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AIDS Action foundation

Analyzing the Proposals for Health Care Reform

A Supplement to *AIDS Care is Health Care*

January 1994

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AIDS Action Monograph #101

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Introduction

This analysis of the various proposals for national health care reform is designed to provide an in-depth look at how the Clinton, Wellstone/McDermott, Cooper/Breaux, Chafee-Thomas and Michel-Lott plans would affect the health care needs of people living with HIV. It is a supplement to the primer on health care reform published recently by AIDS Action, entitled *AIDS Care is Health Care.*

While the focus of the national debate is on the proposal put forward by President Bill Clinton, it is important for the AIDS community to understand the range of options that are before Congress as it considers this major issue that affects one-seventh of the nation's economy. What finally emerges will, in all likelihood, be drawn from each of these proposals.

Ultimately, the value of any health care reform proposal will be measured by how well it provides for the sick. Like it or not, every family has or will have a member who needs health care for a chronic disease at some point -- whether it is AIDS, cancer, heart disease, or any number of other illnesses. People need a health care system that will offer comprehensive benefits at a reasonable cost while retaining some individual control over health care decision making -- not just while people are healthy but when they are sick. The analysis in this monograph focuses on how well these proposals will address those who have one disease, HIV, but could well be a general statement on the value of these plans for all people living with a chronic disease.

This analysis is organized around the same key questions for each plan: who is covered, what benefits are offered, how much they will cost, what levels of choice will be available, how care will be structured, etc. Underlying these key questions are some fundamental principles about health care reform that are articulated in AIDS Action's *Health Care Reform: Statement of Principles for People Living with HIV/AIDS.* To be of benefit to people living with HIV disease, the health care reform plan adopted by Congress must:

- **Cover everyone.** Coverage should be universal, meaning that all U.S. residents, without regard to employment status or health, should be included in the health plan.

• **Cover basic medical care.** Comprehensive coverage means that all medically necessary services should be available including physician visits, inpatient and outpatient hospital care, prescription drugs, medical equipment, diagnostic and lab services, rehabilitation services, home health care, long-term and hospice care, ob-gyn services, including maternity care, well-child services, substance abuse and mental health services, and preventive care.

• **Allow people to choose their doctors.** Freedom of choice means that people should be free to choose their own AIDS-knowledgeable, culturally sensitive, locally available doctors and other health care providers.

• **Be affordable for everyone.** Affordability means payment should be based on ability to pay and not be prohibitively expensive.

• **Hold the government responsible.** Government responsibility means the federal government must commit itself to enforce fairness and cost effectiveness, eliminate discrimination, protect confidentiality, and ensure quality care.

As the following analysis will show, it is AIDS Action's conclusion that President Clinton's proposal and the Wellstone/McDermott single-payer bill are the only two plans currently being considered that offer hope for meaningful health care reform. The Cooper, Chafee, and Michel proposals fall short because they don't guarantee universal coverage, don't guarantee comprehensive benefits, don't make health care sufficiently affordable for all Americans, and don't protect consumers from discrimination or poor quality care.

This analysis was written by Jeffrey Levi of the AIDS Action staff. Aimee Berenson, Christine Lubinski, and Pat Taylor of AIDS Action and Ruth Finkelstein of Gay Men's Health Crisis did major portions of the analytical work; Lynora Williams of AIDS Action edited this paper.

The Clinton Plan

1. Summary

President Clinton's Health Security Act (S. 1757/H.R. 3600) proposes to guarantee health insurance coverage with a standard set of comprehensive benefits to all legal residents of the United States. Insurance would be provided through regional alliances that would oversee the purchase and administration of health insurance plans for all residents of a geographic area. All employers would be required to offer their employees health insurance while paying, on average, 80% of the premium for full-time employees. The self-employed and unemployed would also be required to purchase health insurance through the regional alliances, with their premiums subsidized or covered by Medicaid if they qualify. All plans offered under a regional alliance would have to offer the same package of basic benefits, which are fairly comprehensive in covering basic primary care needs (both inpatient and outpatient). While everyone would be required to pay something for their care (in the form of copayments or coinsurance), different plans could offer different options for accessing care (e.g., closed network managed care plans vs. traditional fee-for-service options); generally speaking the more choice an individual has, the greater the cost that individual will have to contribute in the form of premiums and copayments or coinsurance. Importantly, premiums would be the same for any individual, regardless of health status, buying the same insurance plan within an alliance area, and all pre-existing conditions and caps on reimbursement would be eliminated. Premium increases would also not be allowed to increase at a rate higher than the rate of health care inflation, which is calculated yearly by health economists. Individual out-of-pocket costs for covered services would be limited to about $1,500 a year.

2. Who is covered by the Clinton plan?

All U.S. citizens and legal residents would be covered by January 1, 1998. Coverage would be initiated on a state-by-state basis, so some states may adopt this approach sooner than others -- but all must do so by January 1, 1998 (with a possible six-month extension). Undocumented persons would not be covered, therefore excluding a group of individuals with a relatively high incidence of HIV infection. These individuals could still access care through the existing safety net -- emergency rooms, community and migrant health centers, etc. --

but it is not clear that these systems will continue to be as open and as well funded to provide this care. Prisoners, another population with high HIV incidence, would also be excluded from the Clinton plan, meaning that discontinuities of care will exist for people with HIV as they enter and leave the criminal justice system.

Coverage would be assured through various mechanisms. Critical to universality under the Clinton plan is the requirement that all employers provide health insurance and that they pay at least 80 percent of the average premium for all full-time employees. This is known as the employer mandate. This insurance would be bought through the regional health alliance (or, in the case of employers with more than 5,000 employees, their own optional corporate alliance) from whose plans the employee could choose. (The employer would only have to pay 80% of the average cost plan; if an employee chose a more expensive plan, he/she would have to pay more than 20% of the premium. Subsidies will be available for small businesses.) Special arrangements would be made for families so that they can all be in one plan. (The definition of family is one based on blood or marriage; efforts are underway to broaden that definition so that it recognizes alternative family arrangements, including domestic partners and multi-generational dependents.)

Self-employed individuals will also be required to purchase health insurance through their regional alliances; their costs may be subsidized depending on income. Those currently on Medicaid, the federal/state health assistance program for the poor, would also participate through the new regional alliance system, with Medicaid paying the premiums for those on cash assistance. Those on Medicare, the federal health assistance program for senior citizens, would remain outside the current system; the Department of Veterans Affairs system would also remain separate, although a VA center could choose to operate as a health plan within a regional alliance.

All plans would be required to have the same minimum benefits. No pre-existing conditions exclusions could be placed on accessing any benefits. This is one of the major reasons why access to care for people with HIV has been restricted under the current system. Coverage would be continuous: individuals would continue to be covered if they switch jobs or move to a new region, and there would be no waiting periods for coverage of any pre-existing conditions.

Also, all plans would be required to have open enrollment: no plan may exclude an eligible individual based on health status or any other factor.

Premiums would be determined by community rating -- in other words, everyone in a regional alliance would pay the same premium for a plan regardless of health status. Under the current system, premiums based on one individual's health status or the experience of a small group have dramatically affected the ability of people with HIV to purchase insurance and has prevented many small employers from being able to afford health insurance for their employees. Moving to a community rating system is a major step forward in assuring access to health care for all people, regardless of health status.

3. What benefits are provided in the plan?

The Clinton plan offers a fairly comprehensive set of benefits covering medically necessary services as part of the minimum package that must be offered by all health insurance plans. The benefits include: hospital and emergency room services; services of health professionals (inpatient and outpatient); emergency and ambulatory medical and surgical services; clinical preventive services (including screening for cervical and breast cancer, HIV testing, immunizations); limited mental health and substance abuse services prior to 2001 (see below); family planning services and services for pregnant women; hospice care; 60 days of home health care as an alternative to inpatient hospitalization, skilled nursing facility or rehabilitation center; 100 days of extended care services in a skilled nursing facility or rehabilitation facility as an alternative to hospitalization; outpatient laboratory, radiology and diagnostic services (including HIV testing, blood tests monitoring the progression of HIV disease such as CD4 testing, etc.); outpatient prescription drugs (including off-label indications); outpatient rehabilitation services, durable medical equipment, prosthetic and orthotic devices; and vision and dental care for those under 18. This minimum benefits package would be legislated. Later additions or changes could be made legislatively or through the National Health Board created to oversee the entire new system.

Within the basic benefits package are several elements critical to people with HIV or at risk for HIV. HIV counseling and testing would be considered a preventive service that does not require any copayments. There would be no

anonymous testing under the Clinton plan, although the administration does plan to retain anonymous testing sites funded through the Centers for Disease Control and Prevention.

A number of the preventive benefits for women have been the source of controversy. Pap smears every three years for women with HIV are far below the standard of care. The administration has indicated that coverage could be more comprehensive where underlying medical conditions warrant. Women over 50 are assured mammograms every two years; there is considerable pressure from the medical community to extend this to women over 40.

Access to experimental treatments and off-label uses of approved treatments is critical to the care of people with HIV. Off-label use occurs when a drug is prescribed for a condition other than the licensed use approved by the Food and Drug Administration. The Clinton plan assures access to off-label indications as a general principle. However, the plan is silent on whether insurance companies can create formularies of drugs covered, i.e., a list of drugs to which, with rare exceptions, physicians are limited to prescribing. The needs of people with HIV would be better served if the Clinton plan created formularies at the national level so that coverage would be consistent regardless of plan enrollment or geography.

Participants in a formal government- or drug company-sponsored clinical trial to evaluate the effectiveness of an investigational treatment would be assured coverage of costs that would have otherwise been incurred -- in other words, non-research related costs of care. Hospitalization associated with a clinical trial would not automatically be covered under the Clinton plan, even though these costs are now often absorbed by insurance companies (though not Medicaid). Coverage of investigational treatments for life-threatening conditions outside a clinical trial is not guaranteed; it is left to the discretion of the insurance company. Coverage of investigational treatments should be required for all treatments for which the Food and Drug Administration is willing to permit expanded access beyond clinical trial participants.

The substance abuse and mental health benefit of the Clinton plan is one of the most limited. It is a combined benefit with severe limitations on usage; for example, each time a mental health benefit is accessed, available substance

abuse treatment is diminished accordingly, and vice versa. Not until 2001 does the plan intend for substance abuse and mental health services to achieve the same level of coverage as other health benefits. Within limits, the Clinton plan covers inpatient and residential mental illness and substance abuse treatment; intensive nonresidential mental illness and substance abuse treatment; outpatient mental illness and substance abuse treatment including case management, screening, assessment, and crisis services; and collateral services. The combined benefit is limited to a total of 30 days per year of residential or inpatient treatment; a plan may agree to extend it another 30 days. Sixty days of outpatient care are also covered. Each day of residential or inpatient treatment can be swapped for two days of intensive nonresidential treatment or three days (visits) of outpatient counseling, with the possibility of 120 days of outpatient care altogether if all residential care is sacrificed. There are also significant copayments or coinsurance requirements associated with this benefit, at higher levels than required for other parts of the plan.

These severe limitations pose major concerns for people with HIV or at risk to HIV. People with HIV often need both mental health and substance abuse services to address underlying substance abuse issues as well as mental health issues associated with having HIV disease. The offered benefit makes it almost impossible to get effective substance abuse treatment *and* adequate mental health services.

Separate from the benefits package, the Clinton plan creates a new federal-state program for home and community-based services for people with disabilities. Home and community-based care is a cornerstone of services for people with HIV that has dramatically reduced hospitalization and care costs for people with AIDS. Though people with AIDS are often considered disabled, this benefit is so severely restricted by limited funding provided to this program that few people with AIDS are likely to be eligible. (The limited nature of this benefit contributes to the requirement that states maintain any currently existing home and community based care programs that are part of their Medicaid programs.) The benefit is limited to those who need assistance with three activities of daily living (eating, toileting, dressing, and/or transferring in and out of bed) and are expected to need this assistance for a minimum of 100 days. The Social Security Administration recently adopted a less restrictive definition of disability for people with HIV after years of prodding from the AIDS

community. Adoption of modified eligibility criteria or a special exemption for people with HIV and other chronic diseases in the last 24 months of life would be necessary to make this new program meaningful to people with AIDS.

4. How much will I have to pay for this coverage?

The Clinton plan is somewhat progressive in its approach to asking people to pay for care. All told, no employed individual will have to pay on an average more than 20% of premium costs (with some subsidies for working poor people) and no more than an additional $1,500 per person or $3,000 per family in other out-of-pocket expenses in a year. Both premiums and out-of-pocket maximums will rise with health care inflation each year.

Employers will be picking up the lion's share of premiums for those who are working. Employers will be required to pay at least 80% of the average premium. An employee will have to pay the remaining approximately 20% of the premium cost. (Depending on the nature of the plan, the premium for some plans might be more or less expensive than the average plan.) No one earning under $40,000 a year will have to pay more than 3.9% of their adjusted income for their share of the premiums. The working poor will have direct subsidies of their premiums if their income falls 150% below poverty; part-time workers and those unemployed but not on Medicaid will be subsidized up to 250% of poverty. (Part-timers and the unemployed are subsidized to a greater degree because they must cover 100% of their premiums.)

In so-called low cost-sharing plans (primarily managed care plans, such as health maintenance organizations or preferred provider networks where individuals are required to choose from a limited number of providers), patients will be charged small copayments -- flat fees such as $10 per outpatient visit and $5 per prescription -- each time services are accessed. In high cost-sharing plans (such as a fee-for-service plan where individuals can choose any provider), individuals will be required to pay 20% of the set fee for outpatient services. There is no cost sharing for any preventive services. In the high cost-sharing plan, there is also a $200 individual/$400 family deductible, with a separate $250 per person deductible for prescription drugs. In either case, no individual will have to pay more than $1,500 in cost sharing fees and no family will have to pay more than $3,000 in cost sharing fees in 1994 dollars for covered

services. This cap on out-of-pocket expenses does not include cost-sharing for mental health and substance abuse services or the new long-term care program. In those regions where low cost-sharing plans are not available, subsidies will be provided to those on cash assistance programs -- Social Security's Supplemental Security Income (SSI), AID to Families with Dependent Children (AFDC) -- or with incomes below 150% of the federally designated poverty level (approximately $16,000 for a family of four) to reduce the cost-sharing burden.

It should also be noted that the Clinton plan places no caps on the amount of care that will be reimbursed either generally or for a specific disease. For individuals with diseases associated with catastrophic costs, this is an important feature. Many people with HIV have run into general or disease-specific caps in their health insurance plans. Both would be eliminated. In addition, the Clinton plan establishes fee schedules for all covered services, so there will be uniformity in charges for services across plans, and balance billing (charging for more than the fee schedule or for more than the insurance plan covers) is prohibited.

While this approach certainly sets specific caps on the costs individuals may incur, there are several aspects that will continue to pose a challenge to people with HIV disease who have limited incomes. People with chronic diseases such as HIV in all likelihood will meet their out-of-pocket maximums earlier than others because they are more frequent users of services. For those with limited incomes, coming up with the $1,500 in out-of-pocket expenses in the first few months of the year would be a significant financial burden; it would make more sense to pro-rate the out-of-pocket maximum on a monthly basis for those who are high users of the health care system. Ending the subsidies for premiums at 150% percent of poverty -- rather than on a sliding scale as income increases -- is somewhat arbitrary and may result in a special burden on people with disabilities when combined with more rapid accrual of out-of-pocket expenses. Some kind of accommodation in subsidies or other limits on costs will be needed for people with chronic diseases so they can afford to access the full range of benefits meant to be available.

5. Will I be able to choose my own plan or physician?

There are two levels of choice within the Clinton plan. First, people can choose among the various health plans that will be available within a regional alliance. Second, they may then choose among providers within a given health plan. For those who currently receive health insurance through their workplace, there will be a new level of choice since employees will not be required to enroll in the one plan offered by their employer. A range of options will be available to all employees through the regional alliance and their employer will be required to pay 80% of the average premium of the various plans.

Every individual will be able to choose from at least three kinds of plans: from lower cost-sharing plans that emphasize low copayments in exchange for being required to seek care from a closed network of providers; higher cost-sharing plans that permit the individual a wider range of choice of providers but require a 20% coinsurance payment (usually a fee-for-service arrangement with any provider an individual may choose); and combination cost-sharing plans where there is lower cost-sharing if one stays within a network but higher cost sharing if one goes outside the network. For those who can afford the additional cost-sharing that allows a full range of provider choices, there is great flexibility. Those on limited incomes must hope the providers they prefer will be in the network of the plan they choose and that they will remain within that plan. (It will be possible to switch plans once a year; more often under special circumstances.)

Poor people who are dependent on subsidies for their premiums or people whose premiums are being paid through Medicaid will be required to be in the low or average cost plan. For them, going out of their plan's network for care is simply not a realistic option.

This is particularly troublesome for people with HIV disease. The kind of expertise required to care for HIV may not be present in every plan, especially in smaller communities. The need to put together a health care team with various types of expertise may simply be impossible within the confines of one plan. While this would argue for opting for a fee-for-service plan, the higher cost sharing associated with these plans may make it prohibitive for a person with HIV and would be impossible for someone on Medicaid.

There are two elements of the Clinton plan that mitigate this situation somewhat. All plans are required to have arrangements with academic health centers (teaching hospitals associated with medical schools) to provide the expert care for diseases like HIV that might not be available within the plan. It is not clear, however, whether treatment at these centers would be considered to be within the network of the plan, and therefore not subject to higher cost sharing, or whether the individual might have to pay a substantial penalty for going outside a network.

Similarly, each plan is required to have arrangements with so-called essential community providers: those existing health clinics and programs that specialize in caring for underserved populations. These include community and migrant health centers and primary care providers funded under the Ryan White CARE Act. This would increase access to HIV expertise and culturally sensitive providers. However, not all essential community providers would have to be treated by the health plan as "in network" and thus these providers might have to absorb certain costs if their patients cannot afford the cost sharing.

Choice of providers is essential for people with HIV. The current structure of the Clinton plan places obstacles that might diminish the quality of care available to people with HIV. Thus an accommodation should be made that would permit poor people who are disabled to have premiums and cost-sharing subsidized for fee-for-service plans. In addition, care received through essential community providers should be covered as though it is an in-network service.

6. What happens to me if I am now on Medicaid?

Those who are on Medicaid because of their eligibility for cash assistance (SSI or AFDC) will now have a choice of plans through the regional alliance and receive the same benefits package as all others. Their premiums will be paid by the Medicaid program up to the average cost plan. (Above that, the Medicaid recipient would have to pay the difference.) Those on cash assistance would only have to pay 20 percent of the usual copayments (e.g., $2 per office visit rather than $10). This same group would continue to receive Medicaid services not covered under the regional health alliance plans (e.g., case management, transportation services, etc.). These are called wraparound

services. In addition, the Medicaid long-term care program would be maintained.

All others currently on Medicaid would be pooled with those eligible for premium subsidies because their incomes fall below 150 percent of poverty. They too would receive their care through the regional alliances. (This includes those on the medically needy program, i.e., those who have are poor and have high medical costs, but are not poor enough to be eligible for SSI or AFDC.)

Those on Medicaid would be required to enter low cost-sharing plans, generally managed care plans that strictly limit choice of providers to a prescribed network. This includes those who are disabled and might require special expertise available only in more flexible higher cost-sharing plans. This will dramatically limit the level of choice available to poor people with HIV and may well mean they will not receive the same quality of care as those able to afford higher cost-sharing plans. Those who are disabled and poor should have the premiums covered by Medicaid for the more costly plans to assure equal access to quality care for all people with HIV.

7. What happens to me if I am now on Medicare?

Medicare will remain a separate program under the Clinton plan with an added prescription drug benefit (with a $250 deductible and maximum $1,000 out of pocket payment). Those who retire will be able to choose between continuing with their existing alliance plan or joining Medicare. (Medicare would pick up premiums for the alliance plan.) Those who are disabled and become Medicare eligible could also choose between staying with their current alliance plan or enrolling in Medicare. For those with AIDS already on Medicare, the additional prescription drug benefit is an important improvement. Medicare has some disadvantages: there is no out-of-pocket maximum for covered services and there are no preventive services covered without copayments or deductibles as under the regional alliance plans.

8. What happens if I get my care through the Veterans Affairs system?

The VA system will remain in place. Individual VA programs may choose to operate as health plans in a given regional alliance.

9. Will my rights as a consumer be protected?

The Clinton plan offers a number of protections against discrimination. First and foremost, the plan (as mentioned above) eliminates pre-existing condition exclusions, disease-specific caps on costs that will be reimbursed, and other medical underwriting practices that have limited or denied coverage of health care for people living with HIV/AIDS in the past. These practices are prohibited for health care plans run by both regional alliances and corporate alliances. One negative feature of the existing system, redlining, is technically illegal under the Clinton plan. Redlining is the practice of health insurance companies choosing not to market to certain geographic areas because of race, age, socio-economic status, sexual orientation, etc. Monitoring of this practice will be essential since plans will, under the Clinton plan, have the right not to market to an entire alliance area and thus might, de facto, engage in redlining by limiting their geographic area to avoid certain neighborhoods.

The Clinton plan also provides a number of new protections against discrimination. Individuals discriminated against by an alliance or a health plan on the basis of race, national origin, gender, income, health status, or anticipated need for health services (such as HIV-related services) can file suit in federal court. Additionally, the Department of Health and Human Services can take action to remedy discrimination and refer cases to the Department of Justice for court action. Sexual orientation discrimination is not prohibited in the Clinton plan, nor does the definition of "eligible families" in the plan include domestic partners unless state law defines them as spouses.

Because of the ongoing stigmatization of HIV disease, confidentiality and privacy concerns in the health care setting are significant for people with HIV. Currently, no federal law provides for national confidentiality and privacy protections in the health care setting. The Clinton plan assumes the use of a "health security card" -- very much like a credit card containing a magnetic strip with important identifying and medical information. The plan provides a broad framework for structuring information systems in a manner designed to be consistent with privacy principles and provides for new administrative remedies for breaches of confidentiality in addition to those already on the books. Unfortunately, the design of these systems is still in the development stage and it is not clear that these protections will be in place prior to initiation of the

universal reporting systems. One issue of great importance to the HIV community is maintaining the separation of the health care system's reporting system from the public health reporting system for epidemiologic purposes. State health departments maintain lists of people with certain diseases such as HIV or AIDS. To retain confidence in the new health care system, it will be critical for its information systems to be kept separate from the public health system records.

Questions also remain as to how adolescents or others within a family can access health care services without family members finding out. Even if each family member has a separate health security card, information about health care use might be disclosed as a result of billing practices for deductibles and copayments. Additionally, given the definition of "eligible family," it is unclear how out-of-school or runaway youth who do not live with their defined "family" will get access to a health security card or health services without a card. The National Health Board is left with the responsibility to address such issues, but no timeline is set in the plan.

Finally, as consumers, people with HIV may also need to challenge some of the decisions of their plans, which might inappropriately restrict access to certain kinds of services. The Clinton plan provides very detailed provisions to assure consumers due process, timely rights of appeal, and options to go to court, mediation, etc. The plan creates a system of administrative remedies which, with some exceptions, must be exhausted before a consumer can appeal elsewhere, although provisions limiting time for review of appeals and cases where administrative remedies will be considered exhausted automatically provide some protection against abuse of this process. Preauthorization cannot be required for emergency services; preauthorization for services or items that are needed immediately to prevent serious illness or impairment must be decided within 24 hours of the request or the claim will be considered approved.

Each regional alliance is required to establish a complaint review office to which consumers may turn once they have exhausted the administrative appeals process. All consumers in both regional alliances and corporate alliances must also be offered the option of submitting a complaint to an early resolution program for mediation.

10. What is the operating structure of the plan and who gets to make decisions?

While the federal government is setting broad parameters and requirements for how the reformed health care system will work, much of the decisionmaking about the mechanics of delivering health care will be made at the state and local levels.

Starting the system in each jurisdiction will be the responsibility of the state governments. The first decision that will have to be made is whether to adopt the regional alliance structure suggested in the Clinton plan, where states are divided into one or more regional alliances that function as purchasing cooperatives for health insurance. Alternatively, a state may choose to adopt a single-payer approach, much like the Canadian system. Under such a system, rather than paying insurance premiums to insurance companies, individuals would have their health bills paid by the state government, which would fund health care through the tax system.

A state has numerous responsibilities under the Clinton plan. It must decide how many regional alliances are needed in a state (from one to several; the only restriction is that a standard metropolitan area must be in one alliance). It must certify health plans (insurance companies) as eligible to compete for business within the state's regional alliances based on federal criteria as well as any additional requirements a state may impose. Among the criteria by which the states must judge plans are capacity to deliver the required package of comprehensive services, quality, and financial stability. The states must also assure that each regional alliance is able to offer consumers an adequate range of choice in plans, including a lower cost option and a fee-for-service plan. The states will monitor the fiscal stability of the plans over time. They will also continue to administer their Medicaid systems both in terms of integrating those on cash assistance into the new system and in delivering the auxiliary services beyond what is in the basic benefits package that those on Medicaid now receive.

There are two types of alliances: regional alliances serving a geographic area and corporate alliances covering large employers with more than 5,000 employees. (Corporations do not have to form their own alliance but they may

opt to do so.) The corporate alliances must comply with most of the same requirements and protections imposed on the regional alliances (offering employees a choice of plans, paying the employer's share of the premiums, offering the same level of benefits, etc.).

Regional alliances are to be governed by a board comprised of equal numbers of employers and consumers. No one on the board may have a financial stake in health care. No providers of health care may serve on the alliance board; their input is received through a provider advisory board. The alliance contracts with health plans certified by the state to compete for patients living in the regional alliance area. The alliance must make certain that a choice of plans is offered all individuals. These choices must include a plan that offers the fee-for-service option. The alliance issues the health security cards and is responsible for making sure everyone is enrolled, setting up procedures to assure that all individuals are well-informed about their choices, and ensuring the plans are being overseen. The alliance also computes premiums and reimbursement rates, collects funds owed to the plans, and determines eligibility for cost sharing reductions for those below 150% of the federally designated poverty level.

The health plans function just as insurance companies or health maintenance organizations do today. They provide the basic benefits based on the federal, state, and regional criteria established. They are required to market their plans fairly and in a nondiscriminatory manner, providing key information regarding costs, consumer rights, and disenrollment levels, among other things.

The Clinton plan also creates a new category of providers called essential community providers. These are existing health organizations that provide care to traditionally underserved populations such as community and migrant health centers and, importantly for people with HIV, Ryan White CARE Act providers. During the first five years of the Clinton plan, every health plan will be required to have an arrangement with essential community providers in their geographic area, either by direct agreement that makes the essential community provider part of their network or by reimbursing the essential community provider under a Medicare reimbursement rate. This is a critical element in helping assure continuity of care for people with HIV in a sensitive and informed setting.

The federal role in the Clinton plan is divided among the Department of Health and Human Services (HHS), the Department of Labor, and the newly created National Health Board. HHS continues to run the Medicaid, Medicare, and traditional public health and health services programs and has the power to step in and take over state systems that are not working up to standards. Labor has oversight over the corporate alliances. The new board has the potential for exercising tremendous influence over the nation's health care system.

The National Health Board will have seven full-time members appointed by the president and confirmed by the Senate. The board will certify state plans before they can begin operation and will notify the Department of Health and Human Services if a state is not operating up to standards. It will have the power to interpret the benefits package and recommend to the president any changes in the benefits. It will oversee adherence to uniform national standards, cost containment, quality management, and the development of a national health information system and a risk adjustment methodology. The board will also set standards for the states and establish fiscal standards for plans.

This is not a simple structure. For consumers to be assured adequate protection, it will be necessary to be heard at multiple levels. It remains unclear where all decisions will be made -- and the challenge for the HIV community will be, if this approach is passed into law, to have its presence felt at all points so that the community's interests will be protected at each stage of regulation and program development.

The essential community provider function bears additional comment. The Clinton plan does not require that essential community providers be considered part of a health plan's network. For the individual, this will make a big difference: if this is considered an "out of network" service, copayments may be required. Thus, the essential community provider will either have to absorb the cost differential or be forced to charge the individual. Ideally, essential community providers should be considered in network for all plans because, by definition, they are providing services not necessarily available through the health plans.

11. How will costs -- and premium increases -- be contained?

The Clinton plan has a complicated system of regulating the overall national spending on health care. The system ultimately translates into strict limits on annual premium increases. Essentially, the plan limits overall health spending growth (limited to health inflation plus 1.5% initially and winding down to health inflation only in 1999) by not permitting the average premium for each alliance to grow by more than those inflation factors.

The National Health Board computes a per capita baseline premium target, with annual adjustments for inflation, for all alliances. This is the functional equivalent of setting an overall budget cap on health care spending in a given alliance. If a plan is not in compliance with those cost limits, the alliance will reduce the plan's federal support payments accordingly. In turn, the plan is likely to reduce pay to providers to bring them within the cap. Corporate alliances would be subject to similar restrictions through a methodology still to be determined.

This is one of the more controversial aspects of the Clinton plan. It is often criticized as overregulation by the government. But government regulation only begins if the plans do not stay within a given budget -- which is allowed to grow based on health care inflation. Without such restrictions, there would be nothing to prevent premium costs from rising out of control, as they have in some communities under the current system.

12. What is being done to assure that there are enough providers and that providers offer quality care?

The Clinton plan has a number of approaches designed to encourage primary care providers to work in underserved areas and with underserved populations including tax incentives, expanded loan repayment programs, increased incentives to medical schools, and allowing states to increase resources in underserved areas through adjustments in fee schedules, capital spending, and other authorities. Funding for community and migrant health centers and Ryan White CARE Act providers is continued. However, it should be noted that funding for these programs is discretionary and is dependent on annual appropriations by the Congress.

Quality control is a philosophical commitment of the Clinton plan. But its effectiveness will be dependent on the willingness of the states, who certify health plans, to set tough standards regarding quality of care and to require collection of data that would permit both regulators and consumers to know whether a plan is adhering to standards.

13. What happens to my health care coverage during the transition?

This is one of the important features of the Clinton plan. Once the legislation is signed into law, as it is now written, it would be illegal to cancel an existing insurance policy as long as premiums are paid. In addition, restrictions would be placed on premium increases that would move toward a community rating approach for various sized groups. Further, an employer-based plan would be required to accept all new full-time employees and any pre-existing condition clauses would be limited to six months. Self-insured companies could not modify their plans to avoid high care costs. And finally, a high-risk pool would be created by the federal government from which individuals could obtain insurance not otherwise available on the private market. For people with HIV, this would be an important intermediate step that would permit them to maintain existing coverage without fear of diminished benefits or exorbitant premium increases.

14. What happens to existing public health programs -- like the Ryan White CARE Act and HIV prevention programs -- after health care reform?

The Clinton Administration has committed to the continuation and full funding of the Ryan White CARE Act programs in the initial years of the reformed health care system. However, there may be efforts to reduce CARE act funding in anticipation of health care reform. Ryan White CARE Act providers will be eligible for "essential community provider" status, making it possible to receive reimbursement from the new system for HIV-related care services covered in the basic benefits package. Retention of the Ryan White infrastructure will be critical until it is clear what, if any, services will be adequately provided under a reformed health care system. It will be essential to make sure that during congressional consideration of the health care reform, attempts are not made to reduce Ryan White funding (or slow its growth) to help pay for health care reform. They must progress together hand in hand.

Prevention-related programs would remain intact. The CDC's programs are not seen as potential offsets for the cost of health care reform, and effective prevention would obviously reduce the cost for care in the reformed system. The Clinton administration does propose two new public health programs one to help states rebuild their public health infrastructure, and another to support new initiatives in health promotion (including HIV prevention). No funding source is provided in the Clinton proposal for these programs. While they are laudable, there is danger that funding of these new initiatives could come at the expense of funding levels in existing public health programs, such as those for HIV prevention.

Among the other public health programs important to remain in place and well funded are tuberculosis control, sexually transmitted disease prevention and control, family planning, community and migrant health centers, and the mental health and substance abuse block grant.

The Single Payer Alternative

1. Summary

The American Health Security Act of 1990 (HR 12200/S 491) is the single payer approach to health insurance reform whose chief sponsors are Sen. Paul Wellstone (D-MN) and Rep. Jim McDermott (D-WA). Under the single payer approach, most private health insurance, Medicare, and Medicaid would be replaced with a government-run system administered at the state level. It would establish a universal, single-tier health care system that provides all Americans with comprehensive coverage, financed by tax increases such as graduated increases in personal income and corporate taxes, an increase in the payroll tax, and a long-term care premium.

2. Who is covered by the single payer plan?

The plan would provide universal coverage for all citizens and legal residents regardless of age, income, employment or health status effective January 1, 1995. Because Medicare and Medicaid would be replaced with the new system, the opportunities to exclude or restrict care for low-income and high-risk citizens would be eliminated. The bill addresses the issue of coverage for undocumented workers to the extent that it allows states to include undocumented workers at their own expense.

3. What benefits are provided in the plan?

The plan would provide almost all medically necessary health care. It spells out the specific services and sets up a system to coordinate care so that patients and providers determine which medical services are needed. Specifically, it would include inpatient and outpatient primary health services, including full gynecological services, preventive health services such as prenatal and well-baby care, prescription drugs, home and community-based care, hospice care, dental care for those under the age of 18, vision care, and mental health and substance abuse services.

While the plan does cover prescription drugs, it does not cover the off-label use of approved drugs. Bill sponsors have indicated a willingness to improve this benefit, which is so critical for people with HIV disease. The plan

calls for its national board to decide, after consulting with professionals and the public, whether or not the costs associated with experimental treatments or the cost of the treatments themselves will be covered. If they are to be covered, coverage will be nationwide.

The substance abuse and mental health provision covers a continuum of services, without copayments. There are no caps on the length of stay in a treatment program. Coverage includes long-term residential care as well as hospital and free-standing programs. There are no caps on outpatient coverage.

4. How much will I pay for this coverage?

The single payer system is not financed through the traditional premium, deductible, fees, and copayment structure. The system is financed through taxes, and providers are reimbursed for care by the state government from a fixed schedule of fees. Thus, individuals would contribute to the health care system based on a relatively progressive taxation approach based on their income. No premiums would be charged and there would be no cost-sharing for any benefits except, possibly, for a future long-term care benefit. There are no costs to consumers related to care utilization for covered benefits.

5. Will I get to choose my own plan or physician?

This plan establishes a single-tier system that would allow consumers to choose their own doctors and other providers. This would operate essentially on a fee-for-service basis, with the fee paid by the government. Health maintenance organizations would be permitted (if they have one-third consumer representation on their boards), but they would not be the centerpiece of care delivery as under the Clinton plan. Because all consumers would be operating on a level playing field, the likelihood of income or health status determining the quality of care is virtually eliminated. Since providers would be reimbursed at the same rate for every patient, they, too, would have no incentive to discriminate. The plan allows for the sale of supplemental insurance, but only for services not covered by the plan. There is no system of regulation for supplemental insurance established in the bill.

6. What happens if I am on Medicaid?

Everyone on Medicaid would receive services through the new system. Since there are no premiums or out-of-pocket expenses, there would be no separate need for determining eligibility for government-funded care. The single payer legislation as introduced does not make provisions for continuation of the supplementary services now part of the Medicaid program (e.g., case management services, transportation, etc.) which can be critical to accessing care for poor people.

7. What happens if I am now on Medicare?

Medicare recipients would also be folded into the new system. This would be a net improvement in benefits, since prescription drugs would be covered and there would be no deductibles, copayments, or out-of-pocket expenditures for covered services.

8. What happens if I am now getting care in the VA system?

The VA system would be retained. However, individuals could choose between getting care through the VA or through the new single payer system at no additional cost.

9. Will my rights as a consumer be protected?

As with most reform plans, the single payer approach creates a more centralized approach to information collection and management. Each individual, for example, would have a health card using a unique identifier (possibly his/her social security number) through which care and billing would be handled. The national board overseeing the system would be required to protect confidentiality of that data.

There is a general provision requiring that all providers in the system not discriminate, including on the basis of sexual orientation. Providers found in violation can, after attempts to resolve the problems, be expelled from the program. State plans must include ombudsman programs and a complaint resolution procedure.

Unlike the Clinton plan, there are no provisions regarding the marketing of care and the disclosure of various quality measures of providers. This is because the single payer plan does not assume managed care plans will be the centerpiece of the program and individuals dissatisfied with an individual provider can change providers at any time. The bill does, however, propose a fairly extensive system of quality assurance oversight.

10. What is the operating structure of the plan and who gets to make decisions?

The system will be managed from the national level by a seven member board comprised of the Secretary of Health and Human Services and six bipartisan appointees nominated by the president and confirmed by the Senate. It will have authority over all aspects of the program, from basic administration and setting of global budgets for health care in each state to establishing benefits and quality assurance. An advisory council (including consumer representation) will work with the board. Several standing advisory committees are created on various issues: benefits, cost containment, primary care and the underserved, mental health and substance abuse, and prescription drugs. A quality assurance council is also created.

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Routine administration of the program would occur at the state level. States would have to submit plans to the national board regarding how they plan to administer the program. States would be required to have advisory councils that include consumer representation. States would administer the global budget assigned them by the national board and negotiate fee schedules and other reimbursement rates with providers in the state. The state government would be responsible for overseeing quality of care and non-discrimination in its delivery.

Insurance companies as we know them today would no longer exist. Providers would bill the state government for reimbursement rather than insurance companies.

11. How will costs -- and premium increases -- be contained?

The national board would establish a national health care budget for all the services covered under the plan (including operating expenses, capital-related

items, education, and administration). This could only rise, on an annual basis, by the increase in the gross domestic product. States would be assigned an appropriate share of that budget and would be required to enforce those spending limits on providers of care in their jurisdictions. This is possibly the most controversial aspect of the single payer plan.

There would no longer be insurance premiums. Financing of health care would be through the federal taxation system: a new payroll tax (7.9%) and other existing revenue streams. This is a far more progressive approach to financing health care since under all other plans, people (above a minimum level of poverty) would be paying the same amount for health care services regardless of income.

12. What is done to assure that there are enough providers and that providers offer quality care?

Under the single payer plan, states would be required to increase resources in underserved areas through adjustments in fee schedules, capital spending, and other authorities. The federal government would double funding for community and migrant health centers and increase training and placement of primary care providers in underserved communities through the National Health Service Corps.

All states would be required to have quality assurance programs. Mechanisms would be in place to resolve complaints about care provided under the system and quality assurance in general would be overseen by a special national committee reviewing data from around the country.

13. What happens to my health care coverage during the transition?

The single payer bill assumes a very rapid transition in its current form, the new system would begin in January 1995. No other arrangements are proposed for the transition.

14. What happens to existing public health programs -- like the Ryan White CARE Act and HIV prevention programs -- after health care reform?

These would remain in place after health care reform. The proposal includes supplementary funds (based on a percentage of revenue collected for health care) to increase support for the following programs: the Ryan White CARE Act (all three titles), the maternal and child health block grant, the preventive health block grant, community mental health programs, and the substance abuse and mental health block grant.

The "Managed Competition" Option

1. Summary

The Cooper/Breaux plan (S. 1579/H.R. 3222) is a "purer" version of managed competition than the Clinton plan. Its chief sponsors are Cong. Jim Cooper (D-TN) and Sen. John Breaux (D-LA), both conservative Democrats. This plan has much less government regulation of the health care system: market forces are relied upon to control the cost of health care and to assure that health insurance plans offer quality care. Individuals and small employers would purchase coverage through Health Plan Purchasing Cooperatives (HPPCs) designed to pool risk, thus moving closer to community rating. A standard benefits package is not offered in the bill; it will be defined after enactment by a National Health Standards Commission appointed by the president. There is no requirement for employers to pay for insurance. Employers who do contribute to premium costs get a tax deduction only for the lowest cost plan available. Employees would have to pay income tax on any premiums or benefits offered beyond the lowest cost plan. Medicaid is eliminated; some low income people are eligible for assistance in purchasing insurance and meeting cost sharing requirements. Many public health programs, such as Titles I and II of the Ryan White CARE Act, are eliminated.

2. Who is covered by the Cooper-Breaux plan?

No one is assured coverage under this plan; there are no requirements that individuals or their employers purchase health insurance. The "universality" of the proposal is a requirement that every employer offer every employee the opportunity to purchase health insurance coverage through either an agreement with the local Health Plan Purchasing Cooperative (HPPC) to provide access to an Accountable Health Plan (AHP), or through the employer's own Accountable Health Plan (AHP) if the employer has more than 100 employees. However, there is no requirement that the employer participate in paying for this coverage.

Starting January 1, 1995, access to insurance would be expanded in the following ways: it would be more affordable because experience rating (charging groups based on actual costs rather than spreading costs across an entire community) is prohibited and thus small groups with high health care

expenses would not see their premiums rise more than any other group; community rating (where all in an area pay the same premium) would be the general rule but not absolute since differentials in premiums would be permitted based on age band, geographic variation, and "premium class factors" (different types of coverage); purchasing cooperatives will increase pool size; and the premium price of the lowest cost AHP is fully tax deductible for the employee. In addition, AHPs would be required to enroll all applicants regardless of health status, and preexisting condition exclusions would be limited to six months maximum.

Mechanisms to expand access to the poor and to underserved areas include: subsidies for the premium and cost sharing expenses in the lowest cost AHP for poor people (instead of the current Medicaid program); risk adjustment; and special risk adjustment and possible direct subsidies, paid for by the states, for AHPs serving residents of urban and rural underserved areas; and transitional technical assistance grants to set up AHPs in urban and rural underserved areas.

In sum, the voluntary nature of participation renders the claim of universal coverage rhetorical. The only acknowledgement that these voluntary steps might not be adequate is a required annual study of who is covered and who isn't to evaluate whether to mandate coverage.

3. What benefits are provided in the plan?

The legislation establishes no guaranteed benefits. Instead, the bill creates a Health Standards Commission that would establish a uniform set of benefits after enactment. These, and any subsequent modifications, must be approved by Congress. The package would include treatments, preventive services, and diagnostic services. Plans would be allowed to offer additional benefits beyond the basic package; however, these would be taxed if paid for by employers.

Under the Cooper plan, there is no assurance that prescription drugs (or any other specific service) so important to people with HIV would be covered. The bill explicitly excludes investigational treatments but does allow coverage of off-label uses and routine costs associated with an approved clinical research trial.

To be covered, a treatment or diagnostic procedure must be consistent with practice guidelines established by a new agency created by this bill, the Agency for Clinical Evaluations. This could diminish the flexibility of physicians in the community to adapt practice to the evolving needs and knowledge associated with HIV treatment.

Long-term care services are not covered and existing federal funding for such services through the Medicaid program is phased out over a four-year period. The bill simply offers a "sense of the Congress" that, as financing becomes available (through undefined means), there be tax benefits for long-term care benefits, subsidies for long-term care, expanded prescription drug programs, and long-term care services as part of Medicare.

Without assuring a minimum benefits package, the Cooper plan preempts state mandates for coverage.

4. How much will I pay for this coverage?

The Cooper bill makes no effort to control or regulate premium costs. It is assumed that competition in the market place will control inflation. While community rating might help in leveling the playing field of premium costs, in reality, premium differences by age and "premium class factors" (to be defined by the commission) are permitted.

Copayments are required for all but preventive services; there are no limits specified for copayments or deductibles. Out-of-pocket limits would be recommended by the Health Care Standards Commission. Cost sharing is to be designed to "restrain consumers from seeking unnecessary services" and to maintain overall utilization rates. This implies relatively high out-of-pocket payments would be permitted.

Subsidies would be provided for the least costly plan premiums and for cost sharing beyond a nominal level on a sliding scale for people up to 200% of a state adjusted federal poverty line. The total dollar amount available for subsidies is the federal Medicaid share plus tax revenues derived from "excess benefits" and any other savings derived from the plan.

The Cooper plan does not offer the consumer much assurance about affordability of health insurance or predictability of maximum health care costs. There is also no guarantee that poor people will be adequately subsidized for premiums or out-of-pocket expenses.

5. Will I get to choose my own plan or physician?

The Cooper plan would assure a choice of health insurance plans, with an annual open enrollment period allowing people to switch plans. Genuine freedom of choice will probably be limited to those who can afford the more costly plans and the taxation associated with accessing them. The lowest cost plans that are subsidized for the poor will in all likelihood be closed network plans. The bill permits totally closed network plans. Indeed, the Cooper plan forbids states from prohibiting or restricting the ability of plans to limit coverage to participating providers.

6. What happens if I am on Medicaid?

The Medicaid program would be eliminated by the Cooper plan. Instead, some poor people would receive subsidies for the lowest cost plan offered by their HPPC (see above). These are not likely to be comparable benefits (especially since the basic benefits package is undefined and Medicaid provides many supportive services generally not in standard health insurance plans). There is a supplemental package of benefits including prescription drugs, eyeglasses, hearing aids, and other Medicaid services defined by the commission offered to the very poor (defined as below 100 percent of poverty) at "nominal copayments." The Cooper plan eliminates the federal long-term care assistance under Medicaid after three years. Instead, states would be responsible for long-term care services.

7. What happens if I am on Medicare?

Medicare remains unchanged, except for a small increase in preventive services covered (some blood screening not related to HIV, immunizations, and mammography). It would cut future spending on Medicare by $61.5 billion because of expected reductions in medical inflation and greater use of health maintenance organizations. Premiums would increase for high-income seniors.

For people with HIV who generally gain Medicare eligibility through their disability, the failure to expand coverage to include prescription drugs is a major deficiency.

8. What happens if I get my care through the VA?

There are no changes proposed by the Cooper bill for the VA system.

9. Will my rights as a consumer be protected?

Under the Cooper plan, HPPCs will be required to report on and publicly disseminate the performance record of each plan in meeting clinical health requirements, functional needs, well being and satisfaction of enrollees. Each HPPC will have an ombudsman for dispute resolution.

In the critical area of confidentiality and non-discrimination, plans are required to follow rules similar to those now used in Medicare. The bill charges the commission with protecting privacy and confidentiality of individual patient records in electronic form by all players, and requires publication of the existence of health care data banks. It specifically adds special protections for "highly sensitive data" such as substance abuse, mental health, and communicable and genetic diseases.

10. What is the operating structure of the plan and who gets to make decisions?

The basic operating structure is the voluntary Health Plan Purchasing Cooperatives for individuals and small businesses. HPPCs may cover an entire state, a contiguous interstate area, or part of a state as long as each includes at least 250,0000 eligible individuals and does not divide a metropolitan statistical area. By January 1, 1996, each HPPC will elect a cooperative board, all of whom must be enrolled in accountable health plans and not employed by them or the HPPC. Responsibilities of HPPCs include entering into agreements with AHPs and small employers, enrollment, adjustments of premiums, monitoring enrollee satisfaction and disenrollment, and running an ombudsman office.

The National Health Standards Commission would establish the basic benefits package and regulate quality of services offered by HPPCs. The commission is appointed by the president (with the advice and consent of the Senate) as an independent agency in the Executive Branch. The five members of the commission shall "demonstrate experience and knowledge of the health system" and must not have other employment during the seven year terms. No more than three shall come from the same political party. The role of the Department of Health and Human Services would be reduced significantly. While it would continue to run the Medicare program, Medicaid is eliminated.

11. How will costs -- and premium increases -- be contained?

There are no mechanisms established to control premium costs or other health care costs. In fact, the national commission is explicitly forbidden from placing any controls on health spending, even though expansion of benefits can only be financed from entirely mythical savings to be realized from the salutary effects of "competition in the market."

12. What would be done to assure there are enough providers and that providers offer quality care?

The Cooper plan encourages plans to locate in underserved areas through grants and technical assistance. It continues support for community and migrant health centers for a transition period only. Medical education and residency slots are also centrally planned by the commission and primary care residencies are reimbursed at a higher rate. The Cooper plan also increases funding for the National Health Service Corps, which provides financial aid for medical students in exchange for service in medically underserved communities. Support for some key providers for people with HIV, such as Ryan White Title I and II grantees, would discontinue. Title IIIB would be continued.

The Cooper plan, with only one exception, provides no enforcement mechanisms for quality assurance. It is believed that the market will assure quality if people have sufficient information and disenroll from ineffective plans. The only exception is in cases when a disenrollment pattern is not reflective of the demographic distribution of those enrolled, in which case the HPPC may petition the Commission for revocation of the health plan.

13. What happens to my health care coverage during the transition?

The Cooper bill would take effect on January 1, 1995, so there is no real transition period.

14. What happens to existing public health programs -- like the Ryan White CARE Act and HIV prevention programs -- after health care reform?

Community and migrant health centers are retained only through 1999. A new designation of rural emergency access hospitals (facilities that are the only source of care in rural areas but are losing money) is created along with transitional assistance to other "safety net" hospitals.

The Cooper plan explicitly preserves some public health programs: child immunization, tuberculosis control, lead poisoning prevention, breast cancer prevention, office of disease prevention and health promotion, the preventive health and health services block grant, and anti-smoking programs.

Only Title IIIB of the Ryan White CARE Act is explicitly retained. It is unclear what happens to other critical programs such as Titles I and II of CARE, substance abuse block grant, family planning and STD, HIV/AIDS prevention and education, etc.

No special protection is given for public hospitals, academic medical centers, or community health centers after four years. In addition, no allowance is given for the Medicaid enabling services unlikely to be in the benefits package (transportation, case management, etc.) that are necessary for poor people to access other care.

The Chafee-Thomas Republican Proposal

1. Summary.

The "Health Equity Access Reform Today Act" (S. 1770/H.R. 3704), sponsored by Senator John Chafee (R-RI) and Cong. Bill Thomas (R-CA), embraces some progressive goals, such as universal coverage, but rejects the use of employer mandates or significant federal involvement to achieve those goals. Instead, the plan relies on states to develop and implement reforms in insurance markets within their borders, with guidance from several federal bodies, and imposes a requirement on individuals to achieve universal coverage. Under the Chafee-Thomas plan, individuals and small employers may purchase coverage through voluntary purchase cooperatives.

2. Who is covered by the Chafee-Thomas plan?

The centerpiece of the Chafee-Thomas plan is its attempt to achieve universal coverage through a mandate that all citizens and legal residents of the U.S. purchase health insurance by the year 2005. If an individual does not do so, he or she will be required to pay a penalty tax. A voucher system would be created to help poor people with premium costs (starting at 90 percent of the federally designated poverty rate in 1997 and rising to 240 percent of poverty in 2005). The financing of this voucher system, however, is dependent on savings in health care costs over the years. If those savings do not materialize, the vouchers would not be available and poor people -- those most in need of health insurance -- would be exempted from the individual mandate to obtain coverage.

3. What benefits are covered in the plan?

No specific list of basic benefits is legislated by the Chafee-Thomas plan. Instead, it establishes a National Benefits Commission, which is directed to create a standard benefits package. The plan outlines the benefits that may be included in the package, including medical and surgical services, prescription drugs, substance abuse services, services for the "severely" mentally ill, hospice care, home health care and rehabilitation services related to an acute care episode, and "preventive services." Although the plan directs the commission to establish a benefits package, the commission only has the power to delete services from the list of benefits set out in the legislation, not add to it.

Moreover, any new benefits must be approved by Congress.

While the range of services potentially covered is comprehensive, the extent of that coverage for each service is undefined. In fact, if funding is not available to support this basic package, the commission may reduce benefits and/or increase cost sharing. This provides little reassurance to people with HIV that their health care needs will be met in a comprehensive manner.

Without assuring a minimum benefits packages, the Chafee-Thomas plan does preempt state mandates for coverage.

4. How much will I pay for this coverage?

This is unclear under the Chafee-Thomas plan. It leaves to the National Benefits Commission to decide whether to set limits on premiums, co-payments, or deductibles. However, the plan does prohibit discrimination on the basis of health status or medical history, limits the waiting periods for pre-existing conditions, and premiums for enrollees in the same age ranges cannot vary by more than a specified percentage among geographic areas.

The plan includes a phased-in voucher program to enable the poor who are not on Medicaid to pay for their premiums. Vouchers become available in 1997 for people living at 90 percent of the official poverty line or below, and eligibility for vouchers increases by 20 percent each year until 2005, when vouchers will become available for everyone living at or below 240 percent of the poverty line. The phase-in schedule for vouchers is dependent on how much savings are achieved, allowing the phase-in to be delayed or sped up accordingly. If the phase-in is delayed, persons who otherwise would have been eligible for vouchers that year will not be required to pay the penalty tax imposed on individuals who do not comply with the mandate to purchase coverage. However, anyone else is subject to the penalty tax, even if he or she can't afford to purchase coverage.

The Chafee-Thomas plan also imposes no requirement for employers to contribute to premium payments (though they may do so).

5. Will I get to choose my own plan or physician?

The Chafee-Thomas plan provides consumers with two options: a standard package and a catastrophic package. Both packages consist of the same benefits but have different cost-sharing requirements, with higher cost-sharing required in the catastrophic plan. As part of the catastrophic plan, individuals can establish Medical Savings Accounts, which are non-taxed savings accounts used to pay deductibles and co-payments (not premiums). Therefore, non-Medicaid recipients theoretically can choose whatever plans/providers they want, as long as they can afford it.

The plan deliberately leaves the question of what providers are to be included in reform up to states and health plans. Therefore, it is very likely that consumers' choice of providers may be limited in lower cost managed care plans, while those who can afford more may be able to opt for a fee-for-service plan.

6. What happens if I am now on Medicaid?

Medicaid would be retained by the Chafee-Thomas plan. Medicaid recipients would not be eligible to receive vouchers to buy private insurance. States would have the option of letting Medicaid recipients enroll in the system of qualified health plans used by everyone else. This would have the effect of retaining a two-tiered system for the poor, denying many people with HIV access to the same level of care that is available in the private sector. Under the plan, states would also have the option to put Medicaid recipients into "coordinated care" plans, in which states contract with "risk contracting entities" to provide services. These entities may include federally funded programs like the Ryan White CARE Act, community and migrant health centers, and maternal and child health programs.

7. What happens if I am now on Medicare?

The Medicare program is retained as a separate system. Some of the costs of the Chafee-Thomas plan, however, come from reductions in future Medicare spending, increased copayments for lab and home health services, and increases in premiums for some beneficiaries. No new benefits (such as

prescription drugs) are included in the Chafee-Thomas plan. The Chafee-Thomas bill does require a study by the Department of Health and Human Services to investigate integrating the Medicare system into the new system of purchasing cooperatives. Medicare recipients can, in the mean time, choose to voluntarily join these purchasing cooperatives.

8. What happens if I am now in the VA system?

There is no change in the VA system under the Chafee-Thomas plan.

9. Will my rights as a consumer be protected?

The Chafee-Thomas plan directs a national panel to establish rules to protect the confidentiality of health care information, in part by developing a system of "unique identifiers." Discrimination is restricted on the basis of health status or medical history. In addition, insurance companies are required to renew policies except in instances of non-payment. No protections are provided based on family status or sexual orientation.

The Chafee plan requires consumers to appeal denials of claims through alternative dispute resolution mechanisms set up by states and run by the states or by insurance companies. Going to court is discouraged under the plan: if a consumer appeals to a court and loses, or gets awarded less money than the insurance company offered as a settlement, then the consumer has to pay all of the insurance company's legal and court costs.

10. What is the operating structure of the plan and who gets to make decisions?

The Chafee-Thomas plan relies on the current system of private insurers, Medicare, and Medicaid. The centerpiece is permitting the creation of voluntary purchasing cooperatives in Health Care Coverage Areas (HCCA) through which individuals and small employers may join together (essentially to pool risk and administrative costs) to purchase insurance from the private sector. Consumers may serve on the boards of these cooperatives.

The federal role is relatively limited. A National Benefits Commission establishes a national benefits package -- but any additions to it must be approved by Congress.

States are required to establish a "state program" to carry out their responsibilities under the plan, which include designating health care coverage areas (HCCAs) and providing information to employers regarding the plans in each HCCA. Employers, in turn, are required to provide this information to each eligible employee (including seasonal or part-time employees).

In creating HCCAs, states may not divide a metropolitan area. Each HCCA must consist of at least 250,000 residents and each HCCA must be exclusive. States may provide for the establishment of an HCCA that includes portions of an adjoining state. States must certify "qualified health plans" using insurance reform standards developed by the National Association of Insurance Commissioners and approved by the Secretary of HHS; set rules for the establishment and operation of purchasing groups; develop a binding arbitration process; and implement risk-adjustment programs, based on federal guidelines, which each qualified "general access" health plan must adopt. Risk-adjustments are to be based on increased or diminished risk for consumption of the type of health services provided, although the only specific factor set out is age.

States may establish "alternative systems" as long as similar benefits are provided for the same percent of people outlined in the Chafee-Thomas plan, but such systems must limit cost increases to the national average and the costs of the alternative system must be "budget-neutral" to the federal government.

11. How will costs -- and premiums -- be contained?

The Chafee-Thomas plan assumes that competition in the market place -- in part through the increased negotiating power created by the purchasing cooperatives -- will bring premiums under control. Therefore, for those relying on the private sector, there are only theoretical assurances of cost and premium containment. Those dependent on the voucher system created by the Chafee-Thomas plan to assist people who are poor but do not receive Medicaid in buying insurance will only see those benefits if savings in other areas of federal spending materialize, including reductions in budget increases in Medicaid and

Medicare. In a sense, the voucher system is a transfer payment from one class of poor people to another.

Savings are achieved through cuts in Medicare and Medicaid and through changes in the tax code. The plan limits the growth of Medicaid and Medicare to 7 percent over six years; additionally, fees and government co-payments are limited. The tax code is amended to allow employed individuals to deduct the average cost of the cheapest 50 percent of health care plan premiums offered in their HCCA from their adjusted gross income for tax purposes. While this may be of some benefit to employees with regard to the cost of their premiums, all other costs remain non-deductible unless they exceed 7.5 percent of the employee's income. Moreover, the plan limits the current ability of employers to deduct the costs of health benefits they provide to employees as business expenses, which may serve to discourage employers from voluntarily contributing to employees' health care coverage costs.

12. What is done to assure there are enough providers and that providers offer quality care?

The Chafee-Thomas plan attempts to improve access to care in underserved areas by providing block grants to states to expand delivery in rural and inner city areas. It also offers tax and other incentives to encourage providers to locate in such areas, and includes grants to federally qualified health centers. Additionally, the Secretary of Health and Human Services is to develop a national health data system and a quality assurance/performance measurement program, which health plans must comply with in establishing and maintaining their own quality assurance programs.

13. What happens to my health care coverage during the transition?

The current health care system stays in place during the transition to the individual mandate, which takes effect in 2005. There is a gradual phase in of vouchers to support poor people, starting in 1997. In addition, states are required to have established purchasing cooperatives within two years of enactment.

14. What happens to existing public health programs -- like the Ryan White CARE Act and HIV prevention programs -- after health care reform?

The Chafee-Thomas plan is silent on current public health programs. Presumably they would remain in place; none are identified as sources of funding for the plan. Under the plan, states have the option to put Medicaid recipients into "coordinated care" plans, in which states contract with "risk contracting entities" to provide services. These entities may include federally funded programs like the Ryan White CARE Act, community and migrant health centers, and maternal and child health programs.

The Michel-Lott Republican Proposal

1. Summary.

The Michel/Lott bill (S. 1533/H.R. 3080), one of the Republican alternative proposals whose chief sponsors are House Republican leader Bob Michel (R-IL) and Sen. Trent Lott (R-MS), relies on the current system: Medicare, Medicaid, employer-provided coverage and individual coverage. There are no guaranteed benefits; there is no requirement for universal coverage. This is essentially a small insurance market reform bill requiring insurers to cover all eligible applicants and to renew policies, encouraging the creation of voluntary purchasing cooperatives, and making coverage of pre-existing conditions portable from one plan to another (as long as coverage is continuous). Employers would be required to offer, but not pay for, coverage.

2. Who is covered by the Michel/Lott plan?

There is no requirement for coverage in the Michel/Lott plan. Employers are not required to provide insurance and individuals are not required to purchase it. Employers with two employees or more, however, must offer coverage and allow employees to have premiums deducted from their pay. Employers may impose up to a 60 day waiting period for eligibility and may exclude family members from coverage. Failure to pay monthly insurance premiums may result in loss of coverage.

Pre-existing condition exclusions are eliminated for individuals who change jobs and were covered under another plan prior to the change. The continuous coverage provision is waived if an individual is without group plan coverage for more than 60 days. People who do not now have coverage could be subject to a six month waiting period for pre-existing conditions.

With the exception of portability of current coverage from job-to-job, this does not in any significant way improve or assure access to insurance for people with HIV, especially since premiums can be adjusted based on medical history.

3. What benefits are covered in the plan?

There is no minimum benefits package associated with this plan. Rather,

it is left up to the market place and the individual. However, state mandates for coverage would be pre-empted.

Employers would be required to offer workers three insurance plan choices: (1) a standard plan with benefits and criteria to be established by the National Association of Insurance Commissioners, with benefits sufficient to cover only essential and medically necessary services, including medical, surgical, hospital and preventive services; (2) a catastrophic major medical services plan; and (3) a Medisave plan which would create a tax-free medical savings account for individuals and families. The last choice requires that a Medisave Plan be linked to the purchase of a health insurance policy with a deductible of at least $1,800 ($3,600 for family).

4. How much will I pay for this coverage?

No direct estimates can be made regarding cost, since there is no cap on premiums or their rate of increase, and there is no limit on deductibles or copayments. Premium rate variations for small businesses may vary based on factors *other than* geography, age, gender, and plan design. Annual increases for small businesses are limited to the increase in the new business rate (based on annual underwriting) *plus* 15 percent. This does not address one of the primary needs of people with HIV and their small employers: community rating of plans so that premiums are not increased beyond affordability for individuals or small groups with HIV or other catastrophic disease experience.

States would also be allowed to develop pooling mechanisms so that all families and individuals without health insurance can join Accessible Health Benefit Systems for the purpose of buying health insurance, presumably at a lower rate if their risk is pooled.

Uninsured individuals would have the option to buy into the state's Medicaid program with gradual subsidies of up to 200 percent of poverty. Self-employed individuals would have a 100 percent tax deduction for their insurance premiums.

5. Will I get to choose my own plan or physician?

As mentioned above, the Michel bill requires employers to offer a choice among a traditional insurance plan with a range of benefits, a catastrophic insurance plan, or a plan with a very high ($1,000) deductible linked to a Medisave program (a health care savings account). Choice of provider is unregulated; it would be dependent on the plan purchased.

6. What happens if I am now on Medicaid?

Medicaid would remain essentially the same for current recipients. States are allowed to expand their Medicaid programs to cover individuals and families living under 100 percent of the federal poverty level. States would also be allowed the option of setting up a sliding scale subsidy to offer individuals up to 200 percent of the federal poverty level the option of buying into the program. States would also be allowed to enroll Medicaid beneficiaries in HMOs and PPOs without submitting waiver applications, as is currently required.

7. What happens if I am now on Medicare?

Medicare would remain essentially the same, with no new benefits provided. The Michel/Lott plan eliminates the current requirement that HMOs that serve Medicare patients have a membership that is more than 50 percent Medicare and/or Medicaid beneficiaries, an important consumer protection designed to prevent HMOs from becoming "Medicare mills."

8. What happens if I am now in the VA system?

There is no change in the VA system proposed.

9. Will my rights as a consumer be protected?

Consumer protections are not addressed directly by the Michel/Lott bill. There are no direct protections against discrimination in delivery of services. There are, however, numerous requirements regarding providers and insurers adopting electronic and uniform record keeping and claims forms and a requirement that Social Security numbers be used as patient identifiers. The bill

directs the Secretary of Health and Human Services to develop standards for hospitals related to electronic medical data including protecting consumers against unauthorized use, disclosure of information, and the confidentiality of patient-specific information.

10. What is the operating structure of the plan and who gets to make decisions?

This plan has minimal government involvement. Insurance companies retain their current role; some state regulation of the insurance industry is pre-empted by the plan. States may expand their Medicaid coverage and provide subsidies. The Secretary of Labor monitors compliance of insurance companies with new rules regarding pre-existing conditions, limitations on rate variation, etc., with penalties for non-compliance imposed by the Internal Revenue Service. Otherwise, clear federal authority exists only to increase penalties, prosecute health care fraud, and dramatically limit medical practice liability, in part by shifting the burden of proof to the health care consumer.

11. How will costs -- and premiums -- be contained?

There is no attempt to set an overall budget for health care in the Michel/Lott plan. The only restriction on premiums is that for small businesses they cannot rise more than 15 percent after adjusting for actuarial factors (such as costs associated with HIV).

12. What is done to assure there are enough providers and that providers offer quality care?

Under the Michel/Lott plan, community and migrant health centers funding would be increased to help provide services to underserved populations. An Office of Emergency Medical Services would be established to provide assistance to rural trauma and emergency networks. Unlike most of the other plans proposed, there are no specific provisions regarding availability of providers.

States are required to develop a state health care value information program for purchasers of health care and may apply for federal grant assistance

to develop and implement such a system. The Secretary of Health and Human Services monitors implementation, develops models for use by the states, and steps in and sets up a program if the state is recalcitrant.

13. What happens to my health care coverage during the transition?

Since the Michel/Lott bill builds on the existing system, there are no transition issues.

14. What happens to existing public health programs -- like the Ryan White CARE Act and HIV prevention programs -- after health care reform?

The Michel/Lott bill is silent on the continuation of current public health programs; thus it is assumed they would remain in place. Increases are called for in rural, migrant, and community health programs.