From: News and Views | Opinion |
Tuesday, July 18, 2000

Old, Sad Story Needs New Ending

Back in March, the U.S. Health Care Financing Administration raised a number of questions with the state Department of Health regarding its oversight of nursing homes. The state, of course, is defensive of its record. And some patient advocates concede that progress has been made. Does the department deserve the benefit of the doubt? Absolutely not.

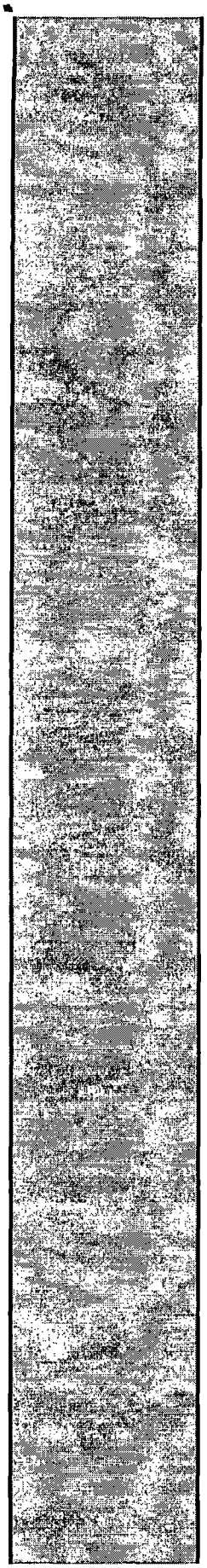
Sometimes, an issue is so crucial that the drumbeat of criticism must be kept up even as progress is being made. This is one of those issues. Which is why U.S. government findings from March, outlined by the Daily News on Sunday, are still significant.

The feds flunked the state in several key areas, including failure of inspectors to identify "immediate jeopardy" violations, failure to identify nursing homes providing poor nutrition to patients and failure to fine homes using unwarranted restraints. Those are the sanitized ways of describing things; reality is much nastier. Ask anyone who is left to lie in his own waste for so long he develops bed sores.

The state, feeling unfairly criticized, notes that it is committed to providing quality care and, to that end, has instituted a new training program and is hiring 105 more inspectors.

Patients' advocates agree that the state methodology recently has improved. The Nursing Home Community Coalition notes that the number of fines levied against nursing homes has jumped from one — one! — in 1997 to 21 in the last 12 months. And proceedings have been started against 22 more. While percentagewise this is a significant increase, numerically it is not.

Can you actually believe that only 43 homes across the state had conditions deserving of fines? In the metropolitan area alone, the HCFA says it found serious violations in a dozen facilities — violations state inspectors reportedly missed.



Allegations of inadequate nursing home care provide perennial stories. How many have you read over the decades? Deficiencies, even horrors, are uncovered. Promises of reform are made. Society feels good about itself. And, a while later, out comes another report excoriating this facility or that.

It is time to stop dabbling in reform. In addition to children, the elderly and the infirm are the individuals who most require society's protection. For they are among the most vulnerable. And for too long, society has betrayed their trust.

Is the state doing its job? Perhaps it is trying. But a definitive "yes" can be given only when it can guarantee that every nursing home patient is being treated with compassion and dignity.

Sign of the Times

An epidemic of billboards — on buildings, buses and even on trucks that have no purpose but to hawk merchandise — is threatening to turn the city into one giant eyesore. Many of the signs are illegal, but city officials can't pull them down. They can only slap offenders with fines.

That must change. Fines aren't stopping the visual assault.

Last year, the Buildings Department levied fines in about 1,000 of the 1,200 complaints it received. But you only have to look out a window to see how much good that did. (That is, if the window isn't covered by one of the huge "flex signs" that are turning whole sides of buildings into advertisements.) If anything, there are more offending signs now than ever.

Take the 24-foot video screen that Covenant House installed atop its headquarters at 41st St. and 10th Ave. The Buildings Department said the sign was illegal because it was too close to the Lincoln Tunnel. But it's still up — soliciting contributions for troubled street kids instead of running commercials — and still distracting motorists.

Then there are those billboards-on-wheels that contribute to gridlock and pollution when they're moving and take up scarce parking spaces when they're standing still. A city Department of Transportation rule forbids the operation of a vehicle for the sole "purpose of commercial advertising." But companies dodge the law by claiming that the trucks, some of which are no more than 18 inches wide, are transporting goods. What, a ham sandwich?

Said Acting Buildings Commissioner Richard Visconti: "The city doesn't have the enforcement tools we need. ... We have to go to criminal court for each and every sign violation."

Clearly, tougher enforcement and stiffer fines are needed. But until city officials get the power to remove illegal signage, New Yorkers will continue to be bedeviled by billboards.

Morbidly Fascinating

From The Mirror of London: *A shortage of bodies has triggered a price war among European undertakers. A Czech firm offers free coffee and cake to mourners; in Romania, the deceased can be accompanied to the grave by mini-skirted pall bearers dancing a samba.*

In this case, shouldn't it be called a "somber"?

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Nursing Home Compare

About the Nursing Home Inspection Results

Nursing Homes you selected in **New York County, New York**

Nursing Home Compare Home | New Search | Print-Friendly Version

Contact Information:

Long Term Care Ombudsman: 1-800-342-9871

State Survey Agency: 1-518-478-1133

The State inspection results provide useful information that can help you compare nursing homes in your area and decide what types of questions you may want to ask when you visit the nursing home. Before using this information, we suggest that you read the **Important Information on Nursing Home Compare** and **Details on Data Collection and Updates** sections. **NOTE: Every attempt is made to assure that the most recent survey results are available on this Web site. Surveys are generally conducted every 12 months. If the survey results listed below are older than 15 months, please contact the nursing home or state survey agency and ask if another survey has been conducted. The nursing home must make available a copy of the most recent survey report for you to read. The state survey agency can also provide you with a copy of the most recent survey report.**

Definitions for Level of Harm and Residents Affected are

View, download, or order Medicare or health related publications

Fraud and Abuse
How to recognize and prevent fraud and abuse

Health Information
Contains information and references to help you stay healthy

[redacted] are available for your reference.

You can **choose a new topic** if you have completed reviewing the About the Nursing Home Inspection Results information.

Range of health deficiencies in this state: 0 - 23

Average number of health deficiencies in this state: 3

Average number of health deficiencies in the United States: 5

FLORENCE NIGHTINGALE HEALTH CENTER
1760 THIRD AVENUE
NEW YORK, NY 10028
(212) 410-8757

Date of last Inspection: 03/09/1999

Total number of health deficiencies for this nursing home: 0

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Choose a New Topic

Data Last Updated: Jul 14, 2000

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Search for information on health plans, nursing homes, Medigap policies, contacts, and Medicare activities in your area

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Nursing Home Compare

About the Residents of the Nursing Home

Nursing Homes you selected in **New York County, New York**

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The results for all of the measures you selected are presented below.

You can **choose a new topic** if you have completed reviewing the About the Residents in the Nursing Home information.

You can also **choose new resident measures** if necessary.

Residents Who are Very Dependent In Eating

What does the measure mean?

The percent of residents who are very physically dependent and need a lot of help with eating.

Why is this measure important?

Residents who are very physically dependent and need help with eating require extra resources from the nursing home. If a nursing home has a large number of residents who are dependent in eating, it is important to make sure that the nursing home has adequate resources to meet this need (e.g. staffing).

View, download, or order Medicare or health related publications

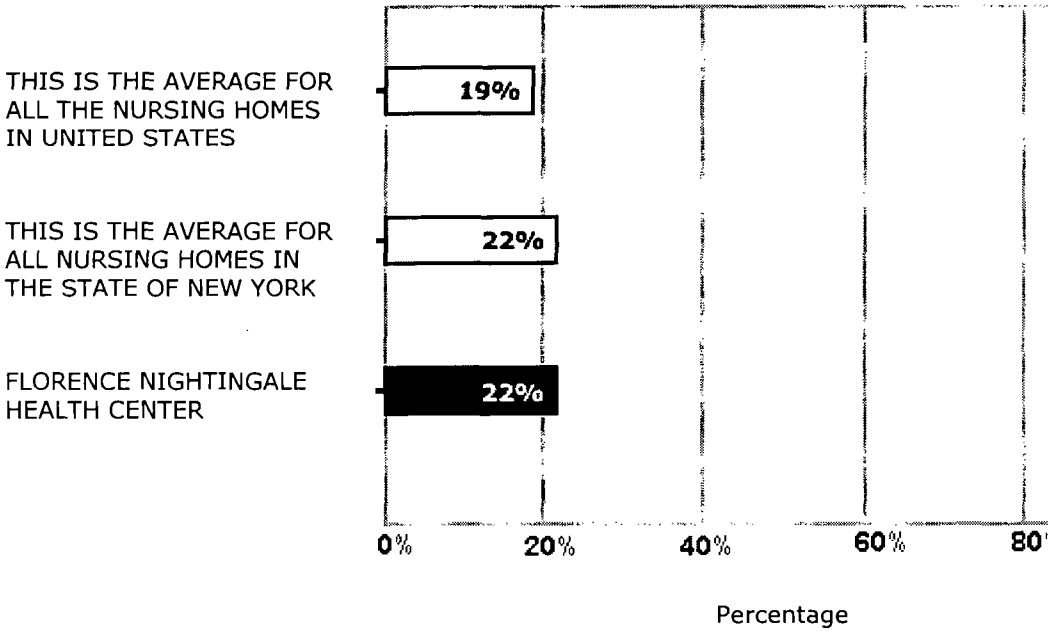
Fraud and Abuse
How to recognize and prevent fraud and abuse

Health Information
Contains information and references to help you stay healthy

staffing).

Please refer to the **Nursing Home Checklist** for questions or observations about this measure that can help you evaluate the nursing homes you visit. You should also look at the State inspection results, found in the **About the Nursing Home Inspection Results** section of this web site, particularly for any deficiencies relating to this measure. **It is important to remember also that these numbers are reported by the nursing home and are not audited by HCFA so they must be interpreted cautiously.**

The Percent of Residents Who are Very Dependent In Eating for the N Homes you selected in New York County, New York



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Residents Who are Bedfast

What does the measure mean?

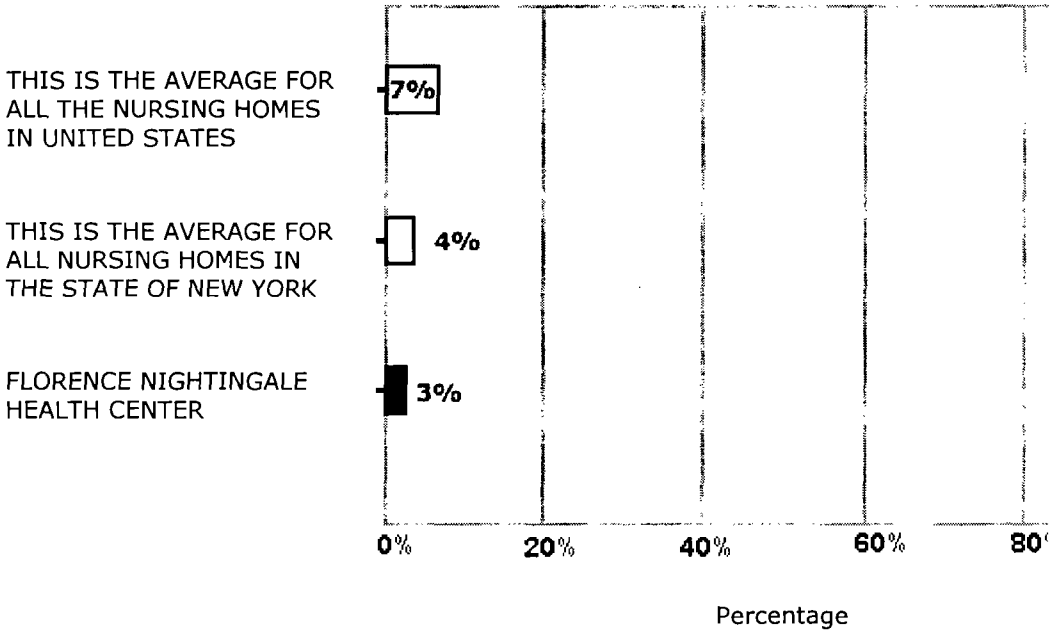
The percent of resident who are in bed all or almost all of the time.

Why is this measure important?

Residents who are willing, able, and want to be out of bed, should be out as much as possible. Residents who are unable to be out of bed are at risk of having pressure (bed) sores. They should be turned and moved in bed frequently to prevent this condition. A nursing home may have a high percentage of residents who are bedfast because it has special expertise in treating residents who have many functional impairments. In addition, some residents are bedfast due to their medical condition.

Please refer to the **Nursing Home Checklist** for questions or observations about this measure that can help you evaluate the nursing homes you visit. You should also look at the State inspection results, found in the **About the Nursing Home Inspection Results** section of this web site, particularly for any deficiencies relating to this measure. **It is important to remember also that these numbers are reported by the nursing home and are not audited by HCFA so they must be interpreted cautiously.**

The Percent of Residents Who are Bedfast for the Nursing Homes you in New York County, New York



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Residents With Restricted Joint Motion

What does the measure mean?

The percent of residents whose joint motion in their arms, legs, wrists, ankles, or hips is restricted because of lack of movement due to disease, deformity, pain, muscle weakness or paralysis, or severe disability.

Why is this measure important?

Limited joint motion interferes with functioning such as eating, walking, dressing, etc. Exercise to the joints through walking or moving about or with the assistance of another person or device helps to maintain joint motion. Residents who are unable to move joints completely by themselves need assistance to maintain motion and encouragement to move as possible.

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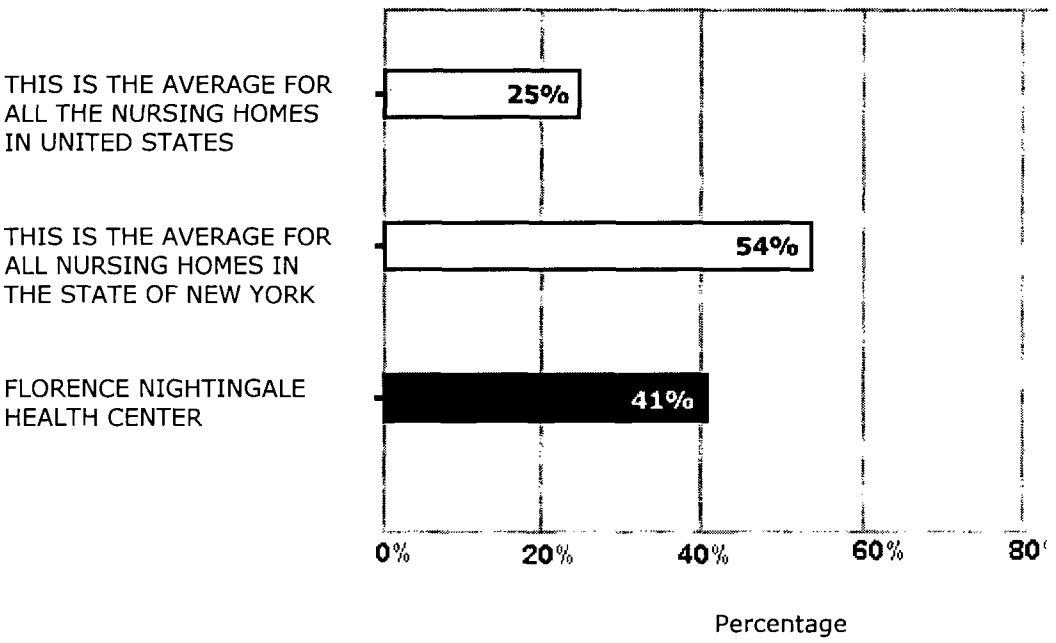
The Percent of Residents With Restricted Joint Motion for the Nursing you selected in New York County, New York



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Residents With Restraints

What does the measure mean?

The percent of residents who are in physical restraints. Physical restraints are devices, material, or equipment attached or adjacent to the resident that restrict movement and cannot be easily removed by the resident.

Why is this measure important?

Restraints may not be used for discipline or convenience and may only be used to treat medical symptoms. If restraints are used, they must be removed frequently to let the resident move around. If restraints are used unnecessarily and without allowing the resident to move periodically, complications such as stiffness or pressure (bed) sores may result.

Please refer to the **Nursing Home Checklist** for questions or observations about this measure that can help you evaluate the nursing homes you visit. You should also look at the State inspection results, found in the **About the Nursing Home**

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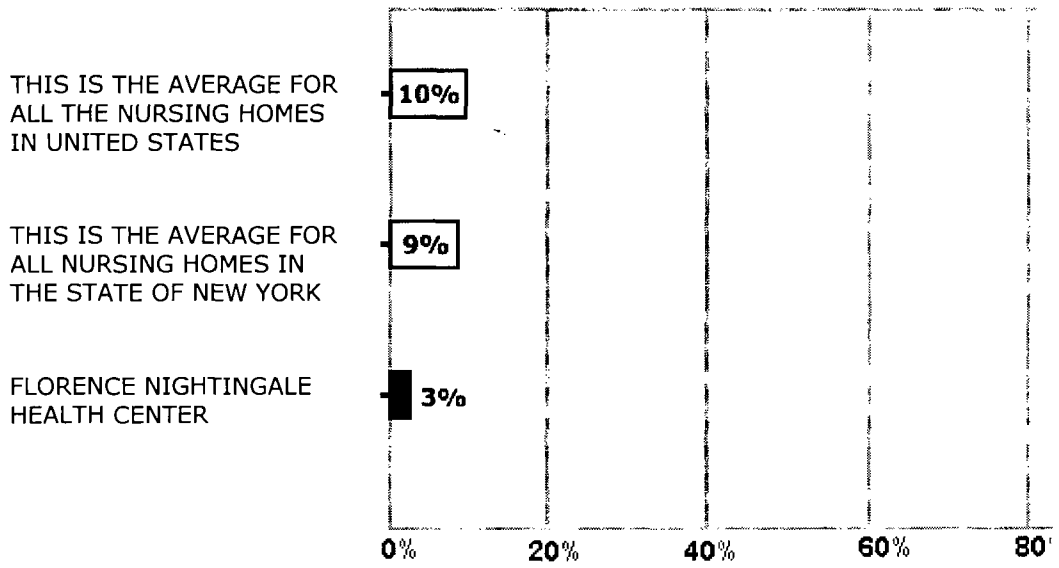

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Residents With Pressure (Bed) Sores

What does the measure mean?

The percent of residents who have pressure (bed) sores, usually occurring on the skin over bony parts of the body such as the hips, buttocks, or heels. These can range from a large or small reddened area to a deep open wound.

Why is this measure important?

Pressure sores may be very painful and may become infected.

For residents at risk, the development of pressure sores may be greatly reduced if they are turned, fed, given liquids, kept clean and dry and pressure relieving methods are used. Some residents have pressure sores when they are admitted to the nursing home. Once a pressure sore has developed it takes time to heal the sore. A pressure sore is not always indicative of poor care as in the case of people in terminal stages of disease who may develop pressure sores despite care interventions. However, most pressure sores can be treated or prevented.

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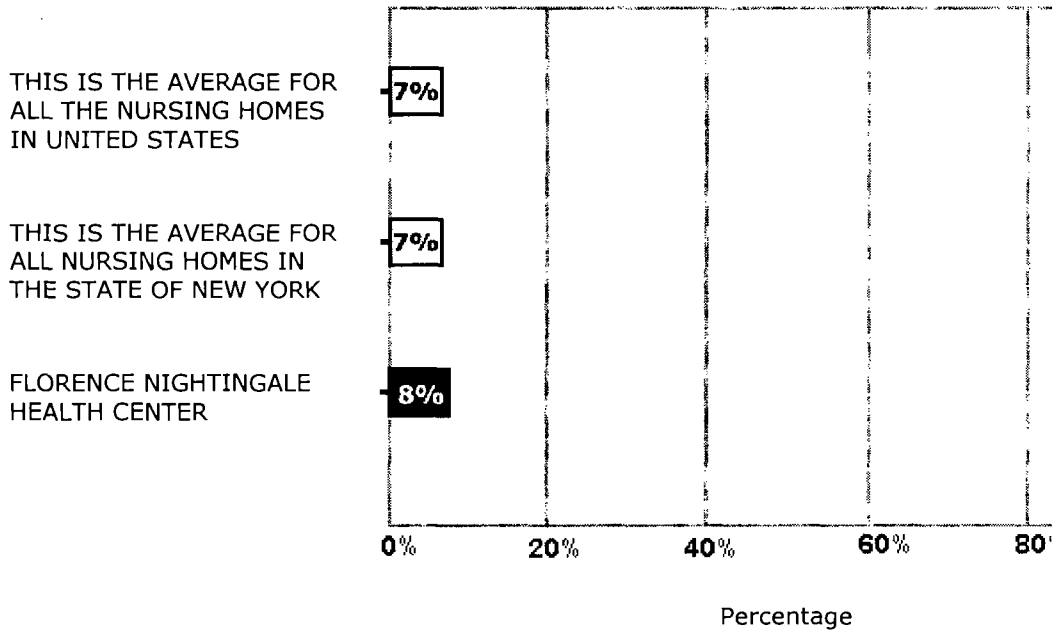

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Residents With Urinary Incontinence

What does the measure mean?

The percent of residents who cannot control their bladder.

Why is this measure important?

Incontinence can cause many problems such as skin rashes, falls, isolation, pressure sores, odors, and embarrassment to residents. Many residents have urinary incontinence when they are admitted to the nursing home. If residents are given individualized care and help in toileting, incontinence of the bladder can be managed and sometimes prevented or greatly reduced. A high percentage of residents with urinary incontinence may indicate a nursing home specializes in care for incontinent individuals.

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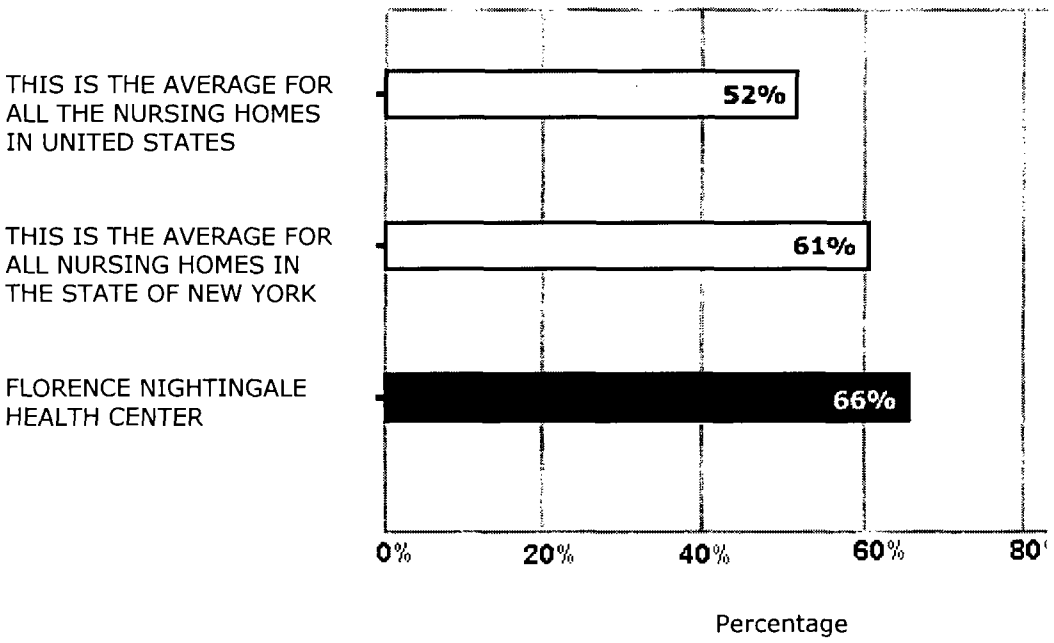

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Residents With Unplanned Weight Gain or Loss

What does the measure mean?

The percent of residents who have unplanned weight gain or loss.

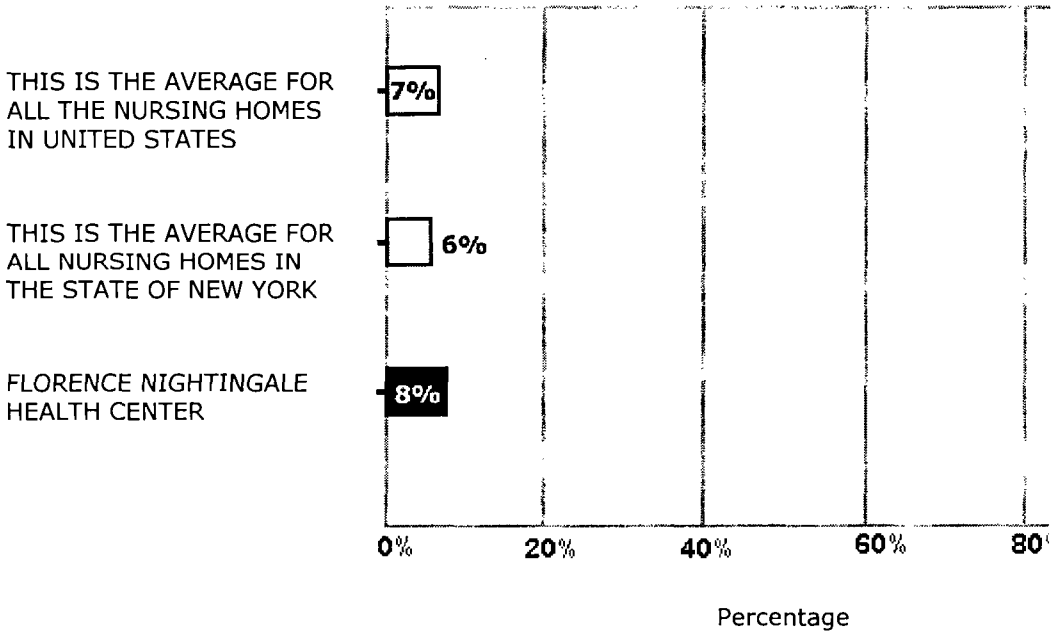
Why are these measures important?

Unplanned weight loss or gain may mean that residents are refusing to eat or have a medical condition that leads to weight loss or gain. Or, it could mean that they are not being fed properly, that the nutritional program is poor, or that medical care is not being properly managed. Some residents may have trouble swallowing due to disease, or have other conditions such as a stroke that make eating difficult. Ask the Director of Nursing how residents who need help to eat because of these conditions are assisted to eat. Note that residents with terminal illness may be unable to eat, and therefore lose weight.

Please refer to the **Nursing Home Checklist** for questions or observations about this measure that can help you evaluate the

nursing homes you visit. You should also look at the State inspection results, found in the **About the Nursing Home Inspection Results** section of this web site, particularly for any deficiencies relating to this measure. **It is important to remember also that these numbers are reported by the nursing home and are not audited by HCFA so they must be interpreted cautiously.**

The Percent of Residents With Unplanned Weight Gain or Loss for the Homes you selected in New York County, New York



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Residents With Behavioral Symptoms

What does the measure mean?

The percent of residents who have behavioral symptoms such as wandering, aggressive verbal or physical behavior, or inappropriate social actions.

Why is these measures important?

Behavioral symptoms can be difficult for staff, residents, and families to cope with. Treatment and management techniques may include support and communication by staff as well as changes in the environment. It is important to note that Alzheimer's disease and dementia are common conditions for nursing home residents. Residents with these conditions may exhibit behavioral symptoms and need special treatment and sensitive care. A high percentage of residents with behavioral symptoms may indicate a nursing home specializes in Alzheimers care or other related conditions.

Please refer to the **Nursing Home Checklist** for questions or observations about this measure that can help you evaluate the nursing homes you visit. You should also look at the State inspection results, found in the **About the Nursing Home Inspection Results** section of this web site, particularly for any deficiencies relating to this measure. **It is important to remember also that these numbers are reported by the *nursing home and are not audited by HCFA so they must* be interpreted cautiously.**

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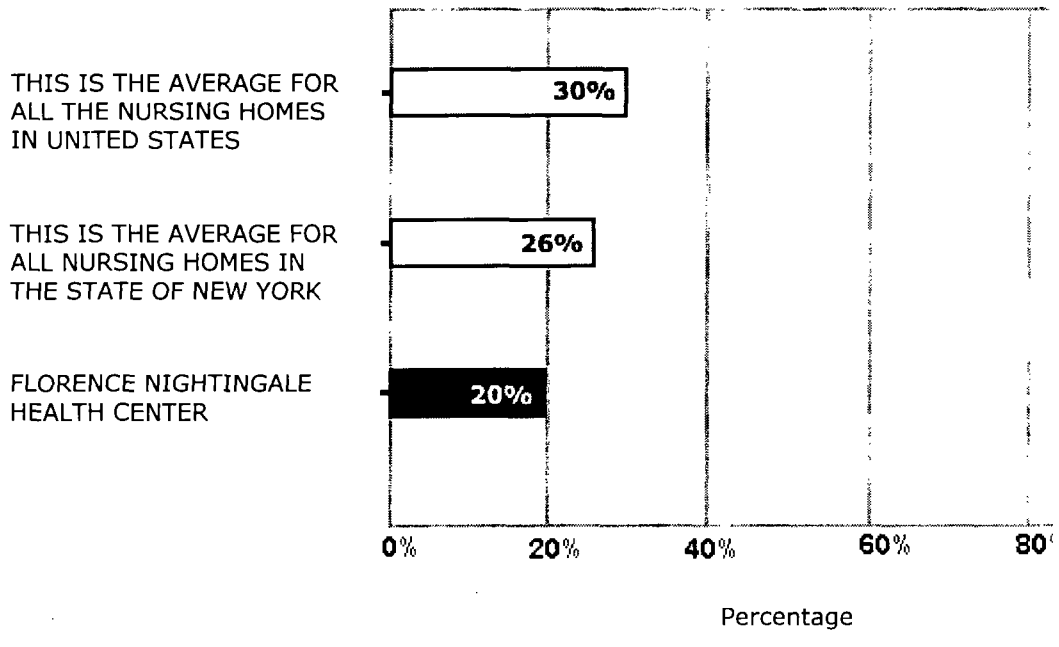

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Data Last Updated: Jul 14, 2000

THE WHITE HOUSE
Office of Media Affairs

September 14, 1995 Contact: 202/456-7150

NEW YORK

The Republican Budget Resolution Conference Agreement:
Medicaid Cuts Will Force States to Reduce Health Coverage

Republican□s Proposal: Reduces Medicaid Payments to States by 30% in 2002

Republicans are proposing to cut more than $182 billion from Federal Medicaid spending between 1996 and 2002: a cut of 20% over seven years and 30% in 2002. New York would lose $19 billion over the seven years, a 27% reduction in 2002 alone. Even if New York could absorb half of the cuts by reducing services and provider payments, it would still have to eliminate coverage for 645,000 people in 2002, according to the Urban Institute, including:

- 66,400 older Americans;
- 100,400 people with disabilities; and
- 478,200 children and their families.

The Republican proposal would force New York to eliminate coverage for about 71,300 people needing long-term care in 2002.* Medicaid is the largest insurer of long-term care for all Americans, including the middle class. Currently, Medicaid covers 79% of the 84,500 nursing home residents in New York. Medicaid also serves about 241,800 older Americans and people with disabilities using home care in New York. Without Medicaid, families of the elderly and disabled could not afford nursing home care that costs an average of $38,000 per year nationally.

The Republican proposal would force New York to eliminate coverage for 343,700 children in 2002.* Currently, 25% of the children in New York rely on Medicaid for their basic health needs. Medicaid pays for immunizations, regular check-ups, and intensive care in case of emergencies for about 1,300,000 children in New York.

New York could avoid these difficult choices forced by the Republican proposal only by increasing its Medicaid spending by 27% in 2002 -- by raising property or sales taxes, or cutting other critical state spending.

The President's Balanced Budget Proposal

The President□s proposal saves $54 billion over seven years from Medicaid, less than one-third the Republican cut and still a significant contribution toward deficit reduction. The President□s Medicaid policy produces savings by reducing and retargetting disproportionate share payments, increasing state flexibility, and limiting the growth in Federal Medicaid spending per recipient. This policy constrains Federal spending but allows states to respond to unexpected changes in the number of people covered. It does not put states at risk and dismantle a program that has served as a critical safety net -- as would happen under the Republican proposal.

* U.S. Department of Health & Human Services estimates based on the Urban Institute data; numbers may not sum to totals due to rounding.

MEDICAID

- **REPUBLICANS' UNPRECEDENTED CUTS:** The Republican Budget Resolution Conference Agreement would cut $182 billion from Medicaid over the next seven years by making the program a block grant to states.

- **HEAVY BURDENS TO FAMILIES FACING LONG-TERM CARE:** While most people think that Medicaid helps only low-income mothers and children, about two-thirds of Medicaid funds are spent on services for elderly and disabled Americans. Without Medicaid, working families with a parent or spouse who need long-term care would face nursing home bills that average $38,000 a year.

- **MANAGED CARE SAVINGS NOT NEARLY SUFFICIENT:** Savings from managed care cannot produce anywhere near the magnitude of cuts proposed by the Republicans. Two-thirds of Medicaid funds are spent on the elderly and disabled, and there is little evidence that putting them in managed care can produce savings. And because the baseline projections already assume that a growing number of mothers and children on Medicaid will be in managed care plans, there are little additional savings left in the remaining one-third of the program.

- **LIKELY IMPACTS:** The Republicans argue that they are not cutting Medicaid since states will get an increase in the block grant every year. But, given that CBO projects that the number of people covered will grow by 3 percent and that the Republicans block grant will grow by only 4 percent by 1998, the funding does not even keep up with inflation. It's a cut in real terms.

  - Assuming states would be forced to respond to these cuts by reducing services, provider payments and coverage:

    - **8.8 million children, elderly, and disabled individuals would lose coverage in 2002, according to the Urban Institute.** This would further worsen our nation's uncompensated care problem and create more incentives for cost-shifting to American businesses and families who still have insurance.

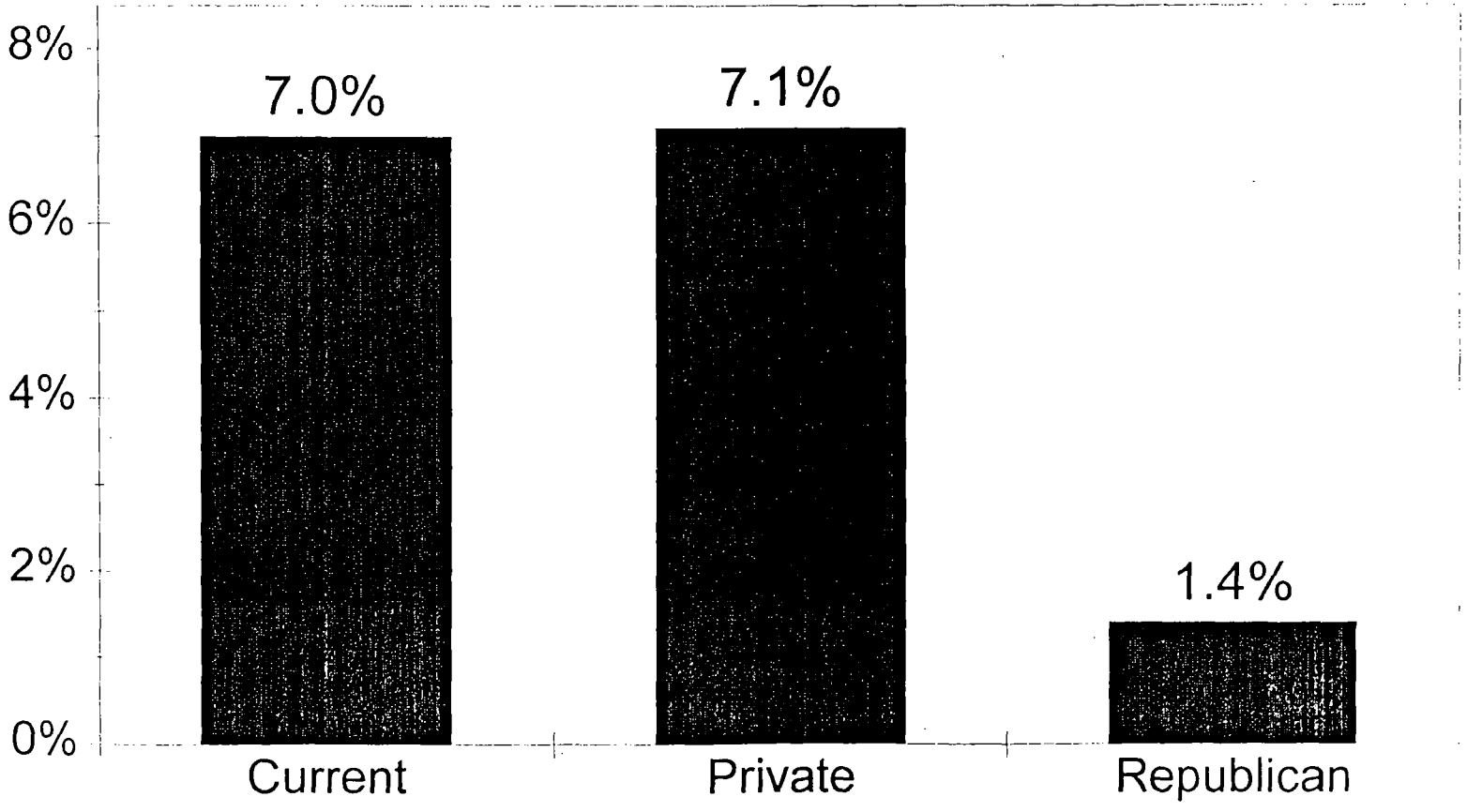
- **THE PRESIDENT'S PROPOSAL PROTECTS COVERAGE:** The President's proposal contains a mix of policies that save $54 billion between now and 2002 -- less than a third of the Republican proposal. It promotes efficiency and gives states more flexibility while protecting coverage. Every single Democratic Governor has endorsed the President's Medicaid target as a reasonable and achievable savings number.

  - Maintaining coverage under Medicaid is critical since it serves as a safety net for many Americans. Between 1989 and 1994, employer health coverage declined from 66 percent of the nonelderly population to 59 percent. Medicaid coverage increased from 9 to 14 percent during this same period.

Medicaid Growth Per Recipient

Effect of the Republican Proposal

1996-2002



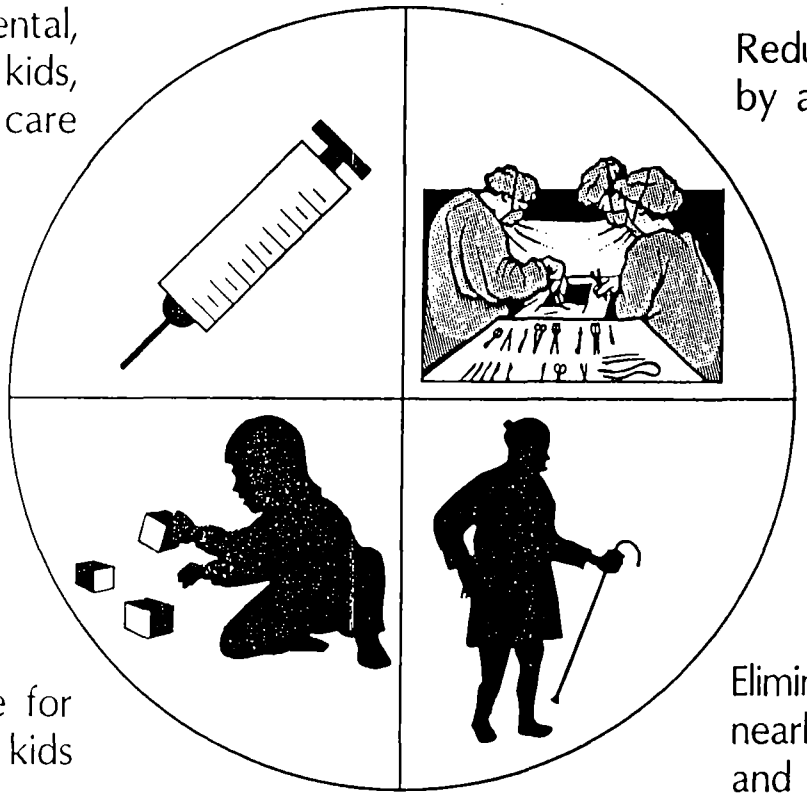
All estimates are calculated by the Administration using CBO data.

Medicaid Cuts That States Would Be Forced to Make

2002

Eliminate coverage for dental, screening services for kids, and hospice and home care

Reduce provider payments by almost $13 billion



Eliminate coverage for 7 million kids

Eliminate coverage for nearly one million elderly and persons with disabilities

NOTE: Assuming 25% cut in each of these categories.

MEDICAID: WHAT IS AT STAKE IN THE BUDGET NEGOTIATIONS

January 23, 1996

MEDICAID GUARANTEE. Republicans are insisting on ending the Medicaid guarantee to meaningful health benefits for millions of people with disabilities, pregnant women, poor children, and older Americans in need of nursing home care -- even though it is not necessary to balance the budget.

- Republicans want to replace the Medicaid guarantee with a deeply underfunded block grant that could *deny health benefits to 3-6 million Americans in 2002, including more than 1 million children.* And the *only* required benefits would be immunizations and limited family planning -- hardly what one would call "coverage." The depth of the Medicaid cuts could force States to significantly reduce coverage, increasing the number of uninsured people, uncompensated care, and cost-shifting to people with private insurance.

- President Clinton is refusing to go backwards on coverage, insisting on retaining the guarantee of meaningful Medicaid health benefits for people with disabilities, pregnant women, poor children, and older Americans in need of nursing home care.

DEPTH OF THE CUTS. Republicans want to cut Federal Medicaid funding to States by $85 billion in order to pay for an excessive tax cut for the well-off.

- Republicans are insisting on $85 billion in Medicaid cuts -- 45% more then the President -- largely to fund an excessive tax cut. They would cut spending growth per person to rates one-third below inflation. And the total Medicaid cuts would more than triple if States only spent the minimum required.

- President Clinton's balanced budget achieves $59 billion in savings by capping spending growth per beneficiary, giving States incentives to reduce costs without denying anyone health care coverage while providing States with unprecedented flexibility to operate their programs and pay providers.

LEAVES STATES VULNERABLE. Republicans are insisting on block granting Medicaid, which will leave States vulnerable to economic downturns, inflation, demographic changes, and natural disasters -- even though it is not necessary to balance the budget.

- Under a block grant, States would be responsible for 100% of the additional costs from circumstances beyond their control. According to analysis by the Center on Budget and Policy Priorities, if inflation were just 1 percentage point higher than projected over 7 years, States would have to spend about $65 billion more, or cut eligibility, benefits, or establish waiting lists.

- President Clinton is standing firm on maintaining the 30-year Federal partnership with States, protecting States from circumstances beyond their control and increasing State flexibility.

NURSING HOME QUALITY STANDARDS. Republicans want to repeal Federal enforcement of the nursing home quality standards that have dramatically improved the quality of nursing home care -- even though it is not necessary to balance the budget.

- Excessive Medicaid cuts combined with the elimination of Federal enforcement of nursing home quality standards may lead to inadequate and inconsistent enforcement of quality.

- President Clinton's balanced budget retains Federal quality standards and enforcement. Since these Federal standards were signed into law by President Reagan, there has been a 50% reduction in dehydration among nursing home residents, a 31% reduction in hospitalization rates, and a 25% reduction in the use of physical restraints.

FINANCIAL PROTECTIONS. Republicans want to repeal financial protections for families, their homes and farms -- even though this is not necessary to balance the budget.

- Republicans would repeal the laws that prevent States from forcing adult children to have to pay for their parents' nursing home care, if their income is above the State median income -- even though it is not necessary to balance the budget. They would repeal laws that protect families from having to sell their home or family farm in order to qualify for Medicaid, and would repeal the laws that restrict the placing of liens on homes and family farms of Medicaid recipients.

- President Clinton's balanced budget maintains current financial protections.

POOR ELDERLY AND PEOPLE WITH DISABILITIES' ACCESS TO MEDICARE. Republicans are insisting on repealing the guarantee that Medicaid pay poor older Americans and people with disabilities' Medicare premiums, deductibles, and copayments.

- The Medicaid guarantee of assistance with Medicare premiums, deductibles, and copayments ensures that more than 5 million poor older Americans and people with disabilities can afford Medicare physician services. Yet Republicans do not set aside *any* Medicaid block grant funding for Medicare deductibles and copayments, and set aside less than half of the funds needed to cover premiums. Hundreds of thousands of poor and near poor older Americans and people with disabilities could lose funding for their Medicare premiums -- at the same time that Republicans would increase Medicare premiums.

- President Clinton's balanced budget maintains the guarantee of this critical assistance.

SPOUSAL IMPOVERISHMENT PROTECTIONS. Republicans would undermine protections for spouses of nursing home residents from impoverishment -- even though it is not necessary to balance the budget.

- Republicans undermine these spousal impoverishment protections by repealing the guarantee of nursing home coverage, making it more difficult for the Federal government to ensure that States enforce spousal impoverishment protections, and repealing the right of spouses to seek redress in Federal court if they are wrongly denied protection.

- President Clinton's balanced budget maintains the current spousal impoverishment protections which have protected about 450,000 spouses of nursing home residents since they went into effect. Most of these spouses are women.

MEDICAID:
Comparison of Two Different Approaches
January 23, 1996

I. *Cost Differences*

	President	Republicans	Difference
Federal Spending Reductions (1996 - 2002)	-$59 billion Federal	-$85 billion Federal	Republican plan cuts Federal spending by $26 billion (45%) more than the President's plan. Total Federal and state cuts would triple ($285 billion) if states only spend the minimum required.
7-Year Growth Rates Per Person *	5%	2%	Republican plan slows spending per person to rates 33% below inflation -- making it a cut in real terms.
Estimated Number of People Losing Coverage in 2002	0	3 to 6 million	Even if states were to significantly slow spending growth, they could be forced to reduce coverage by 3 to 6 million in 2002 under the Republican plan.

* The Republicans' $85 billion offer (January 8) was not accompanied by specific policies or CBO scoring so the policies associated with the $117 billion proposal were used. Assumes baseline enrollment growth rates.

MEDICAID:
Comparison of Two Different Approaches

II. Policy Differences

	President	Republicans*
Coverage Guarantee	Maintains individual entitlement to meaningful benefits.	Repeals Federal guarantee of coverage, and only requires immunization and limited family planning services.
Financial Protection for States	Shares unexpected costs of recession, inflation or demographic changes.	Fixes Federal funding -- leaving states responsible for 100% of unexpected costs.
Family Protections	Maintains protections against spousal and family impoverishment when the relative is in a nursing home.	Weakens asset and spousal protections, and repeals protections for adult children with incomes above the median state income.
Quality Protections	Maintains Federal nursing home quality standards and requires quality standards for Medicaid managed care plans.	Appears to retain nursing home quality protections, but in fact substantially weakens the protection because there is no Federal authority to enforce quality provisions either across states or within states. Repeals Federal managed care quality standards.
Medicare Protections	Maintains guarantee of coverage for low-income Medicare beneficiaries.	Eliminates guarantee; "set asides" do not cover cost sharing, and are not sufficient to cover premiums.

MEDICAID-RELATED LEGISLATION NOT ENACTED BY THE 104TH CONGRESS

Overall

Despite their majority status in both the House and the Senate, the Republicans failed to enact their Medicaid repeal agenda in the 104th Congress.

1st Session (1995)

Budget Resolution. On June 29, 1995, the House and Senate adopted a budget resolution (H. Con. Res. 67) directing a cut in Federal Medicaid spending of $182 billion over the 7-year period FY 1996 through FY 2002.

Reconciliation. On November 17, 1995, the House and the Senate adopted a budget reconciliation conference report (H.R. 2491, "The Balanced Budget Act of 1995") that, among other things, would have repealed the current Medicaid program and replaced it with a block grant to the States ("Medigrant") and cut Federal Medicaid spending by $163.4 billion (under the March, 1995, CBO baseline) over the 7-year period FY 1996 through FY 2002. (Under the December, 1995, CBO baseline, the cut would have been $133 billion). On December 6, 1995, the President vetoed H.R. 2491.

2nd Session (1996)

NGA Medicaid Proposal. On February 6, 1996, the National Governors' Association adopted a 6-page proposal entitled "Restructuring Medicaid." On May 22, 1996, Republicans introduced the "Personal Responsibility and Work Opportunity Act of 1996," (H.R. 3507, S. 1795), which contained a repeal of the Aid to Families with Dependent Children (AFDC) program as well as a repeal of the Medicaid program. The Medicaid repeal was titled the "Medicaid Restructuring Act of 1996." On May 29, 1996, Democratic Governors wrote to the Chairmen of the House and Senate committees of jurisdiction to inform them that "your Medicaid proposal is far from the NGA agreement and appears to be more like the proposal vetoed by the President last year...."

Budget Resolution. On June 12 and 13, 1996, the House and Senate adopted a budget resolution for FY 1997 (H. Con. Res. 178) directing a cut in Federal Medicaid spending of $72 billion over the 6-year period FY 1997 through FY 2002. In contrast to the FY 1996 resolution, this resolution called for the enactment of not one, but three separate reconciliation bills: one relating to welfare and Medicaid and tax relief; one relating to Medicare; and one relating to taxes and miscellaneous direct spending.

Reconciliation. On July 31 and August 1, 1996, the House and Senate adopted the conference report on the first reconciliation bill, H.R. 3734, from which the Republican "Medicaid Restructuring Act of 1996" was excluded. The legislation repeals the current AFDC program and replaces it with a block grant. The President signed H.R. 3734 on August 22, 1996 (P.L. 104-193).

REPUBLICAN MEDICAID CUTS: A SCORECARD FOR THE 104TH CONGRESS

(Totals in billions, 7-year period FY 1996 - FY 2002)

Legislation Proposing Cuts in Federal Medicaid Spending	Amount of Cut Proposed
FY 1996 Budget Resolution (6/29/95)	- $182.0
FY 1996 Budget Reconciliation Conference Report (vetoed 12/6/95)*	- $163.4
FY 1996 Budget Reconciliation Conference Report (reestimated under new CBO baseline, 12/11/95)*	- $133.0
FY 1997 Budget Resolution (6/13/96)	- $ 72.0
FY 1997 Budget Reconciliation ("Welfare and Medicaid Reform Act") (6/27/96)*	- $ 71.7

Medicaid Cuts Enacted	Amount
Termination of SSI Benefits and Medicaid Coverage for Individuals Disabled by Alcoholism or Drug Abuse (Section 105(b) of P.L. 104-121) (3/29/96)*	- $ 0.6
Welfare Law (P.L. 104-193)(8/22/96)*	- $ 4.1

** Final Congressional Budget Office estimates.*

ASSETS TRANSFER

Period of ineligibility. This is the number of months equal to (1) the value of all the assets transferred by the individual divided by (2) the average monthly cost of nursing home care for a private patient. Ineligibility begins in the month during which the transfer occurred, not on the date of application for Medicaid.

Example. One year before entering a nursing home, an individual gives $30,000 to his son and $30,000 to his daughter. Six months after entering a nursing home, he applies for Medicaid, having already spent $18,000 of his remaining funds. (The cost of his nursing home care, which is also the average cost of nursing home care for private patients in the State, is $3000 per month). Since the $60,000 transfer for less than fair market value occurred 18 months prior to application, it falls within the 36-month "look-back" period. The period of ineligibility is 20 months ($60,000/$3000), and it begins running 18 months prior to application. Thus, the individual must wait two months (continuing to use his own or his children's resources to pay for an addition $6,000 worth of care) and reapply. If the transfer had occurred two years prior to the individual's admission to the nursing home, the individual would not have had his eligibility delayed.

Exceptions. States are required to implement this basic prohibition. They are not allowed to be more (or less) restrictive, although they do have authority to waive the prohibition in cases where delay in eligibility would "work an undue hardship." They also have the option as to whether to apply a parallel prohibition to individuals who are not nursing home residents but are seeking Medicaid coverage for home- and community-based services.

Most Recent Republican Proposal. Both the 1995 and 1996 versions of the Republican Medicaid block grant (H.R. 2491; H.R. 3507/S. 1795) would have repealed current Medicaid law, including all of the provisions relating to transfers of assets. Under the Republican block grant, States would have had complete discretion in writing eligibility rules with respect to assets transfers that were more restrictive, as restrictive, or less restrictive than current Medicaid law.

Criminalization. Although the Republicans did not succeed in enacting their block grant, they did enact a criminal penalty for transfers of assets in the "Health Insurance Portability and Accountability Act of 1996," P.L. 104-191 (Kennedy-Kassebaum). Section 217 of this legislation makes it a crime to "knowingly and willfully" dispose of assets (by the use of a trust or otherwise) in order to qualify for Medicaid if the disposal would result in the imposition of a "period of ineligibility" for Medicaid under current Medicaid law. The provision is unclear on a number of points, including whether the crime is a misdemeanor (subject to a fine of up to $10,000 and imprisonment of up to 1 year) or a felony ($25,000 or 5 years). The provision is effective January 1, 1997, although it is not clear to what behavior that date applies.

Resident Neglect and Abuse. The State agencies that conduct surveys and certifications are required to investigate allegations of neglect and abuse of nursing home residents. In addition, the State Medicaid Fraud Control Units are required to review complaints of abuse and neglect of residents in participating nursing facilities (and other Medicaid-funded institutions) and to initiate criminal prosecutions where appropriate. Nurse aides found to have neglected or abused nursing home residents or misappropriated their personal property are to be listed in a nurse aide registry maintained by each State. The costs to the States of these investigative and enforcement activities are matched by the Federal government at a 75 percent rate in all States.

Implementation. The OBRA '87 nursing home reforms were phased in over 8 years, with ample opportunity for input from beneficiaries, the nursing home industry, and the States. The minimum requirements were first applied to participating facilities on October 1, 1990. The final survey and certification and enforcement regulations took effect on July 1, 1995.

Between July, 1995, and August, 1996, over 18,000 nursing homes were inspected by State surveyors. Of these, "about 10 percent of all facilities were judged to be providing substandard quality of care, meaning they had serious deficiencies in certain areas dealing with quality of care, quality of life of the resident and/or quality of facility practices. As a result of these findings, civil money penalties have been imposed on 290 facilities (after the time allotted for correction had expired), 41 facilities were terminated from the Medicare and Medicaid programs, 560 were denied payments for new admissions until the quality of care improved, and 843 were subject to other types of sanctions." (HCFA, September, 1996).

Although there has, as of this writing, been less than 2 years of full implementation of the OBRA '87 nursing home reforms, they have already had a demonstrable, positive impact on the quality of life of many nursing home residents. Perhaps the most striking change has come with respect to the use of physical and chemical restraints: in a four-year, 10-State study, researchers have documented a reduction of nearly 50 percent in the strapping in and drugging of nursing home residents, resulting in a dramatic increase in the independence and quality of life of those residents. This nearly 50 percent reduction translates into about a quarter of a million elderly Americans in nursing homes each year who were untied or never restrained as a result of the OBRA '87 reforms.

Most Recent Republican Proposal. Both the 1995 version of the Republican Medicaid block grant (H.R. 2491), and the 1996 version (H.R. 3734, S. 1795) would have repealed current Medicaid law, including (1) the minimum Federal quality standards for nursing homes, (2) the Boren amendment requirement for "reasonable and adequate" payment rates for efficient nursing homes complying with those quality standards, and (3) the open-ended Federal matching payments (at a 75 percent rate) for the costs of nursing home surveys or the costs of resident neglect or abuse prosecutions. In addition, both the 1995 and 1996 versions would have barred nursing facility residents and their families from seeking relief in Federal court against States that were not complying with their monitoring or enforcement responsibilities.

The 1996 version of the Republican Medicaid block grant did include a section titled "quality assurance requirements for nursing facilities" which restated, almost verbatim, the minimum nursing facility requirements in current Medicaid law. In the context of the Republican block grant, however, these "requirements" are essentially rhetorical. The reduction in both Federal and State Medicaid spending under the Republican block grant would, over time, place more and more downward pressure on payment rates, making it increasingly difficult for nursing facilities to deliver services of acceptable quality to Medicaid eligibles without greater and greater cross-subsidies from other residents. States would know that a reputation for high quality nursing home care would put them at risk as a "Medicaid magnet" for families seeking good care for their frail elders. The reduction in both Federal and State Medicaid spending would also make it increasingly difficult to maintain adequate monitoring of nursing homes and investigation and prosecution of resident neglect and abuse. Finally, the exclusion of beneficiaries and their families from Federal court would make it easier for States to avoid compliance with their responsibilities under the block grant with respect to nursing home quality.

FINAL VOTE RESULTS FOR ROLL CALL 743

(Republicans in roman; Democrats in *italic*; Independents underlined)

H R 2491 YEA-AND-NAY 26-OCT-1995 6:49 PM
QUESTION: On Passage
BILL TITLE: Budget Reconciliation Act of 1995

	YEAS	NAYS	PRES	NV
REPUBLICAN	223	10		
DEMOCRATIC	4	192		3
INDEPENDENT		1		
TOTALS	**227**	**203**		**3**

--- YEAS 227 ---

Allard	Frelinghuysen	Moorhead
Archer	Frisa	Myers
Armey	Funderburk	Myrick
Bachus	Gallegly	Nethercutt
Baker (CA)	Ganske	Neumann
Baker (LA)	Gekas	Ney
Ballenger	*Geren*	Norwood
Barr	Gilchrest	Nussle
Barrett (NE)	Gillmor	Oxley
Bartlett	Gilman	Packard
Barton	Gingrich	*Parker*
Bass	Goodlatte	Paxon
Bateman	Goodling	Petri
Bereuter	Goss	Pombo
Bilbray	Graham	Porter
Bilirakis	Greenwood	Portman
Bliley	Gunderson	Pryce
Blute	Gutknecht	Quillen
Boehner	*Hall (TX)*	Quinn
Bonilla	Hancock	Radanovich
Bono	Hansen	Ramstad
Brownback	Hastert	Regula
Bryant (TN)	Hastings (WA)	Riggs
Bunn	Hayworth	Roberts
Bunning	Hefley	Rogers
Burr	Heineman	Rohrabacher
Burton	Herger	Ros-Lehtinen
Buyer	Hilleary	Roth

Callahan	Hobson	Roukema
Calvert	Hoekstra	Royce
Camp	Hoke	Salmon
Canady	Horn	Sanford
Castle	Hostettler	Schaefer
Chabot	Houghton	Schiff
Chambliss	Hunter	Seastrand
Chenoweth	Hutchinson	Sensenbrenner
Christensen	Hyde	Shadegg
Chrysler	Inglis	Shaw
Clinger	Istook	Shays
Coble	Johnson (CT)	Shuster
Coburn	Johnson, Sam	Skeen
Collins (GA)	Jones	Smith (MI)
Combest	Kasich	Smith (TX)
Cooley	Kelly	Smith (WA)
Cox	Kim	Solomon
Crane	King	Souder
Crapo	Kingston	Spence
Cremeans	Klug	Stearns
Cubin	Knollenberg	Stockman
Cunningham	Kolbe	Stump
Davis	Largent	Talent
Deal	Latham	Tate
DeLay	Laughlin	Tauzin
Diaz-Balart	Lazio	Taylor (NC)
Dickey	Leach	Thomas
Doolittle	Lewis (CA)	Thornberry
Dornan	Lewis (KY)	Tiahrt
Dreier	Lightfoot	Torkildsen
Duncan	Linder	Upton
Dunn	Livingston	Vucanovich
Ehlers	Longley	Waldholtz
Ehrlich	Lucas	Walker
Emerson	Manzullo	Walsh
English	Martini	Wamp
Ensign	McCollum	Watts (OK)
Everett	McCrery	Weldon (FL)
Ewing	McDade	Weldon (PA)
Fawell	McInnis	Weller
Fields (TX)	McIntosh	White
Flanagan	McKeon	Whitfield

Foley	Metcalf	Wicker
Forbes	Meyers	Wolf
Fowler	Mica	Young (AK)
Fox	Miller (FL)	Young (FL)
Franks (CT)	Molinari	Zeliff
Franks (NJ)	*Montgomery*	

--- NAYS 203 ---

Abercrombie	*Gonzalez*	*Ortiz*
Ackerman	*Gordon*	*Orton*
Andrews	*Green*	*Owens*
Baesler	*Gutierrez*	*Pallone*
Baldacci	*Hall (OH)*	*Pastor*
Barcia	*Hamilton*	*Payne (NJ)*
Barrett (WI)	*Harman*	*Payne (VA)*
Becerra	*Hastings (FL)*	*Pelosi*
Beilenson	*Hayes*	*Peterson (FL)*
Bentsen	*Hefner*	*Peterson (MN)*
Berman	*Hinchey*	*Pickett*
Bevill	*Holden*	*Pomeroy*
Bishop	*Hoyer*	*Poshard*
Boehlert	*Jackson-Lee*	*Rahall*
Bonior	*Jacobs*	*Rangel*
Borski	*Jefferson*	*Reed*
Boucher	*Johnson (SD)*	*Richardson*
Brewster	*Johnson, E. B.*	*Rivers*
Browder	*Johnston*	*Roemer*
Brown (CA)	*Kanjorski*	*Rose*
Brown (FL)	*Kaptur*	*Roybal-Allard*
Brown (OH)	*Kennedy (MA)*	*Rush*
Bryant (TX)	*Kennedy (RI)*	*Sabo*
Cardin	*Kennelly*	Sanders
Chapman	*Kildee*	*Sawyer*
Clay	*Kleczka*	Saxton
Clayton	*Klink*	Scarborough
Clement	*LaFalce*	*Schroeder*
Clyburn	LaHood	*Schumer*
Coleman	*Lantos*	*Scott*
Collins (IL)	LaTourette	*Serrano*
Collins (MI)	*Levin*	*Skaggs*
Condit	*Lewis (GA)*	*Skelton*

Conyers	*Lincoln*	*Slaughter*
Costello	*Lipinski*	Smith (NJ)
Coyne	LoBiondo	*Spratt*
Cramer	*Lofgren*	*Stark*
Danner	*Lowey*	*Stenholm*
de la Garza	*Luther*	*Stokes*
DeFazio	*Maloney*	*Studds*
DeLauro	*Manton*	*Stupak*
Dellums	*Markey*	*Tanner*
Deutsch	*Martinez*	*Taylor (MS)*
Dicks	*Mascara*	*Tejeda*
Dingell	*Matsui*	*Thompson*
Dixon	*McCarthy*	*Thornton*
Doggett	*McDermott*	*Thurman*
Dooley	*McHale*	*Torres*
Doyle	McHugh	*Torricelli*
Durbin	*McKinney*	*Towns*
Edwards	*McNulty*	*Traficant*
Engel	*Meehan*	*Velazquez*
Eshoo	*Meek*	*Vento*
Evans	*Menendez*	*Visclosky*
Farr	*Mfume*	*Volkmer*
Fattah	*Miller (CA)*	*Ward*
Fazio	*Minge*	*Waters*
Fields (LA)	*Mink*	*Watt (NC)*
Filner	*Moakley*	*Waxman*
Flake	*Mollohan*	*Williams*
Foglietta	*Moran*	*Wilson*
Ford	Morella	*Wise*
Frank (MA)	*Murtha*	*Woolsey*
Frost	*Nadler*	*Wyden*
Furse	*Neal*	*Wynn*
Gejdenson	*Oberstar*	*Yates*
Gephardt	*Obey*	Zimmer
Gibbons	*Olver*	

--- NOT VOTING 3 ---

Hilliard	*Sisisky*	*Tucker*

THE WHITE HOUSE

WASHINGTON

December 27, 1994

Dear Bob:

While we could not achieve broad-based agreement on a health reform initiative last year, there can be little disagreement that we still face the enormous problems of increasing health care costs and decreasing coverage. We need to confront these problems on a bipartisan basis and address the insecurities that too many Americans have about their health care. I am writing to reiterate my strong desire to work with you in this regard.

I remain firmly committed to providing insurance coverage for every American and containing health care costs for families, businesses, and Federal, State, and local governments. In the upcoming session of Congress, we can and should work together to take the first steps toward achieving these goals. We can pass legislation that includes measures to address the unfairness in the insurance market, make coverage more affordable for working families and children, assure quality and efficiency in the Medicare and Medicaid programs, and reduce the long-term Federal deficit.

We look forward to talking with you in the upcoming weeks about a bipartisan effort to deliver health care reform to the American public. Hillary and I send our best wishes for a safe and happy holiday season.

Sincerely,

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United States Senate
Washington, D.C. 20510

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WE.

104788
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December 27, 1994

Dear Tom:

While we could not achieve broad-based agreement on a health reform initiative last year, there can be little disagreement that we still face the enormous problems of increasing health care costs and decreasing coverage. We need to confront these problems on a bipartisan basis and address the insecurities that too many Americans have about their health care. I am writing to reiterate my strong desire to work with you in this regard.

I remain firmly committed to providing insurance coverage for every American and containing health care costs for families, businesses, and Federal, State, and local governments. In the upcoming session of Congress, we can and should work together to take the first steps toward achieving these goals. We can pass legislation that includes measures to address the unfairness in the insurance market, make coverage more affordable for working families and children, assure quality and efficiency in the Medicare and Medicaid programs, and reduce the long-term Federal deficit.

We look forward to talking with you in the upcoming weeks about a bipartisan effort to deliver health care reform to the American public. Hillary and I send our best wishes for a safe and happy holiday season.

Sincerely,

Bill Clinton

The Honorable Thomas A. Daschle
United States Senate
Washington, D.C. 20510

June 8, 2000

MEMORANDUM TO THE FIRST LADY

FROM: Chris Jennings

RE: Health Security Act Links to Administration Health Care Achievements

cc: Melanne Verveer, Jennifer Klein

In 1994, the President wrote the attached letter to Speaker Gingrich and Senator Dole reaffirming his commitment assuring "insurance coverage for every American". He urged the Congress to take the first steps towards addressing the public's insecurity about the health care system by: (1) prohibiting unfair insurance practices and reforming the market; (2) expanding affordable coverage for children and working families; (3)assuring quality and efficiency in the Medicare and Medicaid programs; and (4) containing health care costs to help reduce the Federal deficit.

Since writing this letter, the Administration has compiled an extraordinarily impressive record of health care achievements, arguably reaching every one of the goals he set out in the 1994 letter. These and numerous other legislative and administrative health care accomplishments can be traced back to many provisions of the Health Security Act. Highlights include:

Enacting legislation, including the Kennedy-Kassenbaum insurance reform legislation; the Children's Health Insurance Program; and comprehensive Medicare reform that extended the solvency of the Medicare program by 26 years, instituted anti-fraud, waste, and abuse measures, and added a range of new preventive benefits.

Taking executive action, including providing the 85 million Americans in Federal health plans receive critical patient protections; and developing privacy protections for electronic medical records.

Proposing major new health reforms, including the investment of $110 billion over 5 years in a comprehensive coverage proposal that includes parents, individuals aged 55-65, and 19 to 20 year olds; financing a new voluntary prescription drug benefit for Medicare; and investing over $28 billion over 10 years in a new long term care initiative to support individuals with long term care needs family caregivers.

Attached is the first draft of a summary documenting those health care achievements with a clear link to the Health Security Act. Jennifer Klein has reviewed this document and is now in the process of adding specific cites of relevant Health Security Act provisions. We both feel confident, however, that each listing has a legitimate Health Security Act lineage.

We wanted to forward you this document to make certain that it reflects the type of presentation that is of interest to you. We will forward you the updated version of this document, along with the specific cites, as soon as it is completed. Please don't hesitate to call if you have any questions or suggestions about this document.

THE IMPACT OF THE HEALTH SECURITY ACT ON SUBSEQUENT HEALTH CARE ACHIEVEMENTS

I. REFORMING THE INSURANCE MARKET / ASSURING PATIENT PROTECTIONS

The Health Security Act had numerous provisions to reform the insurance market and assure consumer protections. These included protections against discriminatory underwriting practices, patient and medical records privacy protections, steps towards mental health parity, and provisions to streamline the duplicative and burdensome red tape associated with insurance and provider claim forms.

Enacted the landmark Kennedy-Kassenbaum legislation that ensures individuals continued access to health insurance (Public Law 104-191). The Kennedy- Kassenbaum (Health Insurance Portability and Accountability Act) legislation prevents individuals from being denied coverage because they have a preexisting medical condition. It requires insurance companies to sell coverage to small employer groups and to individuals who lose group coverage without regard to their health risk status. It also prohibits discrimination in enrollment and premiums against employees and their dependents based on health status. Finally, it requires insurers to renew the policies they sell to groups and individuals.

Enacted legislation requiring mental health parity for annual and lifetime insurance limits (Public Law 104-204). To help eliminate discrimination against individuals with mental illnesses, the President enacted legislation containing provisions prohibiting health plans from establishing separate lifetime and annual limits for mental health coverage.

Enacted legislation to eliminate duplicative and wasteful administrative requirements of the health care system (Public Law 104-191). The Health Insurance Portability and Accountability Act (HIPAA) provided the Administration with the authority to develop a single set of national standards for all health care providers and health plans that engage in electronic administrative and financial transactions to promote more cost-effective electronic claims processing and coordination of benefits. This implementation of this law will eliminate administratively burdensome, duplicative, and wasteful billing requirements for health care providers and insurers.

Issued landmark Federal regulations protecting the privacy of electronic medical records. In the absence of Congressional action, under authority provided by HIPAA, the Administration released a new regulation protecting the privacy of electronic medical records held by health plans, health care clearinghouses, and health care providers. This rule limits the use and release of private health information without consent; restricts the disclosure of protected health information to the minimum amount of information necessary; established new requirements for disclosure of information to researchers and others seeking access to health records; informs consumers about their right to access their health records and to know who else has accessed them; and establishes new administrative and criminal sanctions for the improper use or disclosure of private information.

Enacted legislation prohibiting discriminatory underwriting practices by insurers through the use of genetic information (Public Law 104-191). This legislation, which applies to the insured and self insured markets but not to the individual market, prevents group health insurers from using genetic information to deny individuals health insurance benefits.

Established and endorsed the recommendations of the historic Quality Commission. In 1996, the President created a non-partisan, broad-based Commission on quality and charged them with developing a patients' bill of rights as their first order of business. In October of 1997, the President accepted the Commission's recommendation that all health plans should provide strong patient protections, including guaranteed access to needed health care specialists; access to emergency room services when and where the need arises; continuity of care protections; and access to a fair, unbiased and timely internal and independent external appeals process. The work of the Commission lay the foundation for subsequent administrative and legislative initiatives to improve patient protections and quality improvement.

Issued executive memorandum requiring that the 85 million Americans in Federal health plans receive critical patient protections. In the absence of Congressional action, President Clinton directed HHS, OPM, DOL, DOD, and DVA to ensure that their employees and beneficiaries had the important new benefits and rights that are guaranteed to health care consumers in the Administration's proposed Patients Bill of Rights, including choice of providers and plans, access to emergency services, participation in treatment decisions, confidentiality of health information and a fair complaint and appeals process. Medicare, Medicaid, S-CHIP, the Indian Health Service, FEHBP plans, the Veterans Administration facilities, and the Military Health System are responding by ensuring that all protections that can be extended under current law be provided.

Endorsed the bipartisan Norwood-Dingell Patients' Bill of Rights and worked for its passage. This legislation, endorsed by over 200 health care advocacy groups, is the only proposal that meets the Administration's fundamental criteria: that patient protections be real and that court enforced remedies be accessible and meaningful. The legislation includes: guaranteed access to needed health care specialists; access to emergency room services when and where the need arises; continuity of care protections; access to a fair, unbiased and timely internal and independent external appeals process; and an enforcement mechanism that ensures recourse for patients who have been harmed as a result of health plan's actions.

Issued executive order preventing genetic discrimination in Federal hiring and promotion actions. In February of 2000, President Clinton signed an executive order prohibiting every civilian Federal Department and agency from using genetic information in any hiring or promotion action. This historic action prevents critical information from genetic tests used to help predict, prevent, and treat diseases being used against them by their employer. Since 1997, the Administration has called for legislation that will guarantee that Americans who are self-employed or otherwise buy health insurance themselves will not lose or be denied that health insurance because of genetic information.

Endorsed legislation to prohibit unauthorized use of genetic information by health insurers and employers. President Clinton has endorsed the Genetic Nondiscrimination in Health Insurance & Employment Act of 1999. This bill would extend the protections for genetic information included in the President's executive order preventing discrimination on the basis of genetic information by Federal employers to the private sector. HIPAA prevents group health insurers from using genetic information to deny individuals health insurance benefits. The Daschle-Slaughter legislation finishes the job begun by HIPAA and ensures that genetic information used to help predict, prevent, and treat diseases will not also be used to discriminate against Americans seeking employment, promotion, or health insurance.

II. EXPANDING COVERAGE

The Health Security Act was designed to ensure that every American had affordable, quality, health insurance. Subsequent achievements and proposals by the Clinton Administration provide targeted coverage expansions. Since 1995, the President has enacted the Children's Health Insurance Program, the Work Incentives Improvement Act, and the Foster Care Independence Act. In addition, he has proposed several major health care expansions that would represent the largest investment in health insurance coverage since the enactment of Medicare.

Enacted single largest investment in children's health care since 1965 (Public Law 105-33). The Balanced Budget Act included $48 billion for the State Children's Health Insurance Program – the single largest investment in health care for children since the enactment of Medicaid in 1965. This new program, together with Medicaid, will provide meaningful health care coverage for up to five million previously uninsured children – including prescription drugs, vision, hearing, and mental health services. Within three years of enactment, all 50 states have implemented S-CHIP programs, and over 2 million children have been covered. In addition, the number of states covering children up to 200 percent of poverty increased by more than 7 fold – to 30 states – during that time.

Enacted landmark legislation providing new health insurance opportunities for working people with disabilities (Public Law 106-70). The Jeffords-Kennedy Work Incentives Improvement Act creates important new health insurance options provided to people with disabilities. This landmark new legislation creates two new options for states to offer the Medicaid buy-in for workers with disabilities and provides $150 million in grants to encourage states to take this option; establishes a new Medicaid buy-in demonstration to help people with whose disability is not yet so severe that they cannot work; extends Medicare coverage for an additional 4 and a half years for people in the disability insurance system who return to work; and enhances employment-related services for individuals with disabilities.

Enacted new legislation to help young people leaving foster care (Public Law 106-169). Today, when young people emancipate from foster care, they face numerous health risks, but too often lose their health insurance. The new law grants states the option for these young people to remain eligible for Medicaid up to age 21. HHS issued guidance to all State Medicaid Directors encouraging them to take up this option.

Approved waivers expanding health insurance coverage for Americans. The Clinton Administration has approved 17 state-wide Medicaid waivers linking public health financing with private health plans, providing an estimated 1.4 million low income Americans with critical health insurance coverage for the first time.

Issued Executive Directives to target and enroll uninsured children and launched the national Insure Kids Now Campaign. The President issued two executive directives to enhance current efforts to identify and enroll uninsured children in Medicaid and S-CHIP; one requiring Federal agencies to implement over 150 new actions to enroll eligible but uninsured children, and one directing Cabinet Secretaries to develop strategies to integrate children's health insurance outreach into schools. These Executive Memoranda cut across jurisdiction and traditional agency inflexibility by directing Federal agencies to work together to design collaborative initiatives that build on state innovations. The Insure Kids Now Campaign was designed to build on Administration actions to further promote outreach and enrollment. This bipartisan, public-private education and information campaign includes: the "1-877-KIDS NOW" Hotline, a toll free number to provide information about Medicaid and CHIP to families in all 50 states; running PSAs on national television and radio about Insure Kids Now; printing the toll free number on common products; and reaching out to enlist every school in the country in a children's health outreach campaign.

Proposed $110 billion in FY 2001 budget to extend coverage to over 5 million currently uninsured Americans and provide more affordable coverage to millions more. This initiative would help cover parents of S-CHIP children, 19 and 20 year olds, 55 to 65 year olds, workers in between jobs, and small businesses and their employees. It addresses the nation's multi-faceted coverage challenges by building on and complementing current private and public programs. Specifically, the initiative would:

- **Provide a new, affordable health insurance option for families.** This proposal invests $76 billion over 10 years to provide health insurance to the uninsured families. S-CHIP would be expanded to provide higher Federal matching payments for expanding health insurance to parents of children eligible for or enrolled in Medicaid and S-CHIP. FamilyCare: provides higher Federal matching payments for expanding coverage to parents; increases S-CHIP allotments and makes them permanent to ensure adequate funding for parents and their children; enrolls parents in the same program as their children; covers lower income parents first; and requires all states to cover at least all poor parents by 2006, providing the same coverage their children have today.

- **Accelerate enrollment of uninsured children eligible for Medicaid and S-CHIP.** The President's budget, which will invest $5.5 billion over the next five years in this initiative, will: (1) promote school-based outreach by allowing states to use information on school lunch applications to find uninsured children and to automatically enroll children in the school lunch program in Medicaid and SCHIP while their applications are formally processed; (2) allow additional sites such as child care referral centers to enroll children while their applications are formally processed; (3) require states to synchronize Medicaid and SCHIP eligibility processes.

- **Expand health insurance options for Americans facing unique barriers to coverage.** Some vulnerable groups of Americans often lack access to employer-sponsored insurance and insurance programs like Medicare or Medicaid. This proposal: expands state options to insure children aged 19 and 20 through Medicaid and FamilyCare; establishing a Medicare buy-in option and making it more affordable through a tax credit equal to 25 percent of their insurance premiums; providing a 25 percent tax credit to make COBRA continuation coverage more affordable for workers in between jobs; improving access to affordable insurance by providing tax incentives and technical assistance to establish voluntary purchasing coalitions for workers in small businesses; and extending transitional Medicaid for people leaving welfare for work as well as restoring state options to insure legal immigrants.

- **Strengthen programs that provide health care directly to the uninsured.** This historic new grant program invests $1 billion over 5 years to support community providers of services to the uninsured. These grants will allow providers to deliver the full range of primary care services to the uninsured, rather than treating only the most emergent problems. Currently, many uninsured individuals do not have access to primary care, mental health, and substance abuse services. Funds will be used to preserve access to critical tertiary care services while holding providers accountable for health outcomes.

Invested $220 million in the FY 2001 budget for Medicaid coverage of certain uninsured women with breast and cervical cancer. President Clinton included $220 million in his FY 2001 budget for a new Medicaid option to provide needed insurance coverage to the thousands of uninsured women with breast and cervical cancer detected by Federally supported screening programs. This new proposal will help eliminate the current and frequently overwhelming financial barriers to treatment for these women. The Vice President and the First Lady, national advocates for the prevention, diagnosis, and treatment of breast cancer, strongly advocated for this initiative, which has been endorsed by the National Breast Cancer Coalition and other cancer groups.

III. ELIMINATING TAX INEQUITIES IN HEALTH CARE

The Health Security Act included a number of provisions to eliminate tax inequities in health care, including limiting the exclusion for employer provided health benefits, increasing the deduction for self-employed workers, and providing tax breaks on long-term care insurance premiums.

Enacted legislation to eliminate the discriminatory tax treatment of the self- employed (Public Laws 104-191 and 105-33). HIPAA law increased the tax deduction from 30 percent to 80 percent for the approximately 10 million Americans who are self-employed. The President also signed into law a provision to phase it in to 100 percent in the BBA.

Enacted legislation to provide consumer protections and tax incentives for private long-term care insurance (Public Law 104-191). The HIPAA legislation took steps to make long-term care more affordable by guaranteeing that employer sponsored long-term care insurance receives the same tax treatment as health insurance; implemented new consumer protections to assure that any tax favored product meets basic consumer and quality standards.

Proposed a new 25 percent tax credit for COBRA premiums. COBRA allows workers in firms with greater than 20 employees to pay a full premium (102 percent of the average cost of group health insurance) to buy into their employers' health plan for up to 18 months after leaving their job. This proposal would provide a 25 percent tax credit to make COBRA continuation coverage more affordable for workers in between jobs.

IV. STRENGTHENING AND MODERNIZING MEDICARE

The Health Security Act would have made a significant contribution to extending the life of the Medicare Trust Fund through a series of improvements and program efficiencies, as well as added a new Medicare prescription drug benefit.

Enacted Medicare reforms that extended solvency, provided new preventive benefits, and added new plan choices (Public Laws 105-33 and PL 103-66). The Balanced Budget Act of 1997 contained major new Medicare reforms including:

- **Payment and structural reforms that extend the life of the Medicare Trust Fund until 2025.** When the President came into office, Medicare was projected to become insolvent in 1999. The President's 1993 economic package included policy and structural changes that extended the life of the Medicare Trust Fund by at least three years, and the Balanced Budget Act extended the life of the Trust Fund by an additional 10 years. The Administration's stewardship of Medicare and efforts to combat fraud, waste, and abuse in the program has resulted in the longest Medicare Trust Fund solvency in a quarter century, extending the life of the Medicare Trust Fund by a total of 26 years and offering premiums that are nearly 20 percent lower today than projected in 1993.

- **New structural reforms to modernize the program.** The BBA included a series of structural reforms which modernize the program, bringing it in line with the private sector and preparing it for the baby boom generation. These reforms: increased the number of health plan options; improved Medicare managed care payment methodology and informed beneficiary choice; implemented a prospective payment systems for skilled nursing home facilities, home health, and hospital outpatient departments; and adopted private-sector oriented purchasing.

- **New preventive benefits.** The BBA also: waived cost-sharing for mammography services and provided annual screening mammograms for beneficiaries age 40 and older to help detect breast cancer; established a diabetes self-management benefit; ensured Medicare coverage of colorectal screening and cervical cancer screening (early detection of cancer can result in less costly treatment, enhanced quality of life, and, in some cases, greater likelihood of cure); ensured coverage of bone mass measurement tests to help women detect osteoporosis, and increased reimbursement rates for certain immunizations to protect seniors from pneumonia, influenza, and hepatitis.

Enacted legislation and took administrative action to fight fraud and waste in Medicare (Public Law 104-191). Since 1993, the Clinton Administration has assigned more federal prosecutors and FBI agents to fight health care fraud than ever before. As a result, convictions have gone up a full 410% saving more than $50 billion in health care claims. In addition, HIPAA law created a new stable source of funding to fight fraud and abuse that is coordinated by the HHS Office of the Inspector General and the Department of Justice. Since its passage, nearly $1.6 billion in fraud and abuse savings has been returned to the Medicare Trust Fund.

Enacted legislation to help remedy the reimbursement concerns of health care providers (Public Law 106-113). The Administration advocated strongly for the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, which addresses flawed policy and excessive payment reductions resulting from the Balanced Budget Act of 1997. This legislation invests $16 billion over 5 years to moderate the impact of the BBA by placing a moratorium on therapy caps; increasing payments for very sick patients in nursing homes; restoring funding to teaching hospitals; and easing the transition to the new prospective payment system for hospital outpatients.

Issued an Executive Memorandum directing Medicare to reimburse providers for the cost of routine patient care associated with participation in clinical trials. The President issued an Executive Memorandum directing the Medicare program to revise its payment policy and immediately begin to explicitly reimburse providers for the cost of routine patient care associated with participation in clinical trials. HHS was directed to take additional action to promote the participation of Medicare beneficiaries in clinical trials for all diseases, including: activities to increase beneficiary awareness of the new coverage option; actions to ensure that the information gained from important clinical trials is used to inform coverage decisions by properly structuring the trial; and reviewing the feasibility and advisability of other actions to promote research on issues of importance to Medicare beneficiaries.

Proposed new, comprehensive plan to strengthen and modernize Medicare for the 21st century. This historic initiative would:

- **Make Medicare more competitive and efficient.** The President's plan adds price competition and successful private-sector management tools to Medicare. These policies manage cost growth and allow flexibility to adopt innovative private practices to improve quality and efficiency.

- **Modernize Medicare's benefits, including a long overdue prescription drug benefit.** The current Medicare benefit package does not include all the services needed to treat health problems facing the elderly and people with disabilities. The President's plan would take strong new steps to ensure that Medicare beneficiaries have access to affordable prescription drugs and preventive services that have become essential elements of high-quality medicine by establishing a new voluntary Medicare "Part D" prescription drug benefit that is affordable and available to all beneficiaries and proposal eliminates all cost sharing for all preventive benefits in Medicare. The benefit also provides financial incentives for employers to develop and retain their retiree health coverage if it provides a prescription drug benefit to retirees that was at least equivalent to the new Medicare outpatient drug benefit. In addition, the President's FY 2001 budget also includes financing for protections against the cost of catastrophic drug expenses.

- **Strengthening Medicare's financing for the 21st century.** The President's Medicare plan would strengthen the program and make it more competitive and efficient. However, no amount of policy-sound savings would be sufficient to address the fact that the elderly population will double from almost 40 million today to 80 million over the next three decades. Without new financing, excessive and unsupportable provider payment cuts or beneficiary cost sharing increases would be needed. The President proposes to dedicate $299 billion over 10 years from the non-Social Security surplus to the Medicare Trust Fund, improving its financing and reducing debt.

V. PROTECTING MEDICAID AND IMPROVING LONG-TERM CARE

The Health Security Act ensured that Medicaid beneficiaries received the same stable, high quality health care coverage as other Americans. It also assured that former Medicaid beneficiaries continued to receive all additional specialized services that they received under Medicaid. The Act provided for a new program to deliver home and community based care, as well as tax incentives for quality long-term care insurance.

Vetoed Republican proposals to block grant Medicaid, which threatened insurance coverage for millions of low income people and nursing home residents. The President protected the Medicaid guarantee for children, elderly, pregnant women, and people with disabilities. The President vetoed the Republican proposal to block grant the Medicaid program, and protected the guarantee of meaningful health care coverage or benefits to 37 million beneficiaries.

Enacted new actions to modernize the Medicaid program (Public Law 105-33). The Balanced Budget Act of 1997 (BBA) included several provisions to modernize the Medicaid program and increase state flexibility, including:

- **New steps to increase provider payment flexibility.** The BBA repealed the Boren Amendment and the cost-based reimbursement requirement for Federally qualified health centers and rural health clinics, providing states with greater discretion in establishing their provider payment rates. It also eliminated the burdensome administrative standards for payment to obstetricians and pediatricians, freeing providers from completing up to 300 pages of paperwork before being able to be reimbursed for their services.

- **New flexibility for Medicaid managed care programs.** The BBA allowed states to implement managed care programs without Federal waivers if beneficiaries have a choice of plans. States are permitted to enroll Medicaid beneficiaries in a health plan for up to six months and to guarantee Medicaid eligibility during this enrollment period. It also established Federal guidelines for new state-based quality improvement programs to ensure that managed care providers maintain reasonable access to quality health care.

- **Simplifies state options to expand eligibility and design community based long-term care programs.** States able to manage costs below their per capita limits can expand coverage to any group of people with incomes below 150 percent of the Federal poverty level without a waiver. States can also scale back their coverage expansions to the minimum required by law if they wish. In addition, states can now provide home and community based services to elderly and disabled Medicaid enrollees below 150 percent of the poverty level without a Federal waiver.

Launching a comprehensive nursing home quality initiative. The Clinton Administration has made ensuring the health and safety of nursing home residents a top priority and has issued the toughest nursing home regulations in the history of the Medicare and Medicaid programs, including increased monitoring of nursing homes to ensure that they are in compliance; requiring states to crack down on nursing homes that repeatedly violate health and safety requirements; and changing the inspection process to increase the focus on preventing bedsores, malnutrition and resident abuse. The Administration also established the Nursing Home Compare website, which provides prospective consumers facility specific information on nursing homes. Finally, the Administration recently instructed states to impose immediate sanctions, such as fines, against nursing homes any time that a nursing home is found to have caused harm to a resident on consecutive surveys, in order to put additional pressure on nursing homes to meet all health and safety standards. In addition, the implementation of provisions in the BBRA will invest over $2.7 billion over 5 years in these critical providers, a $500 million increase in reimbursement in 2000 alone.

Approved state waivers to help seniors and individuals with disabilities to stay in their communities. The Clinton Administration has approved over 200 home and community based waivers nationwide, helping hundreds of thousands of people receive the critical health care services they need to function at home rather than requiring them to enter nursing homes in order to receive care.

Proposed new assistance for individuals with long-term care needs and their caregivers. In 1999 and 2000, President Clinton's budgets included an historic long-term care initiative. The President's 2001 budget included a $3,000 tax credit for people with long-term care needs or their caregivers – tripling the credit over last year's proposal and increasing the total investment in long-term care to $28 billion over 10 years. This credit is the centerpiece of the President's historic long-term care initiative. The initiative tackles the complex problem of long-term care that affects millions of elderly, people with disabilities and families who care people in need. In addition, the initiative will:

- **Establish a commitment to provide services to assist family caregivers of older persons.** Recent studies have found that services like respite care can relieve caregiver stress and delay nursing home entry, and that support for families of Alzheimer's patients can delay institutionalization for up to a year. This nationwide program would support families who care for elderly relatives with chronic illnesses or disabilities by enabling states to utilize a visible, reliable network to provide: quality respite care and other support services; critical information about community-based long-term services that best meet a families' needs; and counseling and support.

- **Improve equity in Medicaid eligibility for people in home- and community-based care settings.** This proposal would enable states to provide services to nursing-home qualified beneficiaries at 300 percent of the Supplemental Security Income (SSI) limit (about $15,000) without requiring a complicated and frequently time-consuming Federal waiver. This proposal contributes towards this goal of giving people with long-term care needs the choice of remaining in their homes and communities.

Proposed that the Federal government serve as a model employer by offering quality private long-term care insurance to Federal employees. The Office of Personnel Management (OPM) to use its market leverage and set a national example by offering non-subsidized, quality private long-term care insurance to all federal employees, retirees, and their families at group rates. This proposal will provide employers a nationwide model for offering quality long-term care insurance. OPM anticipates that approximately 300,000 Federal employees would participate in this program.

VI. PUBLIC HEALTH

The Health Security Act included major developments in public health, including significant new investments in biomedical and behavioral research related to health promotion and prevention of disease and health services research. In addition, the Act provided grants to states for core public health functions, a focus on health care for the traditionally underserved, and support for health care professionals and institutions that work in this area.

Enacted unprecedented investments in biomedical research. Funding for NIH has increased by $7.3 billion since 1993 – an increase of 73 percent. In 1997, the President made a commitment to increase the NIH budget 50 percent over the next 5 years. Since that time, the NIH budget has increased by over $4.3 billion, for an all-time high of $18 billion. Last year, NIH received $2.3 billion, a 15 percent increase over FY 1999 funding levels, to build on the President's commitment to biomedical research. With the $1 billion increase proposed by the President in the FY 2001 budget, the Administration will be one year ahead of schedule in reaching the 50 percent goal. As a result, NIH now supports the highest levels of research ever on nearly all types of disease and health conditions, making new breakthroughs possible in vaccine development and use and the treatment of chronic and acute disease.

Enacted historic investments in reproductive health. Since the Clinton-Gore Administration took office, funding for domestic family planning services has increased by 58 percent. During his Administration, President Clinton has taken a number of steps to provide safe and effective family planning services to women, including launching a National Task Force on Violence Against Health Care Providers to coordinate the investigation of violence against women's health care clinics nationwide. In addition, President Clinton has: reversed the ban on the importation of RU-486 and threatened to veto a provision that would have prevented the FDA from using government funds to test, develop or approve drugs that may induce medical abortion; defeated Republican proposals to require minors to obtain parental consent prior to receiving any Title X family planning services and make it illegal to transport a minor across State lines for the purpose of avoiding parental consent or notification laws; and upheld his veto of a bill banning certain late-term abortions without an appropriate exception to protect the life and health of women.

Enacted new investments in mental health prevention and treatment. Since the beginning of the Clinton Administration, funding for mental health services has increased by 65 percent for a total of $631 million in FY 2000. In addition, the President's FY 2001 budget includes a new investment of $100 million for mental health services, an increase of 16 percent over last year's funding level and a 90 percent increase since 1993. This includes a $60 million increase for the Mental Health Block Grant, which provides integral support to States for services for people with severe mental illnesses and $30 million for new Targeted Capacity Expansion grants to assist those with mental illnesses that the Mental Health Block Grant is not authorized to serve.

GREATER NEW YORK HOSPITAL ASSOCIATION
GNYHA

FACSIMILE TRANSMISSION

Greater New York Hospital Association
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

Date: 6/2/00

Time: 1:40 pm

TO: Devorah Adler
Name
fax: (202) 456-5557
Location

FROM: David Rich
Name

Location

We are transmitting 23 pages including this cover sheet. If you have not recieved all of the pages, PLEASE CALL OUR OFFICE AS SOON AS POSSIBLE.

Message: D: CHP & FHP have no asset tests; both have income eligibility requirements. Medicaid has both asset, resource & income tests.
I hope the attached is helpful!
-D

Main Number 212/246-7100
Fax Number 212/262-6350

Hard Copy [ ] will [ ] will not be sent by mail.

Health Care Reform Act 2000: Insurance Initiatives

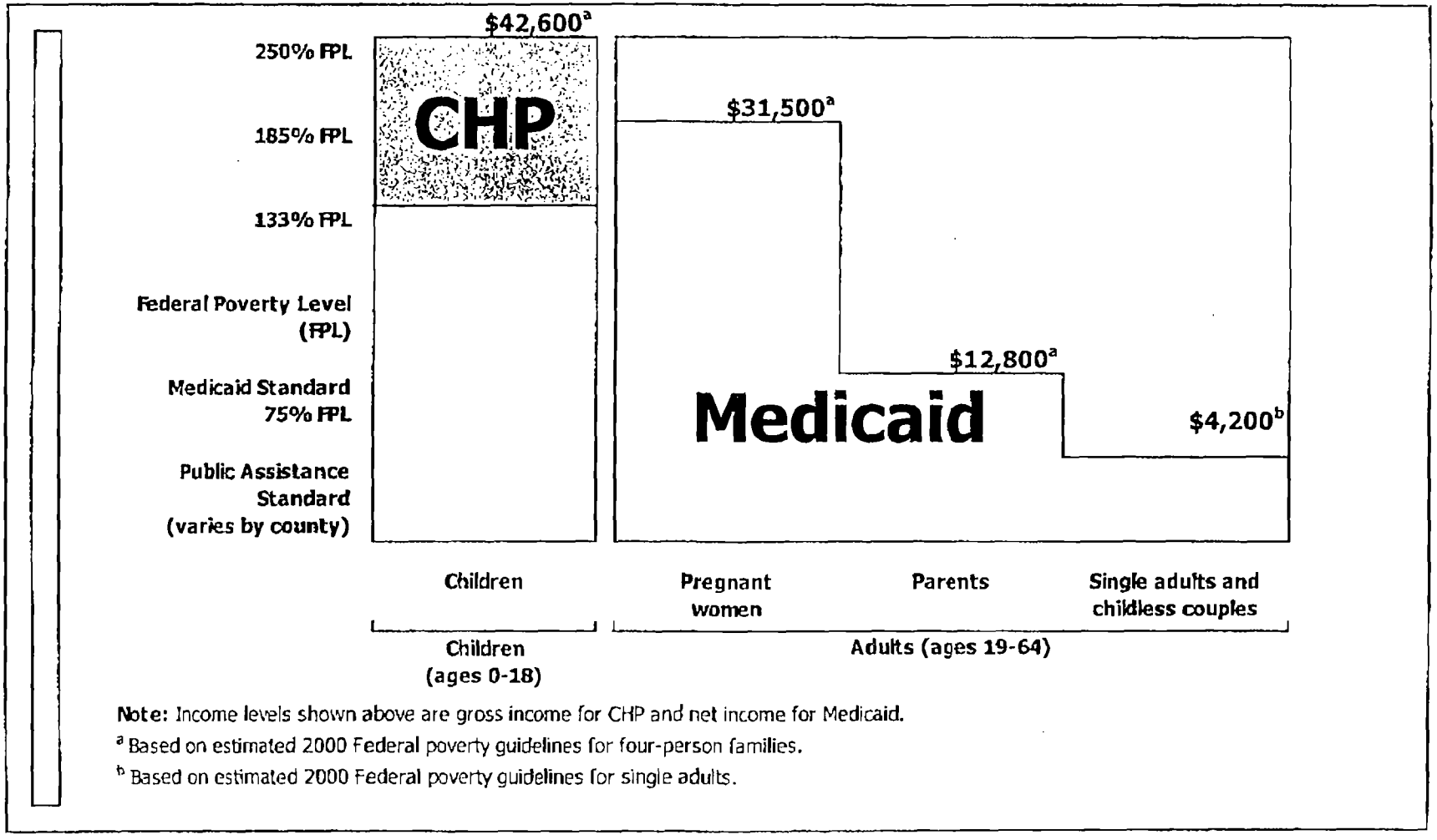
Insurance Initiatives

- HCRA 2000 creates 3 new programs that will expand health coverage in New York:
  - **Family Health Plus** — Provides free health insurance to low-income, working adults.
  - **Healthy New York** (Small Business and Uninsured Workers Programs) — Allows uninsured small businesses and individual workers to buy subsidized insurance.
  - **Direct Pay Fund** — Creates a stop loss fund to soften premium increases in the individual market.

Insurance Initiatives

Together these initiatives will provide $1.5 billion (including Federal matching funds) over 3 1/2 years — and $900 million per year, when fully implemented — to extend coverage to up to 1 million New Yorkers.

Health Coverage in New York: Pre-HCRA 2000



Note: Income levels shown above are gross income for CHP and net income for Medicaid.

[a] Based on estimated 2000 Federal poverty guidelines for four-person families.

[b] Based on estimated 2000 Federal poverty guidelines for single adults.

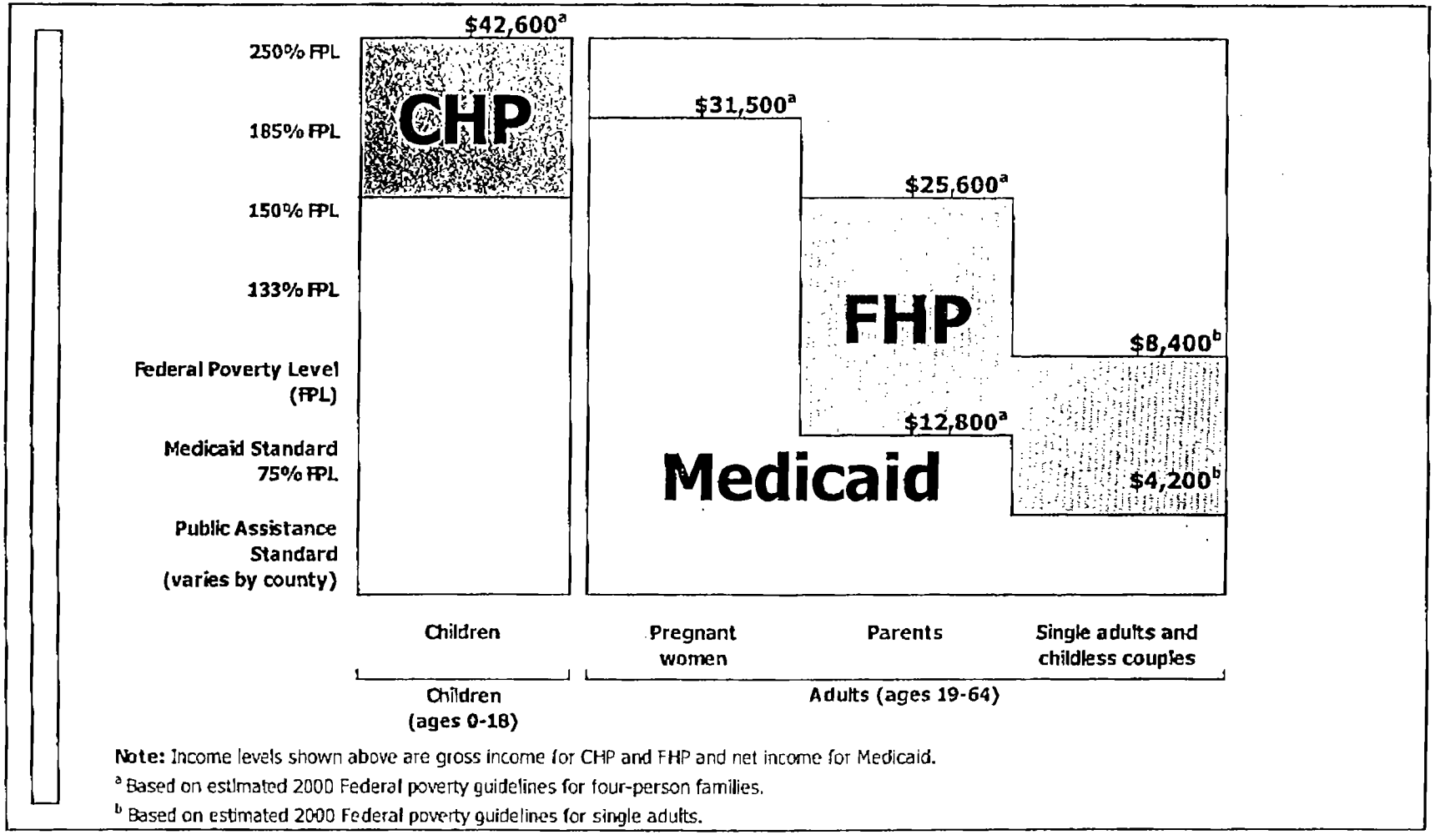
What is Family Health Plus?

Family Health Plus (FHP) is a new entitlement program, modeled on Child Health Plus (CHP), that offers comprehensive health insurance at no cost to low-income, uninsured adults.

Who qualifies for Family Health Plus?

- Adults between the ages of 18 and 65 who are not eligible for Medicaid and
  - Have dependent children and earn up to **150% of the poverty level** ($25,600 for a family of 4); or
  - Have no dependent children and earn up to **100% of poverty** ($8,400 for an individual); and
  - Meet Medicaid's definition of a "qualified immigrant" (e.g. most legal immigrants who arrived in the U.S. before 1996 or, if arrived after 1996, have lived in the U.S. for at least 5 years).

Health Coverage in New York: With Family Health Plus



Note: Income levels shown above are gross income for CHP and FHP and net income for Medicaid.

[a] Based on estimated 2000 Federal poverty guidelines for four-person families.

[b] Based on estimated 2000 Federal poverty guidelines for single adults.

What Benefits does Family Health Plus cover?

- FHP provides comprehensive coverage (nearly identical to CHP) through managed care plans that contract with the State.

- Benefits include inpatient and outpatient hospital care, physician services, lab tests, x-rays, prescription drugs, DME, radiation therapy, ambulance and emergency room care, and dental, hearing, and vision services (routine, preventive, and emergency).

When will Family Health Plus Begin Enrolling People?

- The State must apply to HCFA for Federal matching funds by June 2000

- If Federal approval is timely, FHP will be phased-in according to the following schedule:

January 1, 2001	Single adults up to 100% of poverty; Parents up to 120% of poverty
October 1, 2001	Parents up to 133% of poverty
October 1, 2002	Parents up to 150% of poverty

How Many People will Family Health Plus Cover?

When fully implemented, it is estimated FHP will be available to up to 600,000 adults.

How Will People Apply for Family Health Plus?

FHP will have a simple enrollment process:

- Individuals can sign up through providers and an array of community-based organizations, as well as district social service agencies, and recertification is annual.
- Unlike Medicaid, **FHP has no resource test** and CBOs and providers can conduct enrollment interviews.
- FHP sets aside funds for an extensive outreach, marketing and enrollment assistance campaign.

Who pays for Family Health Plus?

- When fully implemented, the total cost will be split among:

	Millions per year
State	$174
Counties	$174
Federal government	$348
Total	$696

What is Healthy New York for Small Businesses?

Healthy NY is a new program funded at $163 million over 3.5 years (starting in 2001) that will offer small businesses subsidized health insurance with limited benefits.

Who qualifies for Healthy New York?

To participate, businesses must meet the following criteria:

- No more than 50 employees;
- No employer-based insurance for the past 12 months;
- One-third of employees make less than $30,000 per year (or sole proprietor with a household income less than $35,500 per year); and
- Employer must pay at least 50% of employee premiums.

What Benefits will Healthy New York Cover?

- Healthy NY policies will cover most basic health care services, but *will not* cover certain mandated benefits and will have much higher copayments than current small group policies.

- For example:
  - Prescription drug coverage capped at $3,000 per year;
  - $500 copayment for inpatient care;
  - No coverage of
    - Inpatient mental health/substance abuse;
    - Home health care;
    - Chiropractic care.

How are Healthy New York Policies Subsidized?

The State will reimburse plans for 90% of claims paid per member per calendar year between $30,000 and $100,000.

What is Healthy New York for Individuals?

Healthy NY also provides $56 million over 3 years to subsidize insurance for individuals making under 208% of poverty ($35,500 for a family of four) who work for firms that do not provide coverage.

Like the small business program, premiums will be more affordable because health plans will be required to offer a pared-down benefits package and high claims will be subsidized from a stop loss fund.

Direct Pay Stop Loss Fund

- To temper premium increases in the direct pay market, the State will create a "stop loss" fund that will reimburse direct pay policies for claims between $20,000 and $100,000 per member per year.

- Stop loss payments, which will total $40 million per year by 2003, will be split equally between HMO and point of service plans.

HCRA 2000 Health Insurance Initiatives

$ in Millions

Program	Year				Total
	2000	2001	2002	2003 (6 months)	
FHP — Federal, State, & County Share*	$0.0	$240.0	$492.0	$348.0	$1,080.0
Healthy NY — Businesses	$0.0	$34.0	$77.0	$52.0	$163.0
Healthy NY — Individuals	$0.0	$6.0	$29.0	$21.0	$56.0
Direct Pay Stop Loss (split 50/50 between POS & HMO)	$35.0	$36.0	$39.0	$20.0	$130.0

Total $1,429.0

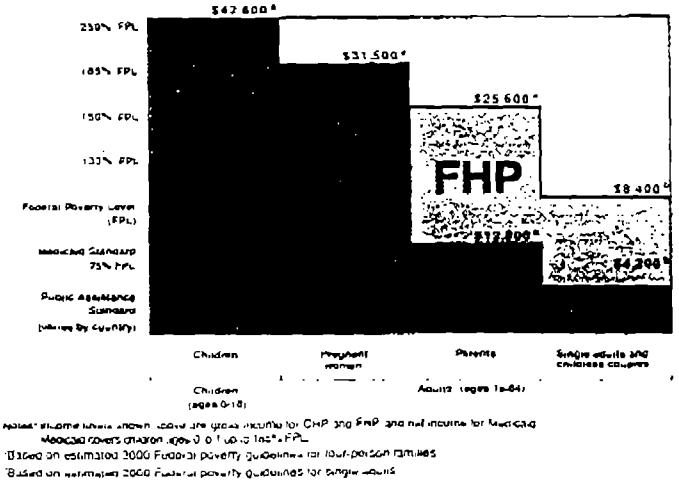
* FHP — State Share = $0.0 M (2000); $60.0 M (2001); $123.0 M (2002); and $87.0 M (2003). Total FHP — State Share = $270.0 M.

Finally, HCRA 2000 increases State funding for Child Health Plus (CHP) from the 1999 level of $181 million to an annualized rate of $348 million by 2003. State funding will continue to be supplemented with approximately $256 million per year in Federal matching contributions.

FAMILY HEALTH PLUS

Family Health Plus (FHP) is a new entitlement program modeled on Child Health Plus (CHP) that offers comprehensive health insurance at no cost to low-income, uninsured adults who do not qualify for Medicaid or Medicare. Like CHP's benefits, FHP's benefits are provided through managed care plans that contract with the State, and FHP recipients can choose among participating health plans in their area. The program includes several features designed to reduce barriers to enrollment; for example, FHP has no resource test, and individuals can apply for coverage through local community-based organizations and providers. FHP is funded through a portion of the 55 cents per pack cigarette tax increase included in HCRA 2000, plus county and Federal matching contributions. When fully implemented, FHP will make coverage available to up to 600,000 individuals.
(See Chart 2)

Chart 2: Health Coverage in New York with Family Health Plus



*Based on estimated 2000 Federal poverty guidelines for four-person families
**Based on estimated 2000 Federal poverty guidelines for single adults

Eligibility for FHP

To qualify for FHP when it is fully implemented, individuals must be uninsured residents of New York State between the ages of 18 and 65 who are not eligible for Medicaid (unless they qualified by "spending down" excess income) and who meet the following income criteria (see Chart 3):

- In the case of a parent who lives with a child under the age of 21, gross family annual income is up to 150% of the Federal poverty level (FPL), or $25,600 for a family of four.
- In the case of an individual not living with a child under the age of 21, gross family annual income is up to 100% of the FPL, or $8,400 for an individual.

Chart 3:
Eligibility for Family Health Plus

Family Size	Maximum Annual Income: Single or Married Adult (not living with children under 21)	Maximum Annual Income: Parent (living with at least one child under 21)
1	$8,350	
2	$11,250	$16,875
3		$21,225
4		$25,575
5		$29,925

Note: Eligibility criteria will apply when program is fully implemented.

Individuals are considered uninsured if, at the time of application for FHP, they do not have "equivalent health coverage" as defined by the New York State Commissioner of Health. However, the New York State Department of Health (DOH) can institute a six-month "waiting period" (i.e., require that individuals be without group health coverage for at least six months prior to becoming eligible for FHP) if substitution of FHP for employer-sponsored insurance exceeds a percentage specified by the Secretary of the U.S. Department of Health and Human Services.

FHP does not consider assets and other non-income resources when determining eligibility, and, once accepted into the program, enrollees are guaranteed six months of coverage. Enrollees must recertify their eligibility annually.

FHP, like Medicaid, will not be available to undocumented immigrants and to immigrants who arrived (or will arrive) in the United States after August 22, 1996, for a five-year period following their arrival.

As noted previously, FHP is an entitlement—all individuals who meet the program's eligibility criteria are entitled to enroll in the program. This feature contrasts with CHP, which can limit enrollment if outlays exceed the amount budgeted in a given year.

Benefits

FHP offers comprehensive benefits that mirror those provided under CHP (with the exception of nonprescription drugs, which CHP covers but FHP does not) with no copayments. FHP benefits include:

- physician and nurse practitioner services;
- inpatient hospital services;
- laboratory tests;
- diagnostic x-rays;
- prescription drugs;
- durable medical equipment;
- radiation therapy, chemotherapy, and hemodialysis;
- emergency room services;
- inpatient and outpatient mental health, alcohol, and substance abuse services, as defined by the Commissioner of Health;
- emergency medical services provided by an ambulance service;
- emergency, preventive, and routine dental care (except orthodontia and cosmetic surgery);
- emergency, preventive, and routine vision care;
- speech and hearing services;
- diabetic supplies and equipment; and
- early and periodic screening, and diagnostic and treatment services for enrollees ages 19 to 21.

Health Plan Requirements

FHP benefits are provided by managed care plans approved by DOH through a competitive bidding process, although the Commissioner may forgo competitive bidding for plans currently participating in CHP and Medicaid. Health plans must demonstrate that they can deliver high-quality, cost-effective care and that their providers are geographically accessible and sufficient in number.

Health plans must also comply with marketing and enrollment guidelines similar to those that currently apply to CHP and Medicaid managed care insurers, including:

- prohibitions on telephone cold-calling and door-to-door solicitations;
- prohibitions on disenrolling participants based on their health status or attempt to file a grievance against the plan;
- requirement that plans have the ability to communicate with all patients, including those who do not speak English and/or are visually or hearing-impaired; and
- requirement that plans comply with State and Federal disability discrimination laws.

Outreach and Enrollment

The Commissioner of Health is required to contract with community-based organizations and other entities that will conduct locally tailored strategies to educate communities about FHP and help individuals apply for the program. These efforts will be coordinated with the similar system recently established for enrolling children in CHP and Medicaid. HCRA 2000 allocates $10 million for FHP outreach, enrollment, and administration.

Outreach strategies will include:

- public education,
- dissemination of outreach materials,
- development of a simple application form, and
- outstationing of workers who are authorized to conduct eligibility interviews.

The Commissioner must arrange for training for outstationed eligibility workers and others approved to conduct outreach and facilitated enrollment, and must periodically monitor the performance of these individuals.

All applicants must be interviewed in person when they initially apply for FHP. This interview can be conducted by community-based organizations and other individuals and groups that contract with DOH and complete the approved training course, although district social service agencies must give final approval to all applications. Recertification is annual and can be completed through a mail-in application. FHP beneficiaries choose among DOH-approved health plans in their communities.

Implementation

Before the program can be implemented, DOH must apply to the U.S. Health Care Financing Administration (HCFA) for approval to receive Federal Medicaid matching contributions. DOH has until June 30, 2000, to submit the necessary documents to HCFA.

If the State's application and HCFA's approval are timely, FHP will be phased in according to the following schedule:

January 1, 2001: Single adults with incomes up to 100% of the FPL; parents with family incomes up to 120% of the FPL.

October 1, 2001: Parents up to 133% of the FPL.

October 1, 2002: Parents up to 150% of the FPL.

The Commissioner is also required to request from HCFA a change in the State's Medicaid managed care waiver so that adults without dependent children who participate in FHP are excluded from the waiver's budget neutrality calculations. If HCFA denies this request or does not approve it within 12 months of its submission, single adults will no longer be eligible for FHP.

Financing

The total cost of FHP will be split among the State (25% the counties (25%), and the Federal government (50%)- identical to the financing scheme for New York's Medica program. The State will finance its 25% share throug proceeds from the 55 cents per pack tobacco tax increas enacted as part of HCRA 2000. When the program is ful implemented, total outlays for FHP are expected to be clos to $700 million per year.

HEALTHY NEW YORK FOR SMALL BUSINESSES AND INDIVIDUALS

The Healthy New York program encourages small businesse and working individuals to purchase health coverage b offering them a new, streamlined health benefits packag that is subsidized by the State. Covered benefits includ basic items and services like inpatient and outpatient hospit care, physician services, and prescription drugs, but som mandated benefits like chiropractic and hospice care are nc included, and copayments for most services are substantia The State subsidy will be in the form of "stop loss" coverag that reimburses insurers for high-cost claims. These tw features of the program—the pared-down benefits packag and the State subsidy—will make coverage more affordabl than what is currently available in the small group and direc pay markets. The program becomes effective on January 1 2001.