agency must be designated to administer AmeriCare. - A State may join others to implement a regional administration of the plan for AmeriCare or may choose to have Secretary of HHS administer the program or choose an agency to do so - Federal payment to States includes a supplement, phased out over 7 years, for administering the program	- Administered by HCFA, through the use of offices in each State - States may request and be granted right to administer program - Secretary will establish a national and state health budget that will specify total expenditures and allocations	The plan will be regulated or certified by state regulatory authorities or the Secretary of HHS	All small group standards to be established by the Secretary of HHS and enforced by HHS
Financing	- Employer contributions - Premiums and cost sharing collected from enrollees - Establishes Americare Trust Fund from which payments will be allocated - Financed through States with matching funds from the Federal government	- Program funded from earmarked taxes and general revenues - States must contribute a sum equal to their current outlays for health care (adjusted annually) and a product of the number of state residents multiplied by 7.083 - Increases top corporate income tax	Up to 15 states may receive grants not to exceed \$10 million per state to fund small employer health purchasing programs.	Not specified
Provisions for Mental Health Services	- Inpatient hospital care for a mental disorder for not less than 45 days/year - Outpatient psychotherapy and counseling for a mental disorder for not less than 20 visits/year provided by a provider who is acting within the scope of State law. Clinical psychologists explicitly included.	45 days/year of inpatient hospital care and 20 visits/year of outpatient psychotherapy and counseling - Inpatient care includes reimbursement for professional care provided by a physician or clinical psychologist operating within the scope of their practice - Outpatient psychotherapy can be provided by a physician, clinical psychologist, clinical social worker, an equivalent mental health professional, or a clinic or center providing duly licensed or certified mental health services	- Mental Health care included in only one of the two plans (the Standard plan). - Limited outpatient psychotherapy and counseling (up to 20 visits) at 50% copay. - Inpatient hospital care not to exceed 45 days.	Mental health services offered under Medicare must be paid to beneficiaries under the plan
Cost Sharing	- Maximum cost sharing for full-time employees is 20 percent of the premium - Limit on deductibles of \$250 for an individual or \$500 for a family	Prohibits coinsurance, deductibles, and copayments applicable to covered benefits	- Insurers may impose cost sharing for the basic plan, and must include an out-of-pocket limit (amount unspecified). - For the Standard Plan, employee premium costs are limited to 20% (50% for part-time	- None for preventative services or inpatient hospital care for children. Other copayments limited to \$2,500 per year for individuals and \$3,000 for families. - Deductibles are \$250 for individuals, and

Mitchell (S.1227)
As Introduced June 5, 1991

Cost
Sharing
(Cont'd)

- ▶ Copayments limited to 20 percent, except for:
 - outpatient psychotherapy for which a copayment may not exceed 50 percent
 - preferred provider arrangements for which a higher copayment can be charged for non-participating providers
- ▶ Out-of-pocket catastrophic cap (on deductibles and copayments) limited to \$3000 per family or 10 percent of total wages
- ▶ Other poverty-level provisions

Cost
Containment

- ▶ Development of outcomes research and practice guidelines for mental health services, including at least the diagnosis and treatment of childhood attention disorders and manic depression
- ▶ Provisions for research of appropriate and efficient use of technology
- ▶ Grants awarded to States for the development and implementation of programs for medical malpractice reform

Provider
Reimbursement

- ▶ AmeriCare reimburses using Medicare payment rates
- ▶ A health benefit plan may establish a different level of payments for reimbursement for different health care providers (as do network and managed care plans). An employer may also establish a fee schedule or other basis of payment that is different from actual charges as long as the payment is sufficient to ensure an adequate level of access to services without additional out-of-pocket expenses for covered services (except for copayments and deductibles permitted).
- ▶ Businesses with fewer than 100 employees which did not provide coverage in the

Russo (H.R. 1300)
As Introduced March 6, 1991

- ▶ Expenditure level is set according to the level of expenditures in the 1992 GNP adjusted by growth in GNP

- ▶ Payment to hospitals and nursing home facilities will be based on an annual, prospective, and global budget for operating expenses of the institution
- ▶ Payment for other facility-based services, including home health services, hospice care, home and community-based services, and facility-based outpatient services will be based either on a budget or fee schedule, as selected by the facility for each reimbursement period
- ▶ Payment for physicians' and other professional services will be based on a fee schedule which is based on a National Relative Value Scale and which varies reimbursement based on the relative value of input factors, the

Bentsen (S.1872)
As Introduced October 24, 1991

- workers), deductibles to \$400 (or 1% wages) per individual and \$700 (2%) per family, and copayments to 20% (possibly higher if non-participating provider is used).
- ▶ 50% copayment for all Mental Health services
- ▶ Out of pocket limits are \$3,000 or 10% of wages.

- ▶ A Commission would be established to report on trends in costs and spending and make recommendations for cost containment.
- ▶ The Commission will also make recommendations to HHS for the development and ongoing review of standards for managed care plans.

- ▶ By January, 1993, HHS must report to Congress on the feasibility and desirability of using Medicare rules for reimbursement.

Rostenkowski (H.R.3626)
As Introduced October 24, 1991

\$500 for families, except for preventative services

- ▶ Establishes a Health Care Cost Containment Commission with 11 members appointed by the President to report annually on health costs

- ▶ HHS would set optional payment rates for hospital, physician and other health items and services based on Medicare rates.
- ▶ Payers would have the option of using those rates.
- ▶ Providers would be required to accept the rates as payment in full or risk civil monetary penalties

Mitchell (S.1227)
As Introduced June 5, 1991

Provider
Reimburse-
ment
(Cont'd)

- preceding year are eligible to provide coverage under which providers are paid at rates based on Medicare rates for a period of up to 5 years
- ▶ Establishes an independent agency in the Executive Branch called the Federal Health Expenditure Board which will convene and oversee negotiations between providers and purchasers of care to develop payment rates and to achieve expenditure goals, establish recommended payment levels, develop goals for states and regions, establish uniform billing and claim forms and mandatory reporting requirements, recommend rates and budgets, and other functions including adjustments to the DRG payment rate and RBRVS. Rates established are not binding to providers and purchasers unless agreed upon by the majority of the Board.

Choice of
Providers

- ▶ Health benefit plans are not required to utilize any health care provider to provide the minimum basic services required that were provided by the plan before the effective date except for clinical psychologists after the end of the 5 year period beginning on the effective date of this Act. This provision does not apply to plans offered to small businesses.
- ▶ If an employer offers only managed care plans, and an employee elects to utilize an out-of-plan provider, the plan may require cost sharing that may not exceed 200 percent of

Russo (H.R. 1300)
As Introduced March 6, 1991

- geographic location to the extent it affects input prices, and the national health budget. The PPRC will be renamed the Professional Payment Review Commission and will be responsible for advising HCFA on the fee schedule
- ▶ Payment for other items and services not described will be made on the basis of fee schedules, and will be reviewed by the newly established General Health Care Payment Review Commission
 - ▶ ProPAC will advise the Secretary concerning the approval of budgets and to make recommendations on how the budget process can be modified to best meet the objectives concerning global budgets and fee schedules. The membership of ProPAC will increase as necessary to include representation of nurses and other health professionals whose services are paid for on the basis of a relative-value fee schedule
 - ▶ Establishes a LTC Payment Review Commission which will advise the Secretary concerning the payment amounts for home health, hospice, and home and community-based services
 - ▶ Prohibits balance billing
 - ▶ Establishes a system based on the standardized electronic cost reporting format for the reporting by hospitals and other providers of service
 - ▶ Allow the use of competitive bidding procedures to contract out the processing of claims

- ▶ Full freedom of choice

Bentsen (S.1872)
As Introduced October 24, 1991

- ▶ For standard plan, mental health care is included and consumers may choose between physicians, psychologists, and other duly licensed or certified providers
- ▶ The basic plan does not mention provider choice

Rostenkowski (H.R.3626)
As Introduced October 24, 1991

- ▶ Not specified

	Mitchell (S.1227) As Introduced June 5, 1991	Russo (H.R. 1300) As Introduced March 6, 1991	Bentsen (S.1872) As Introduced October 24, 1991	Rostenkowski (H.R.3626) As Introduced October 24, 1991
Choice of Providers (Cont'd)	the normal cost sharing imposed under the plan or 200 percent of the cost sharing permitted under the minimum plan established.			
Employer Requirements	Employers are required to enroll employees and their families in a qualified health benefit plan or make a contribution for enrollment of individuals in the Americare program.	- Employer sponsored insurance eliminated 7.5 percent payroll tax - Corporate income tax increases 4 percent for most profitable firms	Small employers must guarantee eligibility and renewability.	- Small employers must guarantee eligibility, issue, and renewability - The health plan must satisfy rating requirements
Impact on Medicare and Medicaid	- Medicaid is replaced by AmeriCare - Impact on Medicare will be more clear when proposals for long-term care are announced	Benefits under Medicare, Medicaid, FEHBP, and CHAMPUS are replaced	- Medicare would be expanded to include colorectal screening, certain immunizations, well-care (thru age 6), and mammograms. - Demonstration projects would address additional preventative services.	Medicare expanded to include certain prevention services (see "Benefits" above)
Insurance Reform	- Federal standards will replace State standards - Plans may not discriminate based on health status, claims experience, receipt of care, medical history, or lack of evidence of insurability - Ensures access through provisions which require guaranteed issue and guaranteed renewability at current rate of issue - State consortia are developed which are responsible for enrolling all small share health insurance companies in the state as members of the consortium	Private insurance no longer available for benefits covered under public program	- Any insurer offering small employer coverage in a state must meet state standards to guarantee availability - Insurers may terminate or deny renewal only on the basis of nonpayment, fraud, misinterpretation, or failure to maintain minimum participation rates - Minimum participation rates must be uniformly applied to similarly sized employers - Pre-existing conditions would be limited to 6 months	- All small group carriers must register with HHS and the insurance commissioner - State mandates preempted - A uniform claims form would be implemented - Excise taxes imposed on insurers who fail to meet the benefits requirements or general requirements.
Provisions for Small Business	- Deductible for health insurance costs for self-employed individuals is increased from 25 percent to 100 percent - New small business can meet requirements by making a contribution at a rate that is half of the rate otherwise required for the first 2 years in which the employer has been an employer - Small employers are guaranteed issue of health benefit plans offered by an insurer to other small businesses in the community	None specified	None specified	Over a period of 4 years, the current 25% self-employed health tax deduction would be increased to 100% and made permanent

Mitchell (S.1227)
As Introduced June 5, 1991

- Quality Assurance
 - ▶ Establishes a quality improvement board responsible for recommending measures for continuous quality improvement
 - ▶ Board is also responsible for periodically reviewing the performance of health care service providers
- Role of Case Management
 - ▶ Establishes various cost management initiatives including case finding and the coordination of social and support services

Russo (H.R. 1300)
As Introduced March 6, 1991

- ▶ Outcomes research and practice guidelines recently incorporated into Medicare are applied to entire national health care system
- ▶ None specified

Bentsen (S.1872)
As Introduced October 24, 1991

- ▶ None specified
- ▶ None specified

Rostenkowski (H.R.3626)
As Introduced October 24, 1991

- ▶ None specified
- ▶ None specified

Consortium for Citizens with Disabilities

December, 1992

THE CONSORTIUM FOR CITIZENS WITH DISABILITIES HEALTH TASK FORCE

PROBLEMS AND SAFEGUARDS FOR PEOPLE WITH DISABILITIES IN MANAGED CARE

The CCD Health Task Force "Principles for Health Care Reform from a Disability Perspective" were developed to assess the ability of various major health care reform measures to meet the needs of people with disabilities. Since many reform proposals utilize some form of managed care, the CCD has applied these principles and identified a number of major problems in managed care systems.

This document identifies these problems and makes recommendations to improve the ability of managed care systems to better meet the needs of people with disabilities. The CCD believes that it is critical for health care policy makers to recognize that there are at least 43 million Americans with disabilities and a large number of others with special health care needs. This includes individuals of all ages with physical and mental impairments, conditions or disorders, that are severe, acute, or chronic and limit or impede their ability to function.

Problems with/Recommendations for Improvement

- I. Managed care systems often include financial incentives to restrict access, limit or deny care, or provide poor quality care. This is especially detrimental to children and adults with disabilities and those with special health care needs.
 - A. Capitated managed care systems must have the flexibility necessary to permit primary care physicians to refer participants with disabilities to specialists without being financially penalized.
 - B. Primary care physicians in managed care plans must be adequately compensated and not placed at inordinate financial risk.
 - C. Methods for ensuring the financial solvency of managed care entities, particularly capitation models, must be considered. These may include financial solvency requirements for HMOs, mandatory reinsurance, state reinsurance for Medicaid managed care programs, stop-loss coverage, and mandatory capitalization requirements.
- II. Managed care systems often do not include the array of comprehensive health related services needed by children and adults with disabilities.
 - A. Managed care programs must offer a comprehensive benefits package that meets the needs of people with disabilities and special health care needs. This includes such basic benefits as prescription drugs, rehabilitation services, durable medical equipment, such as wheelchairs and other assistive technology, and mental health services.
 - B. Managed care programs must not include disincentives, financial or otherwise, to the provision of services in home and community-based settings when appropriate.
 - C. Specific services should be provided not only to treat acute and chronic conditions but also to promote and maintain health and optimum functioning and prevent deterioration and secondary complications.

- III. Managed care systems often have limited experience in providing comprehensive services to children and adults with disabilities because of a systemic emphasis on primary care. This leads to limited access to needed specialized services, delays in services, and a lack of continuity of care needed by children and adults with disabilities.
- A. Managed care systems must offer people with disabilities and special health care needs the option of having a specialist as their "gatekeeper" in the system. This specialist would provide both necessary specialized care (at the specialized rate) and primary care (at the lower primary care reimbursement rate).
 - B. Managed care entities must have specific limits on waiting times for first appointments and for speciality referrals. To assure geographic accessibility of services, there must also be established standards on travel times and distances to both primary and specialized services.
 - C. Managed care systems must be structured to ensure continued, appropriate access to health and health-related services for children and adults with disabilities.
- IV. Managed care systems lack adequate quality assurance mechanisms, as well as effective grievance policies and procedures designed to ensure access to appropriate health services.
- A. Managed care systems must provide participants with clear information on policies, procedures, and grievance mechanisms and must ensure consumer participation in the establishment of such procedures. All reviews must be conducted in a timely manner. An independent ombudsman program should be required.
 - B. Managed care systems should be required to provide health care service in accordance with nationally accepted prevention and treatment protocols, e.g. protocols for prenatal care, well-baby care, and childhood immunization schedules.
 - C. Managed care systems must have in place timely procedures for obtaining independent second opinions when covered benefits are denied for any reason, including a judgement that they are not "medically necessary" or when a consumer challenges the appropriateness of a proposed treatment. These second opinions must be considered in any grievance review.
 - D. Managed care systems must include the option to disenroll for those participants who are not receiving adequate and timely services.
 - E. Managed care programs must have strict quality assurance provisions that require internal and external audits by independent assessors and the results of these audits should be available to consumers to assist them in choosing a managed care program. Outcome reviews should be a component of this process.
 - F. Additional protections which must be included are satisfaction surveys of enrollees and disenrollees, including current and former providers.

For additional information contact: Co-Chairs of the CCD Health Task Force
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National Rehabilitation Caucus

*A national focus for the advancement of rehabilitation . . .
through advocacy, education, research and communications*

MEDICAL REHABILITATION: AN ESSENTIAL COMPONENT OF HEALTH CARE

A POSITION PAPER

DEVELOPED BY

THE FOLLOWING PARTICIPANTS OF THE NATIONAL REHABILITATION CAUCUS

American Academy of Physical Medicine and Rehabilitation; American Association for Respiratory Care; American Congress of Rehabilitation Medicine; American Occupational Therapy Association; American Pain Society; American Physical Therapy Association; American Speech-Language-Hearing Association; National Association for the Support of Long Term Care; National Association of Medical Equipment Suppliers; National Association of Rehabilitation Agencies; National Association of Rehabilitation Facilities; National Committee to Preserve Social Security and Medicare; National Head Injury Foundation; National Stroke Association; Private Practice Section, American Physical Therapy Association

AND

THE FOLLOWING NATIONAL PROVIDERS OF REHABILITATION SERVICES

Communi-Care of America, Inc.; Comprehensive Rehabilitation of America, Inc.; Continental Medical Systems, Inc.; HEALTHSOUTH Rehabilitation Corp.; NovaCare, Inc.; Pro-Rehab, Inc.; RehabClinics, Inc.; Rehabworks, Inc.

JANUARY 1993



National Rehabilitation Caucus

A national focus for the advancement of rehabilitation . . .
through advocacy, education, research and communications

EXECUTIVE SUMMARY

The National Rehabilitation Caucus -- a coalition of organizations representing rehabilitation providers, suppliers and consumers -- in association with various national providers of rehabilitation services, have prepared this statement to voice their support for health care reform and to remind Congress, the Administration and the American public that rehabilitation is an essential, cost-effective component of the U.S. health care system which must be preserved. The benefits of rehabilitation are compelling:

- **Rehabilitation services improve people's lives and productivity** -- The purpose of rehabilitation is to ameliorate physical and cognitive impairments resulting from illness or injury, and to restore or improve functional ability so that individuals can return to work and lead independent and fulfilling lives. Over 80% of those treated return to their homes, work, schools or active retirement. - MAIN TAIL
P. 10
- **Rehabilitation services are cost-effective** -- Rehabilitation services are an investment in human capital. The ability of rehabilitation to significantly reduce the cost of future care has been verified in a number of studies and surveys conducted by the insurance industry over the past several years. For example, a survey conducted by the Health Insurance Association of America (HIAA) of member companies reported a savings of \$11 for every \$1 spent on rehabilitation, with "a savings per claimant ranging from \$1,500 to over \$250,000."
- **Rehabilitation outcomes can be measured** -- The primary focus of the rehabilitation field is on functional outcomes. Persons who participate in medical rehabilitation programs have lower mortality rates, require less skilled nursing care, and are hospitalized less frequently. A 1981 study found that each stroke patient, who through rehabilitation has a reduced exposure to lengthy nursing home stays, can save the American economy \$17,000 per year.
- **Rehabilitation services are provided to over four million Americans each year** -- At any given time, thirteen percent of the U.S. population and nearly half of Americans over 75 require rehabilitation in one form or another.

As the prospect of health care reform grows nearer, so does the opportunity to maximize the quality and productivity of American lives by strengthening the role of rehabilitation in the delivery and financing of health care in this nation. Towards this end, the following points must be addressed regardless of the health care model -- managed competition, single payor, etc. -- ultimately adopted by Congress.

RECOMMENDATIONS

COVERAGE:

- Standard benefits packages available through both public and private health insurance programs must continue to include the full range of rehabilitation services (including therapeutic, restorative and preventive services) which significantly ameliorate patient conditions or reasonably improve functional status. The range of benefits covered by Medicare, plus preventive services and other enhancements, represents a good starting point.
- Rehabilitation services should be covered in every setting deemed appropriate based upon the person's functional status as determined by a qualified rehabilitation professional. Services must be available in a continuum of inpatient and outpatient settings, including community-based facilities and the offices of non-physician and physician practitioners.

ACCESS:

- Barriers to rehabilitation services must be removed. For example, health insurance exclusions and waiting periods based on preexisting conditions should be eliminated because they discourage persons with disabilities from changing jobs or re-entering the work force following a medical absence.

COST CONTAINMENT:

- The cost-effectiveness of rehabilitation services should be recognized, and payment for such services should be reasonable and adequate to ensure quality of care for beneficiaries.
- Health care reform must address and curtail unnecessary increases in health care costs, without imposing blanket and arbitrary limits.
- With respect to cost containment methodologies, specific provisions must be made to ensure that the data on which such payments are based are updated in a timely and accurate manner to reflect market conditions.

PAYMENT POLICY:

- Payment for rehabilitation services and items should be linked directly and fairly to the amount, duration and scope of services delivered, and should not be "bundled" with the payment of other services if, in so doing, the full extent of services needed by individuals is compromised.

- To ensure access to rehabilitation services, payment should be at a sufficient level to attract and retain enough rehabilitation providers to meet present and future demands for such services.
- Payment should reflect variations in geographic location (regional, rural, inner city), treatment intensity (impairment, patient acuity, treatment efficacies) and resource availability (staffing shortages).
- Payment proposals must afford an opportunity for provider input, establish procedures for provider grievances, and protect against retroactive rate-setting and payment inequities.

GOVERNANCE:

- Congress should not abdicate complete responsibility for defining a basic benefits package available to all Americans. It must recognize the need to maintain coverage of rehabilitation services. If there is a national health board, Congress must direct it to include coverage of rehabilitation services as part of the basic benefits package.

RELATIONSHIPS WITH EXISTING PUBLIC PROGRAMS:

- Because even modest Medicare reforms could significantly improve the cost-effectiveness of medical rehabilitation, efforts to upgrade and enhance the rehabilitation benefits of Medicare must be continued.
- Reform measures which eliminate or radically alter the Medicaid program must protect the coverage rights of individuals eligible for Medicare and/or Medicaid.

LONG TERM CARE:

- Securing and paying for long term and continuing care represent a crisis for many American families and individuals. Congress must provide the leadership in addressing these issues.
- Proposals which dismantle the current Medicaid law and continue it as a long term care program for the indigent require careful scrutiny to avoid the disruption of specialized health care delivery systems for people who are indigent, frail or chronically impaired.

MEDICAL REHABILITATION: AN ESSENTIAL COMPONENT OF HEALTH CARE

The National Rehabilitation Caucus -- a coalition of organizations representing rehabilitation providers, suppliers and consumers -- in association with various national providers of rehabilitation services, have prepared this statement to voice their support for health care reform and to remind Congress, the Administration and the American public that rehabilitation is an essential, cost-effective component of the U.S. health care system which must be preserved.

I. A PRIMER ON MEDICAL REHABILITATION

What are Medical Rehabilitation Services?

Medical rehabilitation refers to the range of skilled services provided to individuals in order to minimize physical and cognitive impairments, maximize functional ability and restore lost functional capacity. Rehabilitation enhances the independent physical, cognitive and social function of persons who become disabled as a result of trauma or disease, by helping them develop new ways to accomplish daily tasks. Medical rehabilitation is most effective in improving, restoring or maintaining function when applied during the acute stage soon after the trauma has occurred or the disease has been detected. Rehabilitation professionals provide services to consumers on a one-to-one basis. Each person is individually assessed, and a treatment plan is tailored to meet patient-specific goals. Treatment is evaluated both during and after delivery of services, and success is measured based upon the person's attainment of the pre-established functional goals. Continued support is provided following discharge.

Who Benefits from Medical Rehabilitation Services?

Over four million people receive rehabilitation services annually. Common conditions necessitating rehabilitation are: heart attack or stroke; arthritis, cancer or a neurological disorder; joint replacements or amputation; sensory deficits and/or chronic intractable pain; traumatic accident; debilitating illness; chronic pulmonary disease; as well as congenital or developmental impairments. Over 80 percent of people receiving rehabilitation services return to their homes, work, schools, or active retirement. Thirteen percent of the population overall and nearly half of the population over 75 have some limitation on activities of daily living as the result of a chronic condition. Currently, within the population of individuals who are 18 to 69 years old, 11.5 percent (or 17.4 million persons) report some degree of limitation in working at a job due to a chronic health condition. Of these individuals, approximately 10 million report being unable to work at all. By minimizing the effects of these limitations, rehabilitation can dramatically improve the quality of life for these individuals and eliminate the need for countless hours of care. Yet, the advantages of

rehabilitation do not end at the workplace. Rehabilitation services provide significant support to the elderly. Relevant data show that 75 percent of strokes, 70 percent of amputations and 80 percent of hip fractures occur in persons over the age of 65.

Why are Rehabilitation Services Important?

Rehabilitation services are an investment in human capital. They are important for the following reasons:

- ***Rehabilitation services effectively ameliorate patient conditions, improve function, and facilitate dignity and independence in life.*** Coverage of rehabilitation services in a continuum of settings optimizes the nation's health care investment by focusing on remediation of disability and restoration of functional capacity. Rehabilitation services are efficacious in preventing complications and subsequent re-hospitalization. Rehabilitation can help people adapt to a physical challenge and lead a more independent life.
- ***Rehabilitation services are cost-effective.*** The economic benefits of returning younger recipients of rehabilitation services to productive careers is obvious. Rehabilitation services for the elderly are equally cost-effective insofar as they prevent complications and the need for further hospitalization, which can be very costly. The reduction of health care costs attributable to rehabilitation has been demonstrated by a number of studies and surveys conducted by the insurance industry.
- ***Rehabilitation services outcomes can be measured.*** The primary focus of rehabilitation is on functional outcomes. A study performed in 1991 found that, within a population of individuals who were rehabilitation candidates, those who participated in a medical rehabilitation program had lower mortality rates, spent less time in skilled nursing care and were less frequently hospitalized. A specific measurement scale has been developed (the Functional Independence Measure) and is widely used to determine an individual's functional abilities at admission, to document the person's progress during treatment and to measure his or her level of independence at discharge. This tool and others are being tested for use across the continuum of rehabilitation services.
- ***Rehabilitation services ensure that lives saved remain worthwhile (quality of life) and productive (help individuals return to the work force).*** Rehabilitation assures that those people whose lives are saved through medical intervention remain productive. The key to success in rehabilitation is the individual assessment of patients and the ability of qualified rehabilitation professionals to set goals for measuring progress. The need for rehabilitation

services is not limited to one particular site. To be meaningful and effective, rehabilitation must be available in a continuum of inpatient and outpatient settings, including community-based facilities and the offices of physician and non-physician practitioners.

Where are Rehabilitation Services Delivered?

Depending on an individual's diagnostic and therapeutic needs, rehabilitation services are delivered in a variety of settings, including rehabilitation hospitals, rehabilitation units in general hospitals, nursing facilities, comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies and clinics, home health agencies, home medical equipment suppliers, and by qualified independent practitioners.

Who Delivers Rehabilitation Services?

These services are provided by nearly 200,000 health care professionals drawn from a number of disciplines including physiatrists, occupational therapists, physical therapists, rehabilitation nurses, respiratory therapists, speech-language pathologists, audiologists, social workers, orthotists, prosthetists, and rehabilitation counselors, supported by a number of rehabilitation technology suppliers and suppliers of research, equipment and supported services.

II. COVERAGE OF REHABILITATION SERVICES

As Congress undertakes the daunting task of reforming the nation's health care system, it must ensure that rehabilitation is retained in the basic health care package available to all individuals. Rehabilitation is an integral part of the health care delivery system and should continue to be supported.

Coverage of Rehabilitation Services is Standard in Today's Insurance System

Rehabilitation services are a standard benefit in most health insurance packages currently offered by both public and private payers. Americans have come to expect that the range of therapies needed to improve their functional capacity and autonomy will be provided. Notwithstanding the wide diversity of health care payers in the U.S., virtually all of them cover rehabilitation therapy in one form or another. This is true in both the public and private sectors.

- ***Medicare*** -- The federal Medicare program covers occupational and physical therapy; speech-language pathology and audiology, respiratory therapy, social work services, rehabilitation nursing and psychiatry in a range of inpatient and outpatient settings. The program also provides coverage of items that are frequently essential to rehabilitation care including orthotics (splints),

prosthetics (limbs), and durable medical equipment. Providers recognized under Medicare include rehabilitation hospitals, rehabilitation units in general hospitals, rehabilitation agencies, clinics, nursing facilities, CORFs, home health agencies, home medical equipment suppliers, and independent practitioners.

- **Medicaid** -- Rehabilitation services also are widely covered within the Medicaid program. Every state Medicaid plan covers rehabilitation services when provided within a hospital (both inpatient and outpatient), nursing facility, home care, or under the Early and Periodic Screening, Detection and Treatment (EPSDT) program, since coverage of each of these benefits is mandatory under federal law. With respect to optional Medicaid benefits, rehabilitation services may be covered when provided by clinics, rehabilitation agencies, CORFs, and independent practitioners. Most states have chosen to furnish rehabilitation services in these optional settings.
- **Black Lung** -- The Black Lung Program, which provides federal assistance to coal miners and their dependents, has covered and reimbursed outpatient pulmonary rehabilitation since 1978.
- **State Mandatory Coverage Laws** -- Several states have enacted legislation mandating coverage for specific rehabilitative services. For example, Delaware and Louisiana have recently passed laws requiring coverage of physical therapy, speech-language pathology and audiology services, and occupational therapy. Rehabilitation services are mandatory in one form or another in Connecticut, Maine, Massachusetts, West Virginia, Missouri, Texas, Tennessee and Arkansas.
- **Private Insurance** -- The private health insurance industry also routinely offers coverage of rehabilitation services. While insurers may limit the number of rehabilitation visits covered or apply an annual monetary cap, very few limit coverage by specific diagnosis or clinical indication. Most plans require that rehabilitation services be ordered by a physician and furnished by providers having specific credentials. For example, many plans will cover physical therapy only if provided by a licensed physical therapist.
- **Blue Cross/Blue Shield Plans** -- Based on an informal national survey by this Coalition, it is clear that respiratory therapy, speech-language pathology services, audiology, and physical and occupational therapy services are commonly covered by the Blue Cross/Blue Shield plans in the country. In particular, while the scope of coverage varies by plan and insurance product, physical and occupational therapy are routinely covered, and speech-language

pathology services and respiratory therapy are usually covered subject to certain limitations (e.g., limited diagnoses, time periods, and/or settings).

- **HMOs** -- Coverage of rehabilitation therapy is also well-established within the HMO market. The annual HMO Industry Survey conducted by the Group Health Association of America confirms that virtually all HMOs, regardless of their federal qualification status, cover medical rehabilitation services as part of their best-selling benefit package.

Coverage In a Continuum of Settings

Coverage of rehabilitation services in a continuum of settings optimizes the nation's health care investment by focusing on remediation of disability and restoration of functional capacity. Accordingly, rehabilitation should continue to be covered in multiple settings, including hospitals, rehabilitation agencies, clinics, CORFs, nursing facilities, the home, and the offices of qualified independent practitioners. Services involving orthotics and prosthetics (limbs and splints), augmentative technology devices, equipment, and services which support home care must also be considered in addressing the continuing needs of individuals with residual disabilities. Elimination of any part of this continuum from coverage could jeopardize the recovery or improvement of rehabilitation patients, and even require further treatment in more costly settings, such as an acute care hospital.

New Technologies

In considering the scope of coverage for medical rehabilitation services, it should be recognized that consumers demand access to state-of-the-art technologies. As the survival rate improves for persons suffering from serious illnesses and injuries, the American public will increasingly demand coverage of the latest cost-effective technologies and services, especially if they are generally accepted as safe and effective by the medical community. Provision must be made so that the health benefits package established under reform measures can evolve, assuring responsiveness to both increased utilization demands and new and improved prevention and treatment approaches.

Recommendations:

- Standard benefits packages available through both public and private health insurance programs must continue to include the full range of rehabilitation services (including therapeutic, restorative and preventive services) which significantly ameliorate patient conditions or reasonably improve functional status. The range of benefits covered by Medicare, plus preventive services and other enhancements, represents a good starting point.

- Rehabilitation services should be covered in every setting deemed appropriate based upon the individual's functional status as determined by a qualified rehabilitation professional. Services must be available in a continuum of inpatient and outpatient settings, including community-based facilities and the offices of non-physician and physician practitioners.

III. ACCESS TO REHABILITATION SERVICES

Consumer Demand

A 1992 survey conducted by the Washington Business Group on Health queried member companies about the composition of any standard health benefits package that might result from health care reform. Over two-thirds of the respondents identified rehabilitation services as a benefit that should be available to all individuals covered under a basic health plan. Yet, while rehabilitation services are a common benefit to individuals in most health insurance plans, access to affordable insurance is difficult for those with histories of chronic impairments. Eliminating the exclusions and waiting periods based on preexisting conditions, as well as modifying the underwriting methodologies for medical risks would go a long way toward assuring that individuals with limitations in their activities of daily living will be able to obtain and retain insurance coverage. Furthermore, improving insurance portability would go a long way toward facilitating workplace re-entry for individuals who, as a result of rehabilitation, have regained lost skills and can return to the workplace. Unfortunately, many find that their old jobs have been filled, forcing them to start over again in seeking productive employment.

Recommendation:

- Barriers to rehabilitation services must be removed. For example, health insurance exclusions and waiting periods based on preexisting conditions should be eliminated because they discourage persons with disabilities from changing jobs or re-entering the work force following a medical absence.

IV. REHABILITATION CONTAINS COSTS

Rehabilitation Services Are Cost-Effective and Bring Value

Expenditures made for rehabilitation services are investments in human capital. Rehabilitation intervention to remediate functional impairment caused by illness, disease or injury results in a reduction in the cost of care. This has been verified in a number of studies and surveys conducted by the insurance industry over the past several years. For example, a survey conducted by the Health Insurance Association of America (HIAA) of member companies reported a savings of \$11 for every \$1 spent on rehabilitation, with "a savings per claimant ranging from \$1,500 to over \$250,000." Other studies have confirmed

that early rehabilitation for stroke and traumatic brain injury lead to shorter overall hospitalization, less mortality and fewer complications, that comprehensive rehabilitation programs are effective in treating low back pain, and that pulmonary rehabilitation reduces expensive rehospitalization and emergency room visits.

Why Rehabilitation Services are Cost-Effective

Rehabilitation services are viewed as cost-effective for the following reasons:

- ***Medical rehabilitation services return patients to productive lives*** -- Medical rehabilitation is widely acknowledged as one of the most effective forms of prevention for survivors of serious illness, disease and injury. Through rigorous physical, social and cognitive restoration programs, rehabilitation prevents these survivors from becoming persons with permanent or long-term disabilities. It assures that any residual impairment does not become a disability affecting an individual's activities at work, home, school or play.
- ***Medical rehabilitation prevents recurrence*** -- Rehabilitation is also well known for its efficacy in preventing complications and subsequent re-hospitalization, which can be very costly. For example, rehabilitation helps prevent deep vein thrombosis, cardiac involvement, pressure ulcers, contractures, pulmonary emboli, and emotional dependence and depression.
- ***Medical rehabilitation speeds recovery*** -- Several studies have shown that stroke patients who receive medical rehabilitation have better outcomes than those who do not. Additionally, these studies indicate that stroke rehabilitation patients are more likely to be discharged to home than to a nursing home. They are also likely to live longer and are more likely to retain a higher level of function and activity. A 1981 study found that each stroke patient who, through rehabilitation, has a reduced exposure to lengthy nursing home stays can save the American economy \$17,000 per year.
- ***Medical rehabilitation maximizes the restoration of functional capacity*** -- Rehabilitation can help consumers adapt to a physical challenge and lead a more independent life. To understand the impact of rehabilitation, it can be helpful to consider a daily example: a consumer's ability to dress independently. Many older spouses and family members do not have the physical strength required to assist a loved one in this daily routine. The consequences of employing a nurse or aide to assist in this daily process can be costly and discouraging. In a study of 329 rehabilitation patients, 245 required total or maximum assistance to dress on admission. At discharge, 156 required only a minimal level of assistance. If we assume that helping someone dress requires half an hour a day, then the improvement of 156

patients to require only a minimal level of assistance (which could be provided by a spouse or family member) would save 28,470 hours per year. If a minimum wage of \$4.25 applied to each individual needed to help a person dress, an annual savings of \$120,997 could be realized. Similar logic can be applied to the savings that result from a rehabilitation patient's attaining independence in other areas of daily life. These include independent locomotion and the management of bladder skills, which can reduce the risk of infection and the need for further medical intervention.

- ***Preventive rehabilitation improves workplace productivity*** -- The benefits of rehabilitation do not begin only with the occurrence of an injury, rather they start with injury prevention in the workplace. Through workplace prevention, rehabilitation saves countless health care dollars as well as lost hours of productivity. Some rehabilitation professionals specialize in working with employers to examine work sites, identify hazards and eliminate the potential for work-related injuries. The Public Health Service estimates that in 1989 there were 192 cases of cumulative traumatic disorder (just one kind of work-related injury) per 100,000 workers. These disorders affected workers who engaged in repeated wrist-twisting motions, from computer users to meat cutters to grocery store check-out clerks. The proactive involvement of rehabilitation professionals in the workplace can help reduce the incidence of these cumulative traumatic disorders through the modification of work stations, the analysis and improvement of the motions used in work (particularly in repetitive working situations) and by coaching good lifting techniques. These precautions help prevent workplace injuries and the need for more major medical intervention.

Recommendations:

- The cost-effectiveness of rehabilitation services should be recognized, and payment for such services should be reasonable and adequate to ensure quality of care for beneficiaries.
- Health care reform must address and curtail unnecessary increases in health care costs, without imposing blanket and arbitrary limits.
- With respect to cost containment methodologies, specific provisions must be made to ensure that the data on which such payments are based are updated in a timely and accurate manner to reflect market conditions.

V. REIMBURSEMENT FOR REHABILITATION SERVICES

Cost Containment Initiatives Must be Carefully Structured

Health care reform must contain adequate provisions to curtail unnecessary increases in health care costs. Whatever approach or approaches are adopted, they must ensure that the resources for rehabilitation services increase with the demand for rehabilitation services. Given the cost-effective nature of rehabilitation services, we are concerned that a blanket or all-inclusive cost containment strategy could be a "penny wise and pound foolish." Some of the "global budgeting" approaches being discussed are of particular concern to us. Cost containment policies are most effective when they are targeted. In developing containment approaches, geographic variations (regional, rural, inner city), variations in treatment intensity (impairment, patient acuity, treatment efficacies) and resource variations (staffing availability) need to be considered. Blanket and arbitrary approaches have proven to be counterproductive. This concern regarding arbitrary payment systems is not limited to direct payment arrangements with rehabilitation providers. Bundling of rehabilitation payments with payments for other services - in either a fee-for-service or managed care environment - must be avoided if it compromises the amount, duration and scope of rehabilitation services provided to individuals who need them.

Realistic Reimbursement

The following principles should be observed in reforming payment arrangements relating to rehabilitation services.

- ***Payment should be linked directly to the amount, duration and scope of services delivered*** -- Payment systems that do not recognize the tremendous variation in the needs of individual consumers could severely and adversely affect the quality of services delivered.
- ***Payment must be based on individual needs regardless of setting*** -- Quality and cost-effective care can be delivered in a continuum of settings. The rehabilitation continuum is necessary to meet a broad spectrum of consumer needs. Patient acuity and the intensity of the service necessary to assure improvement in functional conditioning should be addressed in payment methodology.
- ***Payment should be sufficient to guarantee adequate capital formation to provide for future access to rehabilitation services*** -- Payment policy should be attractive to guarantee an adequate supply of providers. While overly generous payment levels discourages efficiency, inadequate payments will lead to access problems in both the short and long term.

Recommendations:

- Payment for rehabilitation services and items should be linked directly and fairly to the amount, duration and scope of services delivered, and should not be "bundled" with the payment of other services if, in so doing, the full extent of services needed by individuals is compromised.
- To ensure access to rehabilitation services, payment should be at a sufficient level to attract and retain enough rehabilitation providers to meet present and future demands for such services.
- Payment should reflect variations in geographic location (regional, rural, inner city), treatment intensity (impairment, patient acuity, treatment efficacies) and resource availability (staffing shortages).
- Payment proposals must afford an opportunity for provider input, establish procedures for provider grievances, and protect against retroactive rate-setting and payment inequities.

VI. GOVERNANCE

A National Health Board Should Not Have Unbridled Discretion

There are several proposals to establish a national health care board whose authorities may vary from defining a universal benefits package, to assessing technology, to establishing global health care budgets. We believe that if a national health board is established, its mission, goals, and statutory authority must specifically recognize that rehabilitation is an essential component of health care services. While we recognize that both the prospect and design of such a board is in its infancy, there are several key points which must be emphasized:

- A national health board's mission should include a strong directive to include rehabilitation services as a necessary component of our health care system.
- Membership on the board must include at least one individual with disabilities. This representation should be required by law.
- Rehabilitation professionals and providers should have representation on the board.
- Support should be provided to applied research in rehabilitation and the transfer of practice improvements.

Due to the demand for the highest quality of life, advances in medical technology, the specialization of emergency medicine and the increase in our elderly population, more people than ever before are candidates for rehabilitation treatment, making it one of the fastest growing areas of medicine. This high level of interest in disability issues is evidenced by the mandates of the Americans with Disabilities Act of 1992. If a national health board is given authority to evaluate technology and quality assessment of health care treatment, the effectiveness of rehabilitation services should not be overlooked. Indeed, because of its effectiveness, the field of rehabilitation not only deserves the board's full support with respect to national health coverage, its role in the U.S. health care system should be expanded through the development of practice guidelines and standards based on outcomes and effectiveness.

Recommendations:

- Congress should not abdicate complete responsibility for defining a basic benefits package available to all Americans. It must recognize the need to maintain coverage of rehabilitation services. If there is a national health board, Congress must direct it to include coverage of rehabilitation services as part of the basic benefits package.

VII. MEDICARE AND MEDICAID

Importance of Medicare

Several health care reform proposals would preserve Medicare as a separate and distinct program. We applaud this differentiation of Medicare as a social health insurance program providing valuable and deserved uniform coverage of a standardized health benefit to the 36 million aged and disabled beneficiaries. In protecting the rights of Medicare eligible individuals, we call upon Congress to continue efforts to upgrade and enhance the rehabilitation benefits available through this program. While Medicare already covers a broad range of rehabilitation services within its existing benefit structures, the effectiveness of these services could be greatly improved through modest reforms in such areas as: coverage criteria (e.g., Part B coverage of respiratory services in nursing facilities); medical review criteria (e.g., recognition of additional qualifying diagnoses for rehabilitation hospitals); payment policies (e.g., update outdated salary equivalency guidelines for physical and respiratory therapy services when provided under arrangement and outdated TEFRA guidelines, and remove arbitrary payment caps on outpatient physical and occupational therapy services); and program administration (e.g., further decoupling of orthotics and prosthetics (limbs and splints) from durable medical equipment.)

Protect Dually Eligible Beneficiaries

The effectiveness of Medicare is significantly augmented by Medicaid. For many Medicare beneficiaries who are indigent or medically needy, Medicaid is the safety net which protects their eligibility. Reforms which eliminate and/or radically transform the Medicaid program must not inadvertently remove the safety net from dually qualified Medicaid beneficiaries. Reforms need to reinforce the uniformity of Medicare coverage for Medicaid beneficiaries and to assure uniformity of benefit and reimbursement for covered services.

Recommendations:

- Because even modest Medicare reforms could significantly improve the cost-effectiveness of medical rehabilitation, efforts to upgrade and enhance the rehabilitation benefits of Medicare must be continued.
- Reform measures which eliminate or radically alter the Medicaid program must protect the coverage rights of individuals eligible for Medicare and/or Medicaid.

VIII. LONG TERM CARE

Maintain Federal Oversight of Long Term Care

Many rehabilitation services are delivered in long term care settings. Nursing facility requirements and conditions of participation for outpatient and home care providers and suppliers specify minimum performance standards and require the provision of treatment services that are responsive to individual needs. Proposals that dismantle the current Medicaid program and continue it as a long term care program for the indigent need careful scrutiny to avoid interrupting important components of our delivery system for the indigent, frail and chronically impaired. Medicaid was written to help overcome the litany of neglect which occurred through previously state-funded Kerr-Mills programs. Moreover, many aspects of current Medicaid law, especially the OBRA '87 nursing home reforms, were written to protect patients and to assure minimum program performance. Absent federal statutory requirements, care for the indigent, especially those in need of long term care services, could be significantly jeopardized. Lest history repeat itself, Congress must maintain care standards and payment requirements and not abdicate this responsibility to the states.

Recommendations:

- Securing and paying for long term and continuing care represent a crisis for many American families and individuals. Congress must provide the leadership in addressing these issues.

- Proposals which dismantle the current Medicaid program and continue it as a long term care program for the indigent require careful scrutiny to avoid the disruption of specialized health care delivery systems for people who are indigent, frail or chronically impaired.

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IMMEDIATE ASSISTANCE TO THE MEDICAID PROGRAM

Rapidly rising Medicaid costs are breaking states' budgets. Without changes in federal law and regulation to allow cost containment in some Medicaid programs, increased flexibility in financing and implementing programs, and financial assistance from the federal government, many states cannot afford to stay in compliance with federal laws and millions of people stand to lose important services. Governors know that, once adopted and implemented, national health reform may change or replace the current Medicaid program. However, until health reforms are in place, states must have cooperation and assistance from the federal government.

Through the National Governors' Association, Governors sent President Clinton a list of recommendations for changes in federal laws and policies to improve access and contain costs in the Medicaid program. From that rather lengthy list, the Governors recommend several priorities for immediate action by the President, the Congress, and the U.S. Department of Health and Human Services (HHS). Action on the following priorities can have a positive impact on state Medicaid budgets and accomplish overall cost containment without limiting access or reducing quality of services:

1. No caps for federal spending on Medicaid entitlements until another health financing system is in place.
Federal caps on medical entitlements will not cut health care costs or reduce people's need for health services. Such caps will shift costs to state and local governments that they simply cannot afford. Capping federal Medicaid entitlements will result in a loss of services for millions of people and will shift additional costs to people with private insurance.
2. Give greater leeway in containing the cost of health services and long-term care through issuing rules for the Boren Amendment.
The Boren Amendment was intended originally to allow states to contain costs for hospital and nursing home services. Because no rules were issued to guide states in implementing the law, hospitals and nursing homes sued states, and courts have interpreted the law in a manner that drives up health care costs significantly. HHS needs to issue rules for the Boren Amendment as soon as possible. In addition, legislative revisions need to be reviewed and strongly considered.
3. Allow states to manage costs in the EPSDT program through providing services within their state Medicaid plan and selecting less costly alternatives for diagnosis and treatment without risking quality.
Under current policy, states have no ability to limit the range or cost of services required in the EPSDT program. This open-ended requirement is driving up the cost of the Medicaid budget at uncontrollable rates. HHS needs to issue rules that allow states to efficiently manage case costs and utilize the least expensive alternatives for providing services without reducing the quality of care.

4. Provide fairness and flexibility in the Disproportionate Share Hospital (DSH) Program through rules and laws that will:
 - a. Modify the interpretation of the statute to allow for growth in low-DSH states without penalizing high-DSH states.
 - b. Ease restrictions on how states raise matching funds for the Disproportionate Share Hospital Program.
 - c. Give states flexibility to use disproportionate share funds in whatever way best fits the needs in serving Medicaid-eligible and other medically indigent people in their state.

When caps were set for spending on the Disproportionate Share Hospital Program, some states' share in the program was frozen at rates below the maximum spending level set for each state. Fairness requires that these low-DSH states be allowed to move up to the level of the cap for states without penalizing high-DSH states that are already at or near the cap.

Different revenue-raising measures are chosen by different states, and the federal government should not dictate to state governments how they raise their matching funds for the Medicaid program.

By allowing states to spend disproportionate share funds in whatever way will serve the most Medicaid-eligible and other medically indigent people in each state, the disproportionate share funds can be used to cover the unmet needs of the greatest number of people. The federal government can give states flexibility in using disproportionate share funds without increasing demands on the federal budget, and the flexibility will allow each state to make the best use of these dollars.

The Governors recognize the Administration is already proceeding on these and other issues relating to provider taxes and disproportionate share. We applaud this work.

5. Provide waivers to encourage or provide incentives to states to use in-home and community-based services for elderly and disabled people as a means of containing long-term care costs and providing the most appropriate services.

Medicaid laws and regulations favor institutional care by paying for services when a person is in a hospital or nursing home that would not be paid for if the person lived at home or in a community-based program. More people can be served for less money in non-institutional settings, and in-home and community-based services allow people to gain or maintain greater independence. HHS needs to expedite waivers that allow states to serve people outside of hospitals or nursing homes and to develop incentives for states to contain costs through increasing in-home and community services when this is in the best interest of the person served.

6. Expedite the waiver process so states can implement managed care systems, comprehensive demonstration projects, and limited Medicaid services in school-linked clinics.

Delays in getting waivers from HCFA have curtailed states' efforts to implement managed care as a means of cost containment and improved access. Waivers also have been delayed or denied for large demonstration projects attempting to set up comprehensive, integrated health care systems in states. School-linked clinics can offer improved access to health services at relatively low costs, and these clinics need to be Medicaid approved even if they do not offer the full range of services available in Medicaid community primary care clinics. HHS needs to respond quickly to waiver requests and to favor requests that will improve access to health care and contain costs.

Adopted February 1, 1993.



NATIONAL HEALTH REFORM AND COST CONTAINMENT

1. Introduction

The United States spends more on health care than any other industrialized nation even though fewer of our citizens have insured access to the health care system. Moreover, growth in the American health care industry has exceeded growth in the overall U.S. economy for almost every one of the last thirty years. As a result, health care expenditures represent an increasing share of the economy as measured by the gross domestic product (GDP). In 1980 health care was approximately 9.1 percent of GDP; in 1992 it represented 13.4 percent; and it is projected to represent about 17 percent of GDP by the turn of the century if current trends continue.

This phenomenal growth in costs has negatively affected government at every level and has seriously eroded the competitive edge of our businesses attempting to compete in a global marketplace.

Clearly the nation cannot sustain the current rate of growth in health care costs. If the system is expanded to include universal coverage without reform, the cost problems will be greatly exacerbated. While people may argue about the final target for an acceptable rate of growth in costs, the nation must develop a health care system that over the next several years will move growth in costs toward a long-term sustainable level.

The kinds of structural changes that must occur in the health care system to control costs cannot be effective unless and until every legal resident has health insurance. Universal access to health care is both a moral imperative and an invaluable cost containment tool.

2. Basic Federal Framework

The Governors support a managed competitive approach to health care reform that is organized by the federal government. However, attention must be paid to ensuring that the approach will work in both rural and inner-city areas. Toward that end, the federal government should establish a national health care board that includes state and local representation. Much of the framework for implementing managed competition could be accomplished by the national board.

The basic and fundamental federal framework for a restructured health care system that both controls costs and provides access and coverage must, at a minimum, include the following.

- **Universal access.** Universal access to health care coverage should be guaranteed to every American. States should have the option of providing access to health care either through public or private programs or through an employer mandated system similar to those pursued in Kentucky, Oregon, and Hawaii.
- **A standardized and federally organized information base for consumers.** The database must include price and quality information for all providers of health care services in a given geographic area.
- **Federally organized national outcomes research.** One component of such research should focus on primary and preventive care. Among other uses, this research could be used as a basis for clinical practice models.
- **Federal minimum standards for the regulation of health insurance.** These minimum standards must be developed in consultation with states and include limitations on the variation in rates that different individuals and groups charge; limitations on medical underwriting; and guaranteed renewability, portability, and availability of insurance products. States can exceed these minimum standards. These standards should apply to nontraditional insurance mechanisms, such as Multiple Employee Welfare Arrangements (MEWAs) and other ERISA plans,

and to newly formed Health Insurance Purchasing Cooperatives. Once reforms are implemented, individuals bear a personal responsibility to obtain coverage either through public or private programs. The cost of coverage would be supplemented for low-income individuals.

- **State-organized purchasing cooperatives.** Through purchasing cooperatives, affordable insurance products will be made available. States and the federal government must work together to ensure that states have flexibility in establishing and operating purchasing cooperatives within a national framework. Purchasing cooperatives should allow for public or private operation under state regulation.
- **Tort and liability reform standards.** Tort and liability standards for health care should be developed by the federal government. However, states must have the flexibility to design and regulate their own programs that meet the federal standards or further limit liability.
- **A single national claims form.** The federal government, in consultation with states, must develop a single claims form and support the development of electronic billing as a means to reduce administrative costs. A single electronic claims form system will simplify the administrative procedures for all health care participants, including hospitals, physicians, insurers, employers, government, and consumers.
- **Core benefits package.** The federal government, in consultation with states, localities, businesses, and labor organizations, must develop a core benefits package comparable to those now provided by the most efficient and cost-effective health maintenance organizations. There may be some state or regional variations in the basic benefit package, but such variations must be certified by a national health care board. Individuals would be free to purchase additional insurance with after-tax dollars. This package could be adjusted as additional information from outcomes research becomes available.
- **Limitations on tax deductibility of health insurance.** The federal tax code must be amended to limit the tax deduction/exemption of health insurance for both employers and employees. Employer-paid insurance above the limit would be taxable to either the employer or employee. The self-employed would be eligible to purchase fully deductible health insurance -- exempt from taxation as personal income -- within the federal limit and/or tied to a percentage of an income level. This limit may be tied to the local cost of a basic benefit package and set at a specific dollar amount. Additional coverage or care can be purchased with after-tax dollars.
- **Primary and preventive care.** The federal government must greatly expand its support for primary and preventive care including, but not limited to, periodic health screenings, prenatal care, well-baby care, and childhood immunizations.

3. Specific Cost Containment Strategies

Even if a federal framework is established that adheres to the principles just described, a real possibility exists that the federal government will attempt cost control by capping the federal medical entitlement programs. A cap only on federal health care entitlement programs will most certainly continue to shift costs to the private sector and local governments and reduce real benefits. A more effective strategy is to control costs throughout the health care system by developing health care expenditure targets.

It is unrealistic to immediately enforce strict budget limits on health care spending, since available data are not sufficient to set accurate spending ceilings. However, the national framework, developed in consultation with the states, should include cost control mechanisms which should be implemented by the states as quickly as possible. Cost containment strategies must consider all the major cost-drivers in the health care and health insurance systems. Incentives such as expedited waivers and Medicaid demonstrations must also be available to contain costs.

- **Goals for the growth of national health care expenditures** should be established for expenditures that are publicly supported either directly or through the tax code. Health care expenditures made by individuals with after-tax dollars would not be included in the targets. The national goals should be used to estimate expenditure targets for each state.
- **Data systems necessary to objectively measure national and state health care expenditures** must be established.
- **As data become available, there should be a review of the progress the federal and state governments have made toward achieving the national expenditure goals.**

- The federal government should issue an annual report to the states that addresses the following.
 - The effectiveness of our health care expenditures toward producing and maintaining health for all of our citizens. The data should be presented in at least the following categories: populations; state-by-state, urban and rural, fee-for-service, various types of managed care, and comparative therapies.
 - The status of data system improvements, including the development of data categories, sample sizes, and timeliness.
 - The progress or failure of each state toward any state or per capita expenditure goals.

4. State and Local Management

Within the context of a managed competitive approach to health care reform that ensures universal access and controls costs, the Governors support the principle of state and local management. State and local governments will need a set of tools to manage a cost-effective health care system.

- States wishing to undertake reforms which complement the federal framework described above and which are aimed at significantly expanding access to health care and controlling health care costs should be encouraged to move ahead in advance of full implementation of national reforms and should be given the tools necessary to be successful. For example, Governors encourage prompt approval of the Oregon waiver request.
- Assuming that there still is a public program, even if that public program is modeled after Medicaid, state and local governments will need stable financing and a uniform definition of eligibility. Beyond that, however, state and local governments must be given the flexibility and authority to fully integrate the public program into a service delivery system that reflects the national movement toward managed care. The federal government must not impose mandates beyond the core benefits or service delivery restrictions on the public program. A streamlined and efficient public program will obviate the need for the complex and costly waiver process.
- If Medicare continues to exist as a separate program, state and local governments will need the flexibility to fully integrate Medicare into their health care systems.
- States must have the ability to include the current self-insured market (ERISA plans) in their state design.
- States must have additional authority now precluded by federal anti-trust statutes.

5. Additional Federal/State Issues

- The federal government must participate in a discussion about how to deal with the access issues of rural areas, inner cities, and populations currently financed by federal programs, including Native Americans, veterans, and dependents of military personnel. The federal government also must participate in discussions about the provision of care to undocumented aliens.
- The federal government must reaffirm the traditional role of public health programs including epidemiology, environmental health, and disease prevention while integrating primary and preventive care services into the core benefits package to the extent possible. Adequate federal resources and technical assistance must be provided to ensure that the public health needs of states and communities can be met.
- Federal, state, and local governments must work toward agreement on a long-term care program that recognizes the need for different levels of care and support either within or outside a health care institution.

The Governors are prepared to work with other interested organizations and with the President and Congress to flesh out the details of specific proposals and then to secure formal support and enactment.

Time limited (effective February 1993-February 1995).

Adopted February 1, 1993.

The CCD had determined that any effort to reform the nation's health care system must be built on five basic principles: non-discrimination, comprehensiveness, appropriateness, equity, and efficiency. Only in this manner can we ensure that national health care reform efforts take into consideration the needs of Americans with disabilities.

PRINCIPLES

The CCD believes that any ultimate solution to the health care crisis must be based on the principle of **non-discrimination** ensuring that people with disabilities of all ages and their families have the opportunity to fully participate. The CCD would define a successful health care system as one that offers a **comprehensive** array of health, rehabilitation, personal, and support services, as well as a system that ensures that these services are **appropriate** in that they are provided on the basis of each individual's need, personal choice, and situation. In addition, any truly effective solution must be **equitable** ensuring that no group of individuals bears a disproportionate burden. Finally, the CCD asserts that an effective and accessible health care system must be **efficient** ensuring that system resources are utilized to meet health care needs. The CCD strongly supports the right to health care for all persons regardless of income or health status.

Non-Discrimination: People with disabilities of all ages and their families must be able to fully participate in the nation's health care system.

People with disabilities are often discriminated against in the health insurance marketplace because they are presumed to be high health care users. In fact, most people with disabilities are not sick. Nevertheless, private insurers use medical underwriting practices which are designed to ensure that high users of health care are charged higher premiums, subjected to preexisting condition exclusions, or rejected totally as an "unacceptable risk". Discrimination occurs when a sizeable proportion of people with disabilities, who are actually low users of health care, are denied insurance or subjected to preexisting condition exclusions. Discrimination also occurs when high users of health care are denied adequate coverage because they cannot afford the premiums or are subjected to limitations on covered services. From a disability perspective, the very practice of experience-rating, which ensures that premiums are set on the basis of previous utilization, is a form of unfair discrimination against high users.

Access to health care for individuals with disabilities cannot be considered in a vacuum. Historically, discrimination on the basis of disability has limited opportunities in employment, education, housing, travel, and other aspects of daily life. Now, with rights guaranteed in so many of these areas by the passage of the Americans with Disabilities Act and other important civil

rights legislation, there is a growing realization in the disability community that access to health care is a major barrier that threatens to interfere with the attainment of these rights. The CCD believes that the present inability of a substantial proportion of people with disabilities to participate in the nation's health care system at a level which meets their needs is a direct reflection of the continued misperception of both the skills and needs of people with disabilities. Non-discrimination requires that the health care financing system:

- prohibits pre-existing condition exclusions;
- prohibits rating practices that discriminate against higher users of health care;
- ensures that all persons, regardless of income or health status, have access to the all needed health related services;
- provides access without regard to age, race, place of residence, or the characteristics of persons with whom one maintains family relationships;
- ensures continuity and portability of coverage.

Comprehensiveness: People with disabilities and their families must have access to a health care system that ensures a comprehensive array of health, rehabilitation, personal, and support services across all service categories and sites of service delivery.

The CCD asserts that an effective and comprehensive health care system, one that is responsive to the needs of people with disabilities, would provide a seamless array of life-long health related services. Comprehensiveness implies the broadest set of services that assist individuals with disabilities and their families to achieve and sustain optimum physical and mental function. The terms "health, rehabilitation, personal, and support services", used by the CCD, refers to a universe of services delivered by a range of practitioners in a variety of sites and illustrates the necessary breadth of a health care delivery system that is truly accessible to people with disabilities. Over the course of a lifetime, all people commonly require a broad array of health, rehabilitation, personal, and support services. However, access to the entire array of these services must be ensured for people with disabilities. Often it is the availability of these services that can determine their ability to live independent lives and fully participate in the community. Moreover, adequate access can prevent exacerbation of a small health problem into a larger more costly health problem. People with disabilities would most benefit from a health care system that includes access to:

- preventive services, including services to prevent the worsening of a disability
- health promotion/education services
- diagnostic services
- inpatient and outpatient physician services
- hospital inpatient and outpatient care

- long and short term home and community-based services
- long term care in medical facilities
- prescription drugs, biologicals, and medical foods
- mental health, counseling, and substance abuse services
- habilitation services
- rehabilitation services, including audiology, occupational therapy, physical therapy, psycho-social services, respiratory therapy, speech-language pathology services, cognitive, vision, and behavioral therapies, and therapeutic recreation
- personal assistance services and independent living services
- durable medical equipment and other assistive devices, equipment, and related services

Appropriateness: People with disabilities and their families must be assured that comprehensive health, rehabilitation, personal, and support services are provided on the basis of individual need, preference, and choice.

Particular attention must be placed on the appropriateness of available services. It is of critical importance to the disability community that full involvement of the "consumer" is assured in all decisions affecting the selection of service, service provider, service timing, and service setting. CCD is concerned that certain forms of managed care create an incentive for under-serving people with disabilities and often utilize gate-keepers who are not knowledgeable about the special health care needs of people with disabilities.

The issue of consumer choice and participation has a particular importance for persons with disabilities. While the present acute-care oriented health care system has a tendency to relegate all "consumers" to a dependent status embodied in the "sick role", this indignity is particularly disempowering to people with disabilities when their chronic health conditions are permanent. That is why the health related services for persons with disabilities must be delivered in a way that minimizes interference with normal activities, and that health care financing policies which govern access to health care for persons with chronic conditions must be sensitive to issues of locus and control.

It is essential that decisions about health care services reflect personal preference and maximum benefit to the individual rather than provider and service setting availability, cost-containment goals, or coverage limits. CCD asserts that meaningful access to health care involves the right of the individual consumer to participate in the decision-making process regarding the provision of needed services and to be educated so appropriate self-care is possible.

In addition, CCD strongly believes that people with disabilities must be involved in policy decisions that will guide

the nation's health care system. An appropriate health care system is one which:

- includes consumer participation;
- ensures consumer choice in relation to services and provider;
- ensures a range of service settings through an integrated delivery system;
- ensures appropriate amount, scope, and duration of services;
- ensure the availability of trained personnel.

Equity: People with disabilities and their families must be ensured equitable participation in the nation's health care system and not burdened with disproportionate costs.

The CCD asserts that equal access to health services will not be readily achievable unless payment for health, rehabilitation, personal, and support services is equitably distributed so that no individual or public or private sector interest is burdened with a disproportionate share of the cost. Because of cost issues, too often people with disabilities and their families have been required to make unfortunate choices between needed health services in appropriate settings and what they can afford. These types of choices obviously do not reflect the principles of non-discrimination, comprehensiveness, and appropriateness of services. Health care reform must ensure that people have access to services based on health care need and not on their employment status or income level. As a group, people with disabilities have lower income than the general population and many adults with disabilities and families with members with disabilities devote a disproportionate share of their income to health care and disability related services. An equitable health care system would be one which:

- limits out of pocket expenses and cost sharing requirements for participants;
- provides access to services based on health care need and not on income level or employment status;
- ensures adequate reimbursement for service providers;

Efficiency: People with disabilities and their families must have access to a health care system that provides a maximum of appropriate effective quality services with a minimum of administrative waste.

The CCD is concerned that the current fragmentary system has failed to achieve effective cost controls, or a rational allocation of health resources, and contributes to substantial administrative waste. It is estimated that more than 20 percent of health care expenditures are attributed to administrative costs as 1,500 private health insurers require different forms of provider

documentation to trace every claim for reimbursement to the utilization by a specific individual with his or her own health insurance plan. In addition, the fragmentary system has contributed to the growth of excess capacity in the health care delivery system, inviting cost shifting, and undermining efforts to achieve effective cost controls. This has reinforced pressures for arbitrary cost containment by limiting coverage in ways that often adversely affect persons with disabilities.

Moreover, health care financing policy has not evolved much beyond acute care, failing to respond to the growing need for preventive care and for chronic health care management which could significantly reduce the growth of preventable diseases.

An efficient health care system is one that:

- reduces administrative complexity and minimizes administrative costs;
- allocates resources in a more balanced way between preventive services, acute care, rehabilitation, and chronic care management;
- ensures the delivery of effective services;
- maintains effective cost controls so that all people can get the health care services which they need.

Based on these "principles" from a disability perspective, CCD is reviewing all the health reform legislation before the Congress and submitting assessments of these bills as they are completed.

CONCLUSION

The disability community needs to be a major player in reexamining health care financing policy. People with disabilities are highly vulnerable to the limitations of both public and private systems as they are squeezed between a private system which is designed to charge accordingly to an assessment of risk and a public system which subsidizes health care according to age, poverty status, family structure, and an inability to work.

Private health insurance was developed and has remained a method for spreading risk of incurring excessive costs primarily for hospital and physician services. For individuals with disabilities, access to health care has been severely restricted because of preexisting conditions and the mistaken assumption that most people with disabilities need more hospital and physician care than the population as a whole. Health care reform needs to eliminate this restriction and assure access to needed hospital and physician services. Equally as important, the tradition of limiting covered services to hospital and physician services must be changed. Rehabilitation services, personal and support

services, mental health services, and assistive technology must be recognized as essential components of health care.

Perhaps our greatest contribution will be in clarifying the principles which should guide our health care system. These include: (1) expanding the definition of "health" to include prevention services, rehabilitation therapies, assistive technology, and on-going health-related maintenance services; (2) distributing all health related expenses equitably throughout the population; and (3) restructuring our health care delivery system to more effectively support consumer-directed chronic care management.

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For more information, please contact any of the CCD Health Task Force Co-chairs:

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Janet O'Keefe, The American Psychological Association, 750 First Street, N.E., Washington, D.C. 20002, telephone: (202) 336-5934

Bill Schmidt, Epilepsy Foundation of America, 4351 Garden City Drive, Landover, Maryland 20785, telephone: (301) 459-3700.

Steve White, American Speech-Language-Hearing Association, 10801 Rockville Pike, Rockville, Maryland 20852, telephone; (301) 897-5700.



February 9, 1993

Dear Advocate,

As this exciting year for health care reform unfolds it is more important than ever for us to work together. With the election of President Clinton and the creation of the White House Task Force chaired by Hillary Clinton there is a very real likelihood of an administration proposal emerging this spring.

While many of us have very specific concerns that should be addressed in the proposal, I think we all agree that every American must be guaranteed health insurance which covers comprehensive benefits. Yet, this basic principle could be in jeopardy.

The initial deliberations on this issue have surfaced a debate on the amount of savings that can be achieved through cost containment. Another question is the speed with which those savings are achieved. If coverage is tied to the timetable in which savings are achieved, guaranteed insurance for all may not be achievable for many years.

As the Task Force deliberates the specifics of this proposal, they must hear our views. We want to tell them that the American public cannot wait for universal comprehensive coverage. Universal coverage is the foundation; without this foundation, the building will not stand.

We think it is time for a joint action. Enclosed is a letter that we hope your organization will be willing to sign. We will be collecting signatures for the next few weeks. Please fill out the enclosed form and return it to us ASAP. Also, please ask other organizations you work with to sign it. We hope we can send this letter to the White House with a broad cross section of as many groups as possible endorsing it.

This letter will be the first of many joint actions that will assure the White House that we are supporting their efforts to enact comprehensive health insurance for all Americans.

Sincerely,

Judith G. Waxman

Judith G. Waxman
Director
Government Affairs

Enclosure

Dear President Clinton:

We applaud your commitment to complete a health care reform proposal within one hundred days. Our confidence in the process soared with your announcement that Mrs. Clinton will chair the Task Force. We think her appointment acknowledges the urgency of the need for solutions to the growing health crisis.

The undersigned groups have long been concerned about the growing lack of coverage and health care services. We know you appreciate the magnitude of the problem, so we do not need to recite the statistics about the growing number of uninsured and underinsured people. But we do want to forcefully convey our shared conviction that the crucial element of health care reform is guaranteeing health insurance with comprehensive benefits for all Americans.

The health care crisis has many facets, which touch on cost, quality and access issues. We believe that many of the intricacies can and will be resolved through hard work and compromise. Each of the groups on this letter will be expressing their particular concerns individually.

Our united message, however, is that each and every American must be assured that they can count on having health care coverage. Otherwise the reforms will be deemed a failure. The American people need to know that they will be covered when they need it, and they are not willing to wait to see this promise become a reality. Anything less than nationally defined comprehensive coverage for all means that the promise to fix the problem will have been broken.

We know that reaching the goal will mean making some hard decisions. Nevertheless, we believe that comprehensive coverage for all is achievable in the near future. We, the undersigned groups—along with the American public—will work with you and Mrs. Clinton to get the job done right.

Consortium for Citizens with Disabilities

CONSORTIUM FOR CITIZENS WITH DISABILITIES HEALTH TASK FORCE

"PRINCIPLES FOR HEALTH CARE REFORM FROM A DISABILITY PERSPECTIVE"

December, 1991
(updated February, 1993)

ON BEHALF OF:

AIDS Action Council
Alliance for Genetic Support Groups
American Academy of Physical Medicine and Rehabilitation
American Association for Counseling and Development
American Association of University Affiliated Programs
American Association on Mental Retardation
American Civil Liberties Union
American Congress of Rehabilitation Medicine
American Foundation for the Blind
American Occupational Therapy Association
American Physical Therapy Association
American Psychological Association
American Speech-Language-Hearing Association
The Arc, Association for Retarded Citizens of the United States
Epilepsy Foundation of America
Immune Deficiency Foundation
International Association of Psychosocial Rehabilitation Services
Learning Disabilities Association
National Alliance for the Mentally Ill
National Association for Music Therapy
National Association of Developmental Disabilities Councils
National Association of Medical Equipment Suppliers
National Association of Private Residential Resources
National Association of Protection and Advocacy Systems
National Association of Rehabilitation Facilities
National Association of State Mental Retardation Program Directors
National Council for Independent Living
National Council of Community Mental Health Centers
National Easter Seal Society
National Head Injury Foundation
National Mental Health Association
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Parent Network on Disabilities
National Recreation and Parks Association
National Rehabilitation Association
National Transplant Support Network
Spina Bifida Association of America
The Association for Persons with Severe Disabilities
United Cerebral Palsy Associations, Inc.
World Institute on Disability

PRINCIPLES FOR HEALTH CARE REFORM FROM A DISABILITY PERSPECTIVE

FROM THE HEALTH TASK FORCE OF THE CONSORTIUM FOR CITIZENS WITH DISABILITIES

INTRODUCTION

The organizations represented in CCD's Health Task Force appreciate the opportunity to express our priorities for health care reform from a disability perspective. The time is ripe to sharpen the debate for national health care reform. The Consortium for Citizens with Disabilities is a working coalition comprised of over 75 consumer, service provider, and professional organizations which advocate on behalf of persons with disabilities and their families. This statement is presented on behalf of 41 national organizations who comprise the overwhelming majority of CCD Health Task Force members. The more than 43 million Americans with disabilities include individuals with physical and mental impairments, conditions, or disorders, severe acute or chronic illness which limit or impede their ability to function.

Such disabilities may occur as a result of disease, injury, sudden trauma, aging, or congenital anomaly. One of the reasons for the passage last year of the historic Americans with Disabilities Act was to finally recognize not only the existence and importance of these millions of American with disabilities, but also to ensure their individual civil rights.

When one considers the number and range of individuals covered by the definition of disability, it is no wonder that the issue of access to appropriate, adequate, and affordable health care and related support systems is of such critical importance to the CCD. In fact, while 43 million is the official number cited for persons with disabilities, the CCD believes that, in actuality, this number is an under-estimation. Therefore, it is also no wonder that any discussion of reform of the nation's health care system must include not only the generic consumer perspective but also the unique perspective of consumers with disabilities. It is the belief of the CCD that addressing the disability perspective in the current health care reform debate will ultimately benefit all Americans.

In considering the issue of health from the disability perspective, it is essential to re-focus our conception of what being "healthy" really is. For so many people with disabilities, health is determined by functional capacity. It is the ability to maintain or increase this functional capacity that is often the measure of the person with disabilities' opportunity to live an independent life and participate as fully as possible in the life of the community. True realization of the rights now guaranteed by the ADA and other important pieces of civil rights legislation, unfortunately, will continue to be limited as long as people with disabilities do not have access to a seamless array of life-long health, personal, and support services.

Susan Golden
6065 Barkwood Lane
Sylvania, OH 43560

February 17, 1993

Lex Frieden
I L R U
2323 S Shepard, Suite 1000
Houston, TX 77069

Dear Lex :

It has come to my attention that in conjunction with the NCIL Executive meeting February 20-21, you have organized a forum on Health Care Reform. I was very pleased to hear this is happening now. The disabled community needs to be VISIBLY involved in this discussion now, before too many decisions have been reached. Changing opinions and bureaucracies may be an impossible task if we wait too long. NCIL has proven to be an effective and appropriate voice for people with disabilities.

I have been very disturbed with the direction and tone of the discussion of late in this area. I hope this is a regional bias only.

Most discussion and publicity here has focused on the END of life. Jack Kevorkian ("Michigan's Suicide Doctor") has been very active lately in this area assisting people in suicide. He identifies it as the "moral" procedure to end suffering. Although assisted suicide may be justified in some circumstances, Kervorkian has definately taken it too far. Most of his victims (12 of 13) are not terminally ill, just chronically and degeneratively disabled. The most common diagnosis is MS. Physical pain is generally not the main concern, but rather mental anguish and human dignity. These obviously are very depressed people.

The discussion on assisted suicide will continue, with strict limits likely to be imposed. Unfortunately, this focus has led most discussion on health care reform to look at the cost of maintaining life during the last year of life. Of course, this is an after-the-fact accounting and may not be of concern to the individual receiving the service. These facts are usually not mentioned. What is noted is the excessive amounts spent for the short time and limited "quality" of life returned. Family members add that the costs are punitive and feel medical care should not have been provided. The individual's wishes are not even considered in the discussion.

- 2 -

In the current medical environment, individuals do not receive treatment that they have not authorized. At every hospitalization, if they have no Living Will, they authorize or deny in advance treatment to resuscitate. The family may not know these orders.

The essence of the Independent Living Movement is that individuals can and must speak for themselves. They make their own life choices based on all available options. Individuals can't be forced out of this decision now because others think the quality of life returned is not worth the cost.

I'm sure there will be very robust discussion at this forum. I hope my thoughts will also be considered.

Sincerely,



Susan Golden

Draft Outline for Consumers Guide to Health Care Reform

INTRODUCTION:

- a) Discussion of Point of change
- b) Brief History
- c) Who we're addressing--target people with disabilities but bringing in the general population and specifically:
 - people with disabilities
 - people who will become disabled
 - people with family members who are disabled
- d) Paradigm shift (changing the concept of the Health Care System from a sickness mode to a wellness mode)
- e) Consumer choice and participation

PRINCIPLES:

- a) Universal/Mandated Coverage
- b) Exclusion of pre-existing conditions
- c) Portability
- d) Non-discrimination
- e) Provides appropriate and comprehensive services (as outlined in CCD document)
- f) consumer choice and participation (CCD document)
- g) prevention
- h) managed care should be service management
- i) continuity and continuum of services should be a component of any plan

FINANCE:

- a) Equitable Financing

COST CONTAINMENT:

- a) cost containment should not penalize the consumer
- b) no arbitrary decisions regarding the amounts or types of services
- c) limited cost sharing
- d) no arbitrary cost sharing (efficiency section in CCD document)
- e) concentrate on prevention which saves money in the long run
- f) dollars need to be spent more wisely/ global budgeting

Principles:

- No pre-existing condition exclusions, cancellations, denials
- Does policy prevent person with a disability from obtaining insurance which is comparable to insurance for non-disabled person?
24. Does the program permit screening tests to determine senile disorders on basis of which you are excluded.

Kennedy/Mitchell:

No, but 6 month exclusion on pre-existing condition.
Not clear.

Community Rating:

(disperse family)

3. Does program result in
4. Family and employer of Disabled person paying more for premiums because of the disabling condition?

Portability:

3. Does the insurance program penalize you from changing your employment status (regarding hi).

Kennedy/Mitchell: No

Universal Access:

1. Does the federal legislation program ensure access to H.I. regardless of income, age, disability, sex, place of residence

Kennedy/Mitchell: yes, but still has 6 mo exclusion on pre-existing conditions.

Cost Containment:

- Global budget
- Fee scheduling
- Deductible Co-pay
- Cost sharing
- Gate Keeper: Managed Care
- Case Management Care

Advantages:

- Explicit
- More Money available
- None
- Potentially offers coordination
- benefit flexibility

Problems:

- Disincentive to treat PWD
- unnecessary treatment
- Forces undesirable choice
- variable burdens imposed
- managed denial
- managed denial (potential)
- potentially cumbersome

Solutions:

- Case mix
- adjustment/incentives
- control malpractice treatment guidelines
- variable guidelines
- variable schedules
- case-managed care
- consumer involvement/control

Bottom Up

Enhances:

- Choice/control

Would require:

- Cost sharing

Subsidies:

- Public support



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

National Institutes of Health
National Institute of Child Health and Human Development
National Center for Medical Rehabilitation Research
Room 450W, EPS
NCMRR, NICHD
6120 Executive Blvd.
Rockville, Maryland 20852
(301) 402-2242
FAX (301) 402-0832
BITNET:YGA@NIHCU

January 8, 1993

Lex Frieden
Senior Vice President
TIRR
Baylor College of Medicine
1333 Moursund
Houston, Texas 77030

Dear Mr. Frieden:

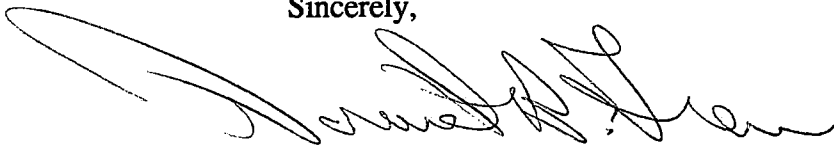
Thank you for agreeing to attend the National Center for Medical Rehabilitation Research (NCMRR) sponsored workshop, "Training Scientists in Medical Rehabilitation Research," on February 21 and 22, 1992. The workshop will be held at two locations. The Sunday evening session will be held at the Hyatt Regency Hotel in Bethesda, Maryland. The Monday sessions will be held in the 5th floor conference room at the National Institute of Child Health and Human Development (NICHD) office building, located at 6100 Executive Boulevard in Rockville, Maryland.

This workshop will bring together the principal investigators of the currently funded NCMRR institutional training grants for the purpose of sharing their experiences in training scientists for careers in medical rehabilitation research. NICHD administrators will describe the grant management and review process, present the reporting requirements and grant management regulations, and provide insights into other mechanisms for funding training activities and career development. Experienced principal investigators from other NICHD funded institutional training grants will make presentations that describe highly successful training strategies. A draft agenda for the workshop providing more details is enclosed.

Please follow the instructions for making hotel reservations and for submitting expenses for reimbursement that are described in the enclosed instruction sheets. Since we are holding a working dinner and lunch, we are requesting that you send Dr. Gray a check for \$50.00 to cover the expense of the meals. Please specify whether you would prefer beef, chicken or fish for your dinner. Your per diem reimbursement will cover this expense. We would appreciate receiving your check on or before February 1, 1993.

I look forward to seeing you there. Thank you again for your commitment. If you have any questions about the workshop, do not hesitate to contact me at (301) 402-2242.

Sincerely,

A handwritten signature in black ink, appearing to read 'David B. Gray', written in a cursive style.

David B. Gray
Acting Deputy Director
National Center for Medical
Rehabilitation Research

Enclosures

Draft Agenda for Workshop

**Training Scientists in Medical
Rehabilitation Research**

February 21-22, 1993

Sunday, February 21st

6:00 - 7:00 pm	Reception	
7:00 - 8:00	Dinner	Mr. Frieden
8:00 - 9:00	Presentations:	Dr. Alexander
	Purpose of Meeting	Dr. Fuhrer
	Focus of Research Training	Dr. Pattishall
	P.I. Introductions and Expectations	

Monday, February 22nd

8:00 - 8:15	Welcome	Dr. Alexander
	Comments by Conference Chair	Dr. Fuhrer
8:15 - 8:35 am	Developing a Successful Institutional Training Grant (e.g. importance of - PI, Institution, mentors, relation to other fields, relation to NIH funding, relation to previous experience in training, monitoring progress of fellows)	Dr. Fishman
8:35 - 8:45	Question and Answer	
8:45 - 9:20	Models of Rehabilitation Research Training (e.g. settings, general vs. selected, basic to clinical, vision, response to need, interdepartmental cooperation, short duration vs. long, etc.) Dr. Gray (5 min.) Dr. Cole (10 min.) Dr. Findley (10 min.) Questions and Answer (10 min.)	Dr. Gray Dr. Cole Dr. Findley

9:20 - 9:50	Recruitment of Fellows (e.g. select for success, sources of fellows, minorities, women and people with disabilities, common barriers, effective advertisement and etc.) Successful strategies from other fields of science (5 min.)	Dr. Harmon
	Comments of funded PIs(10 minutes)	Dr. Anderson Dr. Gans
	Qualifications and regulations (5 minutes)	Ms. Colvin
	Discussion (10 min.)	
9:50 - 10:10	Stipend Supplements (e.g. process, amounts, when, what reasons work, how to supplement fellows) One Approach that Worked (5 min.)	Dr. Harmon
	Guidelines and Program Tips - (5 min.) Question and Answer 10 min.	Dr. McClure
10:10 - 10:25	Coffee	
10:25 - 11:00	Individualizing the Fellowship Experience (e.g. selection of mentor, multiple mentors, and role of mentor, Journal Clubs, Seminars, Grant applications, presentation at scientific meetings) (10 min.)	Dr. Borkowski
	Comments of funded PIs (15 min.)	Dr. Rymer Dr. Brooke Dr. Diller
	Question and Answer (10 min.)	
11:00 - 11:25	Course Work (e.g. ethics, pre and post doctoral, MD summer program,) NIH Guidelines (5 min.) Tips from an experienced PI (10 min.)	Dr. Krotoski Dr. Harmon
	Comments of funded PIs (10 min.)	Dr. Siebens Dr. Sahrman
	Question and Answer (5 min.)	
11:25 - 12:00	Basic and Clinical Balance (e.g. exposure vs. training in techniques, who chooses the course fellow, mentor, or committee?) Integration of clinical and basic for effective research training experiences (10 min.) Staff comments (5 min.) Comments of funded PIs (20 min.)	Dr. Harmon Dr. Chanaud Dr. Dobkin Dr. Selzer Dr. Basford Dr. Protas
	Question and Answer (10 min.)	

12:00 - 1:00	WORKING LUNCH	Dr. Fuhrer
1:00 - 1:30	Program management: Summary Statement, Progress Report, Requests for Change in Program Direction Grants Management: Budget Appraisals, allowable above and below line changes, annual increases, forms and non competitive renewal requirements and dates, administrative reductions	Dr. Quatrano Mary Ellen Colvin
1:30 - 2:15	Competitive Renewal Tips from a Pro (20 min.) NICHD Scientific Review (10 min.) Questions and Answer (15 min.)	Dr. Borkowski Dr. Streufert
2:15 - 2:35	Tracking Graduates Perspective of a Dean Comments of Funded PIs Question and Answer (5 min)	Dr. Pattishall Dr. Ottenbacher Dr. Richards
2:35 - 2:50	Coffee	
2:50 - 3:25	Next Steps on the Career Ladder (20 min.) Comments of Funded PI Question and Answer (15 min.)	Dr. Shaffer Dr. Johnston
3:25	Next Steps for NCMRR Discussion: Possible Topics Workshops for Potential Applicants Meetings and Interactions of Trainees Presentation of Research at Scientific Meetings Central Tracking of Graduates (Fellows)	Dr. Fuhrer
4:00 pm	Adjourn	

Roster

Training Scientists in Medical Rehabilitation Research

February 21-22, 1993

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Essential Information Regarding Travel and Expenses

Workshop on Training Scientists and Medical Rehabilitation Research

We are pleased to extend this invitation to you to attend our workshop. To help defray the cost of your trip, we will be issuing a Professional Service Contract (PSC) to you. Unfortunately, budget constraints dictate that we limit what we can offer in this contract to an amount based upon prevailing government rates for meals, lodging, and coach-class airfare. In an effort to minimize your cost, the following information is provided to assist you in securing the most economical means of transportation.

Since you are traveling on our behalf, you are entitled (but not obligated) to use our travel agent (Ober United Travel) to secure a discounted, unrestricted government airfare or train ticket. If you elect to use another agent (who will not be able to obtain the government discount), or if you wish to upgrade or otherwise increase the cost beyond the government rate, please be aware that we will be unable to reimburse you for the price differential.

There are certain stipulations when using Ober United Travel:

- Tickets can only be issued for American carriers.
- Tickets must be prepaid by cash, check, money order, or wire. Airlines will not allow the use of credit cards for government-rate tickets.

Once the payment is received, Ober United Travel can arrange to have the tickets waiting for you at the airport or available for pickup at an in-town ticket office. In order to make reservations and arrangements, please call Ober United Travel at 1-800-638-8500. Please mention the title of the workshop.

In addition, a hotel reservation has been made for you for Sunday, February 21, 1992, at the Hyatt Regency Hotel in Bethesda, MD. The Hyatt requires that you call and confirm your reservation with a credit card. The telephone number at the Hyatt Regency is (301) 657-1234. Please ask for reservations and mention Dr. Gray's name along with the title of the workshop.

Worksheet For Travelers

Please complete this worksheet as soon as possible and FAX it to Shana at (301) 402-0832. We must have an accurate estimate of your expenses prior to the workshop so that the professional service contract can be prepared.

1. Per Diem - \$144 per day, exact amount based on following information

Date/Time of Arrival in Washington, DC _____

Date/Time of Departure from Washington, DC _____

Exact Cost of Hotel Reservation
(Hyatt Regency Hotel (301) 657-1234) _____

2. Taxis, and other ground transportation: **Limited to \$100** unless utilizing handicapped accessible transportation.

3. Exact Cost of Airline (or Train) Ticket
(Ober United Travel 1-800-638-8500) _____

4. Your Social Security Number _____

5. Correct official mailing address:

6. Home Address:

(We prefer to send your reimbursement to the office address, however, if you have traveled for us before and had your check sent to your residence, it will go there again. Thus, we would like to verify that the home address on record is correct.)

7. Telephone Number: Office: _____

Lab/Clinic: _____

Fax Number: _____

8. Your name and degree(s) _____

9. Please list below any special needs you will have regarding your room, meals, visual aids, etc.:



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

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December 14, 1992

Lex Frieden
Senior Vice President
TIRR
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1333 Moursund
Houston, Texas 77030

Dear Mr. Frieden:

On February 22, 1993, the National Center for Medical Rehabilitation Research is hosting a Workshop on Training Scientists in Medical Rehabilitation Research. The NIH Report of the the Task Force on Medical Rehabilitation Research and the Report and Plan for Medical Rehabilitation Research discusses the need for research to improve the number, quality and variety of individual scientists capable of conducting research on topics in medical rehabilitation.

This conference will bring together scientists from sixteen institutional training grants, funded through the NCMRR. In addition, four individuals who have a distinguished record of training scientists through the institutional training grant mechanism will share their expertise in obtaining, directing and renewing institutional training grants.

As a member of the NCMRR Advisory Board, you are cordially invited to attend this workshop. Please direct your reply to Shana via fax or phone. For planning purposes, we would appreciate receiving your reply no later than Thursday, December 17, 1992.

Happy Holidays,

David B. Gray, Ph.D.
Acting Deputy Director, NCMRR

Meet David & Evan
Sun. Feb. 21

