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Meeting with AIDS Action Council 8/23 & 9/22/93

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KRISTINE M. GEBBIE, R.N., M.N., F.A.A.N.
NATIONAL AIDS POLICY COORDINATOR
DEPARTMENT OF HEALTH & HUMAN SERVICES
Room 729H Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

DAY Wed DATE Sept. 22, 1993

TIME 1:30pm LOCATION

SUBJECT AIDS Action Council

PARTICIPANTS:
AIDS Action Staff

follow up -
Buck - Draft letter to Kennedy
re: his amendments Done
Call Howard Paster
directly @ WH work w/ Sean Donahue HHS
re how to cover floor vote
time
Done

Dear Senator Kennedy:

As you are well aware, an increasing number of adolescents engage in sexual intercourse at earlier ages. With reports from the Centers for Disease Control and Prevention indicating that more than half of students in grades 9-12 engage in sexual intercourse, many communities have decided to offer intensive HIV prevention programs that include the availability of condoms in schools.

Aside from abstinence from sexual intercourse, condoms are highly effective in the prevention of HIV infection and other STDs. Communities must assess their own needs and develop their own answers to preventing HIV among young people. The role of the federal government should be to support local communities in implementing effective prevention strategies. State and local agencies receiving federal funds should not be prohibited or restricted in any way from using those funds to make condoms available, if they determine that such a program is necessary and appropriate. Nor should state and local agencies be prohibited or restricted in using their own state and local funds to make condoms available.

The controversy about condom availability continues to distract attention from the need for comprehensive HIV prevention for all young people. I strongly urge members of the Senate to support and foster the ability of communities to effectively serve the public health needs of their people.

Sincerely

AIDS Action council

September 16, 1993

Philip R. Lee, M.D.
Assistant Secretary for Health
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Lee:

Thank you for the opportunity to comment on the draft proposals regarding the Public Health Core Function and Prevention Initiatives and the Public Health Service Access Initiatives. These are both critical elements in the context of the President's proposed health care reform plan.

The Public Health Core Function and Prevention Initiatives

While we do not oppose the creation of a core grant for on-going public health programs that would include HIV/AIDS prevention programs, it is not clear from the document whether specific earmarks would be included within the core grant. *We believe that a specific earmark establishing a minimum level of HIV prevention services is essential.* Without a federal requirement for these services, we fear that states will opt to support more "popular" prevention programs instead. As the data collected from the Intergovernmental Health Policy Project at George Washington University show, without federally earmarked dollars, many states would spend little or no money on HIV/AIDS prevention -- or would focus their funds on counseling and testing services only. The federal government must assure that comprehensive prevention programs continue and grow.

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We support the concept of the competitive pool of funds for problems of regional and national significance. This would permit targeting of prevention funds for HIV in those communities most in need. We especially like the fact that non-governmental entities could compete for these funds if they can demonstrate the ability to reach targeted populations. We do, however, have a very real practical concern with the creation of two funding streams. Both the core *and* the initiative streams will be critical to a comprehensive public health response. All too often in the past, when two streams for similar purposes are created, Congress has focused its appropriations on one. To the degree that these can be merged into one funding stream with two functions, the more likely it is that the Public Health Service's intentions will be met during implementation.

We have a major concern with the data collection section on page 8. As you know, the protection of confidentiality of HIV-related medical and public health data has been a major concern of the AIDS community since the start of the epidemic. It is no less great today. Even if universal access to health care is

guaranteed by the federal government, other forms of discrimination and stigmatization will, unfortunately, continue. For individuals to have confidence in the new health care system, they have to feel certain that their medical information will be kept absolutely confidential. *Blinded* use of this data for surveillance purposes is appropriate. But any use of medical data collected by the federal government for public health reporting by name would undermine confidence in the new health care system (and increase the burden on categorical services outside the system or cause a costly delay in individuals seeking care or prevention services). Any named (or other traceable unique identifier) public health reporting system must be separate from the data collection associated with the health plan.

Public Health Service Access Initiatives

We are supportive of major elements of this initiative and appreciate the PHS's understanding of the need to continue current service delivery programs for the immediate future. While we appreciate the Administration's support of continued *full* funding of the Ryan White CARE Act programs, we must also point out that there are other categorical programs on which people with HIV/AIDS depend (e.g., community health centers, substance abuse programs). We believe that the adaptations of these programs in the context of health care reform must reflect the reality of improved access under the new system, not an assumed level of access. The essential provider provisions should, at least in theory, mitigate this concern. However, we fear that administrative and funding obstacles may actually create a discontinuity of services through these providers. (For example, it is not without precedent that an old program will be eliminated, a new one authorized but not funded at the same level as the old one -- despite the best intentions of the Administration.)

We also recognize that even the Ryan White program will require some modification in light of the new coverages offered by the health care reform plan. The timing of Ryan White reauthorization in 1995 affords an opportunity to reexamine specific aspects of the program in light of the (we hope) newly established health care system. However, we must always keep in mind that as long as the stigma associated with HIV remains, as long as it affects primarily populations that have felt disenfranchised from the existing medical care system, the need for separate funding streams and services for these populations -- even though covered by the traditional plan -- will remain.

We support the New Access Initiative and only wish to point out that, even with full funding of Ryan White, there may (and should) be providers who serve people with HIV/AIDS who will seek funding under this provision. We hope that continued funding for Ryan White will not eliminate HIV as a priority in this initiative.

We support the Adolescent and School-Aged Youth Initiative. However, we are concerned that, at least as described, the program is strictly school-based or school-linked. For HIV and other critical public health concerns, there must be programs targeting and reaching out-of-school youth and adolescents.

Substance Abuse

We have a number of concerns about the way substance abuse treatment is addressed in the health care reform plan. Obviously we are disappointed that full coverage for substance abuse treatment and mental health services will not be available until the year 2000. However, we have more immediate concerns. The benefit melds mental health and substance abuse coverage, and in its elaboration, reflects a regimen for mental health treatment much more adequately then it reflects substance abuse treatment practice. It does not address the need of many drug dependent individuals, especially those with HIV, for long-term community based residential treatment currently provided by therapeutic communities. Second, by collapsing the benefit for mental health and substance abuse treatment, individuals run the risk of exhausting their coverage rapidly, particularly drug dependent individuals with HIV who may need both drug treatment and mental health counseling. Finally, we are concerned that the plan calls for subsidizing this benefit, in large part, through the substance abuse block grant. That block grant subsidizes precisely the long-term treatment options needed by so many drug dependent persons, especially those with HIV, and represents a much larger percentage of the overall public dollars available for substance abuse services than does the mental health block grant.

In addition to the clear need to separate services for mental health from substance abuse, we would strongly recommend that community-based alcoholism and drug abuse treatment programs be identified as "essential providers" under the plan. We would also recommend that the substance abuse block grant be substantially increased and not provide the primary funding source for the mental health/substance abuse benefit until an analysis of the ability of the health alliances to adequately serve the population in need of substance abuse services can be evaluated.

Again, we thank you for the opportunity to comment on these initiatives. We look forward to continuing to work with your office as these are developed over the next several months.

Sincerely,

Christine Lubinski
Deputy Executive Director for Programs
AIDS Action Council

Jeffrey Levi
Director of Public Policy and Program Development
AIDS Action Foundation

COMPARATIVE STATEMENT OF NEW BUDGET (OBLIGATIONAL) AUTHORITY FOR FISCAL YEAR 1993 AND BUDGET ESTIMATES AND AMOUNTS RECOMMENDED IN THE BILL FOR FISCAL YEAR 1994—Continued

[Amounts in dollars]

Item	1993 appropriation	Budget estimate	House allowance	Committee recommendation	Senate Committee recommendation compared with (+ or −)		
					1993 appropriation	Budget estimate	House allowance
Tuberculosis:							
Grants	73,566,000	123,566,000	115,000,000	101,000,000	+27,434,000	-22,566,000	-14,000,000
Program operations	5,269,000	5,269,000	5,269,000	5,269,000	---	---	---
Subtotal, Tuberculosis	78,835,000	128,835,000	120,269,000	106,269,000	+27,434,000	-22,566,000	-14,000,000
Acquired Immune Deficiency Syndrome (AIDS)	498,253,000	543,253,000	543,253,000	543,253,000	+45,000,000	---	---
Chronic & environmental disease prevention	70,117,000	92,117,000	108,017,000	128,000,000	+57,883,000	+35,883,000	+19,983,000
Lead poisoning prevention	29,683,000	29,683,000	34,683,000	34,683,000	+5,000,000	+5,000,000	---
Breast and cervical cancer screening	71,303,000	85,303,000	72,303,000	80,000,000	+8,697,000	-5,303,000	+7,697,000
Injury control	31,808,000	41,808,000	31,808,000	41,808,000	+10,000,000	---	+10,000,000
Occupational Safety and Health (NIOSH):							
Research	101,252,000	111,252,000	104,000,000	119,252,000	+18,000,000	+8,000,000	+15,252,000
Training	11,092,000	11,092,000	12,592,000	13,000,000	+1,908,000	+1,908,000	+408,000
Subtotal, NIOSH	112,344,000	122,344,000	116,592,000	132,252,000	+19,908,000	+9,908,000	+15,660,000
Epidemic services	73,520,000	73,520,000	73,520,000	73,520,000	---	---	---
National Center for Health Statistics:							
Program operations	48,605,000	56,605,000	48,605,000	52,605,000	+4,000,000	-4,000,000	+4,000,000
Program support	2,927,000	2,927,000	2,927,000	2,927,000	---	---	---
1% evaluation funds (non-add)	(28,873,000)	(28,873,000)	(28,873,000)	(28,873,000)	---	---	---
Subtotal, health statistics	51,532,000	59,532,000	51,532,000	55,532,000	+4,000,000	-4,000,000	+4,000,000
Buildings and facilities	16,648,000	16,648,000	16,648,000	16,648,000	---	---	---
Program management	3,388,000	3,131,000	3,131,000	3,131,000	-257,000	---	---
Total, Disease Control	1,662,545,000	2,161,788,000	1,910,182,000	2,088,781,000	+426,236,000	-73,007,000	+178,599,000
NATIONAL INSTITUTES OF HEALTH (INCLUDES AIDS)							
National Cancer Institute	1,978,341,000	2,041,324,000	2,082,267,000	2,082,267,000	+103,926,000	+40,943,000	---
Forward funding (FY95 - FY97)	---	100,798,000	---	---	---	-100,798,000	---
National Heart, Lung, and Blood Institute	1,214,715,000	1,198,402,000	1,277,880,000	1,277,880,000	+63,165,000	+79,478,000	---
National Institute of Dental Research	161,141,000	163,009,000	169,520,000	169,520,000	+8,379,000	+6,511,000	---
National Institute of Diabetes and Digestive and Kidney Diseases	680,660,000	671,284,000	716,054,000	716,054,000	+35,394,000	+44,770,000	---
Forward funding (FY95 - FY97)	---	5,851,000	---	---	---	-5,851,000	---
National Institute of Neurological Disorders and Stroke	599,477,000	590,065,000	630,650,000	630,650,000	+31,173,000	+40,585,000	---
National Institute of Allergy and Infectious Diseases	984,210,000	1,065,583,000	1,065,583,000	1,065,583,000	+81,373,000	---	---
National Institute of General Medical Sciences	832,235,000	825,897,000	875,511,000	875,511,000	+43,276,000	+49,614,000	---
Forward funding (FY95 - FY97)	---	7,167,000	---	---	---	-7,167,000	---
National Institute of Child Health and Human Development	527,752,000	539,464,000	555,195,000	555,195,000	+27,443,000	+15,731,000	---

AIDS Action council

September 16, 1993

To: Mike Lux

From: Christine Lubinski and Jeff Levi
AIDS Action Council

Re: Concerns and Suggestions on Clinton Health Care Reform Plan

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As you suggested to Mario Cooper, AIDS Action Council board member, we have identified a number of concerns with the Administration's health care reform proposal, from the perspective of the HIV community. We have shared these concerns with Judith Feder and Phil Lee as well. Please feel free to call either of us at (202) 986-1300 if you need further clarity on any of these points.

Coverage of "off-label" uses of prescription drugs.

While we are delighted to see prescription drugs included in the basic benefits package, we are concerned that this benefit not be overly circumscribed -- particularly through the formularies and drug utilization reviews health plans are permitted to establish (page 25). For people with HIV disease, and other diseases where standard of care is ill-defined, it is vital that formularies and drug utilization review processes embrace a broad definition of therapeutic equivalency.

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It is essential that coverage include the use of so-called "off-label" drugs and biologics. Due in part to the paucity of standard treatments for HIV disease and its related opportunistic infections, people with HIV are often heavily dependent on the use of "off-label" therapeutics. "Off-label" refers to the use of an FDA approved product to treat an indication other than that for which the manufacturer sought and obtained FDA marketing approval. FDA has long considered the use of "off-label" treatment as appropriately at the discretion of the provider ("Use of Approved Drugs for Unlabeled Indications." *FDA Drug Bulletin.* (12:1) April, 1982.) and such usage comprises an integral component of the treatment of many conditions, including but hardly limited to, HIV disease.

As currently worded, individual plans could end up with differing treatment regimens for people living with HIV disease. A federal standard is needed to assure comparable access to care across plans and alliances.

The continued need for public health categorical programs.

We are pleased to see that the plan envisions the continuation of the Ryan White CARE Act programs beyond the phase-in of the health care reform package. Clearly, modifications in the program will be needed as some of the services provided will be reimbursable. Many of the supportive services funded under the CARE Act are not covered by the benefits proposed, however, yet contribute to lower utilization rates of covered services. In addition, even where services would now be reimbursable, funding would still be needed to cover copayments and deductibles, which currently do not apply to these primary care services, so that clients would not end up with fewer benefits in the reformed system.

More importantly, we must recognize that given the stigma associated with HIV infection and the potential for discrimination, many individuals will continue to seek either care or diagnosis (counseling and testing) outside the traditional health care system, even though these services are covered by their health plans. There are many legitimate reasons for this and there is a strong public health benefit to encouraging individuals to access these services, even if programs outside the health plans must be funded to deliver them.

Finally, we wish to express some concerns about the future of categorical programs for *prevention.* As we read the September 7th proposal, all existing categorical programs would be melded into a larger formula prevention block grant to the states, with an additional pot of money available on a competitive basis for innovative approaches to problems of greater public health significance, including HIV. We are concerned about elimination of the separate HIV stream in the core grant *unless dollars are earmarked for HIV-specific programs.* Unfortunately, without the availability of specific federal dollars for HIV prevention programs, far too many states would opt to transfer money to more "popular", less "controversial" public health programs. This would be counter to the national public health interest.

The Public Health Core Function and Prevention Initiatives

As noted above, while we do not oppose the creation of a core grant for on-going public health programs that would include HIV/AIDS prevention programs, it is not clear from the document whether specific earmarks would be included within the core grant. *We believe that a specific federal earmark establishing a minimum level of HIV prevention services is essential.* As the data collected from the Intergovernmental Health Policy Project at George Washington University show, without federally earmarked dollars, many states would spend little or no money on HIV/AIDS prevention -- or would focus their funds on counseling and testing services only. The federal government must assure that comprehensive prevention programs continue and grow.

We support the concept of the competitive pool of funds for problems of regional and

national significance. This would permit targeting of prevention funds for HIV in those communities most in need. We especially like the fact that non-governmental entities could compete for these funds if they can demonstrate the ability to reach targeted populations. We do, however, have a very real practical concern with the creation of two funding streams. Both the core *and* the initiative streams will be critical to a comprehensive public health response. All too often in the past, when two streams for similar purposes are created, Congress has focused its appropriations on one. To the degree that these can be merged into one funding stream with two functions, the more likely it is that the Public Health Service's intentions will be met during implementation.

We have a major concern with the data collection section on page 8. As you know, the protection of confidentiality of HIV-related medical and public health data has been a major concern of the AIDS community since the start of the epidemic. It is no less great today. Even if universal access to health care is guaranteed by the federal government, other forms of discrimination and stigmatization will, unfortunately, continue. For individuals to have confidence in the new health care system, they have to feel certain that their medical information will be kept absolutely confidential. *Blinded* use of this data for surveillance purposes is appropriate. But any use of medical data collected by the federal government for public health reporting by name would undermine confidence in the new health care system, increase the burden on categorical services outside the system, and cause costly delays in individuals seeking care or prevention services. Any named (or other traceable unique identifier) public health reporting system must be separate from the data collection associated with the health plan.

Public Health Service Access Initiatives

We are supportive of major elements of this initiative and appreciate the PHS's understanding of the need to continue current service delivery programs for the immediate future. While we appreciate the Administration's support of continued *full* funding of the Ryan White CARE Act programs, we must also point out that there are other categorical programs on which people with HIV/AIDS depend (e.g., community health centers, substance abuse programs). We believe that the adaptations of these programs in the context of health care reform must reflect the reality of improved access under the new system, not an assumed level of access. The essential provider provisions should, at least in theory, mitigate this concern. However, we fear that administrative and funding obstacles may actually create a discontinuity of services through these providers. (For example, it is not without precedent that an old program will be eliminated, a new one authorized but not funded at the same level as the old one -- despite the best intentions of the Administration.)

We also recognize that even the Ryan White program will require some modification in light of the new coverages offered by the health care reform plan. The timing of Ryan White reauthorization in 1995 affords an opportunity to reexamine specific aspects of the program in light of the (we hope) newly established health care system. However, we must always keep in mind that as long as the stigma associated with HIV remains, as long as it affects primarily

populations that have felt disenfranchised from the existing medical care system, the need for separate funding streams and services for these populations -- even though covered by the traditional plan -- will remain.

We support the New Access Initiative and only wish to point out that, even with full funding of Ryan White, there may (and should) be providers who serve people with HIV/AIDS who will seek funding under this provision. We hope that continued funding for Ryan White will not eliminate HIV as a priority in this initiative.

We support the Adolescent and School-Aged Youth Initiative. However, we are concerned that, at least as described, the program is strictly school-based or school-linked. For HIV and other critical public health concerns, there must be programs targeting and reaching out-of-school youth and adolescents.

The need for an explicit federal law protecting confidentiality and prohibiting discrimination.

As the plan is currently drafted, it is not clear that new legislative authority will be forthcoming. This is too vital an issue to leave to the National Health Board. The federal government must set a strong and enforceable confidentiality standard (a floor, not a ceiling) for the states. We strongly agree that all diseases should have the same confidentiality protections (page 122) and would suggest adoption of the current federal confidentiality standards, now on the books for substance abuse records, for all medical records and data.

As we noted earlier, we are deeply concerned by several references to the use of data collected in the context of the health care plan for public health surveillance purposes (pages 116 and 149). *Blinded* use of this data for surveillance purposes is appropriate. But any use of medical data collected by the federal government for public health reporting by name would undermine confidence in the new health care system, increase the burden on categorical services outside the system, and cause costly delays in individuals seeking care or prevention services. Any public health reporting system that uses name-based or other traceable unique identifiers must be kept separate from the data collection associated with the health plan.

Substance Abuse

We have a number of concerns about the way substance abuse treatment is addressed in the health care reform plan. Obviously we are disappointed that full coverage for substance abuse treatment and mental health services will not be available until the year 2000. However, we have more immediate concerns. The benefit melds mental health and substance abuse coverage, and in its elaboration, reflects a regimen for mental health treatment much more adequately then it reflects substance abuse treatment practice. It does not address the need of many drug dependent individuals, especially those with HIV, for long-term community based residential treatment currently provided by therapeutic communities. Second, by collapsing the benefit for mental health and substance abuse treatment, individuals

run the risk of exhausting their coverage rapidly, particularly drug dependent individuals with HIV who may need both drug treatment and mental health counseling. Finally, we are concerned that the plan calls for subsidizing this benefit, in large part, through the substance abuse block grant. That block grant subsidizes precisely the long-term treatment options needed by so many drug dependent persons, especially those with HIV, and represents a much larger percentage of the overall public dollars available for substance abuse services than does the mental health block grant.

In addition to the clear need to separate services for mental health from substance abuse, we would strongly recommend that community-based alcoholism and drug abuse treatment programs be identified as "essential providers" under the plan. We would also recommend that the substance abuse block grant be substantially increased and not provide the primary funding source for the mental health/substance abuse benefit until an analysis of the ability of the health alliances to adequately serve the population in need of substance abuse services can be evaluated.

AIDS Action Council

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September 20, 1993

To: Mike Lux

From: Christine Lubinski and Aimee Berenson
AIDS Action Council

Re: Follow-Up Concerns and Suggestions on Clinton Health Care Reform Plan

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This is a follow-up memo to our September 16th memo identifying AIDS Action Council's concerns with the Administration's health care reform proposal, from the perspective of the HIV community. Please feel free to call Aimee Berenson, Legislative Counsel, at (202) 986-1300 ext. 24 if you need further clarity on any of these points.

Anti-Discrimination

We were very pleased to see that the Clinton plan specifically states that no health care plan may fail to enroll a person based on health condition, anticipated need for health care, occupation, or affiliation with any other person or entity other than another plan, and that the plan clearly states that health care plans may not exclude participants because of pre-existing conditions or establish waiting periods before coverage begins. (See 9/7/93 draft, page 74).

However, we are gravely concerned about provisions in the Clinton draft plan which state that with the approval of the state, a plan may limit enrollment due to "restrictions on the plans capacity to deliver services or maintain financial stability". In fact, one of the major arguments current plans use to discriminate against people living with HIV/AIDS is that covering HIV-infected people would cause the plans "financial ruin" (See, e.g. Mason Tenders v. EEOC). This argument, without any factual support for it, was made by the defendant in the in Mason Tenders v. EEOC, an Americans with Disabilities Act case involving the denial of health insurance benefits to HIV-infected individuals.[1] In response to this case, the EEOC promulgated guidelines in June of this year that try to restrict the use of this argument as a defense to disability-based distinctions in health care coverage. (See EEOC bulletin No. N-915.002, June 8, 1993). ***The Clinton plan should incorporate similarly strict guidelines here as well, and***

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[1] As the attached press release from EEOC explains, the defendants in Mason Tenders have also argued, successfully to date, that the ADA does not apply to them and that they are exempted from the ADA by ERISA. This case clearly exemplifies the crisis people living with HIV/AIDS are facing in health care coverage.

should specify that health care benefits provided under reform are considered benefits for purposes of the ADA.

We believe it is critical that the Clinton plan specify that all health care benefits provided through health care reform, regardless of what entity provides them (states, corporate alliances, etc.) are considered benefits subject to the anti-discrimination provisions of the Americans with Disabilities Act. The current confusion over how health care benefits are treated under the ADA has caused unnecessary litigation and provided a back-door for employers and other insurers to discriminate against people with HIV/AIDS. (See, e.g., Mason Tenders).

Another concern that we have with regard to the Clinton draft plan is the requirement that benefit claims disputes must go through Alternative Dispute Resolution (ADR) first. The use of ADR delays the process of appeals, and this delay is particularly problematic for people living with HIV/AIDS, who cannot afford life-threatening delays in accessing care. In fact, experience shows that the use of ADR does not significantly reduce costs (See. e.g., attached Legal Times article dated September 13, 1993). While we do not oppose the plan to have DOL set up and monitor grievance system boards, etc. (See Clinton draft plan page 76), we believe that ADR should be an option that both parties must agree on, not a mandatory requirement.

We were pleased to see provisions in the draft plan that prohibit discrimination against providers by health care plans based on race, ethnicity, gender, religion, or mix of health professionals or patient population. (See draft plan page 77). However, the waiver provision for essential service providers upon demonstration by the state that "comparable range and level of services to consumers in the area served by" such providers may be problematic. (See draft plan page 77). We urge you to specify that in demonstrating that comparable services are available, the state must solicit input from the communities currently served by these essential providers and document these findings.

Lastly, we were pleased to see the much-needed ERISA reforms outlined in the plan. (See draft plan pages 72-73). However, we urge you to specify that plans subject to the revised ERISA must contain the same anti-discrimination and confidentiality protections outlined in the plan, that ADR is optional, not mandatory, and that the benefits provided by these plans are subject to the ADA as well.

CC: Judy Feder
Phil Lee

-more-

the coverage of the ADA. The express language of both ERISA and the ADA, and Supreme Court precedent interpreting ERISA, make clear that all federal laws, including fair employment statutes like the ADA, are unaffected by ERISA and fully govern ERISA-regulated benefit plans, the brief states.

Furthermore, EEOC argues that the District Court has no jurisdiction over the Mason Tenders lawsuit because the ADA does not provide for entities who claim they have not violated the statute to file suit. EEOC urges the court to dismiss the lawsuit.

In addition, EEOC's brief maintains that Mason Tenders is an entity covered by the ADA. By providing health benefits available to participants by virtue of their employment with contributing employers, Mason Tenders functions in the capacity of an employer and should be deemed an employer covered by the ADA. This position is consistent with settled precedent under Title VII of the Civil Rights Act of 1964, EEOC argues.

Finally, EEOC states that the AIDS exclusion denies benefits to plan participants based solely on their disability. Because Mason Tenders has failed to provide adequate justification for this disability-based difference in employment benefits, the AIDS exclusion violates the ADA.

EEOC enforces Title VII of the Civil Rights Act of 1964, which prohibits employment discrimination based on race, color, religion, sex or national origin; the Age Discrimination in Employment Act; the Equal Pay Act; prohibitions against discrimination affecting individuals with disabilities in the federal government; sections of the Civil Rights Act of 1991; and discrimination against people with disabilities in the private sector and state and local governments.

When private actions taken under these statutes raise significant legal issues on which the Commission has taken a position, it is an important part of the agency's enforcement responsibility to file amicus curiae briefs presenting the Commission's view to the courts.

# # #

To: Ken Sgut

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To Aimee	From KGS
Co.	Co.
Dept.	Phone #
Fax #	Fax #

U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

FOR IMMEDIATE RELEASE
Monday, September 20, 1993

CONTACT: David Summers
(202) 663-4900
TDD: (202) 663-4494

EEOC OPPOSES MASON TENDERS' DECLARATION OF LAWFUL AIDS EXCLUSION IN AMICUS CURIAE BRIEF

WASHINGTON -- The U.S. Equal Employment Opportunity Commission (EEOC) today filed an amicus curiae brief in federal District Court in New York opposing summary judgment in a lawsuit filed by Mason Tenders District Council Trust Fund which seeks a declaration that an AIDS exclusion in the Trust Fund's comprehensive health plan is lawful.

EEOC filed a lawsuit against Mason Tenders on June 9 claiming that a health insurance plan amendment by the Trust Fund violated the American with Disabilities Act (ADA) by excluding coverage for treatment of conditions resulting from the AIDS virus. Mason Tenders then moved for a summary judgment in its lawsuit, declaring that the AIDS exclusion is a lawful exercise of discretion by the fund's trustees.

Terence Donaghey, a plan participant of the multi-employer labor-management trust fund which provides health benefits to eligible employees of contributing employers, filed an EEOC charge against Mason Tenders when he was denied coverage for AIDS-related medical expenses. The Commission determined that the plan's AIDS exclusion appeared to violate the ADA. In March 1993, Mason Tenders sued the EEOC & Donaghey, and several other plan participants, seeking a declaration that the AIDS exclusion was lawful. The Commission filed a separate ADA enforcement action against Mason Tenders in June 1993, and has since been dropped from Mason Tenders' suit. Both lawsuits are pending before Judge John E. Sprizzo of the Southern District of New York.

In its brief, EEOC disputes Mason Tenders' argument that its status as an employee benefit plan regulated by the Employee Retirement Income Security Act of 1974 (ERISA) exempts it from

MED-MAL ARBITRATION IN CALIFORNIA: MURKY RESULTS
USSal Times
View of 9/13/93

BY MIKE McKEE

SAN FRANCISCO—For California attorneys who hate insurance policies that require resolving medical malpractice claims through arbitration instead of the courts, Aug. 10, 1976, was a day of infamy.

That was when the California Supreme Court ruled that the type of mandatory-arbitration contract that has become a mainstay at the nation's largest health maintenance organization, Oakland, Calif.'s Kaiser Permanente, does not violate people's right to trial by jury. It also officially recognized arbitration as a cheap and quick method of resolving malpractice disputes.

Ever since *Madden v. Kaiser Foundation Hospitals*, arbitration has become such an integral part of medical malpractice claims that California's experience—among others—is being studied by the Clinton administration for possible inclusion in its proposal to reform the nation's health-care system. (The proposal is scheduled for formal release on Sept. 22.)

Mandatory-arbitration contracts have been interpreted broadly by California's courts, even covering claims by a child who wasn't conceived when his mother signed her contract.

What the California example offers isn't clear, though. The spread of arbitration in the state presumably means that it has delivered at least partly on its promise to reduce medical costs and lower malpractice premiums. But there's no way to gauge the magnitude of cost savings or the effect on quality of care.

'The tendency of lawyers is always to guarantee as much due process as possible.'

FRED HIESTAND
Association for California Tort Reform

RICH PEDRONCELLI

Few solid figures exist upon which to base a judgment because only Kaiser, the Pasadena, Calif.-based Ross-Loos Medical Group, and other large insurers have kept long-term statistics, and they refuse to release their results to anyone, even the federal government. They claim that the information is proprietary.

In the absence of concrete evidence, a fierce debate has flourished between the supporters and detractors of arbitration. Defense attorneys claim that arbitration has reduced litigation costs tremendously and cut years off cases, while plaintiffs lawyers say just the opposite.

Each side, in turn, accuses the other of having selfish reasons for its position. While defense attorneys say their opponents are irked at the smaller fees they earn through arbitration, plaintiffs attorneys say their adversaries are benefiting from a system that one calls "an amorphous creature that is unfair, unregulated, and can be biased."

An Attempted Solution

Mandatory-arbitration clauses first appeared 50 years ago in the contracts of Ross-Loos, which now has about one million subscribers. A 1992 government report says the company was seeking a less adversarial method of handling disagreements. When Kaiser followed suit in 1971, the same report says, it did so because of rising medical malpractice claims and costs.

Arbitration gained statewide legitimacy in 1975 when the California legislature included binding arbitration "for individual health care providers and for defined health care service plans" in the Medical Injury Compensation Reform Act (MICRA), the state's cutting-edge—and controversial—attack on medical malpractice claims. The law also capped noneconomic damages, such as those for pain and suffering, at $250,000; based the fees of plaintiffs attorneys on a sliding scale, and set periodic payments for future damages that exceed $50,000.

Since MICRA and *Madden* a year later, there has been a slew of court cases that have given pro-arbitration forces the advantage. Appellate courts have said that arbitration agreements can be retroactive, that the original contractual agreement covers all subsequent disputes over medical practices, and that even adult heirs are bound by their parents' contracts. Courts also have found that arbitration can be compelled even if subscribers were not aware that their insurance contract required it and that an arbitration award cannot be vacated even if an error of law or fact resulted in a substantial injustice.

The state's courts have held that medical malpractice arbitrations are binding and generally unappealable, except for a 100-day window in which either side can seek to have the panel's holding vacated. Plaintiffs attorneys contend that binding arbitration violates people's due-process rights, but defense attorneys, health maintenance organizations, and medical associations say that it is essential if arbitrations are to remain cost-effective and swift.

Uncertain Reception

The Sacramento-based California Association of HMOs isn't sure how many of its members use mandatory arbitration, only that "some do, some don't."

While the same is true for private physicians, Joseph Sabella, chief executive officer of The Doctors' Co.—a Napa, Calif.-based, doctor-owned insurance firm that has 17,400 members nationwide—says that doctors are more reluctant to go the arbitration route.

Sabella, who is a doctor himself, says that physicians "are reluctant to start a doctor-patient relationship by telling a patient something might go terribly wrong and we are going to arbitrate it."

He criticizes Kaiser Permanente for keeping its track record secret.

"They could really inform the public and do a public service if they would put out an analysis of their experience," says Sabella. "Everybody is asking the same

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thing you are asking: 'Is this stuff any good?' And nobody knows."

The closest thing to statistics on arbitration contracts in California was pulled together by the federal General Accounting Office in 1992. That report, using "general information" provided by Kaiser and Ross-Loos, shows that the HMOs depend on arbitration to resolve a relatively small number of claims. Ross-Loos averages about 50 malpractice claims annually, with six to 12 resolved through dispute resolution each year, generally in favor of the HMO, according to the report. Kaiser estimated that it had 3,890 claims between 1985 and 1989, with 40 resolved through arbitration and a favorable result for the HMO 48 percent of the time. The report doesn't say what happened to the rest of the claims.

By comparison, a 1990 GAO report concluded that participation in Michigan's voluntary program of binding arbitration had been so low that it could not determine if the program had been effective. It did, however, criticize alternative dispute resolution methods in the United States as a whole.

"Claims take a long time to be resolved, awards and settlements are unpredictable, and legal costs are high," the report said.

Indications of Success

The D.C.-based American College of Obstetricians and Gynecologists has limited statistics indicating that its California members resolve their malpractice cases more quickly and for less money than the national averages, though the figures are not restricted to arbitrated cases. California cases take 4.4 years from incident to closure, while nationally it is 4.9 years, says Kenneth Heland, head of the professional-liability department for the ob-gyn group. The average California award is $245,746, he says, while the national average is $6,000 higher.

There are also studies showing that, thanks to MICRA, California has been able to rein in the cost of malpractice insurance. But it's not clear to what extent MICRA's impact has been through its damages cap or through its arbitration clause.

The ob-gyn association found that while the cost of malpractice insurance premiums for California's ob-gyns increased by 97 percent from 1983 to 1989—from $14,834 to $29,238—nationally it jumped 248 percent—from $10,946 to $38,138.

GREG URQUIAGA

Bruce Hinze: Arbitrations tend to pose few scheduling problems.

An independent report by the Pasadena-based IBAR Settlement Co.—which serves as an economic expert on legal issues—states that professional-liability insurance premiums for all California doctors increased only 9.32 percent between 1974 and 1989.

But a report by a group called Californians for Patient Rights that examines statistics from several sources insists that MICRA—and its arbitration clause—has done nothing to cap overall expense or ensure patient safety.

"Health-care costs continue to rise, malpractice continues to occur, doctors continue to escape discipline, doctor income continues to rise, and injured patients pay the price," the group states. "Under MICRA, doctors have benefited and consumers have lost."

Opposing Arguments

Plaintiffs lawyers and defense lawyers have equipped themselves with strong arguments on the pluses and minuses of arbitration.

Defense counsel and pro-malpractice-reform lawyers say that lower judgments tend be awarded in arbitration, that what is a three- or four-day arbitration would stretch into a three- or four-week trial, and that arbitrations are less formal, meaning that documentary evidence can often be used instead of witnesses. In addition, they say, scheduling is far easier.

"You can set the arbitration for a date certain, and it will go that day," says Bruce Hinze, an associate in the San Francisco office of Redwood City, Calif.'s Ropers, Majeski, Kohn, Bentley, Wagner & Kane, who has written on medical malpractice arbitration. "You can set it for six months in advance, on a given week, . . . and it will happen that week."

Plaintiffs lawyer Russell Kussman, a partner in Los Angeles' Kussman & Whitehill, notes, however, that scheduling is at the whim of the parties involved.

MERYL SCHENKER

Robert Bokelman says Kaiser blacklists certain arbitrators.

"I have one that has now been rescheduled six times for the last year and a half. It is now set for December," he says. "You don't have the judge tracking the case and keeping [everyone] honest."

Kussman says that he would hate to see Kaiser Permanente-style clauses included in a national health policy because of their binding nature.

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"If, in fact, there was a law in effect that all patients had to arbitrate their claims rather than go to court, you would disenfranchise a large part of the population," he says. "It would be, 'You have a right to trial by jury unless you get sick.' "

Plaintiffs lawyers also say that claims about cheaper litigation through arbitration are fantasies because the most common system—used by Kaiser—requires each side to name one arbitrator. Those two then get together to choose a third.

"Those arbitrators charge $250 an hour apiece," says Stephen Von Till of Fremont, Calif.'s Von Till & Associates. "If you go eight hours a day, that's $6,000 a day for the arbitrators [for which each side pays half]. Kaiser has billions of dollars. If they take 10 days and spend $30,000, that's no problem. . . . And remember, in a jury trial, if you're indigent, you get a jury for free."

Plaintiffs attorneys also fear bias from the panels, insisting that arbitrators who vote against Kaiser are ostracized by the HMO from future cases.

"If they vote against Kaiser, that's a death knell," says partner Robert Bokelman of San Francisco's Cartwright, Slobodin, Bokelman, Borowsky, Wartnick, Moore & Harris. "They'll never get to work again on a Kaiser case, and they depend on this for income."

Milton Cooper, senior attorney in the medical/legal section of Kaiser Permanente, calls all the plaintiffs lawyers' claims, especially those about biased arbitrators, "ridiculous, absurd."

"Both sides have to approve the neutral arbitrator," he says, "and the neutral arbitrator frequently is a person who has served previously in past arbitrations."

While courts generally have supported arbitration since *Madden*, there have been some exceptions. Specifically, it has been held that arbitration awards aren't necessarily subject to MICRA's $250,000 cap on non-economic damages; that a judge's failure to disclose a substantial business relationship with Kaiser voids an arbitration ruling; and that obviously one-sided contractual agreements are not allowable.

Redesigning Arbitration

But defense lawyers say the biggest threat is now pending before the California Supreme Court. In *Moore v. Conliffe*, justices are reviewing a First District Court of Appeal ruling that says testimony in arbitrations—even in the deposition stage—isn't immune from liability, as it is in the regular courts. In *Moore*, a doctor is accused of providing false testimony in a deposition in a case involving the death of a young girl.

"If not overruled, the holding below will destroy private arbitration as a forum for resolving disputes that would otherwise burden court dockets," Oakland defense attorney Kennedy Richardson says in a brief filed with the court. "The risk that parties, lawyers, and witnesses will become embroiled in collateral litigation will convert all types of private arbitration into a legal minefield where no one will dare tread."

But Von Till, the plaintiffs attorney in the case, says that Richardson's argument is misguided.

"If you permit fraud to go on in arbitration without any civil liability penalties, who would want to go into arbitration?" he asks. An affirmance of the lower court's decision, he adds, "will encourage integrity in arbitration proceedings . . . and it will enable individuals to go into them more readily."

The California Medical Association, the California Dental Association, and the California Association of Hospitals and Health Systems filed amicus briefs in support of the doctor. Amicus briefs were filed on the other side by Consumers Union, the Latino Issues Forum, and Legal Assistance for Seniors.

Some attorneys who favor arbitration fear that eventually the process will become yet another clogged court system if such legal battles continue.

"The funny thing is that people wanted a system that was cheaper, more efficient, more economical than the regular court system," says Fred Hiestand, the Sacramento-based general counsel for the Association for California Tort Reform. "Then they get it, and the tendency of lawyers is always to guarantee as much due process as possible, . . . and over time by accretion . . . it becomes indistinguishable from the system you were trying to get away from."

—Mike McKee is an associate editor at The Recorder *in San Francisco. This article was distributed by the American Lawyer News Service.*

ON THE MOVE

Maureen Mahoney

Former Deputy Solicitor General Maureen Mahoney has returned to the D.C. office of Los Angeles' Latham & Watkins as a partner. Mahoney, who left the firm in 1991, specializes in litigating constitutional, international, commercial, and employment law cases.

PROPOSED SCHEDULE APPEARANCE
FOR

KRISTINE GEBBIE
NATIONAL AIDS POLICY COORDINATOR

ONAPC STAFFER: Buckingham
DATE/TIME OF EVENT: Wednesday, September 22, 1:30 p.m.
LOCATION: 750 17th Street

ORGANIZATION: AIDS Action Council
CONTACT: Karen Ryngen / 986-1300 ext13
PURPOSE: Discussion of Negative Amendments Anticipated in Final Actions on FY 1994 Budget

OTHER PARTICIPANTS: Buck and one additional AIDS Action staffer

MEDIA COVERAGE: NONE
REMARKS REQUIRED: NONE

BACKGROUND: AAC has prepared substantial background materials on this topic. They want to present us with a briefing book, and briefly discuss what they anticipate.

KRISTINE M. GEBBIE, R.N., M.N., F.A.A.N.
NATIONAL AIDS POLICY COORDINATOR
DEPARTMENT OF HEALTH & HUMAN SERVICES
Room 729H Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

DAY Monday DATE August 23, 1993

TIME 4:00 p.m. LOCATION 750 17th St., N.W.

SUBJECT Meeting with AIDS Action Council Staff

PARTICIPANTS:
Jeff Levi, Ms. Lubinski and Jay Coburn will be attending this meeting.

August 4, 1993

The Honorable Tom Harkin
United States Senate
Washington, DC 20510

Dear Senator Harkin:

The 1994 Labor-HHS Appropriations bill will provide much of the funding for the nation's response to the HIV/AIDS epidemic in the next fiscal year. President Clinton has identified significant increases in HIV/AIDS research, care and prevention as high priorities for his Administration and the nation. The President's request for HIV/AIDS funding for the Public Health Service in fiscal year 1994 reflects a comprehensive approach to the HIV/AIDS epidemic.

We are writing today to demonstrate our united support for the comprehensive approach to HIV/AIDS reflected in the President's original budget request for HIV/AIDS research, prevention and care funding. In the past you may have heard from our individual organizations in support of various programs in the AIDS budget, or concerning national AIDS policies. As organizations, we represent community-based care and prevention organizations, persons living with HIV/AIDS, public health departments and research advocates. Together we strongly support the President's proposals for an additional $310 million for the Ryan White CARE Act, an additional $227 million for HIV/AIDS research as well as increases in other biomedical and behavioral research at the National Institutes of Health, and an additional $45 million for prevention programming at the Centers for Disease Control and Prevention. These funds are urgently needed, and each programmatic area is vitally important to our shared goal of effectively responding to the HIV/AIDS epidemic.

We hope that you will support this comprehensive approach as you work to develop the Senate Labor-HHS Appropriations Subcommittee's budget for FY94.

Sincerely

Christine Lubinski
Deputy Executive Director for Programs
on behalf of
AIDS Action Council
American Foundation for AIDS Research
The CAEAR Coalition
Coalition for AIDS Prevention and Education
Human Rights Campaign Fund
National Alliance of State and Territorial AIDS Directors
National Association of People With AIDS
National Minority AIDS Council
National Task Force on AIDS Prevention
Pediatric AIDS Coalition

ISSUES NOTE TO KRISTINE GEBBIE

HIV/AIDS and HEALTH CARE REFORM

Based on my meetings with NORA co-chairs, questions raised at my own health reform and HIV speeches, and review of AIDS Action's Federal HIV/AIDS Agenda '93, I think you should anticipate the following issues being raised when you meet with Jeff Levi, Christine Lubinski, et al --

- How will access to preferred HIV specialists be "guaranteed" under managed care (a subset of the larger patient choice issue)?

- What, if any, provision will be made for off-label prescribing? For example, many HIV docs are putting patients on high dose acyclovir therapy even if they've never had a sign of a herpes virus because they believe there is a synergistic effect between it and AZT. (And I'm sure Burroughs, which makes both drugs, loves this.) A footnote: I've heard that every time B-W dropped the price of AZT they quietly raised the price of acyclovir. . .

- What provision will be made for funding of "enabling" services such as transportation, case management, etc.?

- What will happen to categorical programs, most especially to Ryan White?

- What protections will be available for C/MHCs and other community clinics?

- How will confidentiality be protected/enforced?

- Expect a range of questions re: the benefits package --
  - will deductibles/co-pays be indexed to income
  - will there be separate Rx deductibles/co-pays
  - coverage of "the healing arts" (their words, not mine!)
  - coverage for OTC drugs, vitamins, nutritional supplements
  - DME coverage
  - long term care and hospice coverage

- What happens to Medicaid, and on what timetable?

- Need for ERISA reform

- Issues in Puerto Rico and trust territories, esp. current Medicaid caps

Let me know if you want to chat about any of these before the meeting at 4:00.

Buck